BEFORE THE
OHIO ADULT PAROLE AUTHORITY

IN RE: ROBERT J. VAN HOOK, JR.
Chillicothe Correctional Institution, # A186-347

Clemency Hearing: May 24, 2018

APPENDIX TO APPLICATION FOR EXECUTIVE CLEMENCY VOL. I
Exhibits 1 - 54

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APPENDIX

Exhibits

1 Declaration of Tana Waller (Robert Van Hook's half-sister)

2 Report of Duncan Clark, M.D., Ph.D. and Supplemental Report

3 Report of Matthew Mendel, Ph.D.

4 University of Cincinnati Hospital Admission Record, Dec. 25, 1981

5 Court Report, Dr. Teresito Alquizola, Dec. 30, 1983

6 University of Cincinnati Hospital Emergency Record, Feb. 12,

7 1984 Psychiatric Progress Notes of B. Hayes, Ph.D., 4/8/1985

8 Report of Dr. Alquizola, June 10, 1985

9 Report of Dr. Schmidtgoessling, June 25, 1985

10 Treatment Addendum of Dr. Schmidtgoessling, July 25, 1985

11 Report of Dr. Cooper, July 3, 1985

12 Report of Dr. Winter, July 30, 1985

13 Affidavit of Dr. James Eisenberg, December 19, 1989

14 Dr. Gilbert Memorandum, May 31, 1991

15 Report of Dr. Robert L. Smith, Sept. 16, 1993

16 Examination Report of Dr. Rogler, January 23, 1996

17 Affidavit of Martin Ryan, M.D., June 20, 2001

18 Aug. 26, 2014 Interdisciplinary Progress Note by Dr. John Davis

19 Progress Note, Mar. 18, 2014

20 Interdisciplinary Progress Note, May 16, 2014

21 Mental Health Caseload Classification, July 7, 2014

22 Mental Health Treatment Plan, July 7, 2014

23 Mental Health Status Exam and Summary, July 7, 2014

24 Treatment Notes

25 Interdisciplinary Progress Notes, Aug. 19, 2014

26 Interdisciplinary Progress Notes, Sept. 17, 2014

27 Progress Note, Nov. 19, 2014

28 Interdisciplinary Progress Notes, Feb. 27, 2015 & Apr. 6, 2015

29 Mental Health Treatment Plan, July, 2015

30 Progress Note, Feb. 12, 2016

31 Progress Note, Mar. 10, 2016

32 Progress Note, Mar. 28, 2016

33 Progress Note, Mar. 29, 2016

34 Progress Notes from March 30, 2016; April 7, 2016; and April 12, 2016

35 Progress Note, May 19, 2016

36 Progress Note, June 7, 2016

37 Progress Note, June 21, 2016

38 Progress Note, June 28, 2016

39 Progress Note, July 5, 2016

40 Progress Note, July 26, 2016

41 Progress Note, Aug. 9, 2016

42 Progress Note, Aug. 16, 2016

43 Progress Note, Aug. 19, 2016

44 Progress Note, Nov. 9, 2016

45 Progress Note, Nov. 22, 2016

46 Progress Notes, Aug. 30, 2017, and September 15, 2017

47 Progress Note, Oct. 5, 2017

48 Progress Note, Oct. 19, 2017

49 Progress Note, Oct. 24, 2017

50 Interdisciplinary Progress Notes, May 30, 1991, and Aug. 1, 1991

51 Memorandum from Psychology Supervisor Dr. Gilbert to SOCF Warden Tate, June 7, 1991

52 Treatment Plan and Contract for Individual Therapy, April 22, 1996

53 Discharge Documents from the Psychiatric Hospital Unit of the Oakwood Correctional Facility

54 Referral to Mental Health Services, Jan. 21, 2014

55 Enlistment Form Feb. 22, 1977

56 Letter of Commendation April 26, 1977

57 Record of Informal Counseling Oct. 30, 1977

58 Certificate of Achievement Dec. 15, 1978

59 Certificate of Training Feb. 2, 1980

60 Certificate of Achievement June 27, 1980

61 Promotion Orders April 27, 1981

62 Honorable Discharge June 17, 1981

63 National Personnel Records Center June 24, 2004

64 Report of David Ferrier May 1, 2018

65	Report of Mark Grimsley	March 2, 2017
66	Report of Carl Shipp	Jan. 6, 2017
67	Robert Van Hook Letter to Congressman Tim Ryan	June 4, 2004
68	Declaration of Keith Johnson	
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EXHIBIT 1

IN RE APPLICATION OF EXECUTIVE CLEMENCY FOR ROBERT VAN HOOK

DECLARATION OF TANA WALLER

1. My name is Tana Waller. I am the half-sister of Robert Johnson Van Hook ("Bobby"). Bobby and I have the same mother, Joyce Chinn who passed away in 2015.

2. When I was young my mother Joyce married Robert Van Hook Sr. ("Bob"). My sister Trina Berends and I lived with my mother and Bob Van Hook off and on both before and after Bobby was born. I was about five years old when Bobby was born.

3. As a small child, I lived some of the time with my father's parents the Hoeweler's. At other times I lived with my mother's sister's family - my aunt and uncle Earl and Marilyn Johnson when they lived in suburban Lockland. At other times I lived with my father Harold Hoeweler.

4. The time I spent living with my mother and Bob was relatively brief in duration. My mother did factory work and Bob, Sr. drove a cab during the day and played music in bars at night.

5. Early on, my mother did not drink much during the week. However, on Friday and Saturday nights she would go to taverns and get drunk. On the other hand, Bob, Sr. was always drinking, always wild. My mother and Bob Sr. often left Trina and me and Bobby at home to care for ourselves. On one occasion when Trina and I were left to care for Bobby (who could not yet walk), Bobby found a coat hanger and cut his mouth with it. We frantically trying to stanch the blood and "clean him up" before our mother returned.

6. On the weekends, they always drank more heavily. There would be many loud arguments between Bob Sr. and my mother on the weekends because they were always drunk. Bob Sr. several times tried to kill my mother when he was drunk. When I was

seven or eight, I saw Bob. Sr. hold a meat cleaver up against my mother's throat while threatening to kill her. Bob, Sr. was screaming and threatening mom. Bob, Sr. shoved her onto a couch and threatened to cut her throat with the meat cleaver. The neighbors heard the fight and eventually called the police who subdued Bob, Sr. We were all scared to death.

7. I recall my mother coming home drunk some nights and when Bob Sr. also came home drunk, they would have terrible fights. It was always an unfair battle. I remember the sounds of Bob, Sr. hitting my mother and the sound of her being thrown out of the bed onto the bedroom floor. I remember how much this scared all of us.

8. My bedroom was next to my mother and Bob, Sr.'s bedroom. They had to go through my bedroom to get to their bedroom. I could hear Bob, Sr. striking my mother. I could hear the sound of his fists hitting her flesh, her crying out, and then the sounds of him having sex with her.

9. I remember Trina's birthday in 1963. My mother had decorated the house and made a large birthday cake for Trina. We had all gone to bed when Bob, Sr. came home drunk. He was in a rage and tore up the house, ripped the shutters from the windows, and smashed Trina's birthday cake against a wall. He ordered Trina and me to clean up the mess. We were crying and scared to death. When we went back to the bedroom I planned to escape through a bedroom window to get away from Bob, Sr.

10. I will never forget the beatings inflicted on my mother or the sound of her being hit or her drunken behavior. I vowed then that I would never be like my mother or have a life like my mother and Bob Sr. were living. Shortly before she died my mother asked me to forgive her for how she treated me. I had forgiven her long ago.

11. On holidays, my mother and Bob, Sr. would take us to the homes of relatives. These visits were often brief as my mother and Bob,

Sr. wanted to and did go drink in taverns. They went to these taverns and left us in the back seat of the car to fend for themselves. Sometimes we would go into the bars to find our parents. I recall playing games on machines in the bars while waiting for my parents to take us home.

12. When Bobby was only a toddler, two or three years old, we got a monkey as a pet. I remembers Bob, Sr. holding the monkey while Bobby tried to feed it parts of a banana. Bob, Sr. criticized Bobby for doing it wrong and began slapping Bobby's head hard and berating him.

13. I saw Bob Sr. hit Bobby on many occasions with his hand or fist most frequently on the head. He hit Bobby for any reason and often for trivial things. These were not light taps but hard blows to the head and body.

14. In 1968, when I was 11, I had had enough. I could not live there anymore. I called my father, Harold Hoeweler, who was living in Florida and went to stay with him. My dad always had a home, always had a job, didn't drink and was never violent. This was in stark contrast to Bob Van Hook, Sr.

15. At the age of 11, I was able to escape the chaos and live with my father. Prior to that I found comfort, support and escape with my maternal grandmother Lucille Salyers and my aunt and uncle Marilyn and Earl Johnson. Prior to my mother's marriage to Bob Sr., mom, Trina and I lived in part of a duplex located in Cincinnati owned by Marilyn and Earl. Lucille Salyers lived with the Johnsons in the other half of the duplex.

16. Earl and Marilyn had the biggest hearts. Trina and I were always treated as part of the Johnson family, there was no difference between us and their own children. We were hugged and cuddled by the Johnsons, but hardly ever by my mother and never by Bob, Sr. When we were with the Johnsons, we were always bathed, groomed and clean and never had to worry about meals. We had to cast about for scraps when living with my

mother and Bob, Sr. We always knew we were wanted and what we could do at the Johnsons. They had structure and rules.

17. Marilyn Johnson was a special person who loved all the children in the family equally. At Marilyn's funeral, the pastor asked the gathered family, "who was Marilyn's favorite." In automatic response everyone in the room raised their hand.

18. Bobby loved being with the Johnsons as much as I did. But Bobby was never allowed to stay for very long. Bob, Sr.'s influence drew Bobby away. Marilyn must have told me a dozen times that she should have taken Bob, Sr. to court to get custody of Bobby. I believe that being adopted by the Johnsons would have saved Bobby and would have given him the opportunity that I got by living with my father.

19. As a young girl, the influence of my grandmother Lucille Salyers was the key factor in me surviving the chaos of my life with my mother and Bob Sr. and becoming a successful adult. My grandmother and my aunt Marilyn took me to church on a regular basis and I became devout like my grandmother.

20. I did not have much contact with Bobby after I moved out until he was incarcerated in 1985. I tried to visit when we visited my mother in Cincinnati but I have not seen Bobby for several years. I do communicate with Bobby now by telephone and jpay. I have sent Bobby pictures of my children.

21. I would like for the parole board and the governor to understand that Bobby never had a chance. The abuse and neglect Bobby suffered is nothing that any child should have to deal with. Bobby's problems are primarily the fault of his father. If they could have seen Bobby being hit by his father and seen his father terrorizing Joyce in front of Bobby, they would have a better understanding of what Bobby went through.

22. I was able to escape to my dad, but Bobby had no dad to escape to. Bob, Sr. was not a good father, not a good husband, and not a good stepfather. He was a truly evil man.

23. Bobby's early exposure to drugs and alcohol by his father is also particularly troubling. Bobby did not know another path. Bobby became an addict because he was raised by addicts.

24. Bobby was never loved and nurtured as a child. Had Bobby been loved and nurtured as I was, his life would have been different. But Bobby had no advocates, no social services assistance. Bobby did not have someone to provide the most basic things, such as meals, a home, and a bed like other children. Bobby is the product of a horrible environment. For all of this he deserves mercy.

I declare under penalty of perjury that the foregoing is true and correct.

Tana Waller

Executed on April 16, 2018

EXHIBIT 2

Evaluation of Robert Van Hook [DOB: 1/14/1960] **by Duncan B. Clark, M.D., Ph.D.**

I reviewed the documents listed below and conducted a psychiatric examination of Robert Van Hook at the Chillicothe Correctional Institution in Chillicothe, Ohio on January 16, 2017 from 09:00 am to 12:30 pm. The examination was requested by Atty. Carol Wright, Assistant Federal Public Defender. The results from the interview are included in Findings.

Documents reviewed for this evaluation

5/29/85	Teresito Alquizola, MD	evaluation
6/24/85	Nancy Schmidtgoessling PhD	evaluation
7/3/85	Emmitt Cooper MD	evaluation
7/31/85	Donna Winter PhD	evaluation
12/19/89	James Eisenberg PhD	affidavit
9/16/93	Robert L. Smith PhD	evaluation
6/20/2001	Martin T. Ryan MD	affidavit
5/31/91	William Gilbert PhD [ODRC]	mental health records
1/23/96	Margarette Rogler MD	evaluation
7/28/15	Dr. Jeffrey Madden	memorandum
8/16/15	Robert Van Hook's written alcohol and drug history	
5/18/16	Carl L. Shipp Jr.	declaration
9/1/16	David Ferrier	Military History Summary
3/2/17	Mark Grimsley	Military History Memorandum
	Summaries from legal team	

Purpose and structure of the evaluation: The assessment was intended to focus on substance use and related issues, including Robert's substance use history, substance related problems, substance use disorder diagnoses and related psychiatric diagnoses. The evaluation of risk factors for substance use disorders provides important background for the context of the development of substance involvement. The evaluation of risk factors included a review of substance use disorders in family members, parenting practices, and contributing mental disorders. The evaluation of substance use history emphasized substances that are prone to causing substance use disorders, with all substance classes considered, including alcohol, cannabis (e.g., marijuana), stimulants (e.g., amphetamines, cocaine), hallucinogens, inhalants, opioids, and sedatives (e.g., benzodiazepines), and nicotine.

PROFESSIONAL QUALIFICATIONS

I am a psychiatrist and clinical psychologist, Professor of Psychiatry at the University of Pittsburgh School of Medicine. After receiving a Bachelor of Arts degree with distinction in Psychology from the University of Rochester (BA: 1974), I was trained in clinical psychology at UCLA, completing Master of Arts (MA: 1975), Doctor of Philosophy in Psychology (major area: Clinical; PhD: 1980) and clinical internships. I received the Doctor of Medicine degree (MD: 1985) from Harvard Medical School and completed psychiatry residency training (1989) at Stanford University. I am Board Certified in Psychiatry (#33086: certified in 1990) and licensed

to practice medicine in Pennsylvania (MD043985E; National Provider #1164496774; Drug Enforcement Agency: BC0845290).

I have been an attending psychiatrist at the Western Psychiatric Institute and Clinic of UPMC since 1989. I am currently an attending psychiatrist in Addiction Medicine Services. In addition to providing psychiatric services, I have been teaching psychiatry to medical students, psychiatry residents and clinical psychology interns for 27 years.

I am a nationally known expert on the causes and effects of substance use disorders. I have been conducting multidisciplinary research on this topic for 27 years and have received continuous funding from the National Institutes of Health [NIH] for this research program since 1990. I was a founding member and Director of the Pittsburgh Adolescent Alcohol Research Center, the first major National Institute on Alcohol Abuse and Alcoholism research program focused on the effects of alcohol and other drugs on adolescent and young adult development. I was Co-Principal Investigator for the Center for Education and Drug Abuse Research, a Research Center funded by the National Institute on Drug Abuse studying the etiology and consequences of adolescent and young adult drug abuse. I am currently Site Principal Investigator for the National Collaborative on Adolescent Neurodevelopment and Alcohol (NCANDA), and the Adolescent Brain and Cognitive Development (ABCD) study. Funded by NIH, NCANDA and ABCD are the two major national studies on drug and alcohol problems, brain development, and related mental disorder being conducted in the U.S. at this time. I have authored over 180 peer-reviewed journal articles with most addressing the etiology, course, treatment and consequences of substance use disorders in adolescence and young adulthood.

Findings

Observations: Robert is a white male appearing to be his stated age of 57 years old. He was seated at a table and dressed in an issued uniform. The interview was conducted with the examiner and Robert seated in the same room. At the time of the evaluation, Robert had been incarcerated for 32 years [i.e., since 1985].

Mental Status Examination: Robert was alert and cooperative. Robert was clean and neatly groomed, and he exhibited appropriate eye contact and normal social behavior. Robert was oriented to the time, place, his identity, and the examiner's identity. He appeared to understand the purpose and circumstances of the evaluation. Robert exhibited no abnormal behaviors. His speech was normal in tone, volume and articulation. His memory, attention and concentration appeared to be within normal limits by general observation during the interview. His affect and mood were within normal limits. His thought form was logical and coherent. His movements and seated gestures and posture were normal. I determined that Robert had sufficient mental capacity to participate in the interview.

Validity assessment: The interpretation of the information collected from Robert necessitates an assessment of the validity of his report. My opinion is that Robert provided a valid report to the best of his ability based on several factors. In Robert's descriptions, he admitted to a reasonable degree of uncertainty in his recollections. His report at this interview was essentially consistent with his reports in prior interviews conducted over several decades.

Risk Factors for Substance Use Disorders

Family history of substance use disorders, mental disorders and medical problems

Mother: When Robert was about age 7 years old, his mother was "committed" to a residential facility for individuals with mental disorders. He understood that she had a serious mental disorder, but he does not know any details of her condition. Robert describes his mother as "being sick all the time," and he recalls she was ridiculed by relatives for fabricating an illness. He recalls they ridiculed her because she claimed that she had an illness described as "fake prostate cancer." His view was that she was malingering, reporting illnesses and symptoms "to get attention."

Robert observed his mother's substance use disorders involving alcohol, benzodiazepines, and opiates. During his childhood, Robert notes often seeing his mother together with his father being intoxicated from binge alcohol consumption. When he was about age 18, he reports that his mother had addictions to benzodiazepines ("Valium") and opiates ("pain killers"). His mother is now deceased, with the cause of death heart disease.

Father: Robert recalls directly observing his father's use of alcohol, marijuana, amphetamines, and opiates. Robert recalls that his father engaged in binge alcohol use on weekends, and that he was "belligerent" when "drunk." Robert recalls that, starting when Robert was about age 14 years old, that he and his father used alcohol, marijuana and amphetamines together. He recalls that he and his father had periods of several days when they would be continually intoxicated on alcohol and other drugs. Robert recalls that he and his father would combine alcohol with amphetamines, using the stimulant effects of amphetamines to offset the sedating effects of alcohol. He also recalls his father using opiates. He says of his father's use of any available intoxicating substance that "he would do anything." Robert also recalls his father had a "limp" due to a chronic injury caused by a motor vehicle accident. Robert reports that his father's cause of death was liver cirrhosis due to alcohol use disorder.

Siblings & extended family history, including substance use: His older half-sister Trina used alcohol and drugs. His sister Tana did not. His paternal grandfather had alcohol problems. He observed his paternal grandfather and father would "get drunk and fight." His maternal grandmother and mother would also physically fight each other when intoxicated.

Family household and developmental history

Robert was raised by his mother and father, who both lived in the household until their divorce when Robert was 4 years old. He was the youngest child in the household. His two older maternal half-sisters [Trina: 5 years older; Tana: 3 years older] also lived in the household. His father worked as a taxi driver and musician; his mother worked as a barmaid when she worked. He recalls having adequate food, clothing and shelter.

While he was too young at the time to now recall in precise detail, at about age 5, he recalls "running off" and being picked up by police more than once. Robert understands that, at the time of his parent's divorce, when he was age 6 years old, responsibility for his care was transferred from his mother to his father. His parents reconciled, and the family moved to Ohio. His parents

again separated when he was age 8. Robert states that his father told him that his father had "legal custody" of him.

During his childhood, Robert recalls chaotic living arrangements, at various times living with both his parents, and at other times with his mother, his father, his aunt and uncle, or grandparents. He believed and felt that neither his mother nor his father wanted him in their household or in their lives. He described being "passed around" to various households. He has no memories of being loved or wanted by his parents. While he has some positive memories of time with his uncle and aunt, he felt he was "dumped" on them.

Household violence: Robert reports that the fighting between his mother and father was well known among his family members. Robert recalls that, as a child, he witnessed his parents' verbal and physical fights. He recalls an incident in which his father pulling his mother by her hair and violently "pulling her down" to the floor. He was told about an incident that occurred when he was about age 4 years old in which his mother hit his father in the head with a large ashtray, resulting in his father sustaining a significant head injury. Following this incident, his father filed criminal charges against his mother. Robert has been told that he was taken to the court proceedings and that, in court, his father decided to drop the charges. Robert recalls that this sequence of events was recounted as somewhat of a family joke.

Disciplinary methods: As a child, Robert recalls being subjected to physical abuse by his father and mother, including corporal punishment with him sustaining injuries. He reports he was beaten "a lot." He recalls these beatings being in response to his "not behaving," for example, "skipping class." As a young teen, Robert reports incidents when he was beaten by his father as well as incidents that may be described as physical fights between them. At about age 14 y.o., Robert recalls his father punching him with his fist and knocking him down a stairwell. During Robert's teen years, Robert and his father had physical fights when his father was intoxicated. He also recalls witnessing his older sister Trina being physically abused. He recalls his father beating his sister, Trina, with a "shoe brush" that his father used as a "paddle." He saw bruises on Trina's arm and back that resulted from his father beating her. He recalls that he and his sisters being "terrified" of his father. By contrast, Tana was favored in household, and Robert recalls that Trina and he were "treated worse." He does not recall Tana ever being hit.

School participation and achievement: As a school age child [ages 5 through 11], he had many school changes due to his unstable living situation. This resulted in his having disrupted academic achievement. He failed first grade. Robert does recall that, when he felt engaged in academic activities, he had adequate attention and could perform adequately to advance his education. Despite his poor school performance, his parents were not involved in supporting him in school activities such as completing his homework or providing other support for his academic advancement. As a result of missed time in school, he increasingly fell behind his peers. In his middle teen years, he essentially dropped out of school. He achieved about a 9th grade education by age 16 years old. While incarcerated, he has completed a high school general equivalency diploma (GED).

Substance use with father: Beginning about age 9, Robert reports that his father would take him to bars and that he gave Robert alcohol [i.e., "shots" of liquor] for him to drink. Beginning when Robert was 14 years old, Robert and his father together had multiple day "binges" using alcohol and other drugs. Robert reports his father and he would use marijuana together, and they would combine alcohol with marijuana and other drugs. Robert reports his father and he would also combine alcohol with amphetamines, using the stimulant effects of amphetamines to offset the sedating effects of alcohol. Robert observed his father using opiates.

Living away from home as a teen: As a young teenager, he alternated living with this father and mother. His father lived with a girlfriend, and his mother with his step-father. He felt he was not welcome and was unwanted in either parental households. In his mother's household, his step-father was very critical of him and he felt they made it clear that his mother and step-father did not want him living with them. At the age of 14, Robert and his father moved to Florida where they lived with the father's girlfriend and her daughter. At a time when his father was intoxicated, Robert recalls that his father accused his girlfriend of having sex with Robert. Robert denied that this occurred. However, as a result of hostility his father expressed to him, he ran away and lived on the streets of Key West, Fort Lauderdale and New Orleans.

Sexual history

Robert has a pathological sexual history that is pertinent to his sexual identify difficulties. As a child, he slept in parents' bed and witnessed them having sex. He recalls them ordering him to "turn away" while they engaged in sexual activity in his presence. He recalls becoming sexually active himself at about age 9 years old. As a young teen, in the context of using drugs and alcohol with his father, he also recalls "sharing women" sexually with his father. Robert describes his mother as "promiscuous" and living a lifestyle in which "men took care of her."

About age 14, he left his home to live on his own, becoming a homeless teen. He described living "on the streets" in Key West and Ft. Lauderdale, Florida and New Orleans, Louisiana. During this time, he was using alcohol, marijuana, and LSD. Prompted by homeless peers, and feeling he had no other viable options for survival, he became involved in providing sex to men in exchange for money. He reports he was not at that time and never was sexually attracted to men. He felt he "had no choice" and that he was therefore forced to exchange sex for money. He took alcohol and drugs prior to sex acts to diminish the uncomfortable feelings he experienced. In many instances, the adult men demanded acts he refused and would not cooperate with providing. However, in some cases, the men gave him alcohol and drugs to induce submission, and he at time did not recall the events that consequently occurred. At the time as well as subsequently, he viewed these encounters as unwanted sexual experiences. He "felt angry, ashamed and humiliated" about being forced into these unwanted sexual encounters. In some instances, he became very angry, would sometimes become violent toward these men, and would sometimes rob them.

Military Service

Robert joined the U.S. Army in 1977, at age 17, with an enlistment term of three years. His father provided consent for his enlistment. In some respects, he was successful in contributing during his service. Early in his service, he received a Letter of Commendation. He successfully completed

training, and was posted to Germany in August 1977. In October 1978, he received a recommendation for promotion that described him as follows: "...you have been doing an excellent job. You are performing your duties in an outstanding manner." In 1979, he reenlisted for an additional six years.

On the other hand, after being posted to Germany, Robert resumed having problems with alcohol and drugs. In November 1977, he was diagnosed with viral hepatitis and "drug abuse." In January 1978, he was treated for injuries from a fight. In January 1981, he was diagnosed with "alcoholism," along with admission of past drug use including amphetamines, hallucinogens and PCP. Early in 1981, he became intoxicated, had a fight with a fellow soldier and, after the fight, he cut his wrist with a razor and was hospitalized. In April 1981, he was absent from duty due to "excessive consumption of alcohol" and was demoted. He was noted to be "a rehabilitation failure" and he was discharged. His separation order describes incidents of fighting while intoxicated, and attempted suicide. The reports state that Robert received assistance, including counseling and a program through a half-way house and antabuse medication. He received an Honorable discharge in June 1981.

Legal History

Robert's first arrest was at age 12, reportedly for "unruly drinking." At age 16, he was arrested for "disorderly conduct while intoxicated." At age 24, after his discharge, he had two arrests when intoxicated involving resisting being detained by security officers. He has admitted to acts of robbery against homosexuals.

On 2/19/85, Robert reports that he had intended to rob Mr. Self. Prior to his encounter with Mr. Self, he had been binge drinking and taking amphetamines. He admits to killing Mr. Self. His recollection is that he "went berserk" and "lost control." Other than this description, he has not been able to explain his behavior and he was not able to provide an explanation during this assessment.

During his incarceration, Robert has had incidents involving altercations with other inmates, refusing to obey officers, and contraband in his cell. He has had periods when he was kept in a higher level of supervision and confinement ("Level 5"). He has also had extended periods without notable incidents. He has had no recorded incidents for over two years.

Treatment History

During his military service, Robert received counseling focused on substance use disorders, participated in a residential program and was prescribed the medication Antabuse, which is intended to discourage alcohol use. The treatment in the army was notably ineffective in curbing his substance abuse primarily because it only addressed the alcohol and drug problems and not the underlying posttraumatic stress disorder. From January 1984 through January 1985, Robert received treatment at the VA Medical Center, including inpatient and outpatient treatment, focused on his alcohol and drug problems. In recent years, during his incarceration, Robert has received counseling on an individual and group basis.

Robert has tried several prescription medications to, by his description, "control moods." By his report, these have included Thorazine (chlorpromazine), Risperdal (risperidone), Sinequan (doxepin), and Vistaril (hydroxyzine). The available records indicate that, since 2013, he has tried Neurontin (gabapentin), Elavil (amitriptyline), Zoloft (sertraline), Celexa (citalopram), and BuSpar (buspirone). In 2014, he was noted to be diagnosed with "bipolar disorder" and tried Lamictal (lomotragine), which he recalls was 200 mg. per day and discontinued due to a rash. Starting 10/22/2015, Robert has regularly been taking Lamictal (lomotragine) at 150 mg per day without side effects.

Other medical conditions include a history of Hepatitis C Virus (HCV). He also reports hypothyroidism that is treated with Synthroid. He reports he has elevated cholesterol and an enlarged prostate. He reports diminished hearing and tinnitus.

Mental Disorders

Posttraumatic Stress Disorder [PTSD] with dissociative symptoms DSM-5: 309.81

Posttraumatic Stress Disorder (PTSD) is described in DSM-5 as follows:

The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events...The directly experienced traumatic events include...childhood physical abuse...alcohol/drug-facilitated sexual penetration...sexual trafficking... witnessed events include...domestic violence...The disorder may be especially severe or long-lasting when the stressor is interpersonal and intentional...a common reexperiencing symptom is distressing dreams that replay the event itself or that are representative or thematically related to the...traumatic event. The individual may experience dissociative states...Such events occur on a continuum...to complete loss of awareness of present surroundings...a negative change in perceived identity since the trauma (e.g., "I can't trust anyone ever again." Individuals with PTSD may have persistent erroneous cognitions about the causes of the traumatic event that lead them to blame themselves...a persistent negative mood state...anger, guilt, shame...a persistent inability to feel positive emotions...Individuals with PTSD may be quick tempered and may even engage in aggressive verbal and/or physical behavior with little or no provocation...They may also engage in reckless or self-destructive behavior such as dangerous driving, excessive alcohol or drug use, or self-injurious or suicidal behavior. PTSD is often characterized by a heightened sensitivity to potential threats...Problems with sleep onset and maintenance are common

Robert meets the criteria for Posttraumatic Stress Disorder (PTSD) as follows:

A. Trauma: Robert has experienced physical abuse, sexual abuse, and witnessing violence to a sufficient degree that he meets the criteria for having had traumatic experiences.

Directly experienced trauma: [1] *Physical abuse:* As a child, Robert recalls being subjected to physical abuse by his father and mother, including corporal punishment with his sustaining injuries. Robert recalls his father and mother hitting him with the shoe brush, a belt and by hand. He recalls the belt buckle producing "welts." He reports he was beaten "a lot." He recalls these beating being in response to his "not behaving," for example, "skipping class." As a young teen,

Robert reports incidents when he was beaten by his father as well as incidents that may be described as physical fights between them. At about age 14, Robert recalls his father punching him with his fist and knocking him down a stairwell.

[2] *Sexual abuse:* About age 14, he left his home to live on his own, becoming a homeless teen. He describes incidents in which when he refused to perform certain homosexual acts, men gave him alcohol and drugs to induce submission, and the men performed the sexual acts he had refused with him. He recalls feeling dissociation and de-realization during some of these encounters, and he sometimes had difficulty recalling the details of these events. He "felt angry, ashamed and humiliated" about feeling forced into these unwanted sexual encounters.

Witnessing violence: Robert witnessed incidents of his father beating and injuring his older sister. He also witnessed violent incidents between his mother and father and between his grandparents and parents.

B. Intrusion symptoms: He reports upsetting nightmares involving traumatic sexual experiences, and related to nightmares he sometimes "feels an evil presence." He reports that he feels distressed and disgusted by cues that remind him of homosexual acts.

C. Persistent avoidance: Robert reports that he attempts to avoid situations, memories, thoughts, and feelings associated with his homosexual acts when he was a teen. He reports "I don't like to remember." He also reports feelings of depersonalization and de-realization. These experiences primarily occurred during sex acts as a teen, during which he recalls he was "projecting myself somewhere else." Also, during the murder of Mr. Self, he recalls feeling depersonalization and de-realization.

D. Negative cognitions & mood: Robert reports he blames himself for the sexual abuse he experienced as a teen. In relationship to these feelings, he feels ashamed and he finds he says to himself "I am bad." In addition, also in relationship to sexual abuse as a teen, he feels "no one can be trusted" and he has anger toward others. He feels estrangement from others. As a result, he finds he has difficulty experiencing happiness, and difficulty experiencing positive emotions with others. His shame, estrangement and anger are persistent.

E. Increased arousal or reactivity: Robert reports a variety of experiences indicating increased arousal or reactivity. He reports he feels irritable and that he has had angry outbursts. He reports reckless and self-destructive behavior, including driving while intoxicated. He reports hypervigilance and exaggerated startle response. For example, he reports he becomes startled when someone approaches him from behind. He also reports sleep difficulties.

The problems indicated above have occurred over many years, and have clearly resulted in impairment in social and occupational functioning. The disturbance is not attributable to substance effects or a medical condition.

Interpretation: As a child and a young adolescent, Robert experienced physical abuse by his father, and he witnessed domestic violence, including his father physically abusing his sister, and violence between his parents. By this history, Robert is a victim of child abuse and he has a sufficient history of traumatic experiences to consider a PTSD diagnosis. A history of childhood

abuse with PTSD is common among adolescents who develop substance use disorders (Clark et al., 1997). In the period prior to Robert's incarceration, however, PTSD related to traumatic experiences in childhood and adolescence was often not recognized (Clark et al., 1995). Robert's also experienced sexual abuse as a young teen. Such experiences are traumas that are the most likely to result in persistent PTSD symptoms (Clark et al., 2010).

Borderline Personality Disorder DSM-5: 301.83

Robert meets the criteria for Borderline Personality Disorder. This problem is defined in DSM-5 as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and present in a variety of contexts." Five or more features are required. His most evident features are unstable relationships, identity disturbance, impulsivity, suicidal or self-injurious behavior, difficulty controlling anger, and dissociative symptoms.

Unstable relationships: Robert has had few stable relationships. His relationships with his parents were inconsistent and troubled, and he has not had stable relationships with his sisters or other relatives. At age 23, he was married for 10 months. In some cases, his relationships are characterized by extremes of idealization and devaluation. This may be currently illustrated by his idealized relationship with a woman he has not met. On the other hand, he tends to easily feel angry and mistreated in relationships with others.

Identity disturbance: Robert has weak self-identity in most areas. He has had unclear goals with regard to important areas of life, including work or other goals, values, and sexual identity. He has had few goals regarding his education and vocation. He has been uncertain about the types of friends he values or prefers. He has not had a clear system of values. His sexual identity has been particularly uncertain. He reports he does not consider himself to be homosexual and he reports has not had an attraction to men, yet he has an extensive history of homosexual behavior. While he reports his attraction is to women, he has not had stable heterosexual relationships. During his incarceration, this ambivalence has been evidence in that, early during his incarceration, he submitted to homosexual acts in exchange for alcohol or drugs. Later, he became self-critical and angry at others for these acts, he has responded violently at times when reminded of these acts and has felt that he needed to defend himself.

Impulsivity: Robert reports impulsive behavior that includes having unsafe sex and reckless driving. In addition, Robert's history of exchanging homosexual sex for money has been reckless, placing him in risky situations. Furthermore, and most problematic, he has a history of impulsive violence, including the killing of Mr. Self.

Suicidal or self-injurious behavior: Robert has a history of suicidal or self-injurious behavior, including multiple incidents of cutting himself with visible scars on his arms and abdomen.

Difficulty controlling anger: Robert has a history of angry outbursts, the most extreme example being the killing of Mr. Self. He had angry outbursts before and during incarceration. During incarceration, he has sometimes responded to insults or minor provocations with violence, has had

repeated fights with other inmates, although these outbursts have significantly decreased in recent years and appear to be controlled with appropriate medications such as lamictol.

Dissociative symptoms: Robert's recalls he initially had dissociative symptoms when performing homosexual acts as a teen. During the killing of Mr. Self, he reported felt as though he was standing outside his body, and that he was "watching myself do it."

Interpretation: In making the Borderline Personality Disorder diagnosis, I am concurring with several prior evaluations (Hayes in 1985; Cooper in 1985; Winter in 1985; Smith in 1993; Ryan in 2001; Rogler in 1996).

Borderline Personality Disorder (BPD) is one of the most severe psychiatric disorders, typically characterized by a high level of personal distress and functional disability. Most people with BPD have school problems, high rates of unemployment, and lack sustained relationships. Self-injurious and suicidal behaviors are common, and about 8% of those with BPD die by suicide. This disorder is present in about 1% of adolescents and adults. BPD is more often diagnosed in women, and often goes unrecognized in men. The onset is typically in adolescence. Most individuals with BPD develop substance use disorders. Because individuals with BPD often have unstable mood as well as periods of depression and anxiety, BPD is often mistaken for Bipolar Disorder. Childhood trauma is typically present in the history of those with BPD, and high rates of PTSD have been observed. In my research program, we have demonstrated that individuals with childhood abuse and adolescent substance problems are more likely than others to develop BPD along with PTSD (Thatcher, Cornelius and Clark, 2005).

Sexual precocity (i.e., early age of first sexual intercourse), promiscuity, prostitution and sexual identity disturbances are more common among individuals with BPD (Frias et al., 2016). In an article on BPD and prostitution (Schindler, 2011), the observation is made that "Risk factors for BPD and prostitution show a substantial overlap...Additional risk factors for prostitution are early sexual experiences, lack of parental supervision and care, running away, and homelessness. A second developmental track is leading from substance use disorders to prostitution...prostitution might be a risk factor for posttraumatic or borderline symptomatology..."

Those with BPD features of anger and impulsivity, particularly when combined with alcohol and drug intoxication, are more likely to commit violent acts that result in injuries to others (Gonzalez et al., 2016).

In recent years, specialized psychological treatments for BPD have been developed and found to be effective. With the exception of opinions expressed in evaluations, there is no indication that Robert's BPD was recognized by any treatment providers or that he received any psychological treatment that would be expected to be helpful for BPD. In 1991, Dr. Gilbert apparently expressed concern that Robert was not receiving treatment for this condition. In 1996, Dr. Rogler described the optimal psychological intervention for Borderline Personality Disorder. I have concluded that Robert has not received psychological treatment that would be expected to be beneficial for BPD.

For those with BPD, lamotrigine has been found to be helpful for mood instability and impulsive behavior (Reich et al., 2009).

Substance Use Disorders

Robert has a history of substance use disorders related to alcohol, cannabis (i.e., marijuana), stimulants (amphetamine, methamphetamine, cocaine), and opiates (i.e., illicit use of prescription opiate pills, heroin). In addition, starting at about 14 years old, he used hallucinogens and inhalants.

Alcohol Use Disorder [Severe: In a controlled environment] DSM-5: 303.90

Robert initiated significant alcohol use at about 9 years old, progressed to regular use at about age 15 years old. As a teen, he would consume alcohol with his father, drinking about 24 beers during a weekend. He had daily binge alcohol use at 25 years old. Robert describes using alcohol in **larger amounts over a longer time than intended**, sometimes planning to consume three drinks but instead drinking until he had a blackout. He reports multiple **unsuccessful attempts to control alcohol consumption**, including at age 25 three months of abstinence followed by resuming alcohol use. He reports when he was not using he had **craving**. His alcohol consumption resulted in **failure of obligations**, specifically missing work due to intoxication or hangovers. He reports driving while intoxicated [i.e., **hazardous use**.] He reports he **spent a great deal of time** using, he **gave up activities or jobs** due to alcohol, he had **depression and injuries** from fighting due to alcohol, and **continued to use despite these problems**. He reports he had **tolerance** [i.e., requiring an increased amount for the same effect]. He experienced **withdrawal**, including a hand tremor, psychomotor agitation, and anxiety, when he discontinued alcohol, and he **used alcohol to avoid withdrawal**. He reports he had **disinhibition** with alcohol use. He reports he "regularly" had **blackouts** associated with alcohol use.

Cannabis Use Disorder [Mild: In a controlled environment] DSM-5: 305.20

Robert initiated cannabis use at 14 years old, he soon progressed to daily use and continued daily use from age 14 to age 17, when he started military service. He reports he **spent a great deal of time** using. He reports driving while intoxicated [i.e., **hazardous use**.] He **continued to use despite psychological problems**, including poor motivation, fatigue and "flashbacks."

Stimulant Use Disorder [Mild: In a controlled environment] DSM-5: 305.20

Robert initiated stimulant use at 14 years old. This included amphetamine and methamphetamine and infrequently cocaine. His frequent use peaked at age 21 years old. Robert describes using stimulants in **larger amounts over a longer time than intended**, and he experienced **tolerance**. He experienced **withdrawal**, evidenced by headaches. He **continued to use** amphetamines despite work and **psychological problems**, which included impulsive aggression [e.g., fighting].

Opiate Use Disorder [Severe: In a controlled environment] DSM-5: 304.00

Robert initiated opiate use at 14 years old. In his teens, this included illicit use of prescription opiate pills and intravenous heroin. His frequent use peaked at age 18 and 19 years old. On days off while in the military, he would use daily for three day periods.

Robert describes using opiates in **larger amounts over a longer time than intended**, and he experienced **tolerance**. He reports driving while intoxicated [i.e., **hazardous use**.] He **continued to use** opiates despite work and **psychological problems**, which included impulsive aggression [i.e., fighting]. He also experienced the death of his girlfriend due to a heroin overdose. When not using, he experienced **withdrawal**, evidenced by tremor, agitation and anxiety, and **craving**. He used substances to avoid opiate withdrawal.

Interpretation

Risk factors for substance use disorders: The evaluation of risk factors focuses on influences that have been demonstrated to predict substance use disorders (Clark & Winters, 2002; Clark et al., 2005, 2013). Robert's family history of substance use disorders is extensive. In the determination of risks for substance use disorders, approximately half the causal influences are heritable or genetic in origin and half environmental (Vanyukov et al., 2003). Based on his family history alone, even if Robert were hypothetically raised in an ideal environment, I would expect that he would have a substantially elevated risk of developing substance use disorders. However, an environment with more positive influences may reduce the risk for substance use. Note that when Robert was placed in a more supportive environment with his Aunt and Uncle, he refrained from substance use – possible due in part to alcohol and drugs not being unavailable. Clearly, Robert's typical home environment was far from ideal, resulting in transmission of risk through both genetic and environmental mechanisms (Clark et al., 2004).

Another risk factor for substance use disorders is lack of effective supervision and support (Clark et al., 2005). Robert's parents provided little parental supervision or appropriate guidance. As a young child, this lack of supervision is illustrated by his repeatedly leaving home unnoticed and being brought back by police. Particularly in early adolescence, parental efforts to provide supervision, to guide adolescents to constructive activities and to discourage illicit drug and alcohol use have been shown to reduce or delay substance use and prevent later problems (Clark et al., 2005). Robert's parents did not provide guidance to discourage substance use. On the contrary, his father essentially instructed him to consume "shots" of liquor to amuse himself and his friends when Robert was 9 and 10 years old. As a young teen, his father made a regular habit of using alcohol and drugs with his son, Robert. By the time Robert left home in his teens, he had an established alcohol and drug addiction. In addition, periods of homelessness would be expected to further contribute to what became his chronic and severe alcohol and drug addiction.

In addition to influencing Robert through hereditary mechanisms, parents and other adults observed by Robert during his childhood and adolescent development would serve as role models. Robert's upbringing was carried out by parents with active substance use disorders. Robert often observed his parents engaging in problematic substance use. Robert's parents had an unstable and abusive relationship, with violence between them that was sometimes witnessed by Robert. Robert's observation of these behaviors in his parents would reinforce and further influence his inherited propensity toward substance use disorders. Compounding the influences of heritable risks, lack of supervision and inappropriate role models was the direct encouragement of Robert's illicit alcohol and drug use by the adult who arguably had the most influence on him, his father. In

addition to illicit drugs and alcohol being available to him, his father actively encouraged him to use alcohol illicit drugs from a very young age.

Substance use pattern: The final step toward the development of substance use disorders is, of course, substance use itself. The use of alcohol in the early teen years has been shown to be a risk factor for the development of substance use disorders (Clark & Winters, 2002). Robert's consumption of significant alcohol amounts prior to the age of 12 is a very rare and extreme risk, predicting the very early and rapid onset of substance use disorders (Clark et al., 1998). In addition, Robert's use of marijuana, amphetamine and methamphetamine, and opiates at age 14 and 15 was extraordinarily early and intensive. Based on survey information, including surveys conducted about the time of Robert's adolescent years (Johnson et al., 1991), I estimate that less than 1 in 1000 teens would have as early and severe a substance use pattern as that seen with Robert. Robert's substance use pattern in early adolescence far exceeds what is observed in any but the most aberrant teens.

Substance use disorders: As noted in the diagnostic summary, Robert met the diagnostic criteria for substance use disorders for at least four substance classes, including alcohol, cannabis, amphetamines, and opiates, during his teens. While this constellation of disorders indicates a very high level of severity, my impression is that, like many individuals with substance use disorders, Robert may have a tendency to underreport the extent of his substance related problems. While we obviously have no way to recover a contemporaneous assessment of Robert's substance use disorders in his teen years and early adulthood, my impression is that he may have had more problems related to his substance use than he recalls.

Substance use disorder effects: The consequences of substance use are, to a large extent, indicated by the evaluation of substance use disorders noted above. The consideration of the extent to which substance use contributed to Robert having difficulties with self-control and violent behavior is very important. The known effects of the pattern of substance use and substance use disorders Robert manifested can lead to inferences on the likely effects Robert's substance use had on his brain and related brain functions, including his ability to exercise self-control and to control violent impulses (Clark et al., 2008).

The effects of alcohol, marijuana and amphetamines, particularly in combination, likely had adverse effects on his self-control capabilities. Adolescents with alcohol and drug use disorders have been shown to have disruption of brain areas and the physical connections in the brain that provide the basis for self-control, particularly in emotional situations (Clark et al., 2008, 2012; De Bellis, Clark et al., 2000, 2005). In teens, even moderate alcohol use has been shown to be related to disrupted functional brain connections in systems that are the foundation for self-control (Muller-Oehring, Clark et al., in press). When taken in large quantities, amphetamines can be neurotoxic. Some of the mechanisms by which methamphetamine disrupts brain function have been determined, including depletion of important neurotransmitters.

Recent studies demonstrating strong relationships between intoxication and violent behavior, including homicide, have been reported for alcohol (Felson and Staff, 2010) and for amphetamines (amphetamine or methamphetamine: McKetin et al., 2014). Violence is particularly related to the

combination of alcohol and amphetamine intoxication (McKetin et al., 2014). Both alcohol and amphetamine intoxication result in impulsive violent behavior, and the alerting effects of amphetamines offset the sedating effects of alcohol so that continued substance consumption may occur and a higher degree of intoxication results.

DIAGNOSTIC SUMMARY

Posttraumatic Stress Disorder [PTSD]	**DSM-5: 309.81**
Borderline Personality Disorder	**DSM-5: 301.83**
Alcohol Use Disorder [Severe: In a controlled environment]	**DSM-5: 303.90**
Cannabis Use Disorder [Mild: In a controlled environment]	**DSM-5: 305.20**
Stimulant Use Disorder [Mild: In a controlled environment]	**DSM-5: 305.20**
Opiate Use Disorder [Severe: In a controlled environment]	**DSM-5: 304.00**

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Professor of Psychiatry

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Robert Van Hook Supplement to Evaluation Duncan B Clark MD PhD 05/14/2018

I have recently had the opportunity to review additional information on Robert van Hook's history of psychotherapy and phamacological treatment during his incarceration. I would like to provide clarification and elaboration in two areas: [1] diagnoses and [2] treatment history.

Diagnoses: The diagnoses that are utilized by various clinicians to characterize Mr. Van Hook's psychiatric symptoms that I subsume under the diagnosis Borderline Personality Disorder include Atypical Bipolar Disorder, Impulse Control Disorder and Ego-Dystonic Homosexuality. My viewpoint is that the characteristics described by these diagnostic labels overlap and, therefore, these diagnoses fundamentally reflect agreement on Mr. Van Hook's essential problems. Atypical Bipolar Disorder refers to mood swings or labile moods that do not meet the definition for Bipolar Disorder. Utilization of the diagnosis of Impulse Control Disorder emphasizes Mr. Van Hook's impulsive behavior. Ego-Dystonic Homosexuality refers to his homosexual behavior in the context of his stated identification as heterosexual. I agree that Mr. Van Hook shows these characteristics, and that these diagnoses summarize these facets of Mr. Van Hook's psychiatric problems. However, these characteristic are also included in the symptoms defining Borderline Personality Disorder. My preference is for the more parsimonious approach, which is clustering these characteristics under the diagnosis of Borderline Personality Disorder.

Treatment history: In my report, I state that Mr. Van Hook "...has not received psychological treatment that would be expected to be beneficial for BPD." My review of additional information and records indicates that Mr. Van Hook did benefit from psychological treatment provided by Kevin Littler, a licensed social worker who evidently began working with Mr. Van Hook in May 2014 and continued through August 2016. Mr. Littler's notes indicate an understanding of the ways in which Borderline Personality Disorder influences Mr. Van Hook. For example, Mr. Littler states that Mr. Van Hook "appears to have a very weak sense of himself which leaves him hypersensitive to the opinions of others, as well as in a cycle of anger and worry." Mr. Littler's notes indicate that he utilized specific exercises to help Mr. Van Hook control his habitual distorted style of thinking and to adopt a more rational thought process. My understanding is that, during this period, Mr. Van Hook had no misconduct charges, indicating that the psychological treatment provided by Mr. Littler was beneficial.

I also now have more information on prescribed psychiatric medications. In general, I would expect that more helpful medications would be those targeting the fundamental characteristics of Borderline Personality Disorder, such as antiepileptic medications typically used for unstable mood [e.g., Depakote, Lamictal] or antipsychotic medications which may be helpful for distorted or paranoid thinking and irritability [e.g., Stelazine]. Other medications may also be helpful, but only in a more limited way, such as antidepressants that may be used to help sleep [e.g., Sinequan], other antidepressants [i.e., Zoloft, Celexa, mirtzepine] or antianxiety medication [i.e., Vistaril, BuSpar]. My overview of his records suggests he had some improvement in response to Stelazine, Depakote and Lamictal.

In summary, my impression is that Mr. Van Hook evidently showed some improvement during psychological and/or pharmacological treatment targeting Borderline Personality Disorder and worsening in periods when such interventions were not provided.

References

Angrist BM, Gershon S (1969) Amphetamine abuse in New York city, 1966-1968. Seminars in Psychiatry 1: 195-208, 1969

Clark DB, Bukstein OG, Smith MG, Kaczynski NA, Mezzich A, Donovan JE: Identifying anxiety disorders in adolescents hospitalized for alcohol abuse or dependence. Psychiatric Services 46: 618-620, 1995 PMID: 7641008

Clark DB, Chung T, Pajtek S, Zhai Z, Long E, Hasler B. Neuroimaging methods for adolescent substance use disorder prevention science. Prevention Science 14: 300-309, 2013 [PMID: 23417665; PMCID: PMC3640678; NIHMS447049]

Clark DB, Chung T, Thatcher DL, Pajtek S, Long EC: Psychological dysregulation, white matter disorganization and substance use disorders in adolescence. Addiction 107: 206-214, 2012

Clark DB, Cornelius JR, Wood DS, Vanyukov M: Psychopathology risk transmission in children of parents with substance use disorders. American Journal of Psychiatry 161: 685-691, 2004 [PMID: 15056515; PMC3155941]

Clark DB, Kirisci L, Tarter RE: Adolescent versus adult onset and the development of substance use disorders in males. Drug and Alcohol Dependence 49: 115-121, 1998

Clark DB, Lesnick L, Hegedus A: Trauma and other stressors in adolescent alcohol dependence and abuse. Journal of the American Academy of Child and Adolescent Psychiatry 36(12):1744-1751, 1997 PMID: 9401336

Clark DB, Thatcher DL, Maisto S: Supervisory neglect and adolescent alcohol use disorders: Effects on AUD onset and treatment outcome. Addictive Behaviors 30: 1737-1750, 2005

Clark DB, Thatcher DL, Martin CS: Child abuse and other traumatic experiences, alcohol use disorders, and health problems in adolescence and young adulthood. Journal of Pediatric Psychology 35(5): 499-510, 2010 [PM 19966317; PMCID: PMC2874673]

Clark DB, Thatcher DL, Tapert S: Alcohol, psychological dysregulation and adolescent brain development. Alcoholism: Clinical and Experimental Research 32 (3): 375-385, 2008

Clark DB, Winters KC: Measuring risks and outcomes in substance use disorders prevention research. Journal of Consulting and Clinical Psychology 70(6): 1207-1223, 2002 PMID: 12472298

DeBellis MD, **Clark DB**, Beers SR, Soloff P, Boring AM, Hall J, Kersh A, Keshavan MS: Hippocampal volume in adolescent onset alcohol use disorders. American Journal of Psychiatry 157: 737-744, 2000. PMID: 10784466

DeBellis MD, Narasimhan A, Thatcher DL, Keshavan MS, Soloff P, **Clark DB**: Prefrontal cortex, thalamus and cerebellar volumes in adolesent onset alcohol use disorders. Alcoholism: Experimental and Clinical Research 29: 1590-1600, 2005 PMID: 16205359

Ellinwood EH (1971) assault and homicide associated with amphetamine abuse. Amer J Psychiat 127 (9): 1170-1175

Felson RB, Staff J (2010) the effects of alcohol intoxication on violent versus other offending. Criminal Justice and behavior 37(12), 1343-1360.

Frias A, Palma C, Farriols N, Gonzalez L (2016) Sexuality-related issues in borderline personality disorder: a comprehensive review. Personality and Mental Health 10(3), 216-231

Giancola PR, Mezzich A, **Clark DB**, Tarter RE: Cognitive distortions, aggressive behavior, and drug use in adolescent boys with and without a family history of a substance use disorder. Psychology of Addictive Behaviors 13: 22-32, 1999

Gonzalez RA, Igoumenou A, Kallis C, Coid JW (2016) Borderline personality disorder and violence in the UK population: categorical and dimensional trait assessment. BMC Psychiatry 16: 180

Griffith J (1966) a study of illicit amphetamine drug traffic in Oklahoma city. Amer J Psychiatry 123: 560-569.

Johnson LD, O'Malley PM, Bachman, JG: Drug use among American high school seniors, college students, and young adults, 1975-1990. Volume 1: High school seniors. DHHS Publication 91-1813. Available at monitoringthefuture.org.

Krasnova IN, Cadet JL: Methamphetamine toxicity and messengers of death. Brain Research Reviews 60: 379-407, 2009

McKetin R, Lubman DI, Najman JM, Dawe S, Butterworth P, Baker AL (2014). Does methamphetamine use increase violent behavior? Evidence from a prospective longitudinal study. Addiction 109(5), 798-806.

Meredith CW, Jaffe C, Ang-Lee K, Saxon AJ: Implications of chronic methamphetamine use: A literature review. Harvard Review of Psychiatry 13(3): 141-154, 2005

Muller-Oehring EM, Kwon D, Nagel B, Sullivan E, Chu W, Rohlfing T, Prouty D, Nichols N, Poline JB, Tapert S, Brown S, Cummins K, Brumback T, Colrain I, Baker F, De Bellis MD, Voyvodic J, **Clark DB**, Pfefferbaum A, Pohl K. Influences of sex, age, and moderate alcohol drinking on the intrinsic functional architecture of adolescent brains. Cerebral Cortex [in press]

Reich DB, Zanarini MC, Bieri KA. (2009) A preliminary study of lamotrigine in the treatment of affective instability in borderline personality disorder. Int Clin Psychopharmacol 2009; 24:270–275.

Schindler A. (2011) Is there a link between borderline personality disorder and prostitution? A review of the literature, case examples, and hypotheses. PTT: Personality Disorders – theory and therapy. 15(2), 145-154.

Thatcher DL, Cornelius J, **Clark DB**: Adolescent alcohol use disorders and borderline personality disorder. Addictive Behaviors 30: 1709-1724, 2005 PMID: 16095845

Vanyukov MM, Tarter RE, Kirisci L, Kirillova GP, Maher BS, **Clark DB**: Liability to substance use disorders: 1. Common mechanisms and manifestations. Neuroscience and Biobehavioral Reviews 27: 507-515, 2003

EXHIBIT 3

Robert Van Hook Forensic Evaluation

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FORENSIC EVALUATION

NAME: ROBERT VAN HOOK

BIRTHDATE: JANUARY 14, 1960

Current Age: 58

State of Ohio v. Robert Van Hook, B851389 & C850567

I. My Professional Background

I am a clinical psychologist licensed to practice in the states of North Carolina and Texas. I am a member in good standing of the American Psychological Association (APA), the American College of Forensic Psychology, the APA Division of Psychology and Law, the North Carolina Psychological Association (NCPA), and the NCPA Division of Professional Practice.

I received a Bachelors' Degree cum laude from Princeton University in 1984 and earned an M.A. in 1989 and a Ph.D. in 1992 in clinical psychology from the University of Michigan. I have been in private practice in North Carolina since 1995, with a specialization in the impact of childhood abuse and trauma. I am the author of *The Male Survivor: Impact of Sexual Abuse*

(Sage Publications, 1995), which was one of the first scholarly works to focus specifically on the impact of sexual abuse perpetrated on males. I have authored numerous articles and presented talks at various conferences on the subject. My private practice includes psychological assessment and therapy with children, families, and adults. I conduct forensic psychological evaluations of adults in civil and criminal cases with a primary focus on evaluating the impact of childhood trauma, particularly sexual abuse, upon later functioning. I have been retained in approximately 170 such cases in seventeen states and in federal jurisdictions and have testified as an expert witness in the states of North Carolina, Arizona, Texas, Mississippi, California, Arkansas, and Wyoming. I estimate that, over the course of my career, I have provided psychotherapy and psychological interventions to over 150 male survivors of sexual trauma, and about ten female survivors.

Robert Van Hook is a 58-year-old man who was convicted and sentenced to death for the 1985 killing of David Self. He has an execution date scheduled for July 18, 2018. I was asked by his counsel to evaluate Robert, and to determine whether there is a nexus between his background and later life outcomes, including the murder and Robert's subsequent conduct while incarcerated on Death Row. Robert is currently housed in the Chillicothe Correctional Institution in Chillicothe, Ohio, where I interviewed him.

II. Information Considered to Write this Report

Prior to writing this report, I received information about Mr. Van Hook's background from the following sources:

1) Two face-to-face, "contact" interviews with Robert Van Hook, on April 19 and April 20, 2018, totaling approximately twelve and one-quarter hours.
2) Review of the following documents:

a) Previous Psychological/Psychiatric Evaluations:

   i) Court Report by Teresito Alquizola, M.D., 12/30/1983 (3 pages)

   ii) Psychiatric Evaluation by Dr. Alquizola, 6/10/1985 (4 pages), including also:

      (1) Memorandum from Mr. Van Hook's attorneys, with background information regarding Robert, 5/29/1985 (7 pages)

   iii) Court Report by Nancy Schmidtgoessling, Ph.D., 6/25/1985 (6 pages)

   iv) Psychiatric Evaluation by Emmett Cooper, M.D., 7/3/1985 (2 pages)

   v) Court Report by Donna Winter, Ph.D., 7/30/1985 (6 pages)

   vi) Affidavit of James R. Eisenberg, Ph.D., 12/19/1989 (12 pages)

   vii) Psychological Report by Robert L. Smith, Ph.D., 9/16/1993 (8 pages)

   viii) "Office Communication" from William H. Gilbert, Ph.D., Psychology Supervisor, 5/31/1991 (1 page)

   ix) Psychiatric Evaluation by Margarette B. Rogler, M.D., 1/11/1996 (4 pages)

   x) Affidavit of Martin T. Ryan, M.D., 6/20/2001 (6 pages)

   xi) Psychiatric Evaluation by Duncan B. Clark, M.D., Ph.D., 1/16/2017 (17 pages)

b) Documents created by Robert's current defense counsel:

   i) Timeline of events in Robert's life, 12/11/2013 (16 pages)

   ii) Social History of Robert, undated (31 pages)

   iii) Memo regarding psychiatric/psychological evaluations of Robert, 8/23/2013 (26 pages)

   iv) Memos regarding attorney visits to Robert on 6/9/2017, 7/7/2017, 8/24/2017 & 4/6/2018

c) Post-Conviction Relief Social History, 1985 (35 pages)

d) Presentence Investigation Report, 7/30/1985 (10 pages)

e) Medical/Psychiatric Records:

   i) University of Cincinnati Hospital, 12/25/1981, regarding suicide attempt (13 pages)

   ii) VA Medical Records Request Response,1985 (11 pages); 1989 (94 pages,119 pages)

iii) Christ Hospital Medical Records, 1968 (9 pages, largely illegible)

iv) Community Correctional Institution Psychiatric Notes, 1983, 1984 & 1985 (24 pages)

v) MMPI Test Data, 1985 (6 pages)

vi) WAIS-R Test Data, 1985 (6 pages)

f) School Transcripts (6 pages)

g) Partial transcript of Robert's 1985 trial

At the outset of the first day of interviews, I explained to Robert that the matters we discussed would be shared with his defense attorneys, could be included in a report that would be turned over to the state, and could potentially be discussed with the clemency board. Robert indicated that he understood and accepted these limits to confidentiality.

III. Relevant Background Details Regarding Robert's Exposure to Severe Childhood Trauma.

This evaluation focuses primarily upon the impact on Robert Van Hook of the severe sexual abuse that began early in his life and continued throughout his adolescence. This focus is not, however, intended to minimize the importance of other factors in his life, particularly the great significance of the severe trauma to which he was exposed virtually from birth. Such factors that Robert experienced include, but are not limited to, the following:

1. Parental neglect
2. Physical abuse
3. Domestic violence
4. Parental alcoholism and drug abuse

5. Instability of home environment, including divorce of parents, frequent moves and change of schools, and parental involvement in the criminal justice system
6. Early introduction to alcohol and drug use and subsequent heavy use of and addiction to alcohol and other drugs

Those factors, even without sexual abuse added to the mix, had severe negative predictive implications for Robert. It has long been accepted within the fields of psychology and psychiatry that childhood trauma is destructive to an individual's healthy development: The greater the number of childhood traumas to which an individual is subjected – and the greater the severity of these traumas – the poorer the prognosis that individual is likely to have. Research has linked childhood abuse, deprivation, and trauma with myriad negative outcomes including subsequent alcohol and drug addiction, mental illness, criminal behavior, unemployment, and medical ailments. More recently, a large-scale set of studies conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, a health maintenance organization in California, has conclusively demonstrated the strong correlations between "adverse childhood experiences" or ACES and problems later in life. Over 17,000 Kaiser Permanente patients were interviewed regarding the presence of adverse childhood experiences including physical, sexual, and emotional abuse, physical neglect, emotional neglect, domestic violence, household substance abuse, household mental illness, and incarcerated household member(s).

Dozens of research articles have been published since the study began. They have shown that the number of ACES strongly predicts a wide range of negative outcomes, including alcoholism and alcohol abuse; illicit drug use; early initiation of sexual activity; multiple sexual partners; risk for intimate partner violence; adult criminality; problems in relationships; and

depression. For example, an individual with four of these adverse childhood experiences is 30 times more likely to have attempted suicide and seven times more likely to be an alcoholic relative to an individual with an ACES score of zero.

Robert presents with every single one of the adverse childhood experiences examined in the Adverse Childhood Experiences (ACES) studies. Thus, it is clear that he was at a very high risk for various negative outcomes, including alcoholism and drug addiction, suicide attempts, and criminal behavior. And, as would be predicted, Robert's history is replete with these negative adult outcomes.

Significantly, the sexual abuse element is intertwined with, and exponentially amplifies the effect of, those other sources of toxic childhood trauma. Unlike those other factors, however, Robert's sexual victimization was introduced only minimally, if at all, in the various evaluations, with virtually no examination of its likely impact on him. As discussed more fully in Section V below and VI below, no exploration of the negative consequences of these experiences of victimization as a child was provided. Consequently, the picture presented at trial and afterwards was critically incomplete and uninformed.

IV. Robert's History of Sexual Abuse at the Hands of Trusted Caregivers and Others.

Robert suffered numerous forms of child sexual abuse over the course of his childhood. Although the types of abuse took different forms, each represents sexual victimization of a child.

A. Robert was victimized by covert incestuous sexual abuse.

Robert was exposed to sexual activity between his mother and father from as far back as he can recall. Psychological evaluations of Robert Van Hook ranging as far back as 1983, two years before he killed David Self, describe him being exposed prematurely to sexual activity,

through witnessing his parents having sex, and witnessing his mother having sex with other men. Both Robert and his sister, Trina, describe watching Robert's mother and father having sexual intercourse. Robert states that his father would simply tell him to look away if he caught Robert watching them having sex. Robert recalls that when he was three-years-old, he would often wake up from a nightmare and crawl into bed with his parents. "I'd wake up to them having sex – really going at it, mom slapping dad on the ass. She was really loud. That's what got me really curious about sex… What my mom and dad were doing always sounded like they were having a good time; they were really enjoying themselves." But reports from Robert's legal proceedings told a less sanitized story. For example, Dr. Nancy Schmidtgoessling's June 24, 1985 evaluation and report stated that Robert "slept in his parents' bed" as a child, and thus "he was subjected to terrifying instances of observing sexual violence." Dr. Donna Winter's July 30, 1985 evaluation and report reconfirmed that Robert would regularly sleep in his parents' bed. Dr. Winter graphically recounted some of the domestic violence that Robert's father perpetrated on Robert's mother, such as when he would "grab her by the hair and swing her around the room, hold her at gun point, hold her at knife point, etc.," and that violence carried over into Robert observing "sexual violence when both his parents were drunk."

Robert also reports having witnessed, on numerous occasions, his mother having sex with men she brought home following her separation from Robert's father.

Robert recounted various instances in which his father would be drunk – which was quite often – and accuse his various girlfriends of wanting to have sex with young Bobby, and then incite or provoke Robert to do just that. According to Robert, his father would say things such as "Oh, you just want to fuck Bobby. Go ahead, Bobby, fuck her." The abuse continued when Robert and his father moved to Florida, when he was about 14 years old. He and his father

stayed in Florida with a woman and her two sons. Robert's father became sexually involved with the woman. Robert's father came home drunk one night and, in Robert's presence, accused the woman of having sex with Robert. Robert recalls his father "having a rampage" that night, after which Robert ran away to Key West, Florida. And after Robert returned to Cincinnati, he recounts times when, after playing with his father's bar band, his father would encourage Robert—who was still a teenager—to have sex with women who wanted to party with the band.

Many of the previous evaluations documented Robert frequently closely observing his parents engaged in sexual activity. Only Dr. Eisenberg's report, however, properly identified that for what it was: child sexual abuse.[1] And even Dr. Eisenberg's report understated matters, both as to the severity and the scope, while omitting entirely any discussion of the connection between that abuse and Robert's mental illness or the murder. That report failed to mention the numerous other instances of abuse Robert suffered at the hands of his father. The activities to which Robert was subjected were not just sexual abuse of a child; they represent covert incest. Covert incestuous sexual abuse is found when a child's trust and sense of safety is betrayed by his parents. In each of these different examples—sleeping in the same bed and witnessing violent sex, witnessing his mother having sex with other men, having his father essentially challenge or provoke Robert to engage in sexual activity with his [Robert Sr.'s] adult girlfriends, or encouraging (or watching) Robert have sex with older women, is properly considered covert incest.

[1] To be most accurate, that type of child sexual abuse is considered "covert child sexual abuse," which is a form of sexual abuse that is not obvious because it does not involve unambiguously sexual activity with the victim.

B. Robert was victimized by sexual abuse by adult men while trying to survive on the streets as a young teenager.

After his father accused his girlfriend of having sex with Robert, Robert ran away from home, and hitchhiked to Key West, Florida. There he had no money, no food, and no place to stay, so he initially supported himself by panhandling and playing music for change. But, having already been sexualized by his exposure to covert incestuous sexual abuse and violence, Robert soon turned to engaging in sex acts with adult men for money after he met a man who was a "hustler." That man offered Robert a chance to make some money, by having sex with men. Although Robert reports initially not wanting to engage sexually with his "johns," it was made clear to him, both by clients and by his "pimp," that he was expected to perform whatever sexual acts the john desired. He was told that "it's not a big deal; you'll be drunk and high." Most often, earning money through transactional sex meant allowing the john to perform fellatio on him, or penetrating the john anally. At other times, Robert was pressured or forced to perform oral sex on the man. On some occasions, male customers forcefully penetrated Robert anally. In order to engage in these acts, Robert would virtually always drink or do drugs first, so that he was drunk or high (or both) while engaged in the sexual activity.

Having internalized his transactional understanding of sex—and sexual abuse—Robert journeyed from the Florida Keys to Ft. Lauderdale, where he continued having sex with men for money while working out of a bar, on the streets, and in a gay club. At some point, Robert left Ft. Lauderdale to travel to New Orleans, and perhaps other places as well, where the same pattern of child sexual abuse by adult men continued.

While the previously produced reports typically include references to Robert's time spent living on the streets and having sex with men to survive in Florida, those earlier reports stopped

with a superficial statement of this fact. But the truth of the matter is that this period was a frightening and life-changing time for Robert. He was living on the streets of Southern tourist cities, drinking and using drugs heavily, and supporting himself through selling himself for sex acts with adult men. The sexual activity in which Robert engaged, even for money, still constitutes child sexual abuse; adult men seeking sexual activity with a young adolescent male contracted him.

C. Robert was victimized by overt incestuous sexual abuse.

Eventually Robert returned to Cincinnati, where he lived with his mother and her new husband, Clark Luttrell. Clark Luttrell was a virulent homophobe much like Robert's father. Robert lied to both his father and his stepfather about what he did when he was away in Florida and how he supported himself. Fearful that Clark would beat him and kick him out of the house, Robert told evasive lies, like "I had a job," or "I robbed a couple fags down there." Clark's brother, Donald, was an openly homosexual man who was often over at their home. Robert reported that Clark hated his brother for being gay and was embarrassed by his brother's sexuality. Clark would regularly beat and kick Donald, and Donald was terrified of Clark.

Nevertheless, Robert and others report that he eventually began a sexual "relationship" with Donald. Robert was 14 or 15 at the time, and Donald was roughly 20 years older than Robert. For the next 10 years, until Robert's arrest, he and Donald would get together "every now and then." According to Robert, their sexual activity primarily involved Donald performing oral sex upon Robert, but at least one other family member has recounted instances of Donald and Robert being overheard having sex. When I asked how often this occurred, Robert replied, "When I wanted it to happen. Largely to keep him happy." This appears to be something of a "slip" for Robert, a departure from his customary defensive stance that sexual activity with males

occurred only for financial purposes, rather than due to any desire on his part. Donald would regularly provide Robert with a place to stay, clothes to wear, food and alcohol, and, on one occasion, he arranged a job for Robert. Donald also visited Robert in Germany for two weeks while Robert was stationed there with the military. Over the course of that visit, Donald attempted to engage in sexual activity with Robert. Given the difference in age, as well as the incestuous nature of the sex acts, it is incorrect to call the sexual activities between Robert and Donald a "relationship." Rather, it was overt incestuous sexual abuse of a child.[2] And even after Robert turned 18, he was still being sexually victimized in an incestuous relationship at the hands of this older adult male.

V. The sexual abuse Robert suffered throughout his childhood and into adulthood was severe, and yet the full extent of it has gone unrecognized and untreated his entire life.

Most of the assessments of Robert that were done around the time of his trial and for subsequent legal proceedings noted the time that Robert spent engaging in sex acts for money while living on the streets as a teenager. A couple of these identified Robert as having been sexually active at a very young age. A few noted Robert's exposure to sexual violence in the form of regularly witnessing his mother and father having sex, including violent sex, or his mother engaging in inappropriate sexual activity with other men. Dr. Eisenberg's assessment even properly identified Robert's exposure to his parents' sexual activities and sexual violence as "sexual abuse." A few of the assessments opined that Robert wrestled with his sexual identity, recounted that he had engaged in homosexual activity, or suggested that Robert's crime was the

[2] In contrast to covert sexual abuse, overt sexual abuse involves unambiguously sexual activity with the victim.

result of "homosexual panic." And Dr. Eisenberg's assessment noted that Robert's "homosexual relationship with his Uncle Donald" began somewhere around age 14.

But at no point has any examiner truly identified by name that Robert was the victim of child sexual abuse of tremendous magnitude and duration, including at the hands of adult men as well as covert and overt incestuous abuse. Put simply, from the time he first witnessed his parents having sex, and at every instance thereafter that involved Robert being exposed to or subjected to sex acts while he was still a child or teenager, he was a victim of child sexual abuse.

Moreover, it is clear that Robert has never received the therapeutic treatment that is so critical for all victims of sexual abuse. This evaluation attempts to redress this earlier gap in our understanding of Robert and how he reached the point he was at in 1985, at the time of the murder of David Self, as well as his behavior since his incarceration on Death Row. The child sexual abuse that Robert suffered, which remains largely untreated, lies at the very heart of Robert's crime and his subsequent prison behavior.

A. Robert was hypersexualized at a very young age, while also being taught that homosexual activity and gay men are to be hated.

One of the most pernicious repercussions of Robert's child sexual victimization is that he was hypersexualized at a very young age. He learned to view events in his life through a lens of potential molestation or seduction long before he was able to understand adult sexual interaction. He also reports that he learned from his mother at a very young age to use sexual activity as a way to get what he wanted or needed. Several of the evaluations conducted in 1985 indicate that Robert's first sexual activity was at an extremely early age, and that is consistent with what he reported to me. While Robert's statements to the various clinicians vary in terms of his specific age at the time of first sexual activity, he has been consistent in stating to multiple reporters for

over thirty years that he began engaging in sexual activity at an extremely early age, long before the onset of puberty. And in light of the covert incestuous sexual abuse to which Robert was a victim during that time, that should not be a surprise.

Robert recounted numerous instances of sexual activity he claims to have had with similar-age girls throughout his elementary school years. The interactions he described are of the sort that would not sound particularly surprising regarding a sexually experienced, and sexually assertive, adolescent. But they are quite striking regarding sexual encounters at age seven or nine.

These early experiences in Robert's life led him to become profoundly over-sexualized, from an age long before puberty and long before he was capable of understanding and entering into appropriate sexual or intimate relationships. It also colored Robert's understanding of interactions with adult women, as he construed encounters with females through the same lens. While the details of his descriptions appear to have varied somewhat over the years, the broader picture of a young boy – then an adolescent, then an adult – who was hypersexual; who viewed the world in relentlessly sexual terms; who saw everyone in his life as likely molesters, seducers, and sexual partners; has remained consistent for over thirty years. Like many male victims of sexual abuse, Robert does not even see much of his sexual victimization as victimization at all. Male victims will often identify with their victimizers and see their sexual activity with them as vindication of their masculinity and virility, particularly when the early sexual activity is with females.

And yet, hypersexualization and other trauma symptoms stemming from child sexual abuse often cause serious gender identity confusion and ego-dystonic behavior. Thus, the second

major distortion in sexuality that grew out of Robert's abusive childhood and adolescence is his pronounced lack of acceptance of his own sexuality and sexual desires. Here, too, clinicians since 1985 have noted conflicts in Robert regarding sexual feelings or attraction toward other men. Dr. Schmidtgoessling hypothesized that the rage which resulted in David Self's death arose due to Robert's feelings of attraction or desire for him, which were utterly intolerable to Robert. In his 1989 affidavit, Dr. James Eisenberg spoke of "ego-dystonic homosexuality" to refer to this same hypothesis – that Robert had homosexual desires, which were "ego-dystonic" (unacceptable to one's ego or sense of self) and that, as a result, these feelings were denied and violently suppressed or projected onto others. In my opinion, Drs. Schmidtgoessling and Eisenberg were absolutely on the right track but did not go nearly far enough in their exploration or understanding of the issues of sexuality and sexual orientation and their role in Robert's life.

As explained in the previous section, exposure to sexual activity with males was a crucial part of Robert's sexual and personal development, both in the context of his prostitution at age 14 and his subsequent sexual activities with his step-uncle, Donald Luttrell. Further complicating the adverse outcomes from that child sexual abuse was the atmosphere in which Robert was raised. His father and his step-father taught him to view homosexuality as abhorrent and weak. Gays were despised and viewed as targets to be beaten and robbed.

Robert's father, Robert Van Hook. Sr., is described by all reporters as virulently homophobic. He spoke about hating gays. Robert stated that his father had told him that he (Robert Sr.) had once learned that he could find places where "fags" would hang out, and then go there, beat up a "fag" and take his money. Robert Sr. then told his son, "Bobby, if you ever get stranded somewhere, you can always roll a fag; they don't fight back. They're all pussies."

Robert Sr. was upfront about his views in this regard; he testified at Robert's sentencing that "I don't like fags. I think that their minds are warped." According to Robert's sister, Trina, Robert had "gay tendencies" for which his father disciplined and criticized him. In the face of this homophobia, and the similar homophobia espoused and demonstrated by his stepfather, but wrestling with his own sexual orientation confusion, Robert developed a sort of hierarchy of interactions with gay men.

At the top of this hierarchy, in the position of greatest acceptance, was "rolling" gay men – beating them up and taking their money. This was a "manly" act, espoused and, as described to Robert, allegedly perpetrated by his father. Far below this place in the hierarchy were the actions by which Robert lived during his year on the streets at age 14 and, again, in the period leading up to the killing of David Self – transactional gay sex, selling his body to men for drugs, alcohol, money, food, shelter, or some combination thereof. Doing this made Robert feel ashamed. He spoke with me, as well as with at least some of the evaluators in 1985, about the shame and self-loathing he experienced as a result. As Dr. Donna Winter wrote in her 1985 evaluation, "He indicates that prior to this, he had been working as a homosexual prostitute in order to earn money. Robert said he felt 'disgraced' by this activity and saw himself as an inferior and worthless person when involved in male prostitution." Robert rationalized this behavior, however, as something he did only for the money or only for drugs. The same rationalization for sexual activity with another male is seen in his abuse at the hands of his Uncle Donald.

But there was a level far more threatening and ego-dystonic for Robert. This level involved gaining pleasure from and feeling attraction toward the men with whom he interacted sexually. This was utterly intolerable to Robert. Ideally, in terms of his preferred self-image, he

would only have beaten up gay men and taken their money, while confining his sexual activity to heterosexual sex with numerous female partners. Had he done only this, he would have viewed himself as strong and masculine, or so he believed. If he had only prostituted himself, he could have rationalized this as being the only way he could survive. When confronted with the fact that he could actually enjoy the company of and sexual interaction with a man, this fact was overwhelming and intolerable to him. Robert was finally, irrevocably, confronted with this fact shortly before he met and subsequently killed David Self. It was only when he met the man whom he refers to as "the light-skinned black guy" that he could no longer pretend that, for him, men were not objects of attraction and sources of pleasure. Robert's discomfort discussing this aspect of himself and his sexuality was apparent in 1985. Dr. Schmidtgoessling wrote, "In general, his emotional expressiveness was very flat, showing neither anxiety nor depression. The one exception to this was the marked anxiety observed (averted eye contact, verbal stammering, excessive feet shufflings) when discussing his history of homosexual behavior."

Faced with the cognitive dissonance between the teaching from his father figures on the one hand, and the sexual activities in which he was engaged from the time he began selling himself in Florida on the other, Robert created another construct by which he could rationalize his activities. Being gay, in Robert's world, as taught by his rabidly homophobic father and step-father, equates to being less than masculine – a "fag," a "sissy," a "queer," a "bottom." Thus, Robert created a framework that is quite common among traumatized male victims of child sexual abuse at the hands of adult males. If a man is penetrated during anal sex, or performs oral sex on another man, then he is gay. But if one does the penetrating of another male during anal sex, or receives oral sex from another male, then he is *not* gay (unlike the other individual in that

sexual activity). In this worldview, a male who is macho, and strong, and fully masculine is not gay (even if he engages in homosexual activities).

Thus, in Robert's view, engaging in sex acts with men did not make him gay, if he was receiving fellatio or anally penetrating the other person. Accordingly, Robert appears to have reconciled himself to allowing fellatio to be performed upon him and to penetrating other men anally (though he stated that he often needed to drink and/or get high in order to tolerate this). It also adds further traumatic significance to the instances on which Robert was penetrated or ordered to perform fellatio on adult males, beyond just the physical pain that Robert reported experiencing when he was penetrated; doing so was entirely ego-dystonic within his understanding of homosexuality.

B. Robert self-medicated with drugs and alcohol.

Robert has an extensive history of excessive alcohol consumption and use of multiple other drugs including marijuana, LSD, heroin, and speed. His heavy use of each of these substances goes back to his early adolescence and was often encouraged by his parents. His drug use has led to multiple difficulties in his life, including his discharge from the military. Robert was apparently drunk at the time of each of his arrests. His first arrest, at age 12, was due to alcohol consumption and intoxication. His drug history is outlined more fully in previous reports, most notably those of Dr. Robert Smith in 1993 and Dr. Duncan Clark in 2017. Clearly, Robert's struggles with alcohol, in particular. and with other drugs stem from multiple causes, including a likely genetic predisposition to alcoholism (both Robert's parents were alcoholics), the modeling of drug and alcohol use provided by both parents, and his father's overt encouragement and facilitation of Robert's drinking since his early adolescence.

But there is one additional factor likely to have contributed heavily to Robert's drug and alcohol use – the sexual abuse he experienced. Several evaluations have noted that Robert's abuse of drugs and alcohol escalated during the time he was living on the street around age 14, and that his substance abuse escalated further still after he returned home. Of course, those times coincide with periods when Robert was being sexually abused by adult men, first by strangers and then by his uncle Donald. It is well known that the rates of substance abuse, including alcohol, are far higher among survivors of childhood sexual abuse than among the population at large. Individuals who have been sexually victimized often turn to drugs in order to escape the feelings associated with the abuse – to numb themselves from their internal distress.

In Robert's case, an additional connection exists between sexual abuse and his drug use. At that time in his life, sexual activity with males was entirely ego-dystonic. Robert stated that when he was first introduced into the world of sex with men for money, at age 14, he always needed to be drunk and/or high at the time in order to engage in sex acts with the adult johns. That further fueled his substance addictions. The same applies to his escalated use of drugs and alcohol after he returned home and the overt incestuous abuse at Uncle Donald's hands began.

C. Robert acted out by engaging in self-destructive behaviors, with multiple suicide attempts.

Another common negative outcome for victims of child sexual abuse is self-harm and self-destructive behaviors, as the victim acts out rather than speaking up. Boys who are the victims of child sexual abuse are frequently reluctant to disclose their abuse, especially when it was at the hands of a male. In fact, male victims wait, on average, at least 20 years before disclosing their abuse verbally. But they cry out for help in other ways, such as disruptive behavior at school, aggressive or violent behavior, and self-destructive actions. Robert clearly

manifested several of these adverse outcomes as well. He has tried to kill himself by cutting his wrists on at least four documented occasions. His abuse of drugs and alcohol is certainly a form of self-destructive behavior. So, too, is his history of engaging in fights and physical violence throughout his childhood and into adulthood. Robert did not divulge the full scope of his child sexual abuse verbally for decades, but he was certainly crying out for help through his actions.

D. Robert developed a severe mental illness in the form of Borderline Personality Disorder.

Robert has been diagnosed with Borderline Personality Disorder. And the trauma to which he was exposed as a child, including not just the pervasive, chronic sexual abuse but all the other ACES factors as well, unquestionably contributed to the development of his mental illness. The behaviors that are associated with Borderline Personality Disorder are similar to the behaviors of many untreated male survivors of sexual abuse, including acting invulnerable or tough and aggressive, as if no one could ever hurt them. In order to deny vulnerability, a male survivor must keep people distant. Robert displays these outcomes, as seen in his history of engaging in fights dating back to his adolescence. Indeed, his stories of "rolling gays" is very likely a cover story, created to foster an image of toughness and invincibility, as will be explained in further detail below.

E. Robert's sexual abuse has gone untreated.

Despite the devastating effect that child sexual abuse has on a person's development, it is clear that Robert has never received the treatment necessary for recovery. That is not surprising, given that the full scope of the sexual abuse to which he was exposed was not previously recognized. For example, Dr. Teresito Alquizola noted in his 1983 evaluation that, "When [Robert] was 15 years old, he ran away from home and worked as a male prostitute in Florida

and New Orleans for three months." The report omits any mention that Robert was victimized during every single sexual encounter with an adult during that period. And Robert was similarly victimized every time he engaged in sex acts with adult men or women while still a young teenager. That essential concept has, to this point, been overlooked in every assessment of Robert's background and his case. The covert and overt incestuous child sexual abuse to which Robert was subjected was similarly minimized. For example, when Robert, starting in his early teenage years, was viewed as having a "sexual relationship" with his Uncle Donald—who was approximately 20 years older than Robert—the fact that Robert was, in truth, a victim of incestuous child sexual abuse at the hands of an adult male was never identified as such.

It is generally accepted among professional therapists at this point that Trauma-Informed Treatment is the most effective way of helping a victim of severe and wide-ranging trauma, such as Robert, begin to recover. But there is no record of which I'm aware that suggests Robert has ever been provided Trauma-Informed Treatment. Even the Cognitive Behavioral Therapy and Rational-Emotive Therapy that he received at the Chillicothe Correctional Institution while working with Kevin Littler, though helpful and certainly better than no treatment at all, did not constitute full-fledged Trauma-Informed Treatment in which Robert could talk about the abuse he suffered, which lies at the root of his mental illness and his associated behavior. Without being able to disclose what he has experienced, Robert will only receive superficial treatment that aims to treat symptoms rather than addressing root causes.

The various psychological assessments of Robert either missed the issue completely or failed to grasp its significance; the end result is the same: Robert is essentially an untreated victim of repeated child sexual abuse. There has never been an explanation of Robert's background that placed matters within the correct, comprehensive context to understand his

behavior, his Borderline Personality Disorder, his severe substance abuse and other self-destructive behaviors, or his horrible crime. When placed in the accurate broader context of Robert's early sexualization and sexual victimhood, however, the rest of his story becomes more easily understood.

To understand this oversight, it is important to reflect on the evolution in our recognition and understanding of male sexual victimization in the 30-plus years that have passed since Robert's initial trial. In my book, *The Male Survivor: Impact of Sexual Abuse*, I spoke at length about the reasons for this under-recognition, with a summary statement that we are "primed and ready to recognize male perpetrators but turn a blind eye to male victims." My research for that book took place in the late 1980's, close in time to Robert's trial. I can attest to how profound and pervasive the inability to recognize or acknowledge the sexual abuse of male children was at the time.

Research on this topic remains an ongoing field of study, and the most recent research, while diving deeper and wider into data gathered from ever-larger sample sizes, still reinforces these concepts. See, for example, Understanding the Sexual Betrayal of Boys and Men: The Trauma of Sexual Abuse, R. Gartner (ed.), published in 2018, which reviews the most recent studies on identification, outcomes, and treatment of child sexual abuse of boys and men. Even today, the sexual abuse of boys is an under-recognized, under-reported phenomenon, for numerous reasons. We tend not to recognize males as victims. It is more comfortable and less dissonant for us to see males only as perpetrators and aggressors, and females only as victims. We miss males the first time around, and step in to help them only if they reemerge as perpetrators or, as in Robert's case, not at all.

Several studies have shown that males are less likely than females to report their abuse, and that sexual victimization of males is less likely to be recognized as such by parents, teachers, protective services personnel, and helping professionals. There are numerous factors for the under-recognition of males as victims, including:

1. Males are socialized to be powerful, active, and competent, rather than passive, helpless, or victimized. The experience of victimization is highly dissonant and threatening to males. A male victim may assume that he is "less of a man" due to his inability to protect himself. Men may equate being abused with being weak, homosexual, or female.

2. The male is likely to act in such a way so as to escape seeing himself as a helpless victim. The male may act out aggressively or even perpetrate abuse in order to avoid this self-perception.

3. Male victims, like society as a whole, misconstrue sexual interaction with older females as desirable or as "initiation" rather than as abuse.

4. The stigma of homosexuality: Regardless of the sex of the perpetrator, male victims have doubts and fears regarding their sexual orientation. Passivity in males is equated with homosexuality and the male victim worries, therefore, that his experience of helplessness indicates that he is gay. Males abused by men often worry that they were chosen on the basis of some attribute indicating that they were, in fact, gay.

5. The societal notion that males are, or should be, constantly and indiscriminately sexually willing and eager: If this is true, then the sexual activity could not have been abusive.

6. Male victimization often only comes to light through their later sexual offenses, if at all. One study found that girls were four times more likely than boys to be referred based solely on the presence of psycho-social indicators of possible sexual abuse. Other studies have shown boy victims are often recognized only when the abuse of their sisters comes to light. In other words, we as a society today do not—and certainly in 1985 did not—adequately recognize symptoms of distress on the part of boys as possible indicators of sexual abuse.

Each of these was likely a factor in the many failures to identify Robert as a victim of sexual abuse. And yet, even with all the red flags there, his life experiences were not understood or recognized for what they were. As can be seen in the psychological and psychiatric evaluations of Robert from that time, even when it was stated that Robert was sexually abused,

that conclusion was only partly informed and thus incomplete. And, crucially, there was no further explanation regarding how those events were likely to have impacted him, first as a child and then as an adult. When the assessments did not identify Robert as a victim of other forms of sexual abuse, they obviously could not provide any explanation for how those types of sexual abuse—including at the hands of trusted family members—affected Robert's development and subsequent actions.

VI. There Is a Direct Link Between Robert's History Of Severe Childhood Trauma And Untreated Sexual Abuse, The Murder Of David Self, And Robert's Conduct While On Death Row.

Once Robert's background is fully understood and placed in context, the direct link between that traumatic history, the killing of David Self, and Robert's prison conduct record, becomes clear.

A. The untreated child sexual abuse manifested in Robert's killing of David Self.

As described above, there are numerous adverse outcomes directly attributable to the long-term consequences of untreated child sexual abuse, particularly when the victim was a boy being abused by males. For example, recent scholarship (Easton, 2014) confirms that the longer a survivor of child sexual abuse waited to tell someone about the abuse, the more mental health problems were evident. Robert is currently 58 years old, and he only disclosed several aspects of his abusive background within the last couple of years. Further, he has not received the trauma-informed treatment that was necessary to heal the deep wounds inflicted by child sexual abuse, and consequently he has never truly had the opportunity to heal and overcome the severe mental illness (Borderline Personality Disorder) that manifested as a result of the sexual abuse and all the other childhood traumas that Robert endured. And, as others have opined, all the

characteristics of that pernicious mental illness, including the potential for explosive rage, manifested during the murder.

Likewise, higher adherence or conformity to traditional masculine norms has been directly linked to higher incidence of outcomes such as depression, anxiety, and suicidality. (Easton, 2011; 2014.) At the time Robert committed his crime, he was in the midst of a drug and alcohol binge triggered by three events, discussed further below. Those events had made him believe once again that he was not worth anything. Robert felt tremendous anxiety over his internal struggle regarding his newly experienced sexual attraction to a man and enjoyment of sexual activities with a man. And in accord with that struggle, with his homophobic parental teaching as the normative backdrop, Robert experienced deep internal hatred and loathing to the point of wanting to kill himself. In other words, Robert's internalized adherence to traditional masculine norms even in the face of his sexual victimization lead to each of these negative outcomes, and each of those outcomes is directly implicated in his killing of David Self.

One of the norms measured in those studies included disdain for homosexuality. Robert grew up with a father and step-father whose disdain for homosexuality was made clear to Robert at all times. As a victim of child sexual abuse at the hands of adult males, Robert has struggled mightily with his sexual identity. He engaged in sexual activities with males throughout his teenage years and into adulthood, and yet he had constructed the framework in which he could generally rationalize those behaviors as "not gay," while telling himself he only engaged in those sex acts-for money or for drugs or alcohol, or a place to stay. Later, he told others that his interactions with gay men revolved around his apparently fictional acts of rolling them. When the sexual behavior did not fit within that construct (and even when it did), Robert drank and

drugged himself until he was numb from the inner torment and indifferent to the "gay" sexual activities in which he engaged, whether as a child or as an adult.

Until a few weeks before he killed David Self, Robert had maintained – at least to himself, if not to others – the self-deception that he was entirely heterosexual, in accordance with the homophobic norms passed on from his father and step-father, at great cost to his own mental health. But even these flimsy distinctions fell apart in the weeks preceding the murder.

In the winter of 1984-1985, Robert went by himself to three different gay bars on at least three occasions. He stated that he had sex with different men and noted that this was not for money, but for a place to crash, and to get high and drunk. In the first of these, he flirted with the bartender, who provided him with free drinks. They then went back to the bartender's home, took amyl nitrate, and had sex.

The second occasion, which began at The Subway, involved meeting two men – "a white guy and a light-skinned black guy" after which Robert engaged in sexual activity with the men. These events, and particularly his interactions with the light-skinned black man, seem clearly to have set Robert on a course of increasing recognition and acknowledgment of his forbidden sexual attraction toward men. Robert reported to me experiencing something different in relation to the light-skinned black man. Whereas Robert had stated that he generally detested when men tried to kiss him and said that he always had to fantasize about sex with women in order to obtain or maintain an erection or to ejaculate during sexual activities with men, that was not the case with this particular individual. Instead of those reported aversions, Robert stated to me that, for the first time, he found himself attracted to another man sexually, and Robert willingly engaged in sexual interactions with him. It is clear from Robert's descriptions of his interaction with this

other man that Robert's long-time insistence that his sexual interactions with men were solely for money (or drugs or a place to stay) was no longer a story he could maintain in the face of his own dawning realization that he was, indeed, sexually attracted to another man.

For a period of time after those first two encounters, Robert seems to have pushed back against his growing recognition of his own feelings toward men. He stopped going to gay bars, started attending church again, and even stopped drinking and doing any other drugs. During these weeks, Robert resolved to turn his life around. He recalls that he was going through withdrawal from not drinking, shaking throughout much of the day and night. Nonetheless, he stated that he resisted the temptation to drink and remained sober throughout this period, the longest period of sobriety he had had since his early adolescence.

Within the space of a week, three events triggered another downward spiral for Robert, leading him to relapse, start drinking again and using drugs, and return to gay bars. He stated that he had discovered a boxing gym, which he wanted to join. He asked his father for the $17 required and his father replied, "No, you'll just end like Muhammad Ali, crack your head open." Then, at the church Robert had been attending, the music director/ youth minister with whom Robert had been spending time said to Robert, "So, how's that pot going for you?" This was at a time when Robert was not drinking or smoking, leaving Robert feeling attacked, distrusted, and betrayed. And third, when driving with someone whom Robert admired, Robert pointed up at a large house on a hill and said, "I really like that house." The other person responded, "You know, I can't see you ever having a house like that, Bobby." This, he said, "made me feel like I was lower-class, and could never aspire to being at the same level" as the other person. This other person, Robert believed, "never thought I could make it, just like my dad, and just like the

youth minister." These events involving trusted persons in Robert's life said to Robert that he was nothing, a nobody, and was destined to a life of failure.[3]

After this series of events and the two previous solo trips to gay bars described above, Robert lost his resolve and returned to his preferred bar, Billy's, around noon. He had done some work for his grandmother and had $10, enough for 20 of the 50-cent drafts featured at this bar. While there, a man who customarily provided drugs to Robert showed up at the bar, smoked a marijuana joint with him and provided him with two "White Crosses" (speed pills). He stated that he does not recall anything further until he woke up at 7:30 p.m. at the Subway, the gay bar where he had earlier met the light-skinned black man, and to which he now returned for the first time since that night. There, he met David Self and, later, the light-skinned black man. As is now well known, he left with David Self, drove him to Mr. Self's home, and subsequently murdered him.

Robert told the police after his arrest, and subsequently told each of the psychologists and psychiatrists who evaluated him, that he had a long pattern of "rolling" homosexuals – enticing them with the prospect of sex and then taking their money. The killing of David Self, he explained, began with a continuation of this pattern. It was unclear to the evaluators to what extent Robert's previous interactions with gay men had involved violence in the course of robbery. But each evaluator appears to have accepted without question Robert's statements that

[3] One additional event, though it occurred somewhat earlier, also played a crucial role in Robert's decline. He had always planned and dreamed of being in the military. Even after his discharge due to problems associated with his alcoholism, he hoped to someday reenlist. He discovered at some point in 1984 that he would not be able to do so, as a result of his conviction for passing a $100 bad check, which constitutes a felony larceny. Had the check been for literally one penny less, so that his conviction was for passing a $99.99 bad check, this would not have precluded him from re-enlisting.

his intent and his pattern was to beat up and rob homosexuals. I do not believe this to be the case. I believe that this represents a defensive, self-protective cover story for Robert. Being a robber or a bully is far more ego-syntonic to Robert than is being gay. In contrast to this, the notion that he would be with a man sexually because he is attracted or drawn to the man, or that he obtains pleasure from these interactions, is completely ego-dystonic and unacceptable to him.

Fears of homosexuality, and lack of acceptance of homosexual feelings and attractions, are well-known negative outcomes of child sexual abuse of boys perpetrated by men. Robert maintained this cover story of rolling gays and of having a plan to roll David Self, despite the fact that doing so is likely to have been utterly self-destructive for him. By insisting that he was engaging in this pattern of activity when he killed David Self, he painted himself as a selfish person, out only for his own financial gain, caring nothing for anyone but himself. The truth, I believe, is that a mirror was held up to Robert and he had no choice but to look into it and to accept that he is, in fact, gay (or, probably more accurately, bisexual) and that he longed to be with the light-skinned black man.

Robert's insistence on his own financial motivation, when it is apparently so contrary to self-interest, seems strange until one considers that it is consistent with the deep sense of shame and well-established barriers to disclosure by male victims of child sexual abuse. In fact, one recent study (Easton, Saltzman, Willis, 2014) found a range of complex, overlapping barriers to disclosure by male victims of child sexual abuse, including fear of societal masculinity norms that lead the victim to believe that his sexual abuse is deeply shameful, and makes him feel weak, damaged, inferior, unworthy, and unmanly. Each of those is directly seen in the murder of David Self and Robert's actions afterwards. "Real men" don't let themselves be abused, goes the thinking. Likewise, a fear of being labeled "gay" is another significant barrier to disclosure

that is directly applicable in Robert's case, including the stigmas of that label that Robert himself was taught to believe by his father and step-father.

As a direct result of his child sexual abuse, Robert despises a part of himself – the part that is attracted to men and wants to be with men sexually. He would rather die—or be convicted of murder and sentenced to death—than think of himself as gay or be viewed as gay. A related social construct led the psychologists and psychiatrists in 1985 to accept so readily that Robert was a mean, thuggish bully who lured and beat up gays in order to take their money: particularly at that time, when our society was significantly less willing to accept the full personhood of gay men, this idea of Robert as a straight man who preyed upon gay men was easier to see and accept than the actual fact.

And yet, Robert confessed to me that he had never "rolled" a gay man until *after* David's death. Instead, his interactions with the various men in the various cities consisted of receiving money (or drugs or food or a place to stay) in exchange for providing a sexual act, most typically allowing these men to perform oral sex on him. At times, male customers would insist on Robert performing oral sex on them. He was very reluctant to do so, but did at times, either under pressure or coercion, or with the aid of substantial amounts of drugs and alcohol to numb him to the experience. Still, he was able to rationalize these actions as necessary for his survival. Quite simply, Robert viewed himself as entirely straight, and as someone who engaged in sexual activity with males solely to survive. This world-view maintained until 1985, when he met the "light-skinned black man" and the view of himself beaten into him since early childhood crumbled, with tragic consequences.

With all of this background in mind, then, the murder itself demonstrates several additional psychological aspects that can be traced directly back to the sexual abuse Robert suffered. Again, survivors of childhood sexual abuse frequently experience depression, anxiety, and suicidality. Robert was self-medicating with drugs and alcohol to numb the roiling pain and dissonance in his own mind about his sexuality. He lashed out in fear and rage at the self-realization that he was attracted to males following his interaction with the light-skinned black man. This struggle also grew out of the internal sexual identify struggle that is commonly seen amongst male victims of child sexual abuse. His family's open hatred of homosexuals, which Robert internalized from a young age, exacerbated Robert's struggle. It is striking that Robert reported that he called his mother's home that night from David Self's home, and was prepared to just leave and go home to sleep. But when he called home, Clark Lutrell was there and answered the phone. Robert did not talk, but instead just hung up the phone, making his homophobic stepfather's voice the last thing Robert heard before the crime happened.

Robert was suicidal before the killing, with at least four, perhaps five suicide attempts, which is likely associated with his untreated child sexual abuse, as explained previously. (According to official records, Robert was also treated as a suicide threat after his arrest for David Self's murder and when he was moved to Death Row after his trial.) Notably, Robert was also suicidal during the killing itself. He has divulged that he "snapped, because I saw something in [David] that I hated about myself. I wanted myself dead, but I didn't have the balls to do it to myself." And the fact that Robert used amyl nitrate during the incident adds to our understanding of his actions. He had taken a bottle of amyl nitrate from The Subway, and he reported that while he was stabbing David's body, he would stab with the knife and then inhale from the bottle, so that he would "stab and sniff, stab and sniff." Amyl nitrate is a drug

popularly used by gay men during sex because of how it intensifies sensations. That Robert was symbolically killing himself (by stabbing David) while simultaneously embracing his own sexual feelings (by using a drug closely identified with gay male sexual activities and taken from the very same gay bar where Robert had just met David and where he had met the light-skinned black man) is a striking display of the intensely conflicting feelings Robert has regarding his sexuality which lead directly to his crime.

Robert also seems to have dissociated during the killing, as when he described being outside himself as if he was watching someone else kill David, noted in Dr. Schmidtgoessling's pre-trial evaluation dated June 24, 1985, and in Dr. Rogler's evaluation and report dated January 23, 1996. Robert described the same kind of occurrence to me. Dissociation is another common coping mechanism for victims of child sexual abuse.

B. The untreated child sexual abuse manifests in Robert's prison disciplinary record.

Finally, Robert's attitude toward his own sexuality and sexual orientation also plays an enormous role in his history of violence and disciplinary problems in the prison setting. I believe that this issue has heretofore been unexamined. As discussed earlier, Robert has never received Trauma-Informed Treatment. Accordingly, and with such an extensive history of severe child sexual abuse, Robert's behavior in prison can be traced directly to how he learned to survive from a very young age, with a distorted, hyper-sexualized view of the world. Robert states that all, or virtually all, of the fights and disciplinary issues he has had while incarcerated stemmed from sexual approaches or provocations.

Whether that is, indeed, objectively accurate does not really matter, because it is his subjective reality as a child sexual abuse victim. In his hypersexualized perspective, he sees

himself as living in a world that is filled with people who are constantly looking to seduce or assault him, leaving Robert, in his mind, with only two choices: submit or fight. Robert explained that when he first came to prison, in 1985, the fact that his crime involved homosexual activity was well known and there was enormous pressure placed upon him to engage in sexual activity with other inmates. Other prisoners viewed Robert as a young white target and he had to fight frequently so that he would not be taken advantage of sexually. He thus learned early on in prison that his only choice was between being violent or being a victim yet again. And that viewpoint, along with the impulsive rage and anger that is endemic to having Borderline Personality Disorder, has manifested itself throughout Robert's time on Death Row.

Nevertheless, that does not mean that Robert is irredeemable or would necessarily be a threat to himself or others if living in General Population. The truth of the matter is that he has suffered the untreated effects of childhood sexual abuse for years; if provided with the appropriate mental health treatment, he could begin, for the first time, to heal. This course can lead to dramatically changed behaviors and expected outcomes in a sexual abuse survivor.

VII. Conclusion

In my professional opinion, Robert Van Hook was a victim of child sexual abuse from an extremely young age, at the hands of numerous persons including adult males and females, and family members. He was subjected to severe trauma in multiple forms beyond the sexual abuse as well. That toxic combination manifested in a severe form of mental illness with pernicious symptomology, specifically Borderline Personality Disorder, and the child sexual abuse (still untreated today) formed the lens throughout which Robert views the world. There is also a direct link between that traumatic but untreated background that informed Robert's

understanding of the world and Robert's tragic killing of David Self, as well as an analogous link to Robert's prison disciplinary record.

Respectfully Submitted,

Matthew Mendel, Ph.D., May 15, 2018

EXHIBIT 4

CGH-97
REV. 9/80

UNIVERSITY OF CINCINNATI HOSPITAL-CINCINNATI GENERAL DIVISION
ADMISSION RECORD

MEDICAL RECORD NO. 724459-3591

ADM. DATE	ADM. TIME	DISCH. DATE	DISCH. STATUS	SERVICE	DIV.	TEAM	ROOM/BED	CONDITION
122581	0455	12-28-81		PLAS			S602B	2

PATIENT NAME LAST	FIRST	MIDDLE	MAIDEN	SEX	RACE	MAR. ST.	AGE	BIRTHDATE	B. STATE
VANHOOK,	ROBERT			M	CA	S	021	0114960	OH

ADDRESS-STREET	APT.	CITY	STATE	ZIP CODE	COUNTY	TELEPHONE-HOME
4144 CRYSTAL VIEW CT		CINCINNATI	OH	45241	HAMIL	5135541944

ADM. CAT.	REFERRAL SOURCE	ADM. THROUGH	RELIGION	SOCIAL SECURITY NO.	ADMITTED BY
EM	NCH LIFESQUAD, BETTS AV	EMRG	PRO		CHW

NEAREST RELATIVE'S NAME	RELATIONSHIP	TELEPHONE-HOME	TELEPHONE-WORK
LUTTRELL, JOYCE	MOTHER	5135541944	513

NOTIFY IN CASE OF EMERGENCY-NAME	RELATIONSHIP	TELEPHONE-HOME	TELEPHONE-WORK
LUTTRELL, JOYCE	MOTHER	5135541944	513

ADMITTING DIAGNOSIS	ATTENDING M.D.	RESIDENT M.D.
STAB WOUND LEFT FOREARM	NEALE, H	**

REFERRING M.D./AGENCY/HOSPITAL	REFERRING M.D./AGENCY/HOSPITAL ADDRESS

ACCIDENT-INJURY-HOLD DETAILS	PATIENT OCCUPATION
ACC-SELF INFLICTED (L) FOREARM	UNK

FINAL DIAGNOSIS ON DISCHARGE

	CODE NUMBER
PRINCIPAL (MOST ACCURATELY DESCRIBES THE HOSPITAL EPISODE):	
LEFT FOREARM LACERATION	881.20
	E986
SECONDARY:	

COMPLICATIONS AND NOSOCOMIAL INFECTIONS — DATE OF ONSET

OPERATIONS, PROCEDURES, AND/OR SPECIAL TREATMENTS

PRINCIPAL:	SURGEON	DATE
REPAIR LFT ARM FOREARM WITH PALMARIS LONGUS TENDON		83.64
MUSCLE BELLY OF FLEXOR DIGITORUM SUBLIMIS		
SECONDARY: AND FLEXOR CARPI RADIALIS	DUANE SMITH 12/25/81	

DISCHARGED ALIVE TO: ☑ HOME ☐ OPD APPT. TRANSFERRED TO: ☐ OTHER HOSPITAL ☐ SNF ☐ ECF

LEFT: ☐ AMA DIED ☐ OVER 48 HOURS ☐ UNDER 48 HOURS ☐ OR DEATH

CORONER'S CASE? ☐ YES ☐ NO AUTOPSY? ☐ YES ☐ NO

AUTOPSY PERFORMED BY: ☐ HOSPITAL ☐ CORONER

Perkins Neale
RESIDENT

UNIVERSITY OF CINCINNATI HOSPITAL
CINCINNATI GENERAL DIVISION
CINCINNATI, OHIO 45267

VAN HOOK Robert	724-4-59	DISCHARGE SUMMARY

DATE OF ADMISSION: 12-25-81

DATE OF DISCHARGE: 12-28-81

DICTATOR: Dr. Paul Perkins, Plastic Surgery Service

ATTENDING PHYSICIAN: Dr. Henry Neale

ADMITTING DIAGNOSIS:
1. Laceration of the left arm.

DISCHARGE DIAGNOSIS:
1. Laceration of left forearm with complete transection of the palmaris longus tendon, partial transection of the muscle belly of the flexor digitorum sublimis and partial transection of flexor carpi radialis.

CLINICAL COURSE: The patient is a 30-year-old white male who while under the influence of alcohol and speed suffered self inflicted laceration to his left arm. He was subsequently brought to the Cincinnati General Emergency Room by the Life Squad for therapy.

PAST MEDICAL HISTORY:

PREVIOUS SURGERIES: He had an appendectomy.

ALLERGIES: None.

CURRENT MEDICATIONS: None.

REVIEW OF SYSTEMS: Non-contributory.

PHYSICAL EXAM: There was a 15 cm. long laceration of the left forearm, obliquely over the flexor muscle bellies with penetration into the muscle. Radial and ulnar pulses were present. Sensation to the hand was intact in the ulnar, median and radial nerve distributions. Finger flexor, profundus and superficialis were both seen to be intact to all digits but very weak. There was questionable ability to pronate and supinate the arm. This was painful for the patient.

X-rays were negative.

The patient was taken to the operating room and repair of the palmaris longus tendon, flexor digitorum sublimis muscle belly and flexor carpi radialis was undertaken.

The patient was discharged to home with dressing and sling on 12-28-81 with instructions to return to Clinic on Thursday, 12-31-81. At the time of discharge the patient was given a prescription for Velosef 250 mg. po q6

(Continued)

VAN HOOK, Robert	724-4-59	DISCHARGE SUMMARY

and for Tylenol #3 one to two q3-4h. During the course of his hospital stay a Psychiatry consult was called. It was not felt at the time of discharge that the patient was suicidal.

M.D.
Paul Perkins, M.D.

M.D.
Henry Neale, M.D.

80
Cass: #0085
D: 12-28-81
T: 12-30-81

CGH-13
Rev. 5/78

University of Cincinnati Medical Center
Cincinnati General Hospital
CONSULTATION FORM

VANHOOK, ROBERT
4144 CRYSTAL VIEW CT
CINCINNATI OH 45241
PLA[illegible] [illegible]E. M

CONSULTATION REQUEST TO: PSYCHIATRY (SERVICE)
E-SOMOZA (PHYSICIAN)

CONSULTATION FROM: PLASTICS (SERVICE)
NEALE (PHYSICIAN)

Page 1/2

REASON FOR CONSULT:

21 y.o. WO♂ WITH SELF INFLICTED LACERATION(S) TO LEFT FOREARM.

DATE/TIME CONSULT INITIATED/CALLED 12/27/81 1145 AM DATE/TIME CONSULTANT ANSWERED

HPI

Mr. VanHook is a 21 y/o WO♂ who was brought in by police on Christmas day after cutting his left wrist in a suicide attempt. He had been at a Christmas Eve party over his paternal grandparents and apparently doing well and getting ready to go to the midnight church service. At this point (according to the patient and independently by his mother) his aunt came to the party and gave him Speed and whiskey. He drank about one fifth of whiskey and afterwards was found in the cellar crawling on the floor very disoriented thinking that he was still in Germany in the army. They put him in bed and later found him bleeding in the bathroom. He became very agitated and police had to break down the door to bring him to the hospital.

He has had two previous suicide attempts, both of which took place while he was in the army. One of these was not serious and was done in order to get himself out of some work, the other took place after very heavy drinking. While in the army (D/C in Aug 81) he drank ≈ 1 case of beer/day and was on drugs - Speed, LSD, THC, Marihuana - He received a drug and EtOH discharge

RESIDENT PHYSICIAN CONSULTANT

ATTENDING PHYSICIAN CONSULTANT

ORIGINAL — CHART COPY

COPY — CONSULTANT

CGH-13
Rev. 5/78

University of Cincinnati Medical Center
Cincinnati General Hospital
CONSULTATION FORM

CONSULTATION REQUEST TO: Psychiatry (SERVICE)
E. Somoza (PHYSICIAN)

Robert Vanhook

CONSULTATION FROM: _____ (SERVICE)
_____ (PHYSICIAN)

REASON FOR CONSULT:

Page 2/2

[Mother: Joyce Luttrell 554-1944
Father: 752-9856]

DATE/TIME CONSULT INITIATED/CALLED	DATE/TIME CONSULTANT ANSWERED

Since D/C in Aug 81 Pt. has been living with his mother and step father and apparently doing well. He has had 3 jobs since then for ≃ 1 M periods and quit two of them for higher paying jobs. The last one he did not like. He is now drawing unemployment. He spends most of the day at home watching TV and is waiting until his unemployment comp. expires to look for another job. He also hopes to go back to the service when he is allowed to (2 yrs after D/C)

MSH Pt. is calm, speaks in a quiet tone & pressured speech or loose associations. Denies derression, feels the future will be OK. Denies suicidal ideation and does not remember the episode leading to hospitalization. The last he remembers is drinking a lot of whiskey.

Asesment Pt. has a history of etoh abuse and poly-drug abuse. He denies taking any drugs since D/C from army. All of his suicide attempts have been after large ingestion of etoh. He is disappointed that his father who remarried shortly before pt joined army does not have more time for him. This problem should be addressed in therapy. However he is not suicidal at this time and he can be discharged from the hospital when medically clear. His Mother has already made arrangements for Mr. Vanhook to be seen by a councilor from their church: Central Parkway Church of Christ.

_____ MD
RESIDENT PHYSICIAN CONSULTANT — ATTENDING PHYSICIAN CONSULTANT

ORIGINAL – CHART COPY — COPY – CONSULTANT

EXHIBIT 5

COURT REPORT

CENTRAL PSYCHIATRIC CLINIC
COURT PSYCHIATRIC CENTER

222 E. Central Parkway - Lower Level
Cincinnati, Ohio 45202
(513) 352-3111

CONFIDENTIAL

NAME Robert Johnson Van Hook DATE OF BIRTH 1-14-60

DOCKET NUMBER C83CRB-27531; 32 OFFENSE Assault; Resisting Arrest

REFERRAL DATE 12-13-83 EVALUATION DATE 12-30-83 COURT DATE 1-5-84

The Honorable J. Howard Sundermann
Hamilton County Municipal Court
Cincinnati, Ohio

Dear Judge Sundermann:

This is in response to your request for a psychiatric evaluation of Mr. Robert Johnson Van Hook with regards to advisability of treatment and his potential for dangerousness toward himself and others, pursuant to Ohio Revised Code 2947.06. For this report, Mr. Van Hook was interviewed at the Court Psychiatric Center on December 30, 1983. The non-confidential nature of the interview was explained to Mr. Van Hook who indicated his understanding by signing an explanation form. In addition to this interview, records of Mr. Van Hook's two previous hospitalizations, one at the University Hospital in December, 1981, and the other at the Cincinnati Veterans Administration Hospital, were reviewed. The following is a summary of this examiner's observations and recommendations.

Mr. Robert Johnson Van Hook is a 23 year old, white, single male presently employed as a mover, who has been charged with Assault and Resisting Arrest. These charges arose out of an incident in a Sharonville bar on the weekend before Thanksgiving when Mr. Van Hook, in a very inebriated state, was told "not to harass" the female patrons of the bar. Mr. Van Hook continued to do this, in addition to shouting obscenities at the bouncer. This then escalated into a situation where Mr. Van Hook threw a glass at the bouncer and broke an ashtray which he used to attack the bouncer. When the police came, Mr. Van Hook fought with them. On his own admission, he had been drinking alcohol since noon that day. He had completely lost count of the amount of alcohol he had consumed, saying only "I was already very very drunk."

Mr. Van Hook is fully aware and readily volunteers the information that drinking is a serious problem with him. He has been drinking since he was about 10 years old. Alcohol and drug consumption escalated at the age of 13 years old. When he was 15 years old, he ran away from home and worked

as a male prostitute in Florida and New Orleans for three months. During this time his alcohol and multiple drug abuse remarkedly increased. He came back to Cincinnati and played music professionally with his father who is a professional musician. His alcohol and drug abuse continued. In 1977, he enlisted in the Army and was stationed in Germany. His drinking and drug abuse increased while in the service. In 1978, while stationed in Germany, he intentionally cut his wrist to avoid doing some work assignment. Because of this he was assigned to a remote radio outpost in Germany, where his heroin abuse started. Before being sent to a new assignment, he was told to attend an out-patient drug and alcohol counseling. In 1979, while stationed in a remote area in California, he cut his wrist again while heavily intoxicated. After this, he was again told to attend an in-patient treatment program which he did not complete. His non-completion of the treatment program contributed to his discharge. His third suicide attempt was on Christmas Eve of 1981 while also drinking alcohol and taking amphetamines. He was admitted to University Hospital. In June of 1982, while also very intoxicated, he made his fourth suicide attempt and was admitted to Veterans Administration Hospital in Cincinnati.

Mr. Van Hook's parents, both characterized by the client as alcoholics, were divorced when Mr. Van Hook was only 9 years old. "I moved back and forth a lot, I was kicked around a lot, and left at home a lot as a small child", was how he described his early childhood. Mr. Van Hook has an 8th grade education and had been employed in numerous jobs. He has had previous arrests for Disorderly Conduct and Theft, all of which were alcohol related.

Mr. Van Hook was cooperative, pleasant, and easily engaging with this interviewer. He gave a very good chronology of his life history and readily gave enlightening details. He was calm and appropriately responsive throughout the interview. There was no evidence of thought or emotional disorder or evidence of a continuing chronic depression or mania.

Observations and Recommendations: Mr. Van Hook who is an individual who grew up in an unstable environment (the feeling of being "moved back and forth, being kicked around and left alone a lot") and was raised by parental models who were and/or dependent on alcohol. It seems he has learned a pattern of eliciting caring from people around him by drastic acts, which can mobilize general alarm in his surroundings and immediately focus attention on him. Thus, we see the repeated self-mutilating acts to avoid responsibility (as in the Army) or to take care of feelings of isolation and feelings of being uncared for. It seems that Mr. Van Hook has chosen two ways to amplify his relationships: to drink a lot and by acts of self-destruction. To begin the effort to alter this pattern of behavior, this examiner recommends that Mr. Van Hook enter an in-patient substance abuse treatment program such as available at the Veterans Administration Hospital. Concurrent with this or after this, Mr. Van Hook might be well advised to get involved with AA and individual counseling such as is available at the VA Mental Health Service. Mr. Van Hook has a number of

characteriological issues which need to be sorted out with a therapist.

On the question of dangerousness, there seems to be mimimum evidence in Mr. Van Hook's history revealing assaultive behavior until this last offense. Mr. Van Hook seems more dangerous to himself with his tendency to self-destruction once he is in a seriously intoxicated condition. Thus, the danger is more to himself and to a certain extent to other people, if he continues to drink and operate motor vehicles. If probation be considered for Mr. Van Hook, his attendance to a substance abuse program should be a stipulation for probation as an added insurance to his compliance.

I appreciate this interesting referral.

Sincerely,

Teresito Alquizola, M.D.
Staff Psychiatrist

TA:das

EXHIBIT 6

REV. 8/81

UNIVERSITY OF CINCINNATI HOSPITAL — EMERGENCY RECORD

CENTER FOR EMERGENCY CARE

MEDICAL RECORD NO. 724-459

ENCOUNTER NO.	CARE AREA	IN DATE	TIME	LAST SEEN: E.D.	LAST SEEN: IN/OUT
F060301	ACS	021284	1255	021184	I 122581

PATIENT'S NAME - LAST, FIRST, MIDDLE	MAIDEN	SEX	RACE	MAR ST	AGE	BIRTH DATE	REL
VANHOOK, ROBERT		M	CA	S	024	0114960	PRO

ADDRESS - STREET	APT	CITY	STATE	ZIP CODE
4144 CRYSTAL VIEW CT		CINCINNATI	OH	45241

COUNTY	HOME PHONE	WORK PHONE	PERSON ACCOMPANYING PATIENT
HAMILTON	513 5541944	513 0000000	HAM CTY CAR

TYPE OF VEHICLE BROUGHT BY	BROUGHT FROM
* OTHER	CENTRAL STATION

ACCIDENT - PLACE	DATE	TIME
0-321 W 9TH STREET	021284	1150

NOTIFICATION - POLICE NAME	DATE	TIME	NOTIFICATION - RELATIVE NAME	DATE	TIME	VALUABLES RECEIPT NO
9K32						

NATURE OF INJURY/ILLNESS: WRIST LACERATIONS

B/P	TEMP.	PULSE	RESP.	*REGISTRATION INFORMATION SOURCE	COMMENTS	REGISTRAR
					SECURITY-HOLD	BAN

PHYSICIAN ORDERS

X-RAY: ☐ CHEST PA/LAT ☐ ABDOMINAL KUB ☐ ABDOMINAL 2 VIEW ☐ ABDOMINAL DECUBE: ___ L ___ R ☐ SKULL ☐ C SPINE ☐ HAND: ___ L ___ R ☐ KNEE: ___ L ___ R ☐ ANKLE: ___ L ___ R ☐ OTHER:

LAB: STAT ☐ CBC ☐ WBC # ☐ TOXICOLOGY: ___ TOXIC SCREEN COMPLETE ☐ SMA 7 ☐ PLATELET COUNT ☐ EKG ☐ UCG ☐ AMYLASE ☐ OTHER ☐ BHCG ☐ ABG ☐ PROTIME ☐ T & X ___ UNITS ☐ URINE ANALYSIS

ROUTINE ☐ CULTURES: ___ THROAT ___ SPUTUM ___ URINE ___ GC OTHER:

TREATMENT: ☐ IPPB # 1 ___ AP5 WITH 0.5 cc BRONKOSOL + (___) CC/NS ___ HHN ☐ #2 ☐ #3

☐ IVF # 1 SOLUTION: ___ L R ___ D5½NS ___ D5W VOLUME: ___ 500cc ___ 1000cc RATE: ___ cc/HR.
☐ IVF # 2 SOLUTION: ___ L R ___ D5½NS ___ D5W VOLUME: ___ 500cc ___ 1000cc RATE: ___ cc/HR.
☐ IVF # 3 SOLUTION: ___ L R ___ D5½NS ___ D5W VOLUME: ___ 500cc ___ 1000cc RATE: ___ cc/HR.

☐ MONITOR ☐ FX/SPRAIN CARE (ICE) ☐ TET TOX 0.5 ccIM ☐ OTHER

MEDICINES:

PROCEDURES: ☐ CPR ☐ INTUBATION ☐ THORACOSTOMY ☐ NG TUBE PLACEMENT ☐ CENTRAL LINE # 1 ___ SOL ___ RATE # 2 ___ SOL ___ RATE ☐ MINOR WOUND CARE (X ___) ___ STITCHES ___ DSD ☐ OTHER ☐ SLING ☐ CRUTCHES ☐ ACE WRAP ☐ CUT DOWN ☐ FINGER SPLINT ☐ POSTERIOR SPLINT ☐ CLAVICLE STRAP ☐ GUTTER ARM CAST

PHYSICIAN REPORT — TREATMENT TIME

Pt cut his (L) wrist with a piece of aluminum. Laceration was superficial. Area was cleaned with Betadine, rinsed with saline. Laceration was closed using 4-0 Nylon, 9 sutures. PSD and dressing was applied. (1% Carbocaine infiltrated for local anesthesia) Laceration closed was 4 cm. across left wrist.
When asked if he would try to commit suicide again, he didn't say no or yes. Pt. alert, responsive oriented x 3.
Refer to psych.

A: ① Laceration (L) wrist
② Suicide gesture

D. ① [illegible]
② R.T. ED. 8 days for Suture removal.

Pt. not suicidal at present — threatens suicide if incarcerated. [signature] MSW

[signature] UC III

PRESS HARD — WRITE LEGIBLY

PATIENT INSTRUCTIONS ☐ GIVEN ☐ NOT GIVEN

CONSULTANT NAME	SERVICE	TIME CALLED

ICD CODE	DIAGNOSIS	CONDITION
	Suicidal Gesture / Laceration (L) wrist.	II

DISPOSITION	ROOM/BED	SERVICE	ADMITTING PHYSICIAN	RESIDENT
Central Station		PES		

DISPOSITION TIME	REFERRAL	ED ATTENDING PHYSICIAN
	① CCI — suicide watch	[signature]

☐ SEE CONSULTANT / CONTINUATION SHEET — CARE LEVEL — ATTENDING/RESIDENT PHYSICIAN'S SIGNATURE: [signature]

MEDICAL RECORD COPY

UH-10

UNIVERSITY HOSPITAL
PSYCHIATRIC EMERGENCY SERVICE
INTAKE SHEET

In 2 15 A (P) / Out 4 A (P) / Date Out 2-12-84	Tx Area Time In 215 Out 315	Catch 3	Private / Medicare / Medicaid / (None)	Violent / Restraints / Invol. / Rights	
AGE 24	SEX (M) F	RACE (W) B O	MARITAL STATUS (S) M D Sep W	Prev. P.E.S. Date 0	INTAKE WORKER

Pt. Referred From ~~A[illegible]~~ Central Station Phone 554-1944

Out-pt. Care _____ Last Psych. Hospt. _____

Nearest Person(s) & Phone(s) _____

Diagnosis alcohol / drug abuse
ī suicidal gesture
r/o borderline syndrome

Referred to _____

Forward Copy to Central Sta / CCI

You are authorized to release this form to, and to receive information from, the above.

Signature Robert J. Van Dorn

Therapist	Minutes Direct	Indirect
1.		
2.		
3.		
4.		
5.		
6.		
Major Final 7. [illegible]mell	40	
Medical Review 8. [illegible]homson		10.

Current Meds:

Triage:

Medical Attn. Medical Triage

Treatment & Meds. in P.E.S.

Response: Good Fair Poor

Prescription Given

Time 1st Seen _____ Presenting Problem Pt. brought from Central Station after

Summary cutting wrist in cell. Had been seen in acs early a.m. on Saturday (2/11) having been brought by police after smashing windows of Daniels Hall. Was initially high on hash, proudly showed ī PCP. was taken to Central Station from acs & cut wrist ī ID wrist band. Pt. states he's been dkg & going into trouble since

Discharge Instructions: 14 y.o. Also took various drugs. Used ini

White Copy-Medical Records Yellow Copy-P.E.S. Records Pink Copy-Referral

Cont'd Y N

UH-10a

UNIVERSITY HOSPITAL
PSYCHIATRIC EMERGENCY SERVICE
INTAKE SHEET CONTINUATION

NAME Van Hook, Robert D.O.B. PAGE 2

DATE/TIME	(SIGN NAME AFTER EACH PROGRESS NOTE)

Army for 4½ yrs & made sergeant. Given medical discharge for alc/drug problems. "Joined" the army but can't re-enlist because of court record. Now wants to be a "soldier of fortune."

Pt. married for 6 mos. Divorced 9/83. Marriage ended re alc. problems. Has been employed @ Atlas Moving since 11/82.

Pt. drinks almost e/day. No ~~hx~~ hx out-pt army. Knows of VA alc/Drug Unit. Has never sought tx on own.

MSE:

Pt. calm, alert, cooperative, oriented ⊖ suicidal ideation currently. Threatens suicide if sent to CCI cell block. Feels he'll be OK at Central Station tonight. Vague suicidal ideation when under stress. This is usually when he is incarcerated. Made serious attempt 2 years ago on Xmas eve while drunk he cut upper arm. Scars looks serious. Required surgery & 3 day hosp (medical). Pt. has no idea why he did this. He does not

UH-10a

UNIVERSITY HOSPITAL
PSYCHIATRIC EMERGENCY SERVICE
INTAKE SHEET CONTINUATION

NAME Van Hook, Robert D.O.B. PAGE 3

DATE/TIME	(SIGN NAME AFTER EACH PROGRESS NOTE)

depressed when feeling he's a burden to his family & whom he loves. Feels worthless when he finds himself in legal trouble.
No hx of psychosis.

Plan: Return to Central Sta. - suicide watch
Ct. Cl. eval. upon arraignment tomorrow.
Suicide watch if pert to CCI.

Pt. has felony charges & cannot be hosp. at This time. Suicide ideation is situation specific.

Dx: Alcohol/drug abuse
No borderline ~~[illegible]~~ syndrome

J Powell MSW

EXHIBIT 7

Psychiatric Progress Notes

1/4/85 Extradicted from Fla. - arrived last nite. Though C.I. prisoner, placed in Suicide Watch Ward in P.I. due to past Hx of Borderline & hx of self-mutilation. In Court this a.m. Will evaluate today when returns.

L. Shaully RN, MSN

1/8/85: Pt new admission: Charged ē murder. Pt appears to be feeling down, 5 acute distress. no major c/o other than requesting to be taken out of 4 pts + denied suicidal ideation. admt charge + feels he has to pay for it & will go to PEN. + get himself an education - + guilt, + anxiety calm. no thought disorder, cooperative. Requested to go to CD: cooperative + polite. Pt was placed at W 8 & 4 pts only Lep risk due to high bond.

Plan: (1) TPI
(2) Ref to Dr. Hopes for Dx + Tx;
(3) Scheduled to take MMPI on 1/6/85 (too tired today)

L. Vaccaro Cencio (RN)

1/8/85: Pt appears to be stable 5 suicide ideation - polite + cooperative - requested MCB - completed MMPI. Pain / no speech disorder. + anxiety - Requested out of W 8 due to ↑ work pressure than from other pts. Can be off to Unit.

Plan (1) Move pt out of W 8 to W 7.
(2) Continue ref to Dr. Hopes.

L. Vaccaro Cencio

1/8/85 MMPI Results: Altho profile bears some similarity to inmate groups typically dx as borderline psych, it is more consistent ē other very pathological grp, comprised mostly of pts ē either psychosis ē strong affective component or "schizotype" pers dis (schizoid, schizotypal, borderline) ē chronic depression.
Maximal ↓ + above clinical data suggest the tables dx: borderline pers dis + dysthymic disorder. Tx: Generally these pt stabilize after brief PI ē FU on 5-C.
Plan: Pt wants to go to Abk. NAD, Normin.
Can TOPI today ē FU on 5-C Thurs.

B. Hopes PhD

1-11-85 Refused 5-C en favor of visit. Reschedule 5-C Mon.

D.11

EXHIBIT 8

TERESITO TITO ALQUIZOLA, M.D.
GENERAL & FORENSIC PSYCHIATRY

526 Nilles Road, Suite 10
Fairfield, Ohio 45014
(513) 829-2558

NAME: ROBERT VAN HOOK

DATE OF BIRTH: January 14, 1960

DOCKET NUMBER: B851389

OFFENSE: Aggrav. Murder, Aggrav. Robbery

EVALUATION DATE: May 29, 1985

June 10, 1985

The Honorable Robert S. Kraft
Hamilton County Court of Common Pleas
Cincinnati, OH 45202

Dear Judge Kraft:

This is in response to your request for a psychiatric evaluation of Mr. Robert Van Hook with regards to his mental state at the time of the alleged offenses pursuant to Ohio Revised Code, Section 2945.39. To do this report, Mr. Van Hook was interviewed on May 29, 1985. The nonconfidential nature of this interview was clarified with Mr. Van Hook who indicated his understanding by signing an explanation form. In addition to this interview, all documents pertaining to this case available at the Hamilton County Court Psychiatric Center were reviewed, including a confession made by Mr. Van Hook to the Cincinnati Police on April 1, 1985, and a personally written autobiography of Mr. Van Hook's. The following is this examiner's observations and conclusions.

Mr. Robert Van Hook is a twenty-five-year-old white single male who has been charged with aggravated murder and aggravated robbery. These charges resulted from an incident on February 18, 1985, when Mr. Van Hook allegedly murdered a Mr. David Self in Mr. Self's apartment

Mr. Van Hook's account of that day started when he said he went to a bar early in the afternoon where he stayed for about three hours. He said he consumed a considerable amount of alcohol (he has forgotten how many drinks he had), was smoking marijuana and, later, taking "speed to sober up myself." He said there

were times between the first bar and the second bar that he could not remember. He did remember going to a bar called The Subway, a bar he knows to be frequented by homosexuals. He said his purpose in going there was to meet some homosexuals, and pretend he was interested in some sexual encounter. However, he knew all along that all he intended to do was to lure them to some place on the pretext of having sex but all he wanted was to rob them of whatever money they have.

He did meet a homosexual at The Subway and arrangements were made for Mr. Van Hook to go to this person's apartment. When they got to this person's apartment, Mr. Van Hook said, he sat down on the couch and, moments later, the person (Mr. David Self, the alleged victim) squatted in front of him, reaching up to him. Mr. Van Hook said, he had his penis out and Mr. Self was shirtless. It was at this point, when Mr. Self was reaching up to Mr. Van Hook presumably for some sexual foreplay, when Mr. Van Hook said "I grabbed his neck in a stranglehold I learned when I was in the service, throwed him down until he stopped breathing and then I don't know what come over me." He said he went to the kitchen to look for a knife and the only one he could find was a paring knife. He said he used this to "stab him behind the ears, as I was trained, to scramble his brain." Mr. Van Hook said he was getting mad because "he looked like he was not gonna die, he kept making all these moaning sounds." Mr. Van Hook said he started cutting and stabbing the victim all over his body and he felt "I wanted to see the insides of his body and pull his heart out as though I was in Vietnam." Mr. Van Hook had been in the service but was never in Vietnam. He then went to the refrigerator to look for food and became angrier when he found the refrigerator empty. He said he smeared the victim's blood all over the place. He searched for money in his clothes and became angrier still when he could not find any. So he grabbed some jewelry from the victim's jewelry box. As he got back to the living room from the victim's bedroom, "I saw his body and freaked out at what I had done. I panicked, very real scared." He wanted to get out and found the door locked. He was able to get out with a butter knife. He proceeded to an elderly doctor friend in Newport, Kentucky, whom he told he had a fight with his stepfather and was afraid he had killed him. According to Mr. Van Hook, the doctor facilitated, with some money, his trip to Ft. Lauderdale, Florida. In Florida, he went back to "hustling homosexuals and working in construction" until he was arrested sometime in April, 1985.

Mr. Van Hook is the only male child of his parents and he has two half-sisters. When he was ten years old, his parents divorced and that started a life of moving back and forth between his father and mother, depending on which parent favored Mr. Van Hook at the time. His parents were both described as heavy drug and alcohol abusers, especially the father. The father was a musician and a cab driver and seemed to move a lot between Cincinnati and Florida. In most of these moves, Mr. Van Hook was with him, and at a very early age (about age eleven) learned how to take care of his basic needs because he was left alone a lot.

At age eleven he said he started to drink alcohol and get involved in fights. At age twelve he had his first arrest for disorderly conduct. After this came a series of involvements with juvenile authorities for behavioral problems and for running away. He also started abusing a variety of street drugs. At age fifteen, while living in Florida with his father, he learned how to hustle homosexuals for money. Instead of improving it appears that Mr. Van Hook's alcohol and drug abuse escalated. In 1977, he joined the service and while in Germany, his abuse of drugs became more sophisticated. He claimed to have been using hashish, amphetamines and heroin in Europe. He was in and out of drug and alcohol treatment programs without any visible beneficial effects on him. When he returned to the United State in 1981, the abuse of drugs continued.

Reviewing Mr. Van Hook's behavior between 1981 and the present time, it appears that his predilection for violence when intoxicated with drugs and alcohol becomes obvious. His "hustling homosexuals" also appeared to have established a certain repetitious pattern, as Mr. Van Hook himself admits. In the matter of this latest victim, it seems that Mr. Van Hook went to The Subway bar with full conscious intention of "luring a homosexual so I can get his money." It is a pattern of actions he has admitted doing repetitiously in the past, and from his account, this is exactly what he did. This examiner is not clear or fully knowledgeable on how violent Mr. Van Hook had been with his previous homosexual contacts in the past in the process of robbing them. Thus, I cannot determine whether his initial action of "strangling" his latest alleged victim was excessive or his usual method. It does appear that Mr. Van Hook was fully aware that he intended to hurt and immobilize his victims in order to get their money, and in this latest incident, it appears that it was the same intent. It is quite possible that Mr. Van Hook became excessive in his violence on his latest alleged victim due to a very momentary fantasy of being "in a combat zone", but the initial act of hurting the victim appeared to be made in full awareness and intent to immobilize the victim so he can be robbed. There was not any form of delusional thinking or hallucinatory perception in Mr. Van Hook's part that he was subduing an enemy or defending himself as a soldier in a combat zone. He knew he was in the victim's apartment and that the victim was about to initiate a sexual act as he (Mr. Van Hook) seemed to have made the victim understand as the purpose of their being together. During the alleged actions of violence on the body of the victim, although Mr. Van Hook claimed to have been in a trance, "as though I was watching somebody else kill a Vietcong" yet, intermittently, Mr. Van Hook appeared fully aware in searching the man's clothes for money, for food in the refrigerator, and for anything valuable in his jewelry box.

This examiner thus concludes that although the actions that night appeared bizarre and excessively violent, the main initiating violent action was done with full mental awareness and intent (to immobilize the victim so he could be robbed) and even the succeeding acts of violence were interspersed with

actions of clear intent like searching for money and other valuables. For these reasons, it is this examiner's opinion that at the time of the alleged offense, although presumably under the influence of drugs and alcohol, Mr. Van Hook did not have a mental disease or defect to impair his thinking as to render him unable to distinguish the rightness and wrongness of his actions. Furthermore, that he was able to refrain from his actions if such restraining influences were present.

I appreciate this referral.

Sincerely,

Teresito Alquizola, M.D.
Psychiatrist

TA:djs

EXHIBIT 9

COURT REPORT

CENTRAL PSYCHIATRIC CLINIC
COURT PSYCHIATRIC CENTER

222 E. Central Parkway - Lower Level
Cincinnati, Ohio 45202
(513) 352-3111

NAME Robert Johnson Van Hook DATE OF BIRTH 1-14-60

DOCKET NUMBER B85-1389 OFFENSE Aggravated Murder; Aggravated Robbery

REFERRAL DATE 4-30-85 EVALUATION DATE 6-24-85 COURT DATE 6-28-85

The Honorable Robert S. Kraft
Hamilton County Court of Common Pleas
Cincinnati, Ohio 45202

CONFIDENTIAL

Dear Judge Kraft: RE: NGBRI

This report is in response to your request for a psychological evaluation of Mr. Robert Johnson Van Hook in regards to his mental state at the time of an alleged offense, as is provided in Ohio Revised Code 2945.39. The defendant is charged with Aggravated Murder With Specifications, to which he has entered a plea of Not Guilty By Reason of Insanity. The defendant was evaluated by the undersigned, Nancy Schmidtgoessling, Ph.D., Clinical Psychologist, on May 27, 28, 29, 1985, and June 24, 1985, at the Hamilton County Jail. The evaluation included an interview as well as psychological testing (the Minnesota Multiphasic Personality Inventory, and the Wechsler Adult Intelligence Scale - Revised). On May 16, 1985, the defendant was interviewed by Louise Camblin, A.C.S.W., Clinical Social Worker. Prior to all sessions the non-confidential nature of the evaluation ws explained and Mr. Van Hook acknowledged understanding these. Collateral contact was made with the prosecutor, Mr. Tom Moorehead; one of the defense attorneys, Mr. Stu Mathews; psychiatric personnel at the Community Correctional Institution and the Hamilton County Jail; the defendant's mother, Mrs. Joyce Luttrell; his aunt, Mrs. Marilyn Johnson; his grandmother, Mrs. Van Hook; and Mr. Carl Shipp, of the VA drug program. Mr. Robert Hoy, a friend of the defendant, refused to talk with the examiner. Records of a 1983 Municipal Court pre-sentence evaluation, and a psychiatric evaluation at our Center were reviewed, as well as information from the Community Correctional Institution psychiatric unit, the Broward County Jail, the VA Hospital, (a summary from December 5-17, 1984, and brief contacts on May 28, 1983, June 27, 1982), and Norwood Elementary and Princeton Junior High Schools. Records were requested but not received from Cincinnati Public Schools, Madeira Schools, Juvenile Court and Detention Center of Hamilton County, Juvenile Court in Key West, Florida, and the National Personnel Records Center (for service records). What follows is a summary of my findings and recommendations.

Mr. Van Hook was found to be an alert man, oriented in all spheres. He was always neat and clean in appearance, always dressed in jail blues. Mr. Van Hook was cooperative to all examiner requests. In general, his emotional expressiveness was very flat, showing neither anxiety nor depression. The one exception to this was the marked anxiety observed (averted eye contact, verbal stammering, excessive feet shufflings) when discussing his history of homosexual behavior. His thoughts were always presented in a logical, coherent, relevant fashion. Concentration and attention were good, especially given that the interview area was often noisy and filled with extraneous activities. There were no signs nor reports of psychotic behavior (i.e., hallucinations, delusions, disordered communication) or major affective disorder (i.e., no crying spells, excessive sighing; weight loss, sleep or appetite disorders, elevated mood, pressured speech, etc.). The defendant impressed as being of average intelligence with intact memory.

The Alleged Offense: Mr. Van Hook recalled events leading to the current charges as follows. He was residing with his mother, in Sharonville, at the time. He recalled getting up early then driving to Mt. Healthy to see his grandmother. He thinks he had with him $20.00 of his own money and borrowed $10.00 from his grandmother. Then he went to Billy's Bar located near his grandmother's to get a drink, and while there he bought some pot and a couple of amphetamine tablets from another patron there. He recalled an old man buying him a drink, then buying another for the old man. He feels confident he had some whiskey as "the whiskey got me started on a blackout."

The client can recall no specific events of the day until arriving at the Subway Bar downtown, "late at night," maybe 10:00 or 11:00 p.m. He described he knew this was a homosexual bar and "it was probably in my mind to go there and rob a homosexual. I needed the money." Another man, the victim, came up next to Mr. Van Hook and started buying Mr. Van Hook some drinks. He said they struck up a conversation in which Mr. Van Hook "led him (the victim) to believe I'd have sex with him, then I'd take his money."

Mr. Van Hook remembers driving the victim, Mr. Self, to Self's apartment in Mr. Van Hook's car. He had been drinking all day, an amount he cannot determine, and he cannot remember what he drank. Additionally, sometime during the day or night he took two "hits of speed." On the way to Mr. Self's, the men smoked a joint. Mr. Van Hook states he then began to feel "light-headed." He also felt "drunk," "bloated," "all messed up" and "spacey."

Once at the victim's apartment, Mr. Van Hook states that he sat in a black chair and smoked a joint while the victim "started taking his clothes off." Mr. Van Hook denies that his own clothes were open or that his body was exposed, even though he admitted such in his confession. He said that when Mr. Self knelt down before him and reached for him, "I snapped, he reached up to grab me and I went crazy on him."

Mr. Van Hook "grabbed him by the throat in a stranglehold which I learned in the service." After he thought he broke the victim's neck, "I went in the kitchen and got a knife. I started using Ranger tactics on him ... I put the knife in his brain and twisted it. I tried to cut his heart

out, to take a bite out of it, explaining how he slit the victim's stomach. He reports that then "I stopped, I don't know why. It was like watching somebody else do it." He described that he thought of the victim "as something like the enemy, like in Vietnam. I thought about being a hero, being in combat." He began to act out military techniques he had seen in the movies "Killing Fields" and "Uncommon Valor," which he had seen shortly before the offense. However, he admitted that some of the assault (i.e., stuffing the cigarettes and medicine vial in the victim) were not in the movies, "I don't know how I thought of them."

Mr. Van Hook thinks he then "panicked" as "I seen him lying there in all that blood. I couldn't do nothing like that. I didn't know what to do." He then went into the kitchen looking for something to eat but became "pissed off" because there was nothing there. He washed off his hands, then searched the body and the apartment for money. As he tried to leave, the door stuck and he had to use a knife to break the lock to exit.

He then went across the river to visit a friend, Robert Hoy, who gave Mr. Van Hook some food and money. He then drove south on I-75, abandoning the car in another state. Upon arriving in Florida, he resided with a friend, robbing some people to support himself although he apparently also obtained a job there, too. He reports he "never thought about" the victim or the offense until he was arrested.

Mr. Van Hook's mother reported that during the period prior to the offense, her son did not act in any unusual way. He was nervous and restless, but this was apparently customary for him. He stayed out at his aunt's house (Marilyn Johnson's) the night prior, and had a reasonable, coherent conversation with the aunt about the aunt's daughter. When he visited his grandmother on the day of the offense, his behavior was also unremarkable.

Background Information: Mr. Van Hook is the product of a bizarre, chaotic family. He has two older half-sisters from his mother's first marriage. He was born eleven months after his parents' marriage. Mrs. Luttrell reported that her husband was unfaithful as soon as two weeks after the wedding. The father reportedly abused drugs and alcohol, and apparently often had rowdy friends at the house. Mrs. Johnson, who resided with the Van Hooks for a while, said she would hide when these men got together, so violent and outrageous were they. The father was openly violent towards the mother, as well as being pathologically jealous. As Mr. Van Hook also slept in his parents' bed, he was subjected to terrifying instances of observing sexual violence, too.

The parents separated and reunited off and on for almost ten years. Mrs. Luttrell began seeing other men, and going on out of town trips, leaving the client in the care of his aunt. Mrs. Luttrell admits she also began drinking alcohol heavily, and thus had little guidance or stability to offer the children. When Mr. Van Hook was about nine, the parents divorced, leaving Mrs. Van Hook "overwhelmed" by having to raise the three children. Two of the children (Mr. Van Hook's half-sisters) decided to move out to Iowa with their father, and Mrs. Van Hook then decided to have the defendant

stay with his father. It was around this time that Mr. Van Hook apparently began to abuse substances. Throughout his developmental years, the family suffered major physical stressors beyond just violence by the father. Apparently there was often inadequate care, with Mr. Van Hook very sickly as a child. There were several physical moves, too, within the Cincinnati area and also to the state of Florida.

Academically, Mr. Van Hook advanced only as far as grade nine. He created many bebavior problems in school and failed to apply his abilities to learning. He admitted to many suspensions and an expulsion. He feels the many physical moves he made between the two parents were not detrimental to his learning as often the schools were less advanced than he was used to and he would "coast." He recalled one year in which he deliberately under-achieved and had himself placed in special classes "so I could get A's without working."

Mr. Van Hook reports using alcohol at age two when he would sneak drinks at home. By nine he drank openly with his father and recalls bar hopping with him. He reports frequent blackouts and a high tolerance for alcohol. He began using marijuana at age 14, and would steal amphetamines and Valium from his father. At age 15, he used acid, and while in the service he used intravenous heroin and morphine. Since getting out of the service he denies using hard drugs regularly but consumes mostly alcohol, pot and occasional "speed."

Sexually Mr. Van Hook recalls being active since age five. He had several close girlfriends, although mostly he reports numerous brief encounters with women. He describes that "I'm so good sexually" it's hard for him to get the women to break off with him, although he says he wants no long-term relationships. He has been married once, "to see what it is like." Apparently this only lasted a short time. Mr. Van Hook admitted he has had homosexual contact with several men. He said he was only a passive participant to oral sex acts, which he was agreeable to "because I wanted something from them, friendship, clothes, a place to stay." He related that he has also engaged in many acts of "rolling" homosexuals, that is, leading them to believe he is agreeable to sex acts and then when they are isolated, Mr. Van Hook intimidates and robs them. He said he's done this numerous times since he was "shown the ropes" at age 15, even engaging in this a couple of weeks prior to the current offense. Mr. Van Hook said he has never robbed a homosexual nor engaged in any homosexual acts without being high on some substance.

Psychiatrically, Mr. Van Hook has never been hospitalized, although he has been treated briefly for several suicide attempts. He has made three suicide attempts since being discharged from the service in 1981, the last being at Central Station in 1984. There were also suicidal gestures in the Army. He was in in-patient substance abuse treatment from May to June, 1984 at the VA Hospital, and had continued in out-patient treatment up until the time of the alleged offense. Carl Shipp, the client's counselor at the VA program, reported that Mr. Van Hook often presented at their interviews in combat fatigues. The client apparently was quite superficial in his discussions. His mother reports a series of violent acts towards others that Mr. Van Hook has perpetrated since his military discharge (i.e., an incident in a Sharonville bar where he cut one of the employees with a broken

ashtray, putting his a[illegible] through a window during a bar f[illegible]t in Clifton). He can articulately explain how his childhood experiences have caused him chronic feelings of anger, insecurity, fear, and low self-esteem.

Vocationally, Mr. Van Hook has had a series of short-term jobs. He has often been fired or quit because of alcohol use. He was in the service for almost four years, with his main desire being to serve in the special services. When this was denied him, he developed a "shit attitude" and became more heavily involved with drugs. He has been unable to establish a stable lifestyle since returning from the military. Mr. Van Hook has been fascinated with the military all his life, and he repeatedly discussed his fantasies of being a war hero. He even stated that he felt deprived because he had not been old enough to serve in combat in Vietnam.

Psychological Testing: Intelligence testing (WAIS-R) shows Mr. Van Hook to be functioning in the average range of intelligence (Verbal IQ = 92, Performance IQ = 99, Full Scale IQ = 95). His intellectual strengths are concentration, abstract concept formation, general fund of knowledge and vocabulary in the verbal realms, and sequential ordering of events, differentiation of essential from nonessential details and reproductive visual motor coordination the performance sphere. His major weaknesses were arithmetic reasoning and judgment. With scores such as these, high school but not college graduation would be expected. Completion of a trade program would be possible. No impairment of daily living could be traced to this source, with scores such as these.

The MMPI shows dysfunction in a variety of areas. Most prominent are paranoid concerns, which are probably exacerbated by the trial process and anxiety. He admits to many physical complaints, bizarre body experiences, and cognitive dysfunction, all of which probably relate to his substance use. He is moderately depressed, which is appropriate to his current situation. Chronic anger is high along with admissions of inability to conform to social conventions. His profile is somewhat different than that obtained on admission to the Community Correctional Institution on April 4, 1985, specifically with more depressive and paranoid symptoms now than at that time.

Conclusions: Mr. Van Hook was found to be the product of a bizarre, chaotic, violent background in which he observed a variety of antisocial, inadequate and inappropriate behaviors. Further, he received no guidance or support from parents. Even physically, his early environment was inadequate for healthy development. Consequently, he suffers chronic feelings of insecurity, anger, emptiness and unworthiness. He, in turn, has demonstrated many of the behaviors modeled in his environment. Because of this, he has developed interpersonal, emotional, identity and behavioral impairments which make him inadequately prepared to productively relate to others, hold a job, or establish an independent lifestyle. He is chemically dependent, further impairing his functioning.

The alleged offense appears to be a unique combination of several factors. Mr. Van Hook's poor judgment was probably weakened further by his excessive substance use. His desire to obtain easy money to satisfy his present needs led him to consider robbery as a solution. His lack of empathy and his manipulative characteristics allowed him to approach a vulnerable

victim. His identity disorder may have led him to be willing to engage in a bonafide homosexual behavior even as his fear of homosexuality may have caused fear and disgust in him and the assault on the victim. His fantasies of being competent, in command and "being a hero" were expressed in his mutilating acts toward the victim.

In conclusion, I find no evidence of impairment by mental disease or defect which affected his sense of right or wrong or his ability to refrain.

Thank you for this referral. If you have further questions, please feel free to contact me at 352-3116.

Respectfully,

nancy Schmidtgoessling, PhD/LC

Nancy Schmidtgoessling, Ph.D.
Clinical Psychologist

If testimony is required on this case, the Court Psychiatric Center will be represented by Nancy Schmidtgoessling, Ph.D., Clinical Psychologist.

NS:cjg
6-25-85

EXHIBIT 10

CENTRAL PSYCHIATRIC CLINIC
COURT PSYCHIATRIC CENTER

222 E. Central Parkway - Lower Level
Cincinnati, Ohio 45202
(513) 352-3111

TREATMENT ADDENDUM

Name Robert Johnson Van Hook

Docket No. B85-1389 Date of Evaluation 6-24-85

Identifying Information: Robert Van Hook is a 25 year old, divorced, white male charged with Aggravated Murder with Specifications, making him eligible for the death penalty if convicted. We were asked to evaluate him for his mental state at the time of the offense.

Presenting Problem: Mr. Van Hook is charged with luring a homosexual into his confidence by promises of sexual activity, then robbing, killing, and mutilating him.

Background : As per Court Report

Dynamics: Two hypothesis are likely and cannot be preferred one over the other because Mr. Van Hook gives different stories of the sequence of events. Based on the police confession it seems Mr. Van Hook assaulted the victim, David Self, in rage after he found no money in the apartment. The second hypothesis - based on Mr. Van Hook's story to us - was that he assaulted Mr. Self in a homosexual panic.

Diagnosis:
Axis I: Alcohol dependence, continuous
History of heroin abuse
Marijuana abuse
Amphetamine abuse
Conduct disorder, undersocialized, aggressive type
Axis II: Borderline personality
Axis III: No condition known

Treatment Recommendations: None at this time.

Nancy Schmidtgoessling, Ph.D.
Clinical Psychologist

NS:cjg
7-25-85

EXHIBIT 11

001-4433

CENTRAL COMMUNITY HEALTH BOARD OF HAMILTON COUNTY, INC.
520-532 Maxwell Avenue
Cincinnati, Ohio 45219

Bennett J. Cooper, Jr.
Executive Director

David W. Caldwell
Board Chairperson

July 3, 1985

The Honorable Judge R. Kraft
Hamilton County Court of Common Pleas
1000 Main St.
Cinti., Ohio 45202

Dear Judge Kraft:

The following is a summary of a psychiatric evaluation of Mr. Robert Van Hook. The evaluation was undertaken in an attempt to establish his mental status at the time of the alleged offenses. Mr. Van Hook has entered a plea of Not Guilty by Reason of Insanity to charges of aggravated murder and aggravated robbery. The information and conclusions contained herein, are subsequent to a psychiatric examination of Mr. Van Hook on June 5, 1985 at the Hamilton County Jail, and a review of relevant materials.

At the time of the examination, Mr. Van Hook was a twenty-five year old white male. His description of the events surrounding the alleged events are summarized as follows. The morning of the alleged offenses, he went to his grandmother's house and went to a local bar in Mt. Healthy. He indicated that he became inebriated on whiskey and beer and smoked a couple of joints. He left at approximately 7:00 p.m. His next recollection was of being at a gay bar, the Subway, in downtown Cincinnati. He stated that it was his custom to go to gay bars to "roll them for money." He identified a prospect and planned to lure him away with a promise of sex, then take his money. He stated this was his pattern on previous encounters.

They drove to the deceased's apartment in Hyde Park. He estimated the time to be approximately 2:30 a.m. They smoked another joint during the drive. After arriving at the apartment, they continued to smoke marijuana and drink whiskey. Mr. Van Hook said that he then sat down, and the deceased knelt in front of him, (the deceased had no shirt or shoes on at the time) and reached up to embrace him. When he did this, Mr. Van Hood grabbed him and began choking him until he became unconscious. He stated that he envisioned him as a Viet Cong and had thoughts of being in combat. He stated that he had had previous episodes of being drunk/high and believing that he was in combat.

When he saw that the man had stopped breathing, he became "obsessed with cutting him up" in ways he had seen it done in a movie, The Killing Fields." He went to the kitchen, got a knife, and attempted to decapitate the body, to stick

it on a bamboo pole. Unable to remove the head, he began to cut his abdomen in an attempt to remove the heart, to eat it. Again, he failed and he got up and went to the kitchen to look for something to eat. He noticed that there was blood and fingerprints on the refrigerator and attempted to remove them. After this, he went through the man's pants pockets looking for money. He then went to the bedroom and took jewelry and a leather jacket. He said he then panicked, realizing what he'd done and left the apartment and drove to Dr. Hoy's house in Kentucky. (Dr. Hoy was a friend). He said he went there to get money to leave town. He told Dr. Hoy that he'd had a fight with his stepfather. After eating and getting money he left and began driving to Florida. He abandoned the car around Chatanooga and hitchhiked to Florida with a trucker.

Mr. Van Hook had a very chaotic childhood, which has been described in other court records. He has had an extensive psychiatric history including inpatient and outpatient treatment. He also has an extensive drug history having abused, alcohol, marijuana, PCP, LSD and a variety of pills. He has experienced auditory and visual hallucinations while on drugs and has had blackouts and DT's.

MENTAL STATUS EXAMINATION:

At the time of the exam, Mr. Van Hook was a twenty five year old white male appearing his stated age. He appeared to be well nourished. He had numerous large scars from self-inflicted wounds, secondary to suicide attempts. He manifested no abnormal motor activity. His speech was coherent, with normal rate and rhythm. He denied auditory or visual hallucinations currently, but has experienced them when using drugs. He manifested no delusional thinking. His mood and affect were very depressed, and there was suicidal ideation. His memory was intact. He was judged to be of normal intelligence.

SUMMARY:

Based upon my examination, and a review of relevant materials, it is my opinion that Mr. Van Hook suffers from a borderline personality disorder. At the time of the alleged offense, I believe he experienced a transient drug-induced psychotic episode. For a brief period he appears to have been unable to distinguish right from wrong. I believe that this was the result of a combination of drugs interacting with a borderline personality structure. He is currently depressed and continues to represent a danger to himself and others.

Sincerely yours,

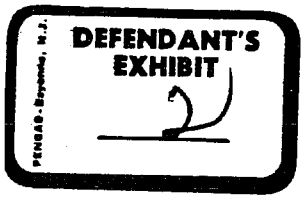
Emmett Cooper, M.D.

Emmett G. Cooper, M.D.

EGC:bjj

EXHIBIT 12

Kraft
rec: 7/31/85



COURT REPORT

CENTRAL PSYCHIATRIC CLINIC
COURT PSYCHIATRIC CENTER

CONFIDENTIAL

222 E. Central Parkway - Lower Level
Cincinnati, Ohio 45202
(513) 352-3111

NAME Robert J. Van Hook DATE OF BIRTH 1/14/60

DOCKET NUMBER B85-1389 OFFENSE Aggravated Murder
Aggravated Robbery

REFERRAL DATE 7/29/85 EVALUATION DATE 7/30/85 COURT DATE 7/31/85

The Honorable Robert S. Kraft
Hamilton County Court of Common Pleas
Cincinnati, Ohio

Dear Judge Kraft: RE: MITIGATION

This is in response to your request that Robert J. Van Hook, who has been convicted of Aggravated Murder with Specifications, be evaluated with regard to mitigation of death penalty, pursuant to Ohio Revised Code 2947.06. Mr. Van Hook was evaluated, by the undersigned, Donna E. Winter, Ph.D., Clinical Psychologist, in the Hamilton County Jail on July 30, 1985. Prior to evaluating Mr. Van Hook, I was able to review all material contained in Court Psychiatric Center charts on Mr. Van Hook. This material includes prior psychiatric evaluations; the results of psychological testing; information gathered from collateral sources such as Mr. Van Hook's relatives, the defense attorneys, the prosecutor, psychiatric services at the Community Correctional Institution; school records; records of prior psychiatric treatment; records from Municipal Court Probation; as well as an autobiographical statement made by Mr. Van Hook and a copy of his statement to the Cincinnati Homicide Squad in regard to the offense. The non-confidential nature of this evaluation was explained to Mr. Van Hook and he acknowledged understanding this. The following is a summary of my findings and conclusions.

On examination, Mr. Van Hook was oriented to reality and he was cooperative. While he was verbally spontaneous, his emotional expression was flat in that his face remained immobile and there was no show of emotion, either negative or positive. The client was logical and coherent throughout, exhibiting no symptoms of impaired or peculiar thought processes.

Evaluation of Mr. Van Hook, together with a review of all available historical material, indicates the following characteristics of his current and long-term functioning: Substance abuse, manipulation or consistent use of others for his own ends, intense anger, physically self-damaging acts such as suicidal gestures and self-mutilation, chronic depression and disturbances in identity (e.g., gender identity). These characteristics

are hallmarks of what is referred to as a borderline personality disorder.

The most salient aspect of borderline personality disorder is the presence of intense anger which can be discharged in a diffuse, primitive rage, resulting in bizarre acts of aggression and violence. This description is consonant with Robert Van Hook's behavior in the murder of David Self.

Development of a borderline personality disorder has its roots in events which occur before the age of three. Mr. Van Hook's background reveals a history of chaotic, violent and unstable family relationships. Prior to his mother's marriage to his natural father, she had been married and divorced and there were two older half-sisters. The mother's first marriage ended in divorce because her husband was abusive to her. The mother indicates that it turned out that Mr. Van Hook was equally abusive. Within two months of the marriage, Mr. Van Hook began "running around" with other women. He was a drug abuser (heroin and amphetamines) who was patholOlgically jealous of her. The client was born 11 months after the marriage, into a setting of marital chaos. When the father continued to abuse drugs, the mother began to drink heavily. When the client was six months old, the mother threw the father out and went on Welfare. The mother described the first year of Mr. Van Hook's life as difficult since she had three children to contend with, she had very little money and Mr. Van Hook was always sick, going from one infant illness to another.

When Mr. Van Hook was one year old, his mother met another man and would often go on out of town trips with him, leaving the client in the care of his aunt. After she broke up with this man, the client's mother returned to his father. In fact, although she filed for divorce three times before finally following through when Mr. Van Hook was nine years old, Mr. and Mr. Van Hook lived together, on and off, during that period of time. When his father was home, Mr. Van Hook observed numerous episodes of violence between his mother and father. Mrs. Van Hook described times when her husband would grab her by her hair and swing her around the room, hold her at gun point, hold her at knife point, etc. Since Mr. Van Hook slept in his parents' bed at times, he also observed sexual violence when both his parents were drunk. At times when the parents were separated and the mother was dating other men, he observed her coming home drunk with these men and may also have been witness to other inappropriate sexual activity.

In other words, Mr. Van Hook's early years were characterized by a mother who could not offer stability or adequate care-taking because she was either drunk, embroiled in a pathological relationship with her husband or running around with other men. His father also offered no stability since he was not there regularly and, when he was in the home, he was either drunk or "high" on drugs, behaving in a manner which would be terrifying to a youngster.

Life, for Mr. Van Hook, was very much like a "combat zone." This may explain his early and continuing attachment to fantansies about war and the military. Whether Mr. Van Hook became involved in military fantasies as a way of coping with anger against family members, or whether he was

attempting to master his own anxiety about the aggression in the household, matters little. What is important is that fantasies about killing and war began very early for Mr. Van Hook. His mother remembers that he always wanted to wear army clothing and he was accustomed to sleeping in his little army uniform. Mr. Van Hook remembers having a set of "GI Joe" figurines which he used to re-enact wars, making the figures punch each other and staging wars with them. As he grew older, his fascination with combat continued. Mr. Van Hook states that he began reading books about World War II and, later, about the Vietnam conflict. Mr. Van Hook did serve in the Army for four-and-a-half years, being honorably discharged as alcohol and drug dependent. He regrets that he was unable to serve in Vietnam and exhibits an obsession with Vietnam-era military exploits.

The client indicated that he would always "hang around" people who had been in Vietnam in order to hear about "war stories." He has read at length on the subjects of guerilla warfare and psychological warfare. At one point during the interview, with no solicitation of this material, the client started talking about various gruesome and gory tortures perpetrated by the Viet Cong. Once started, he was unable to stop and continued until the subject was changed. Mr. Van Hook's discussion in this vein reveals a fantasy-identity as a combat warrior, as well as fascination with bizarre, aggressive behavior.

In addition to soothing his anxiety through fantasies of being strong and brave in combat, Mr. Van Hook soon learned, perhaps by imitation, that substance abuse could also soothe those feelings. Mr. Van Hook states that he began sneaking sips from his parents drinks before he was three years old. At the age of nine, he began drinking and bar-hopping with his father. At the age of 14, Mr. Van Hook began using marijuana, amphetamines and hallucinogens. He began by stealing his father's amphetamines and Valiums. As he entered his teenage years, he continued with abuse of multiple substances. In the Army in Germany, the client began using hashish as well as intravenous use of heroin and morphine. When he discontinued the heroin and morphine, he continued to inject speed and acid. He often combined drugs with alcohol, reaching the point where he could drink a fifth of liquor at one time. There were two occasions, when he was in the service, when he slashed his arms his razor blades, when drunk. Mr. Van Hook was given a drug and alcohol discharge from the service in 1982. In 1984, he did receive in-patient drug treatment at the Veterans Administration Hospital, followed by out-patient treatment with a drug counselor.

Mr. Van Hook's initiation into drug and alcohol abuse coincided with a period of time when he and his father moved to Florida for six months. That was around the age of 11. From age 11 on, Mr. Van Hook spent periods of time with his father, with his mother, with an aunt and later, after his mother remarried, with his mother and stepfather. Around the age of 14, Mr. Van Hook and his father moved back to Florida. It was while living in Florida that Mr. Van Hook was initiated into "rolling gays." Mr. Van Hook stated that he met a man who showed him how to take advantage of gay men - "How to coax them into a room to have sex and knock them out and take their money." He indicates that prior to this, he had been working as a homosexual

prostitute in order to earn money. Mr. Van Hook said he felt "disgraced" by this activity and saw himself as an inferior and worthless person when involved in male prostitution. Accordingly, he decided to be the aggressor and not the victim, and began robbing homosexuals for money. The client indicates that he would do this by luring the man with promises of sex, getting the victim to undress so that he was vulnerable and then using either verbal intimidation or physical force (punching) to get money. He states that none of his victims ever pressed charges against him.

On February 18, 1985, Mr. Van Hook went to the Subway Bar, in downtown Cincinnati, in order to rob a homosexual. Prior to arriving in downtown, Mr. Van Hook had been drinking at a bar in Mt. Healthy. He does not recall the amount of alcohol he drank, but states he was drinking vodka and grapefruit juice. At one point he bought some joints of marijuana and two "speckled birds" (amphetamine tablets) from another bar patron. He smoked the marijuana, but does not recall taking the amphetamine tablets. Mr. Van Hook has difficulty pinpointing the exact time at which events occurred. However, it appears that he had been drinking a number of hours in Mt. Healthy before arriving at the Subway Bar. There, he began talking with David Self. The client stated that he used his usual technique to "feel out" his victim. That is, he told Mr. Self, "I'm expensive." (Mr. Van Hook states that at this point, the would-be victim will either decline because he cannot "afford" Mr. Van Hook's services or, the victim will indicate that he can "afford" him.) Mr. Van Hook states that the victim, Mr. Self, told him that he had money and the two left the bar, driving in Mr. Van Hook's car to the victim's apartment.

When Mr. Van Hook arrived at the victim's apartment, he was under the influence of alcohol. He may have been under the influence of drugs, but this remains unknown because he has given a variety of stories in that regard. That is, Mr. Van Hook told me he could not recall whether he took "two hits of speed" prior to arriving at Mr. Self's apartment, whereas, he told other examiners that he had used speed, as well as alcohol and marijuana. Further, Mr. Van Hook indicated to me that he could not recall whether he and the victim, Mr. Self, smoked marijuana prior to Mr. Van Hook's attack on Mr. Self.

Mr. Van Hook stated that when the victim approached him for oral sex, he grabbed his head in a hammer-lock, rendering him unconscious on the floor. He states that he then went to the kitchen, got a paring knife and, while fantasizing himself as being a military hero in Vietnam, twisted the knife in Mr. Self's head, attempted to cut his head off and slit his stomach open in order to "reach his heart so I could eat it." Mr. Van Hook's only explanation for his behavior is, "I clocked out. I thought I was in the jungle and he was a Viet Cong and had snuck up on me."

The client's bizarre and violent attack on David Self was an expression of diffuse, primitive rage. It was a generalized discharge of his own underlying hate and aggression. What set off the blitz attack remains unclear. In his statement to the police, Mr. Van Hook alludes to the fact that he vented his rage on Mr. Self after finding out that the victim, who had promised him money, actually had no money. This may be one explanation. Another explanation may be that the client found himself interested in, and tempted to have a sexual relationship with Mr. Self, when

the victim approached him. This may have precipitated a homosexual panic, together with an enraged and murderous response to having these "disgraceful" feelings arise in him. Although the motivation cannot be accurately stated, given Mr. Van Hook's inability or unwillingness to articulate it himself, what is clear is that Mr. Van Hook's chronic, intense anger, exhibited previously in assaultive behavior of varying severity, exploded into senseless and bizarre brutality. His murderous acts were carried out while immersed in long-standing fantasies of being a military hero.

Conclusions: Robert Van Hook, a 25 year old, divorced, white male was evaluated in regard to mitigation of penalty, pursuant to Ohio Revised Code 2947.06, having been convicted of Aggravated Murder with Specifications. Evaluation reveals a man who is neither mentally ill, nor mentally retarded. He is the product of an unstable, non-nurturant, violent, and chaotic background, as outlined above. Descriptions given by Mr. Van Hook and family members indicate that his early years were characterized by inadequate parental care due to absence and/or unavailability of the mother because of drinking, repeated abandonment by her, exposure to physical and sexual violence, and exposure to substance abuse. These factors preclude development of a healthy, normal personality. Instead, Mr. Van Hook developed a serious personality disorder, i.e., borderline personality disorder. This disorder is characterized by chronic intense anger, feelings of worthlessness and self hate, inability to develop relationships with others except for meeting one's own needs and chronic feelings of insecurity and emptiness due to inability to function socially or vocationally. Mr. Van Hook has adopted two methods of dealing with these impairments. He has developed a long-term fantasy life in which he is a heroic military man. Even after leaving the Army, he continued to wear combat fatigues on the street and continued to read novels about war. Mr. Van Hook's other method of coping was to seek oblivion through drugs or alcohol. He is, in fact, chemically dependent.

It is my opinion that at the time of committing the offense, Robert Van Hook was not suffering from any mental disease or defect which substantially impaired his capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. The offense was the product of a discharge of primitive rage which is not uncharacteristic in a borderline personality disorder. While the motivation for this rage remains unknown and while the rage evoked familiar fantasies in Mr. Van Hook of being a hero in combat, major elements of his behavior were goal-directed, i.e., intending to rob the victim, wiping off finger prints, searching the house for valuables and flight to avoid detection. The fact that Mr. Van Hook was under the influence of unspecified chemicals at the time also contributed to a lowering of inhibitions and an acting-out of rage.

If there are any further questions, please do not hesitate to call me at 352-3116.

Yours Respectfully,

Donna Winter

Donna E. Winter, Ph.D.
Clinical Psychologist

DEW/ep
7/30/85

EXHIBIT 13

EXHIBIT 9

1989

IN THE COURT OF COMMON PLEAS

HAMILTON COUNTY, OHIO

STATE OF OHIO, :

Plaintiff-Respondent, : Case No.

-vs-

ROBERT VAN HOOK : Judge Robert S. Kraft

Defendant-Petitioner. :

AFFIDAVIT OF JAMES R. EISENBERG, PH.D.

IN THE STATE OF OHIO

COUNTY OF LAKE, SS:

I, James R. Eisenberg, being first duly sworn according to law, state the following:

1) I am a psychologist, licensed to practice in Ohio since 1978.

2) I am a Diplomate of the American Board of Forensic Psychology and a Diplomate of the American Board of Professional Psychology. I am an Associate Professor of Psychology at Lake Erie College and an Adjunct Professor of Psychology at John Carroll University where I teach Psychology and Law. I have lectured on many topics including the insanity plea and the death penalty.

3) For the past ten years I have been the Court Psychologist for the Lake County Forensic Psychiatric Clinic and I continue to serve in that capacity for the Lake County Court of Common Pleas.

4) In the course of my employment with the Psychiatric Clinic and my practice as a Forensic Psychologist, I

EXHIBIT 16

have evaluated more than one thousand criminal defendants including approximately forty capitally charged defendants. I have evaluated numerous defendants who have entered pleas of not guilty by reason of insanity.

5) I have testified for the prosecution, defense and for the court. I am very familiar with the type of preparation required for capital cases, especially mitigation of the death penalty.

6) The preparation for the mitigation phase of a capital case is a long and tedious task. The preparation involves extensive research into the background of the defendant and includes a collection of all available records from schools, mental health clinics, juvenile authorities, hospitals, psychologists, school psychologists, psychiatrists, social workers, employers, probation officers, etc. The collection of records is vitally important in the area of intellectual and emotional development, sexual and marital development, medical history, and other collaborative material. In my experience, given the nature of the dysfunctional families of the defendants, these records often do exist, but it takes months to collect them. This is a task which often requires much foot work, phone calls, follow up letters, travel, more phone calls, and more letters. Though the attorney is responsible for collection of these records, he or she may delegate that responsibility to someone else. The person most qualified for this particular task is a trained social worker and mitigation specialist those interviewing skills and educational background is

appropriate. This process must begin months before trial in order to have an effective and meaningful understanding of the defendant and the crime.

7) A plea of Not Guilty by Reason of Insanity (NGRI) is not a substitute for mitigation. NGRI addresses one moment in time and concerns the defendant's behavior and mental status only during the criminal act. Mitigation permits the defense to present the alleged criminal act in a much larger context emerging from the defendant's unique social, emotional, and psychological history. A broader extension of the NGRI plea under 2929.04 (B3) may also be considered as a part of that mitigation. Though a defendant may initially be evaluated for his pleas of NGRI, in my experience, additional evaluations and interviews would be necessary to render an opinion under the mitigation statute. The circumstances under which a defendant is evaluated for NGRI are different both in substance and procedure than for mitigation. In my opinion, one can not simply restate the NGRI findings at mitigation.

8) In addition to the collection of records, additional information must also be pursued:

a. Extensive interviews of family members, including parents, step-parents, siblings, aunts, uncles, grandparents, cousins, as well as neighbors, professional associations (physicians, etc.), court personnel and the like. In my experience, individuals charged with capital offenses have extremely dysfunctional family units.

9) This information is essential for defense counsel in order to gain detailed, accurate knowledge of the defendant.

10) Such knowledge enables the defense counsel to formulate defense strategies both for the trial and mitigation phases, and to provide the trier of facts with an accurate and detailed understanding of the defendant, his environment, his personality and sexual development, and potentially mitigating factors.

11) As stated previously, the process of gathering this information often takes many months and requires the coordination of criminal and social investigators, mental health professionals and attorneys.

12) The responsibility ultimately lies with the defense attorney to initiate and coordinate this process and provide direction and integration to the defense.

13) To summarize, any preparation for the mitigation phase should include the following:

I. Obtaining the following background information:

a. The defendant's developmental experiences
b. The defendant's family dynamics
c. The parenting capacities in the family of the defendant
d. The defendant's academic capacities and achievements
e. The defendant's work experiences including relationships with co-workers as well as job skills
f. The defendant's interpersonal relationships and social adjustments
g. The defendant's sexual and marital history
h. The defendant's medical history
i. The psychological functioning across the defendant's lifetime

II. This information can only be obtained by lengthy interviews with:

a. family members
b. neighbors

d. teachers
e. significant people in the defendant's life
f. medical and psychiatric professionals
g. any other professionals who might be able to provide valuable information given a defendant's particular circumstances.

14) In the case of Robert Van Hook, I have reviewed extensive materials including the following records:

a. Psychiatric progress notes from the Community Correctional Institute dated from November of 1983 through April of 1985.

b. Psychiatric evaluation under ORC 2947.06 prepared by Teresito Alquizola, M.D. dated 12-30-83.

c. Psychiatric evaluation under ORC 2945.39 prepared by Teresito Alquizola, M.D. dated 6-10-85.

d. Psychological evaluation under ORC 2945.39 prepared by Nancy Schmidtgoessling, Ph.D. dated 6-24-85.

e. Psychiatric evaluation under ORC 2945.39 prepared by Emmet Cooper, M.D. dated 7-3-85.

f. Psychological evaluation under ORC 2947.06, mitigation of the death penalty, prepared by Donna Winter, Ph.D. dated 7-30-85.

g. Probation report prepared by Peter Held and John Pohlmeyer dated 7-30-85.

h. Victim impact statement prepared by Nancy Rankin, probation officer, dated 7-29-85.

i. Statement by Robert Van Hook to police dated 4-4-85 transcribed by Gale Ravenscraft.

j. Transcripts from the NGRI testimony of both defense and prosecution witnesses.

k. Transcripts of mitigation hearing.

15) In addition, I personally interviewed and evaluated Robert Van Hook on September 29, 1989 at the Southern Ohio Correctional Facility in Lucasville, Ohio. In addition to

the interview I administered psychological tests including the Minnesota Multiphasic Personality Inventory (MMPI), the Millon Clinical Multiaxial Inventory (MCMI), and the Rorschach Inkblot Test. I took into consideration previous psychological testing performed by the Court Psychiatric Center in 1985. I also took into consideration the social investigation performed by Richard Ruffin and Patricia Hidy, mitigation specialists of the Ohio Public Defender's Office. That investigation included interviews with numerous immediate family members, other relatives, and Dr. Robert Hoy.

UPON MY REVIEW OF THE ABOVE MENTIONED INFORMATION, I HAVE THE FOLLOWING OPINION:

16) Defense Counsel's presentation of mitigation excluded many relevant psychological, social, emotional, and environmental issues in the defendant's life.

a. Military records were not obtained from the hospitalizations. These records could have verified Robert's fascination with the military, his use and abuse of alcohol and drugs, and his sexual orientation, confusion, and other related matters.

b. Though psychological and psychiatric experts addressed Robert's borderline personality disorder and related alcohol and drug problems, no experts were called to explain Robert's sexual development as it relates to ego-dystonic homosexuality (to be explained later).

17) Available information reveals considerable and significant data relevant to the issue of balancing the aggravating facts of the crime against mitigating circumstances. This information could have been testified to at mitigation and could have provided a much more thorough

understanding of the defendant and the offense.

REVIEW OF AVAILABLE RECORDS, INTERVIEWS, AND EVALUATIONS TO DATE HAS RESULTED IN THE FOLLOWING INFORMATION:

18) Robert Van Hook was born on January 14, 1960 to parents more interested in their own use of drugs and alcohol than to the raising of an infant child. From all reports available, Robert was raised in a bizarre and chaotic home environment. Mr. Van Hook, senior, was physically abusive and unfaithful soon after his marriage. Robert was exposed directly to his parents sexual conduct having observed the "primal scene" including sexual violence while sleeping in their bed. In the atmosphere of violence, alcohol, drugs, and infidelity, it is no wonder that young Robert grew up with overwhelming feelings of sexual identity confusion, anger, ambivalence, and fear. He was often asked by his father which parent he loved more. He would be beaten no matter how he answered the question. The instability of the family had a great effect on Robert's schooling having never attended the same school for more than one year. Therefore, Robert was unable to develope normal childhood relationships which are essential building blocks for developing normal adult relationships. As reported by Dr. Winter, Robert's early years were characterized by a mother who could not offer stability or adequate care-taking because she was either drunk, embroiled in a pathological relationship with her husband or running around with other men. Robert's father offered no stability since he was usually drunk or high on drugs. His behavior at home was described as "terrifying" to Robert. Robert's environment was also described as a "combat zone" which would explain his early and continuing fascination and fantasy with war and the military. These fantasies began very early and continued throughout his life. As a child he used to sleep in his army outfit. During the winter of 1985, just prior to the killing, Robert's uncle (Robert Salyers) reports seeing Robert marching down the street in combat fatigues. During his later years his fantasy (obsession) became quite developed to the point of reading books about Vietnam, World War II and he eventually joined the army for four and one-half years. He was honorably discharged with alcohol and drug dependency. His was not permitted to re-enlist because he had passed a bad check for $100. After his discharge he continued his interest in the military and hung around Vietnam veterans. He soon identified himself as a combat soldier (though he served no combat) and dwelled on bizarre and gruesome tortures perpetrated by the Viet Cong and other guerilla soldiers. He watched many of the movies on Vietnam, but was particularly obsessed with The Killing Fields and Uncommon Valor. The gruesome quality of these films impacted significantly on Robert's psychological development especially when one considers his lack of identification with appropriate adults.

Robert learned to cope with his aggressive instincts through identification with the "special forces" soldier. He also found that alcohol and drugs could ease his anxiety. Robert began drinking at age two, though not seriously until his father encouraged him to be a drinking companion by age nine. The two of them had a long history then of drinking together, going to bars and getting in fights. Robert soon developed a serious alcohol and drug problem which lasted up until his arrest. He has a history of using other drugs including amphetamines and marijuana. Robert's behavior under the influence of alcohol is quite aggressive - another example of a behavior modeled after his father.

Robert's sexual development began by age five. From his earliest memories he is able to recall the sexual exploits of his mother and various partners. He witnessed his mother and father having sex (though his father would tell him to keep his eyes closed). He was involved with several girlfriends and had both heterosexual and homosexual relationships throughout his adolescent years. His first homosexual encounter was at age 14 followed shortly after by a homosexual relationship with his Uncle Donald. Robert's homosexual contacts were numerous. These generally were passive experiences in which he would exchange sexual acts for friendship and places to stay. Under the influence of alcohol and drugs, he would "roll" homosexuals for money. He worked as a homosexual prostitute but felt "disgraced" by this activity. He perceived himself as worthless and inferior when engaging in homosexual behavior. Robert's ego-defense mechanism then was projection (the individual attributes unacceptable desires and impulses to others). As a result, his homosexual encounters became more aggressive as he then blamed others for his unacceptable behavior. Robert married Beth Smith in 1983 to see what marriage was like. They were divorced within the year.

The results of the psychological testing indicate that Mr. Van Hook is functioning in the average range of intelligence with a verbal IQ of 92, performance IQ of 99, and full scale IQ of 95 (testing done by Dr. Schmidtgoessling, Ph.D. in 1985). Mr. Van Hook continues to function in the average range. The results of the MMPI given by myself on September 29, 1989 indicate that Robert continues to have difficulties handling stress and tolerating anxiety. Though he appears well compensated while incarcerated (in other words, he appears to have adapted fairly well), his profile is consistent with individuals diagnosed as borderline personality disorders. He is sensitive, feels easily threatened, and shows continuing signs of sexual identity problems. The current MMPI appears to be consistent with that done by Dr. Schmidtgoessling.

On the Rorschach Inkblot Test, Robert's responses are passive in quality and deteriorate as the cards become more complex. His responses are typical of individuals who have great difficulty identifying and expressing emotions

properly. He appears to have inadequate insulation from the intrusion of emotions. Therefore, he is likely to respond impulsively and unpredictably when placed in situations of stress. Otherwise, his responses indicate that he can function quite well.

The pattern of responses on the MCMI (a test designed for diagnostic screening of basic personality patterns) suggests instability in a wide range of areas combined with depression, a history of alcohol abuse, unrealistic self-importance, and attention-seeking behavior. His profile also reflects serious problems in interpersonal relationships and impulsive, unpredictable behavior.

My diagnostic impressions of Robert Van Hook are as follows:

Axis I. Ego-dystonic Homosexuality 302.90
Alcohol dependence, in remission 303.90
Polysubstance abuse, in remission 305.90

Axis II. Borderline Personality Disorder 301.83
(primary diagnosis)

It is my opinion, with reasonable scientific certainty, that Mr. Van Hook suffers from the disorders listed above. It is also my opinion that the borderline personality disorder is the primary diagnosis from which the alcohol and drug problems develop. The essential feature of a borderline personality disorder is a pervasive pattern of mood, self-image, and interpersonal instability beginning by early adulthood. Individuals with this disorder often present inappropriate emotions or affect. For example, under stressful situations, they may laugh or giggle though the situation might be a serious. The characteristics for Mr. Van Hook include unpredictability, physically self-damaging behavior (he had attempted suicide on several occasions), uncontrolled and inappropriate anger, unstable and intense interpersonal relationships, inappropriate affect and unstable identity. There is general agreement from the other mental health professionals involved in this case that Mr. Van Hook suffers from the borderline personality disorder and alcohol and drug problems. There is some question as to the severity of the disorder and whether or not it (the borderline personality disorder) constitutes a mental illness.

Mr. Van Hook also presents the symptoms of ego-dystonic homosexuality. The term ego-dystonic refers to a personality trait that is recognized by the individual as unacceptable and undesirable such as a homosexual arousal pattern. This disorder is listed when there is persistent and marked distress over one's sexual behavior as is the case with Robert. Mr. Van Hook's ego-dystonic homosexuality is clearly an element of the crime and of his personality development. As stated earlier, the ego-defense mechanism of projection

(clearly present during Robert's homosexual encounters) supports this diagnosis and related behaviors.

In my opinion Robert's borderline personality disorder, alcohol dependence, drug use, and sexual confusion was a direct result of his chaotic home environment and the psychological and sexual abuse he suffered from him parents. The chaos that he experienced on the outside was internalized in a maze of conflicting emotional and sexual feelings. As a young adult, without any adequate role models (until he met Dr. Hoy), he projected these feelings onto others in an attempt to find his own identity. He behaved without much understanding of the consequences. In my opinion, he joined the military in an attempt to deny the sexual confusion he felt about his own homosexuality. He joined an organization which on th surface presents a strong heterosexual image. The perception of a Green Beret, macho, soldier was itself a direct contradiction to the internal turmoil Robert was experiencing. This is another example of a psychological response to internal stress. Robert attempted to deny his homosexual impulses, project blame unto others, and then take on the opposite external affect. Under the influence of drugs and alcohol, his confusion and anger became eroticized during homosexual encounters.

On February 18, 1985, Robert went to the Subway Bar after drinking first at a bar in Mt. Healthy. It appears that on the night that David Self was murdered, Robert was under considerable stress. The stress was precipitated by the knowledge that his step-father, Clark Lauttrell, was returning to Cincinnati due to a job change with Conrail. Robert's mother requested Robert to be home early that evening, February 18, 1985, to celebrate his step-father's return. This is a man with whom Robert has had considerable conflict as well as someone with whom drugs and alcohol had been a serious problem. Previous conflicts with Mr. Lauttrell had resulted in Robert being kicked out of the house. A normally functioning individual would not have any abnormal difficulty in dealing with this. However, a borderline personality disordered individual is someone who often greatly blows things out of proportion and exaggerates negative, as well as positive, outcomes. The lack of emotional control in the borderline individual causes them to make mountains out of molehills. Robert expected the worst upon learning that Clark Lauttrell was coming home. Therefore, on that evening Robert started drinking. Prior to this night, Robert had not been drinking for several months. He even had a job prospect. He consumed a number of drinks (vodka and soda) and smoked some marijuana. He may also have had some amphetamines. He then decided to rob a homosexual. It was at the Subway Bar that he met David Self and then left for Mr. Self's apartment. At the apartment, Robert reports that the victim attempted oral sex and Robert then grabbed him by the neck and head rendering him unconscious. Following this Robert then attempted to cut off the victim's head in a manner similar to jungle guerilla tactics of the

Viet Cong. In my opinion, his actions at the time of the crime were the result of a culmination of experiences that produced a transient psychotic episode typical of borderline individuals. As Dr. Winter states, "The client's bizarre and violent attack on David Self was an expression of diffuse, primitive rage. It was a generalized discharge of his own underlying hate and aggression." This condition may have been triggered by the use of alcohol and drugs prior to the event. However, the condition responsible for the behavior was and remains Robert's borderline personality disorder and resulting ego-dystonic homosexuality. Mr. Van Hook experienced a brief psychotic episode induced by feelings of homosexual panic.

In summary Robert Van Hook is the product of an unstable, chaotic, abusive family characterized by little or no nurturing, lack of supervision, repeated exposure as a young child to explicit sexual behavior and substance abuse. He was continually placed in "double-bind" situations in which he was forced to choose between the lesser of two evils - his mother or his father. Whatever he chose, he was beaten anyway. Given all of the dynamics of his family life, it would not have been possible to develop a healthy, normal personality. In fact, as most of the mental health experts agree, Robert developed a serious personality disorder (Borderline Personality Disorder) and, in my opinion, a serious sexual disorder, ego-dystonic homosexuality. He also has a serious underlying alcohol and drug addiction. He attempted to cope with these problems through a rich fantasy life involving military themes of violence and aggression and by using alcohol and drugs. The victim's attempt to have oral sex with Robert triggered a brief psychotic episode accompanied by uncontrolled rage. The episode may have been caused by homosexual panic combined with the alcohol and drugs. The resulting special forces style murder was part of Robert's overall defense mechanism which includes identification with military, hero figures, and projection. The use of alcohol and drugs would lower his threshold for such aggressive behavior, though the potential for this behavior existed anyway.

19) It is my opinion, with reasonable scientific certainty, that the physical violence, sexual abuse, and other psychological factors and personal tragedies in the life of Robert Van Hook should have been presented to the triers of fact and would have been considered as a mitigating factor under Section (B) (7) of the O.R.C. 2929.04.

20) It is my opinion, with reasonable scientific certainty, that Robert Van Hook's borderline personality

disorder and resulting ego-dystonic homosexuality should have been presented to the triers of fact and would have been considered as a mitigating factor under Section (B) (7) of the O.R.C. 2929.04.

22) It is my opinion that all of the information provided in this affidavit could be testified to in a mitigation hearing and that such information could be of consequence to a trier of fact in weighing the aggravating and mitigating factors in this crime.

FURTHER AFFIANT SAYETH NAUGHT.

James R. Eisenberg, Ph.D.

Sworn to and subscribed before me this 19th day of December, 1989

Notary Public
Attorney at Law

EXHIBIT 14

DEPARTMENT OF REHABILITATION AND CORRECTION

OFFICE COMMUNICATION

TO: Psychiatric Services to Corrections DATE: 5-31-91

FROM: William W. Gilbert, Ph.D., Psychology Supervisor

SUBJECT: VAN HOOK # 186 347

....Necessary Action	....Prepare Reply	....For Your Information	....Approval	....Note and Return	....See Me
....Investigate	....Signature	....Per Conversation	....Comment	....Note and File	....As Requested

21 OSR

I have reviewed a request for an Informal Complaint resolution, and a copy of a kite sent to Dr. Vermeulen, both initiated by Van Hook #186 347.

The general nature of both the kite and the complaint are Van Hook's concerns that he is not receiving appropriate attention from Mental Health staff, in view of his previously diagnosed (by defense witnesses) Borderline Personality and Ego-dystonic Homosexuality.

I had a brief interview with Van Hook in the morning of May 31, 1991. He expressed a feeling that he is getting in fights with other inmates, and is feeling a build up of anger, similar to that which he experienced before his crime. When I discussed his overall institution record and adjustment, however, it became clear that he has had outbursts of acting out behavior throughout his nearly six year stay on death row.

Van Hook also indicated that he was a patient in your service for about one year shortly after he came to the institution, but that he discontinued medication on his own initiative. I have not verified this information.

Throughout the interview he made vague threats in the direction that if he did not receive some kind of treatment, even if it were only talking to someone once a week, he would probably end up killing somebody.

He was well aware of the diagnostic statements, including borderline personality and ego-dystonic homosexuality, made in the past. He does not have a clear understanding, however, of the meanings of these terms or the behavioral indications of either the borderline personality or ego-dystonic acts of homosexuality.

This is being provided for your information. If you feel that at least a brief screening contact from OPSC would be appropriate, we would appreciate the consultation regarding his present mental status and possible diagnostic conclusions.

SOUTHERN OHIO CORRECTIONAL FACILITY

William W. Gilbert, Ph.D.
Psychology Supervisor

CONFIDENTIAL

WWG:ha

cc: File

001013

EXHIBIT 15

BMA

BEHAVIOR MANAGEMENT ASSOCIATES, INC.

- *IMPACT* Employee Assistance Program
- *CENTER FOR STRESS & TRAUMA*
- Corporate Health Promotion & Training
- Clinical & Consulting Services

Joel R. Gecht, PH.D.
Robert G. Kaplan, PH.D.
and Associates

PSYCHOLOGICAL REPORT

DRAFT

Name:	Robert Van Hook
Case No.	186-347
Date of Examination:	September 16, 1993
Examiner:	Robert L. Smith, Ph.D.
Diagnostic Procedures:	Diagnostic Clinical Interview Michigan Alcoholism Screening Test Drug Abuse Screening Test

BACKGROUND INFORMATION

Reason for Referral

Robert Van Hook, a 33-year-old, divorced, white male, was referred for a psychological/chemical dependency assessment by Jane Core of the Ohio Public Defender's Office. Mr. Van Hook was interviewed on September 16, 1993 at the Southern Ohio Correctional Facility in Lucasville, Ohio. He had been convicted of aggravated robbery and aggravated murder and is currently on death row. He understood his sentence and his role in the post-conviction mitigation appeal. He recognized that the evaluation was not confidential and that the results would be conveyed to the Ohio Public Defender's Office. He agreed to participate under these conditions.

In considering the evaluation, Mr. Van Hook was administered the **Michigan Alcoholism Screening Test (MAST)** as well as the **Drug Abuse Screening Test (DAST)**. A clinical interview was also conducted to gather psychosocial data regarding Mr. Van Hook and his family.

Family History

Mr. Van Hook was born and raised in Cincinnati by his working class parents. His father worked as a musician and cab driver and died in 1989 of cirrhosis of the liver. His mother worked as a waitress and a barmaid until her retirement. She is currently living in Cincinnati and is remarried with two stepchildren. She reportedly has contact with Mr. Van Hook on a weekly basis.

Four Commerce Park Square • 23200 Chagrin Blvd. • Suite 325 • Beachwood, Ohio 44122-5402
Call: 216/292-6007 • Fax: 216/292-7352

Medical History
Mr. Van Hook's father was a chronic alcoholic and died of cirrhosis. His mother has suffered several heart attacks, but is currently stable. With regard to Mr. Van Hook, he denied any medical concerns, medications, or allergies.

Psychiatric History
Mr. Van Hook's mother was reportedly hospitalized for a "nervous breakdown" as a child when she discovered her father's body following his death. This was apparently a very traumatic episode in her life and left her insecure and depressed. Mr. Van Hook also related that many of his paternal relatives have had a history of psychiatric hospitalizations. In considering Mr. Van Hook's psychiatric history, he reported receiving treatment for the first time in 1978 while in the Army. He was stationed in Germany and had become depressed and suicidal, cutting his wrist. In 1979, he was referred for chemical dependency treatment by his commander following an arrest for the possession of hashish. Mr. Van Hook made a second suicide attempt in 1980 after being transferred back to the states. Following this attempt, he received nine days of inpatient psychiatric and chemical dependency treatment at Fort Hood. In 1981, Mr. Van Hook slit his arm and was referred to a general hospital. Finally, in 1983, Mr. Van Hook was court ordered into a chemical dependency treatment program following a legal offense.

Chemical Abuse History
Mr. Van Hook reported that his father was alcoholic, as well as his paternal grandmother and grandfather. His mother also reportedly abused alcohol, but switched to prescribed medications during her later years. His maternal uncle is also alcoholic.

Educational History
Mr. Van Hook dropped out of school in the ninth grade. At that point he was enrolled at the Tolesborrough High School in Kentucky. He was apparently a "D" student, having failed a number of his classes. At age 17 he was repeating the ninth grade and decided to quit in order to join the military.

Military History
Mr. Van Hook joined the Army in 1977. He served three years in Germany, one year in Texas, and six months in Georgia. He worked as a radio operator in communications and indicated that he enjoyed his work. While in Germany, he slit his wrist on two occasions. He was also arrested for the possession of hashish. His discharge was considered honorable under Chapter 9 (Alcohol and Drug Abuse).

Work History
Mr. Van Hook has had no significant work history. He has had numerous odd jobs for brief periods, including factory work, construction, laborer, truck driver, and landscaping.

Relationship History
Mr. Van Hook reported that his first sexual experience was at age seven with a female schoolmate. He had slept in bed with his parents as a child and regularly observed them engaging in sexual behavior. As a result, he was extremely knowledgeable about sexuality at a young age. His stepsister approached him as an adolescent and encouraged him to engage in intercourse with

her but he refused. He also engaged in fondling and masturbation with his babysitters. At age 14, Mr. Van Hook ran away from his home to Key West, Florida. He lived with a commune and abused alcohol and other drugs. During this time, he learned to "hustle gays." He indicated that he views himself as heterosexual, but learned to pose as a gay prostitute in order to rob his victims. Mr. Van Hook was married on one occasion for six months. He indicated that it was not a serious relationship and that it was simply "a mistake." There were no children as a result of this union.

Legal History
Mr. Van Hook reported an extensive history of legal involvement. He maintained that virtually all of his arrests for assault occurred while he was either intoxicated or high.

Chemical Abuse History
In considering Mr. Van Hook's use of alcohol and other drugs, two objective measures were used to confirm his being chemically dependent. The first involved the **Michigan Alcoholism Screening Test (MAST)** and the second was the **Drug Abuse Screening Test (DAST)**. Each of these instruments has been the subject of numerous scientific investigations, indicating the reliability and validity in identifying individuals who abuse alcohol and other drugs. With regard to the MAST, it is suggested that a score above five is indicative of a diagnosis of alcohol abuse. Mr. Van Hook scored 41. In considering the DAST, a cut-off score of five is also employed. Mr. Van Hook's DAST scores was 22. Undoubtedly, Mr. Van Hook scored well above the cut-off to indicate a significant problem with alcohol and other drugs.

The research regarding alcohol and other drug addiction clearly indicates that there is a genetic influence for the development of alcohol and other drug dependence. Children of alcoholics and/or other drug abusers are "at risk" for addiction. In the case of Mr. Van Hook, his family history reflects extensive abuse of chemicals by members of his family. In particular, Mr. Van Hook's father is known to have been an alcoholic and died of cirrhosis, and his mother abused alcohol and prescription medication. In addition, both maternal and paternal relatives are reported alcoholics. Undoubtedly, Mr. Van Hook's positive family history of substance abuse placed him at definite risks for becoming chemically dependent.

In interviewing Mr. Van Hook, the following detailed account of his chemical use was established.

Chemicals Used: Alcohol (beer, wine, distilled spirits), marijuana, hashish, PCP, THC, morphine, LSD, amphetamines, and heroin.

Progression of Use:
First Use: Mr. Van Hook reported that his parents had provided him with accounts of his drinking at age two. His father would provide him with alcohol and then laugh as he would become intoxicated. As this pattern continued, Mr. Van Hook reportedly learned to sneak drinks from his parents or from their friends.

Age 11: Mr. Van Hook was living with his father and openly drank with his father. At that time he consumed beer and whiskey, primarily on the weekends. It was at this age that he first willingly became intoxicated and experienced a blackout.

Age 13: Mr. Van Hook was introduced to marijuana by his cousins. After becoming accustomed to marijuana, he discovered marijuana laced with PCP. He immediately enjoyed the affects of the marijuana and PCP and would smoke it as often as he could afford it. This progressed to three to five days per week. In order to have sufficient funds for his drug use, he began selling drugs at school.

Age 14: Mr. Van Hook and his father moved to a trailer park in Florida. At this time, Mr. Van Hook was very open about his use of chemicals with his father and they would use together. He began experimenting with hashish and LSD. He continued to use marijuana, PCP, and alcohol on a regular basis. At this age, Mr. Van Hook was introduced to morphine and used the drug intravenously.

Age 15: Mr. Van Hook became enchanted with his father's musical ability and involvement with a band. He learned to play the drums and was eventually able to join the band and play with them in nightclubs. His father viewed him as a colleague and they "partied together" every weekend. This included engaging in sexual activity with the women that they met in the bars. At this point, Mr. Van Hook shifted from PCP to amphetamines. On several occasions, Mr. Van Hook and his father binged together for three to four days at a time. They would use amphetamines, marijuana, and alcohol.

Age 16: Mr. Van Hook moved with his father and stepmother to Kentucky. Mr. Van Hook met several acquaintances through school and became involved in the production and sale of moonshine.

Age 17: Mr. Van Hook decided to join the Army and discontinued all use of drugs with the exception of marijuana. His drug of choice at this time became beer.

Age 18: Mr. Van Hook was transferred to Germany and felt greater freedom to use illicit drugs. He resumed his use of hashish, amphetamines, and barbiturates. He also experimented with the use of I.V. heroin.

Age 19: Mr. Van Hook's use of I.V. heroin progressed rapidly until a friend overdosed. This caused Mr. Van Hook to re-examine his own use and he decided to restrict his chemical abuse to alcohol, marijuana, and amphetamines.

Age 20: Mr. Van Hook was transferred back to the United States and started to use crystal methadrine intravenously.

Age 21: Mr. Van Hook was discharged from the Army and lived with his father. Together they would use alcohol, marijuana, and amphetamines.

Age 22: Mr. Van Hook stopped living with his father and began residing with various individuals for brief periods of time. His use of chemicals continued to involve alcohol, marijuana, and amphetamines. His use was daily and involved varying amounts of each drug. This pattern continued up to the time of his offense.

A recognized symptom of chemical dependency is an increase in the individual's tolerance for chemicals. In other words, the individual requires more of the drug in order to experience the same effect. Mr. Van Hook's chemical history clearly indicates that he needed an increasing amount of alcohol, marijuana, and barbiturate in order to attain "a high." He acknowledged gulping his drinks of alcohol and mixing chemicals together in order to potentiate the experience of intoxication. He modified the route of the administration of the drug, resorting finally to intravenous use in order to achieve a high in as rapid and as potent a manner as possible. He has reported numerous blackouts and has reached a point of simply accepting blackouts as a part of his every day life. Blackouts are a common symptom of individuals who have developed a high tolerance for alcohol and other drugs.

Another primary symptom of chemical dependency is the experience of withdrawal when a chemical is discontinued. Mr. Van Hook has experienced withdrawal on one occasion. He had a number of severe symptoms of withdrawal when he discontinued his use of I.V. heroin while in Germany. He experienced irritability, tremors, diaphoresis, diarrhea, and mild paranoia. He has not experienced further withdrawal due to his ongoing use of chemicals on a daily basis.

The most notable sign of an individual suffering from alcoholism is a change in the individual's behavior. Chemically dependent individuals experience a disruption in their performance at work, deterioration of their relationships with family and friends, financial problems, declining health, and involvement in illegal activities. Dramatic mood swings are common and may lead to bouts of depression or unpredictable acts of violence. In reviewing Mr. Van Hook's history of chemical use, it is obvious that his addiction led to difficulties at school, most notably ongoing absenteeism. While he and his father used drugs together, Mr. Van Hook seldom attended school. This pattern continued when Mr. Van Hook began working. He would acquire jobs on a temporary basis but was unable to maintain his performance and attendance. With regard to violent and aggressive behavior, Mr. Van Hook acknowledged that his chemical use led to frequent incidents involving violence. As an adult, his chemical use has resulted in a deterioration of all of his relationships. In considering his history of legal offenses, it is noteworthy that virtually all of his illegal activities occurred while he was under the influence of a chemical.

In order to assess Mr. Van Hook's level of functioning on the day of the offense, it is necessary that an assessment is made of his chemical use during that time. At the time of the offense, Mr. Van Hook was 25 years of age. He was unemployed and looking for temporary work to provide funds until he could return to working as a cement mason. At this point, he had attempted to cut back on his use due to a recent arrest for assault. Earlier that day, he had completed an application for a job. He then stopped by his grandmother's house and assisted her with some household chores. As a result, she gave him ten dollars, as well as several beers. Mr. Van Hook left his grandmother's home and went to a nearby bar where he drank with a friend who provided him with several marijuana cigarettes. At this point, Mr. Van Hook has a limited memory of the events that followed. He does not recall if he used other drugs or how he came to being

downtown. He does recall drinking at a bar in the city and making contact with the victim. The victim was clearly interested in a homosexual relationship and Mr. Van Hook encouraged this. Once they were at the victim's house, Mr. Van Hook snorted amyl nitrate and a short time later, committed the offense. He left the victim's house and went to a friend's home, Dr. Hoy. He told Dr. Hoy that he had been involved in a fight with his stepfather. Subsequently, Dr. Hoy gave him approximately thirty dollars and Mr. Van Hook drove to Tennessee. He hitchhiked from that point to Ft. Lauderdale, Florida. He continued to "hustle homosexuals" and to use alcohol, marijuana, and amphetamines until his arrest. He was then returned to Hamilton County and placed in jail. Mr. Van Hook reports that he continued to use alcohol and drugs while incarcerated, as well as using medications prescribed for other inmates. Once convicted and placed at the Southern Ohio Correction Facility, Mr. Van Hook reports making alcohol and smoking marijuana on a regular basis. He also purchased Percosets and other medications.

In considering Mr. Van Hook's use of multiple substances throughout the day of the offense and his use of amyl nitrate at the time of the offense, it is clear that his behavior and judgment were significantly influenced. Although the exact amounts of these chemicals are unknown, the combined effect of these drugs would undoubtedly be sufficient to impair the functioning of the central nervous system. Furthermore, it is believed that Mr. Van Hook's violent behavior in this offense was directly affected by his chemical use. His history demonstrates a pattern of repeated violent behavior while under the influence of alcohol and other drugs. There is reason to believe that had he not been under the influence of these chemicals, he would have been able to refrain from his involvement in the instant offense.

Given Mr. Van Hook's history of prior involvement in chemical dependency treatment, his self-report of abusing numerous substances, and the reports provided by family and friends, the evidence is overwhelming that he suffers from a psychiatric disorder entitled **Psychoactive Substance Dependence.** In particular, his diagnoses are:

Alcohol Dependence (DSM III-R 303.90), Cannabis Abuse (DSM III-R 304.30), and **Amphetamine Dependence (DSM III-R 304.40)**. In considering Mr. Van Hook's use of these substances, he devoted the majority of his life to either procuring these substances or using them. He learned to use various chemicals in combination in order to potentiate the effect experienced and when restricted in his ability to use, he experienced symptoms of acute withdrawal. As Mr. Van Hook's chemical dependency progressed, he lost interest in school, work, relationships, and family. In spite of these clear, negative consequences, Mr. Van Hook continued to abuse alcohol, marijuana, and amphetamines on a near daily basis.

These characteristics represent the primary criteria required by the *Diagnostic and Statistical Manual, Third Edition - Revised by the American Psychiatric Association for Psychoactive Substance Dependence.*

Diagnostic Considerations

In addition to the chemical dependency assessment, several other significant observations were made. Throughout the interview, Mr. Van Hook displayed frequent bouts of tearfulness and extremely labile mood. He acknowledged an obsession with homicidal ideation on a daily basis and indicated that he struggles to not attack inmates and guards. He expressed a "rage" that

requires all of his effort to control. He also reported frequent thoughts of suicide and indicated that he has decreased his use of chemicals as a result of his increasing psychiatric symptoms. In general, the symptomatology that he described was indicative of a borderline personality disorder.

Robert L. Smith, Ph.D.
Clinical Psychologist

RLS:bcr

Van Hook:

- gender identity disorder
- substance abuse - starting age 10 - alcohol + heroin + others pot.
- suicide attempts
- bi sexual
- unstable relationship patterns.
- anger control - outbursts - bar fights
- mood swings.
- chronic boredom, loneliness.
- combat - felt in combat during crime "combat ritual" - copied scenes from movies.
- low tolerance for frustration.
- military experience (discharged ETI)
- problems between M+D - Dad unfaithful
- both parents substance abusers
- dad quite violent - rowdy friends.
- parents relationship unstable - break-up/ back together.
- $ problems.
- little nurturance / guidance
- military experience / desires.
- non & dating others - D left "others".
- D's illness as child.

EXHIBIT 16

PSYCHIATRIC EXAMINATION

Include: reason for admission; legal status; history of previous psychiatric illnesses and hospitalizations; current mental status; assessment of life threatening problems; interpersonal attitudes; speech and communications; affect; ideation; perception; orientation and memory; insight and judgment; admitting and current psychiatric diagnoses; signature and title.

Date

VAN HOOK A186-347 DICTATED: 1-11-96 TIME: 1345

This 35 year old, white, divorced male was admitted to DRC 8-21-85 with a sentence of death subsequent to an Aggravated Murder and Aggravated Robbery. The patient indicates that he went to a bar. The patient told the Intake Interviewer that he ran out of money and a man took him to his home and when he arrived there the man made a sexual advance towards him. He was very really evasive in this area.

CHILDHOOD DEVELOPMENT:

The patient was raised in a two parent family until he was around 7 years of age and the parents separated. His parents were alcoholics and they were constantly fighting with each other. They were quite violent and they would at intervals ask him which parent he liked the best and it was very difficult for him to say anything because if he said something the other parent would be very angry at him. His father was a musician and his mother was a bar maid.

The patient denied ever having any temper tantrums because he said he was too scared to do anything for fear his parents would "beat the shit out of him." The mother and the father would beat him up for nothing. It seemed that his mother had a previous marriage and she had two daughters. She claimed that the oldest daughter was the product of a rape by her ex-husband. He is the only child of his father and his mother. He indicated that his mother was gang raped by some men who were angry at her husband, his father, and they came home to beat his father up and he was not there so they raped his mother. He alleges that he remembers at the age of 3 they're attacking his mother. The patient did not like his mother and felt that he had a better relationship with his father. His subsequent life was chaotic after the separation because he would go to his father when ever he was angry with his mother and it was not clear why he would go from his father to his mother's. He stated that his mother abandoned him in the house when he was about 9 years of age and went to a boyfriend's house partying. He let the dog out, it was 6 months old, and it ran away. I guess he then called his father and at that time went to live with father.

CONFIDENTIAL

SCHOOL:

He had conflictual statements about it. He stated that he got good grades because if he didn't get good grades he would be beaten up by his parents. He denied ever setting fires and he denied ever being cruel to animals. He denied ever having temper tantrums, but he did have lots of fights. He would get his anger by what was going on at home released by fighting at school with his peers. He did not like the teachers telling him what to do. He was a day dreamer and he would look out the window in classes and they would slap him in the head or make him stand in the corner when he did this. He would sit in the back of the room with the other kids being cool. He failed the second grade. He would tell lies and stories and told the teacher that he was German and they would talk about places in Germany. His father remarried and the patient did not like the woman. His mother remarried and the patient didn't like the man. As a result, he ran away from home and he couldn't support himself so he entered the service at 17.

He started alcohol at 3 or 4 years of age, and the father thought it was funny when he drank. He started substances at the age of 14 with marijuana initially. He drank a lot of alcohol and he finally progressed into Amphetamines and valium. He met up with bikers and he started dealing dope at the age of 14. He had drunken disorderly charges and the parents would pick him up. The mother would threaten reform school

Name of Facility MANCI

001007

(continue on reverse side)

VAN HOOK 186-247

He said that in 1987 there was a fight and he was knocked out and he knows that his spirit left his body. He was going up through the clouds and was anticipating that things would be very nice up there and he did not want to return. He was unhappy when they brought him to. He claimed that when he was killing the man he felt as though he were standing outside his body watching his body commit the act. He thinks a lot and fantasies. He feels that he has been very active here and as a result he sleeps better. He feels that he has evil thinking and that he imagines and fantacizes what he would do to these inmates. He feels that he over acts to everything, and that he "has out of body experiences." He has a lot of religiosity and he talks about Genesis 6 and he talks about fallen angles. It is as though his religiosity is very close to breaking over into mental illness, but has not quite made it. He knows right from wrong, but he does not observe society's norms. He has an extremely sadistic facet to his thinking. He is extremely tense and intense when he is talking about these things. His face becomes reddened, and one has the feeling that he could easily explode with no rational provocation. His recent and remote memory is adequate where he wants to tell you. His intellectual levels appears adequate or slightly below. The learning difficulty was probably emotionally accomplished. His judgment seems to be significantly impaired and I am concerned about his motivation at this time telling all of these things which have not been significantly documented previously, but there is some hint of these things in 1986 and 1987.

DIAGNOSIS:

AXIS I:

Oppositional Defiant Disorder 313.81.
Poly-substance Dependence - Continuous - In Controlled Environment. Heroin, Cocaine Amphetamines, Valiums Volumes etc. 304.80.
Alcohol Dependence - Continuous - In Controlled Environment 303.90.
Impulse Control Disorder NOS 312.30. Primary problem.

AXIS II:

Schizo Type Personality Disorder 301.22.

AXIS III:

Rule Out Psychomotor Epilepsy

AXIS IV:

Extremely poor genetic, psycho-social and environmental factors which pre-disposes the patient to an extreme Personality Disorder and a disregard for people's boundaries. He becomes so agitated about other's behavior that he loses self-control.

AXIS V:

GAF: 50 presently and when he is angered and decompensates he probably goes down to a 20.

CONFIDENTIAL

VAN HOOK A186-247

TREATMENT:

1. Since the patient was so apprehensive about medication and indicated that he did not want any Sinequan and seemed to become worse mentally on the Sinequan, I suggested Depakote for behavior and mood stabilization. The patient agreed to take the medication. I gave him the lowest dose possible in the hopes that he might accept the medicine. Depakote 250mg qhs po x 60 days.

2. Return to Clinic in 30 days.

1/23/96
Margarette B. Rogler MD

TRANSCRIBED: 1-22-96 PAC

MARGARETTE B. ROGLER, M.D.
PSYCHIATRIC CONSULTANT

CONFIDENTIAL

EXHIBIT 17

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO, EASTERN DIVISION

ROBERT VAN HOOK	:	
Petitioner,	:	
	:	**CASE NO. C-1-94-269**
v.	:	**JUDGE SMITH**
	:	**Magistrate Judge Abel**
CARL ANDERSON, Warden	:	
Respondent.	:	

AFFIDAVIT OF MARTIN T. RYAN, M.D.

IN THE STATE OF OHIO
COUNTY OF FRANKLIN, SS:

I, Martin T. Ryan, being first duly sworn according to law, state the following:

1. I received a Doctor of Medicine degree from the College of Medicine at The Ohio State University in June 1992. I was a Psychiatry Resident and Clinical Instructor at The Ohio State University, College of Medicine, Department of Psychiatry, from July 1992 to July 1996, when I completed my residency. I have been a Clinical Assistant Professor of Psychiatry at The Ohio State University, College of Medicine, Department of Psychiatry, from October 1996 to the present. I have been licensed to practice medicine in Ohio from1992 to the present, and am a Diplomate of the American Board of Psychiatry and Neurology. I have been engaged in the practice of clinical psychiatry from 1992 to the present.

2. In the case of Robert Van Hook, I have reviewed extensive materials including, but not limited to, the following:

a. Psychiatric progress notes from the Community Correctional Institute from November of 1983 through April of 1985.

b. Psychiatric evaluation under ORC 2947.06 preparedby Teresito Alquizola, M.D. dated 12-30-83.

c. Psychiatric evaluation under ORC 2945.39 prepared by Teresito Alquizola, M.D. dated 6-10-85.

d. Psychological evaluation under ORC 2945.39 prepared by Nancy Schimdtgoessling, Ph.D., dated 6-24-85.

e. Psychiatric evaluation under ORC 2945.39 prepared by Emmet Cooper, M.D. dated 7-3-85.

f. Trial testimony of Emmet Cooper, M.D. given on 7-23-85.

g. Trial Testimony of Nancy Schmidgoessling, Ph.D. given on 7-23-85.

h. Trial Testimony of Teresito Alquizola, M.D. given on 7-24-85.

i. Treatment addendum prepared by Nancy Schmidtgoessling, Ph.D., dated 7-25-85.

j. Psychological evaluation under ORC 2947.06, mitigation of the death penalty, prepared by Donna Winter, Ph.D. dated 7-30-85.

k. Probation report prepared by Peter Held and John Pohlmeyer dated 7-30-85.

l. Victim impact statement prepared by Nancy Rankin, probation officer, dated 7-30-85.

m. Mitigation Hearing Testimony of Emmet Cooper, M.D. given on 7-31-85.

n. Mitigation Hearing Testimony of Testimony of Nancy Schmidtgoessling, Ph.D. given on 7-31-85.

o. Sentencing opinion of the three-judge panel issued on 8-8-85.

p. Transcript of statement by Robert Van Hook to police dated 4-4-85.

q. Affidavit of James R. Eisenberg, Ph.D. dated 12-19-89 and submitted to the trial court in state postconviction.

3. In addition, I personally interviewed Robert Van Hook at the Southern Ohio Correctional Facility in Lucasville, Ohio.

4. My opinions contained in this affidavit assume that at the time of Robert Van Hook's trial in 1985, Ohio law provided that "In order to establish the defense of insanity, the accused must establish by a preponderance of the evidence that disease or other defect of his mind had so

impaired his reason that, at the time of the criminal act with which he is charged, either he did not know that such act was wrong or he did not have the ability to refrain from doing that act." State v. Staten, 18 Ohio St. 2d 13 (1969); and Ohio v. Coombs, 18 Ohio St. 3d 123 (1985).

5. In my opinion, it is more likely than not that in 1985 any reasonable psychiatrist retained by Mr. Van Hook's trial counsel to evaluate the mental health issues involved in this case would have concluded (after examining Mr. Van Hook and the evidence presented in connection to the homicide) that:

a. At the time of the offense, Robert Van Hook suffered from a severe Borderline Personality Disorder.

b. Mr. Van Hook's severe Borderline Personality Disorder constituted a mental disease, as that term was interpreted under the generally accepted standards approved by the American Psychiatric Association. Those standards were set forth in a statement issued by the American Psychiatric Association's Insanity Defense Work Group, approved by the Assembly of District Branches of the American Psychiatric Association in October 1982 and by the American Psychiatric Association's Board of Trustees in December 1982, and published in The American Journal of Psychiatry in June 1983. Am. J. Psychiatry 140:6, June 1983.

c. The homicide committed by Mr. Van Hook was primarily the product of psychosis.

d. Mr. Van Hook's psychotic state was primarily the product of his severe Borderline Personality Disorder.

e. References to Mr. Van Hook's severe Borderline Personality Disorder made in Van Hook's legal proceedings as "deficiencies of personality" or "personality characteristics" or "personality defects" are medically inaccurate and extremely misleading. The diagnosis of a Borderline Personality Disorder is a diagnosis of a mental illness, not of "personality defect," and not of "personality characteristics," and not of "deficiencies of personality." Under the

generally accepted psychiatric standards in effect in 1985, Mr. Van Hook's Borderline Personality Disorder constituted a serious mental illness and a "mental disease." It was blatant medical error to categorize this mental disease in the fashion that it was in Mr. Van Hook's legal proceedings.

6. A report in Van Hook's U.S. Army records recounts an incident that forecast the type of reflexive homophobic panic "going berserk" which Van Hook evidenced on the night of the homicide. This supports the conclusion set forth in Dr. Schmidtgoessling's 7-25-85 Treatment Addendum that it was reasonably likely Robert Van Hook assaulted David Self as the result of homophobic panic. A reasonable psychiatrist examining Mr. Van Hook and the evidence presented in connection to the homicide would have agreed with this conclusion, and would have so advised Mr. Van Hook's trial counsel.

7. Although there was expert medical testimony at Mr. Van Hook's trial that he went in and out of psychosis as the result of intoxication, such an opinion is not consistent with medical knowledge. Medical science does not support a conclusion that as the result of intoxication, a person goes in and out of psychosis over the course of seconds to minutes in the way characterized in the expert medical testimony.

8. Such an opinion also does not seem to be supported by the facts presented in this case because the witnesses, who observed Mr. Van Hook, both before and after the homicide, did not provide a factual basis to support an opinion that Van Hook was intoxicated to the point of psychosis.

9. My opinion that Van Hook's psychosis on the evening of the homicide was the product of his severe Borderline Personality Disorder is consistent with generally known psychiatric

knowledge that psychotic episodes produced by Borderline Personality Disorder typically occur during periods of extreme stress, include paranoid ideation or depersonalization, and tend to be of a short duration.

10. All four of the experts who gave medical testimony conducted independent evaluations of Mr. Van Hook including separate face-to-face interviews with him and a review of pertinent documentation of his psychiatric history. (Emmet Cooper, M.D., Nancy Schmidt goessling Ph.D., and Teresito Alquizola, M.D. testified at trial; James R. Eisenberg, Ph.D. provided sworn testimony by affidavit in Van Hook's state postconviction proceedings). All four experts supported my view that Mr. Van Hook suffered from symptoms consistent with Borderline Personality Disorder. Three of those medical experts formally diagnosed Van Hook with that mental disorder, and the fourth diagnosed him as having a Mixed Personality Disorder, meeting criteria for Borderline Personality Disorder in addition to at least one other personality disorder. This uncommon degree of concordance in the expert medical testimony followed from the consistent observations that Mr. Van Hook's symptoms of mental disease (namely, his impulsivity in areas that were self-damaging, his pattern of unstable and intense interpersonal relationships, marked sudden shifts of attitude, inappropriate intense anger, disturbance of identity, instability of mood, suicide attempts, and frantic efforts to avoid abandonment) meet and exceed the required criteria for the diagnosis of Borderline Personality Disorder. Van Hook's formal diagnosis included the qualifier "severe" because he evidenced several symptoms in excess of those required to make the diagnosis and his symptoms markedly interfered with social and occupational functioning.

The medical experts were in blatant error in testifying that persons with this disorder do

not exhibit psychiatric symptoms; and they were in blatant error in testifying that a severe Borderline Personality Disorder is not, by definition, considered to be a "mental disease."

FURTHER AFFIANT SAYETH NAUGHT.

Martin T. Ryan

Martin T. Ryan, M.D.

Sworn to and subscribed before me this 20th day of June 2001.

NOTARY PUBLIC

JAMES D. OWEN, ATTORNEY AT LAW
NOTARY PUBLIC - STATE OF OHIO

EXHIBIT 18

Interdisciplinary Progress Notes

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.
8/19/14 1:30 pm	S: Therapy Note: Mr Vanhook reports that he is doing well and that he has not had any significant episodes of anxiety or depression. Nor has he experienced any episodes of significant anger or aggression. He states that he has stayed chiefly to himself and usually only comes out for recreation and visits. O: Alert, Oriented and Calm. He was focused during the session and maintained appropriate eye contact, looking away only to gather his thoughts. A: Stable at this time. P: Mr Vanhook was complemented on the progress he has made to which he smiled and expressed his appreciation for the help. We agreed to meet monthly and as needed. He will be continued on the caseload. ---------- Kevin Littler, LISW SW3
8-26-14 1040hrs	Psychiatry: CC: PRN: S: Robert Vanhook is on no meds. Says he is better for the fact that Kevin Littler has been working with him. No unmet complaints. P: Return in 12 weeks. Lamotrigine 150 mg
8/26/14 12:23pm	follow up Scheduled for 11/18/14. — R. Ball (HTT)

Continued on reverse side

Inmate Name: Vanhook, Robert	Number: A186347

DRC 5287 (3/00) INTERDISCIPLINARY PROGRESS NOTES

EXHIBIT 19

Interdisciplinary Progress Notes

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.
2-12-14	1300 Inmate seen on D/I at inmate request this AM. S) States that the buspar is to sedating request it be V to 10mg in HS only. States otherwise he's doing fine. O) AAO calm & cooperative A) med sedating. P) Discussed - Dr Davis Buspar ↓. Maintain appointment for 2-19-14 J Parker
2-19-14 1015 hrs	Psychiatry: CCI: DRT S: Inmate Van Hook submitted a note two days ago requesting meet see D/C his meds (Buspar, Celexa, Vistaril). Feels too sedated and anergic on them. Wants counseling more. O: MSE unremarkable. wt today 201 lbs. A: D/C meds. P: D/C celexa ↓ Buspar ↓ Vistaril Return in 3 weeks. John Davis, MD
2/19/14 1249	Next scheduled @ 4/16/13 mk Smith
3/18/2014 (PM	S Inmate seen at request of MHP. Inmate admitted to some wrong doing in relation to the FC. He stated that he had an argument with a friend in another cell. (over

CCI

Inmate Name: Van Hook	Number: 186-247

Continued on reverse side

DRC 5287 (3/00) INTERDISCIPLINARY PROGRESS NOTES

Top

Date & Time	
Continued 3/10/14 1pm	He stated that he ~~the~~ reported the argument as the person was a friend of his. The inmate brought his Recovery Services material, apparently he thought this writer was from RCS. The inmate was eager to report his progress with the material. The inmate denied any depressive symptoms or significant agitation other than the argument w his friend. O: Inmate presented as clean + neat. Affect was broad + controlled. Thought process was consistent + productive. A: Inmate is stable at this time and is actively working on the issues that prompted his current LOC. P: Will follow up on routine rounds and assist as needed. Kevin Sattler LISW SW3
4/11/2014	Met w Mr Vanhook to complete Tx plan. He reviewed the suggested course of treatment + signed the plan Kevin Sattler LISW SW3
5-07-14 1040a	Psychiatry: CCL: DRE S: Last seen by me on 2/28/14. Taken care all meds. Claims to be OK O: No meds. A: Stable on no meds. P: RTC in 16 weeks Jalandhara MD
5/7/14	14:32 Next scheduled for 8/27/14. R. Bell (HIT)

Inmate Name: VAN HOOK, ROBERT

Number: 186347

INTERDISCIPLINARY PROGRESS NOTES

EXHIBIT 20

Interdisciplinary Progress Notes

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.
5/10/14 1200 pm	S: Inmate seen per his request. He complains of feeling hopeless and depressed especially as his scheduled date for execution draws near. He admits to telling people "push his button" and going off only to begin to worry that his actions will effect his opportunity for clemency. O: Calm, cooperative, with no overt signs of disturbance. A: Mr Vanhook appears to have a very weak sense of himself which leaves him hyper-sensitive to the opinions of others, as well as in a cycle of anger & worry. P: Discussed with him the value of taking an honest personal inventory - he agreed to do this and will review at next session. —— Kevin Stotts SW3 LISW
6/19/14	S: Inmate reports much improvement of his feelings and coping. He reported that he has given much thought as to how he wants to see himself & that he takes a personal inventory that does not rely upon the impressions of others. He reported that he has also increased his spiritual & recreational activities. O: Calm, cooperative - good range of affect, insight & concentration. A: Stable at this time. P: See as needed and with in one month —— Kevin Stotts LISW SW3

DCI

Inmate Name: VANhook, ROBERT

Number: A186-347

Continued on reverse side

DRC 5287 (3/00)

INTERDISCIPLINARY PROGRESS NOTES

EXHIBIT 21

Mental Health Caseload Classification

Inmate Name:	Inmate Number:	Institution:	Date:
Vanhook, Robert	A-186347	CCI	Jul 7, 2014

(Please check one)

☒ **Serious Mental Illness (C1) - Primary Diagnosis** Borderline Personality Disorder 301.83

☐ **Non-Serious Mental Illness - Primary Diagnosis** _____

☐ **N**

☐ **IDD** - Please check if there is a presence of diagnosed Intellectual or Developmental Disabilities

Signature:	Title and Credentials:
SW3 LISW	SW3 LISW
Co-signature (if indicated):	Title and Credentials:

SMI: MUST MEET THE REQUIREMENTS FOR SECTIONS I, II, and III – Circle ALL Criteria Met By Inmate

(I) Must be 18 years of age or older; and

(II) Must meet the diagnostic criteria of any current DSM diagnosis, with the exception of the following exclusionary diagnoses:

A. Developmental disorders (tic disorders, intellectual disability, autism spectrum disorders, specific learning disorders, motor disorders and communication disorders),
B. Substance-related disorders,
C. Conditions or problems classified in current DSM as "other conditions that may be a focus of clinical attention" (ICO-9-CM, ICO-10-CM) ,
D. Neurocognitive Disorders
E. Mental disorders associated with known or unknown physical conditions (e.g. hallucinosis, amnesic disorder or delirium sleep disorders),
F. Antisocial Personality Disorder;

(III) Must have a treatment history which covers at least one current DSM diagnosis other than those listed as "exclusionary diagnoses" specified in section II and meets at least one of the following criteria (A, B, C, D, E, F, G, or H):

A. At least six (6) months total lifetime treatment in any of the following treatment modalities (may combine time to achieve total):
   (1.) Inpatient psychiatric treatment,
   2. Partial hospitalization,
   (3.) Residential program (e.g., supervised residential treatment program, or supervised group home),
   4. Residential Treatment Unit,
   5. Intensive Outpatient Unit;
B. Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period;
C. Utilization of two or more of the following services over the most recent 12 month period (in the community jail or prison
   1. Psychotropic medication management with a mood stabilizer and/or antipsychotic,
   2. Community behavioral health counseling/psychotherapy or counseling/therapy in prison,
   3. CPST (case management), mental health liaison,
   4. Community crisis assessment and treatment,
   (5.) Constant Watch for greater than 72 hours;
D. Previous treatment in an outpatient mental health service (including prison outpatient) for at least six months, and a history of at least two mental health psychiatric hospitalizations;
E. In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 6 months and requires treatment;
F. If the treatment history has been less than 6 months, the duration of the mental disorder is expected to be present for at least 6 months, and will continue to require treatment for the duration;
G. Involuntary Medication is required for more than one month;
H. Hospitalization or Emergency Assessment is required at the time of release.

EXHIBIT 22

Mental Health Treatment Plan

Inmate Name	Inmate Number	Institution	Date of Origination
Vanhook, Robert	A-186347	CCI	Jul 7, 2014

Diagnosis	Level of Current TX (RTU, Outpatient, ITP, Trauma)	MHL Name
Borderline Personality Disorder 301.83 Alcohol Use Disorder, in a controlled environment 303.90	Outpatient	Kevin Littler, SW3 LISW(s)

MH Classification

Date:	MHC:	Date:	MHC:	Date:	MHC:	Date:	MHC:
Jul 7, 2014							

All treatment goals must be objective and measurable, with estimated time frames for completion. The treatment plan is to be developed with the inmate, and the inmate's understanding of the treatment plan is to be documented in the mental health record interdisciplinary progress note.

Identified Problem ("as evidenced by")	Goals stated in measurable behavior terms ("as evidenced by")	Method used to achieve goals (include duration, frequency, and type of service/planned interventions)	Staff Responsible	Target dates of completion	Review 1 Progress Date:	Review 2 Progress Date:	Review 3 Progress Date:
MHL Signature		MHL Signature		MHL Signature			
Borderline Personality as evidenced by history of suicidal attempts and ideations as well as chronic feelings of emptiness and depression.	Mr Vanhook will participate in regular psychiatric evaluations and report any indications of depression and thoughts of self harm.	Psychiatric Staff will complete evaluation, maintain psychiatric contact and prescribe medication to address symptoms and make referrals as needed.	MD / CNP	7/8/15	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved

Borderline personality as evidenced by a history of unstable relationships and suicidal ideations.	Mr Vanhook will identify his warning signs of depression and anxiety, report any suicidal ideations and seek support from Mental Health Satff	Mental Health education, support, and crisis intervention as needed .	RN / MD LISW, LSW, Recreation Therapist.	7/8/15	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved
Medication as evidenced by a history of needing medication to relieve feelings of depression. He is not currently on medication.	Mr Vanhookl will participate in periodic evaluations and take medication as prescribed.	Psychiatric staff will evaluate on a regular basis the need for medication and prescribe as needed.	RN / MD / CNP	7/8/15	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved
					☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved
					☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved

Staff (Printed name and Signature) SLCSW LISW	Date 7/8/2014	Staff (Printed name and Signature)	Date
Staff (Printed name and Signature)	Date	Staff (Printed name and Signature)	Date
Staff (Printed name and Signature)	Date	Staff (Printed name and Signature)	Date

I have participated in the formulation of this treatment plan. Although this is not a legally binding contract, I realize that failure to participate in the planned activities could result in suspension or removal from specific treatment activities.

Inmate (Signature) A186347	Date 7/8/14
Check box if inmate is present and approves the treatment plan reviews: Review 1 ☐ Review 2 ☐ Review 3 ☐	

EXHIBIT 23

Mental Status Exam & Summary

Part A: Mental Status Exam	Name: Vanhook, Robert	Number: A-186347

Institution: CCI	Current Housing: ☐ GP ☐ RTU ☐ ITP ☐ Seg ☐ Other	Date: Jul 7, 2014
Date of Last Biopsychosocial Assessment: Mar 8, 2013	Date of Last MSE & MHE Summary: Mar 8, 2013	
Documents Reviewed: ☒ Initial Screen ☒ Detailed Screen ☒ Biopsychosocial ☒ Last MSE & MHE Summary		

Appearance and Behavior:
Appearance is unremarkable, clean and seems to be in fit health.

Speech:
Clear and understandable

Mood and Affect:
Calm Cooperative

Thought Process:
Consistent and productive.

Thought Content:
No indication of distraction or delusional content.

Cognitive Assessment:

Intellectual Ability:
His intellection ability appears to be with in normal limits. (See Assessment date 10/3/2005)

Orientation:
Oriented to person place and time.

Attention:
He attends well and is able to participate in a detailed conversation.

Concentration:
His concentration level is effective to his situation and daily activities. However, records indicate that he has had difficulty in this area in the past.

Memory:
His memory is intact both recent and remote.

Insight and Judgment:
Mr. Vanhook appears to be capable of insight and judgement when stable and symptom free. When he begins to drift back into depression there is a congruent decline in insight and judgement.

Name:	Number:
Vanhook, Robert	A-186247

Part B: Summary of Findings

Symptoms and History: Significant positive and negative findings.
Mr Vanhook as a long history of poly substance abuse, depression, and anxiety. This has contributed to poor institutional adjustment and conduct reports for alcohol abuse. This has been complicated by a history of difficulty in developing mutually beneficial relationships.

Observations: Significant findings consistent and contrary to history.
None

Testing: Significant normal and abnormal findings.
Deferred

Assessment of Suicide/Violence Risk to Self:
The record reveals a past attempt at Suicide and hospitalization at OCF. He also has a diagnosis of borderline personality as well as several threats of self harm. Currently he denies any thoughts of self harm, but his history indicates a need for continued maintenance on the mental health case load.

Assessment of Violence Toward Others:
Mr Vanhook is on death row and has a history of at least 2 fights while incarcerated. The last occurring this last April. Thus he is capable of explosive episodes, though these are infrequent.

Significant Changes Since Last Exam:
None

Adjustment to the Correctional Setting:
Mr Vanhook has been incarcerated for over 28 years and has reached the pinnacle of his institutional adjustment.

Name:	Number:
Vanhook, Robert	A-186387

Part C: Diagnosis

Diagnostic Formulation: Describe all potential diagnostic considerations

The occasion for this assessment is Mr Vanhook's current diagnosis of Adjustment Disorder, which cannot be sustained under the current time frame and stabilization. His historical pattern of relational instability and impulsive behavior. Further he has a history of suicidal attempts and ideations. This is further complicated by periodic episodes of depression and anxiety. Taken as a whole Mr. Vanhook needs to be maintained on the Mental Health Case Load despite a recent period of stability. The consistent diagnostic picture is that of Borderline Personality Disorder which includes chronic feelings of emptiness that are manifested in depression.

Diagnoses:

	Code	Name of the specific disorder/condition
Axis I:		
	301.83	Borderline Personality
	303.90	Alcohol Use Disorder, in a controlled environment
Axis II:		
Axis III:		
Axis IV:		
Axis V:		

Disposition/Short Term Treatment Plan:

☒ Chronic Care Track (☐ RTU ☐ ITP Outpatient ☐ General)
☐ Psychotherapy
☐ Diagnostic Hold
☐ Non-Caseload
☐ Special Housing Needs
☐ Other:

Report Submitted By (Printed Name):	Title:	Date of Review:
Kevin Littler	SW3 LISW(s)	Jul 7, 2014
Report Submitted By (Signature): Kevin S. Littler	Date: 7/7/2014	

EXHIBIT 24

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Date & Time	
7/8/2014 3pm	~~Tx~~ Treatment plan completed not in chart. S: Inmate was educated on his diagnosis and the treatment plan. He agreed to plan and signed. O: Alert, oriented. thought process relevant + progressive no suicidal ideations noted at this time. A: Stable P: Continue to follow on MH Call list. Kari Potter LISW
7/8/2014	Therapy Note. S: Inmate was able to review his past 2 weeks and reported success in the area of taking his own personal inventory and engaging a step + think perspective when dealing w/ others. He reported 2 situations in which he would have responded with anger + violence but was able to step out reflect upon what he wanted out how he needed to be in control of himself to control the outcome. O: Alert, oriented, calm, reflective, very attentive + open during the session. A: Stable + progressing P: Will see again in 2 weeks. Continue to encourage his sense of identity + effective pros - cons skills Kari Potter SW2 LISW

Inmate Name:	Number:
VAN HOOK	156-347

INTERDISCIPLINARY PROGRESS NOTES

EXHIBIT 25

Interdisciplinary Progress Notes

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.
8/19/14 1:30 pm	S: Therapy Note: Mr Vanhook reports that he is doing well and that he has not had any significant episodes of anxiety or depression. Nor has he experienced any episodes of significant anger or aggression. He states that he has stayed chiefly to himself and usually only comes out for recreation and visits. O: Alert, Oriented and Calm. He was focused during the session and maintained appropriate eye contact, looking away only to gather his thoughts. A: Stable at this time. P: Mr Vanhook was complemented on the progress he has made to which he smiled and expressed his appreciation for the help. We agreed to meet monthly and as needed. He will be continued on the caseload. ---------- Kevin Littler, LISW SW3
8-26-14 1040hrs	Psychiatry: CC: PRN: S: Robert Vanhook is on no meds. Says he is better for the fact that Kevin Littler has been working with him. No unmet complaints. P: Return in 12 weeks. Lamotrigine 150 mg
8/26/14 12:23pm	follow up Scheduled for 11/18/14. — R. Ball (HTT)

Continued on reverse side

Inmate Name: Vanhook, Robert	Number: A186347

DRC 5287 (3/00) INTERDISCIPLINARY PROGRESS NOTES

EXHIBIT 26

Interdisciplinary Progress Notes

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.
9/17/2014	Individual Therapy Note
3pm	S: Mr Vanhook reports that he is doing well and that his month has been without incident. At first he attributed this to several inmates being moved from his range. But he was reminded that he has worked hard on self improvement and that his coping skill have risen to the challenge of the more negative people in his area. He admitted that he continues to use the tools he learned in previous sessions and that these have helped him. He stated that he still does a daily self reflection and is generally satisfied with himself. Success was explored with the need to be vigilant in maintaining what he has gained. O: Calm and reflective. There was no indication of acute anxiety or difficulty with emotional control. A: Mr Vanhook appears to be continuing to progress well and is reaping some of the benefits of his work. He appears to be developing a sense of identity that he can be satisfied with and is goal oriented in his desire to have successes he can present in clemency as well as better coping with his current environment. P: Continue to follow on a monthly basis, and encourage his development of a healthy self image and use of the REBT skills. Kevin Littler, LISW SW3 [signature]
10/7/14	Treatment plan was reviewed and updated no changes were made —— Kevin [signature] SW3 LISW
11-18-14 0920	Psychiatry Clinic: DR2 S: Robert Van Hook, last was seen on 8-26-14. On no meds, he claims to be well. Keeps busy doing crafts. Says his meetings with Mr. Littler are helpful. No complaints O: MSE unremarkable A: Stable without meds P: RTC in 12 weeks. [signature] MD.

CCI

Continued on reverse side

Inmate Name: Vanhook | Number: A186347

DRC 5287 (3/00) INTERDISCIPLINARY PROGRESS NOTES

EXHIBIT 27

Date & Time	
11/18/14	11:44 am Follow up scheduled for 2/10/15. R. Bell (HIT)
11/19/14 3pm	Therapy Note S: Inmate seen per his request. He stated he was feeling down due to the Christmas season and that he just wanted to "talk". He spoke of the craft projects he was working on for presents, especially one he was making for his Priest. He also spoke of preparing music for a coming Church Service. He expressed some fear that he would not do a good job. He was encouraged to continue to do the best he could. He was assured that his best effort would not be rejected. O: Alert, cooperative with good range of affect, good eye contact, speech clear + understandable. A: Stable with some anxiety and loneliness. P: Continue supportive approaches see again as needed. SW Ellis

CCI

Inmate Name: Vanhook

Number: 186-347

INTERDISCIPLINARY PROGRESS NO

EXHIBIT 28

Interdisciplinary Progress Notes

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.
02/27/2015	Inmate seen at his request
3pm	S: Inmate stated that he had a rough time earlier this month due to the death of his mother.
	He admitted that he and his mother were not close as he grew older, but felt the loss none the
	less. He also reminisced the loss of his sister and that he is loosing family members. On the
	positive side he reported being able to get a new guitar and that he was able to play for the
	DR Chapel services. He spoke of having a great love for music and that he gains a lot of peace
	from it. He reported some anxiety regarding a medication renewal, but the prescription was
	refilled with no gap (this was medical prescription). O: Calm in mood with congruent affect.
	His speech was clear, understandable and reasonably paced. Thought process was progressive
	with no indication of distraction or delusion. A: Inmate was commended on his ability to cope
	with multiple stressors without "acting out" or giving up. He presents as emotionally stable.
	P: He requested that I meet with him again so he will be scheduled for two weeks from today.
	----------Kevin Littler, LISW SW2
3-10-15	0835 Inmate refused psych clinic c Dr Davis' Office is report no problems c inmate on unit, and no Δ in behavior. Will reschedule —Parker
3/10/15	13:55pm Follow up Scheduled for 6/2/15. R. Bell (HIT)
4.6.15	Treatment Plan Update
12:00pm	ⓢ Treatment plan Updated d/t MHL absence.
CCI	ⓞ Goals remain appropriate, trough Consideration

CCI	
Inmate Name: Vanhook, Robert	Number: A186347

Continued on reverse side

Inmate Name: Vanhook, Robert	Number: A186347
CCI	

Date & Time	
	Should be given to keeping an (I) on the caseload for only a personality D/O.
	(A) Consider D/C from caseload d/t no SMI, no meds needed, no current distress aside from long-standing personality D/O.
	(P) Consider D/C from CI, but f/u prn and per policy until then. All goals cont'd until next review by MHL. — [illegible], PsyD Psych Sup

Top

EXHIBIT 29

Mental Health Treatment Plan

Inmate Name	Inmate Number	Institution	Date of Origination
Vanhook, Robert	A-186347	CCI	Jul 7, 2015

Diagnosis	Level of Current TX (RTU, Outpatient, ITP, Trauma)	MHL Name
Borderline Personality Disorder 301.83 Alcohol Use Disorder, in a controlled environment 303.90	Outpatient	Kevin Littler, SW3 LISW(s)

MH Classification

Date:	MHC:	Date:	MHC:	Date:	MHC:	Date:	MHC:
Jul 2, 2015	C-2						

All treatment goals must be objective and measurable, with estimated time frames for completion. The treatment plan is to be developed with the inmate, and the inmate's understanding of the treatment plan is to be documented in the mental health record interdisciplinary progress note.

Identified Problem ("as evidenced by")	Goals stated in measurable behavior terms ("as evidenced by")	Method used to achieve goals (include duration, frequency, and type of service/planned interventions)	Staff Responsible	Target dates of completion	Review 1 Progress Date:	Review 2 Progress Date:	Review 3 Progress Date:
MHL Signature		MHL Signature		MHL Signature			
Borderline Personality as evidenced by history of suicidal attempts and ideations as well as chronic feelings of emptiness and depression.	Mr Vanhook will participate in regular psychiatric evaluations and report any indications of depression and thoughts of self harm.	Psychiatric Staff will complete evaluation, maintain psychiatric contact and prescribe medication to address symptoms and make referrals as needed.	MD / CNP	7/7/2016	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved

DRC-5197 E (Rev. 04/2014)

Borderline personality as evidenced by a history of unstable relationships and suicidal ideations.	Mr Vanhook will identify his warning signs of depression and anxiety, report any suicidal ideations and seek support from Mental Health Satff	Mental Health education, support, and crisis intervention as needed .	RN / MD LISW, LSW, Recreation Therapist.	7/7/2016	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved
Medication as evidenced by a history of needing medication to relieve feelings of depression. He is not currently on medication.	Mr Vanhookl will participate in periodic evaluations and take medication as prescribed.	Psychiatric staff will evaluate on a regular basis the need for medication and prescribe as needed.	RN / MD / CNP	7/7/2016	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved
					☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved
					☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved	☐ No ☐ Some ☐ Achieved

Staff (Printed name and Signature) [signature] SW2 LISW	Date 7/2/2015	Staff (Printed name and Signature)	Date
Staff (Printed name and Signature)	Date	Staff (Printed name and Signature)	Date
Staff (Printed name and Signature)	Date	Staff (Printed name and Signature)	Date

I have participated in the formulation of this treatment plan. Although this is not a legally binding contract, I realize that failure to participate in the planned activities could result in suspension or removal from specific treatment activities.

Inmate (Signature) [signature]	Date 7/2/2015
Check box if inmate is present and approves the treatment plan reviews: Review 1 ☐ Review 2 ☐ Review 3 ☐	

DRC-5197 E (Rev. 04/2014)

EXHIBIT 30

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

02/12/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Individual therapy

History of Present Illness
MH SOAP NOTE:

Mental Health Enounter Note

SOAP note date: *02/12/2016*

SUBJECTIVE: *Inmate seen as per routine MHL contact. and monthly individual therapy contact. The inmate reported that he has felt irritated lately with the behavior of his fellow inmates. Minor insults have set him irritated him and that he had felt like "going off." This has been a change from his usually demeanor. He also complained of a rash in his arm pit that he feels my be from his medication.*

OBJECTIVE: *Calm and in no*

acute distress. There was no indication of a disturbance in mood or thought.

ASSESSMENT: *The issues regarding his fellow inmates was discussed and processed using CBT. There was no changes in situation or events that could be considered significant. The increase in ratability could possibly be a medication issues given his complaint of a rash.*

PLAN: *Mr Vanhook is scheduled to be seen by psychiatry on Tuesday. See again for MHL in one month.*

Electronically signed by Kevin Littler-LISW-S on 02/12/2016 at 01:01 PM EST

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 31

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

03/10/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Group

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

3/10/2016

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW (s) SW2*

Total PsyEd group sessions: *1*

Patient's attendance: *1*

PsyEd group participants: *1*

PsyEd Group Note Summary: *This first group focused on the basic elements of CBT and began to work through thinking errors.*

Behavioral Observations:

Appropriate

Participation: Active

☒

Electronically signed by Kevin Littler-LISW-S on 03/10/2016 at 04:53 PM EST

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 32

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

03/28/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Treatment Plan Review

History of Present Illness
MENTAL HEALTH TREATMENT PLAN:

Problems, Treatments and Recommendations

TX plan date: *03/28/2016*

Symptom Management *Good (within 90 days)*

REVIEW *1ST REVIEW*

Problem 1. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Psychiatry staff will provide ongoing assessment,*

prescribe medication as needed and make necessary referrals.

Goal(s): *Mr Vanhook will participate in clinic appointments as well as the ongoing assessment and referrals.*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 2. *Medication management*

AEB: *As evidenced by a need to maintain medication compliance to avoid decompensation and a decrease in functioning.*

Date identified: *12/29/2015*

Intervention(s): *Staff will monitor medication compliance and provide support and education as needed*

Goal(s): *Mr Vanhook will maintain a greater than 80% compliance and will maintain open communication with the prescriber about problems that might be effecting compliance.*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 3. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Mental Health Education / Support / Crisis Intervention on an as needed basis. As well as one on one contact at least once per month to ensure stability.*

Goal(s): *Mr Vanhook will identify when his mood begins*

identify when his mood begins effecting his daily functioning and will seek out mental health support.

Responsible staff: *RN/MD/CNP/LISW/LSW/Psychology Assistant/Psychologist*

Target date *12/29/2016*

Progress: *Some*

MH SOAP NOTE:

Mental Health Enounter Note

SOAP note date: *03/28/2016*

Treatment Plan Review

SUBJECTIVE: *Record reveals that the inmate has been compliant with his treatment plan including medications. There have been no significant issues or concerns voiced by the inmate or staff. The inmate has begun to participate in MH Group when invited.*

OBJECTIVE: *Inmate is seen as in no acute distress at this time.*

ASSESSMENT: *Treatment plan has been effective in addressing the inmate's mental health needs.*

PLAN: *Review plan again in 90 days*

Electronically signed by Kevin Littler-LISW-S on 03/28/2016 at 03:33 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 03/28/2016

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EXHIBIT 33

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

03/29/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Group

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

Individual Group Designation: *Outpatient Psycho-educational*
Facilitator(s): *Kevin Littler, SW2 LISW(s)*
PsyEd group participants: *2*
PsyEd Group Note Summary: *Group focus was on basic CBT and the "ABC" model of emotional management.*
Behavioral Observations: *Appropriate*
Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 03/29/2016 at 04:20 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 34

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

03/30/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Group Screen

History of Present Illness
MH SOAP NOTE:
Mental Health Enounter Note

SOAP note date: *03/30/2016*
Inmate seen on rounds 3/28/2016
SUBJECTIVE: *Inmate stated he was interested in MH Group this week.*
OBJECTIVE: *Inmate in no acute distress, cooprative and polite.*
ASSESSMENT: *Appropriate for group*
PLAN: *Include participated in group 3/29/2016*

Electronically signed by Kevin Littler-LISW-S on 03/30/2016 at 11:59 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 03/30/2016

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

04/07/2016 Progress Note: Kevin S Littler-LISW-S

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Group Screen
2. Inmate has been attending group and is motivated.

☒

Electronically signed by Kevin Littler-LISW-S on 04/07/2016 at 04:05 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 04/07/2016

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

04/12/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

April 12 2016

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW(s) SW2*

PsyEd group participants: *3*

PsyEd Group Note Summary: *The group focus was on Schema / World in Life View that included antecedent events and emotional responses.*

Behavioral Observations: *Appropriate*

Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 04/12/2016 at 04:17 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 04/12/2016

EXHIBIT 35

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

05/19/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

5/19/2016

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW SW2*

PsyEd group participants: *3*

PsyEd Group Note Summary: *The group session dealt with relaxation and breathing*

Behavioral Observations: *Appropriate*

Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 05/20/2016 at 12:20 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 05/19/2016

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EXHIBIT 36

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

06/07/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW(s) SW2*

PsyEd Group Note Summary: *Group discussion and senecios in CBT / ABC*

Behavioral Observations: *Appropriate*

Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 06/09/2016 at 10:36 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 06/07/2016

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

EXHIBIT 37

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

06/21/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

6/21/2016

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW(s)*

PsyEd Group Note Summary: *Group session was a discussion of 12 irrational assumptions.*

Behavioral Observations: *Appropriate*

Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 06/22/2016 at 09:41 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 06/21/2016

EXHIBIT 38

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

06/28/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Treatment Plan Review

History of Present Illness
MENTAL HEALTH TREATMENT PLAN:

Problems, Treatments and Recommendations

TX plan date: *06/28/2016*

Symptom Management *Good (within 90 days)*

REVIEW *2ND REVIEW*

Problem 1. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Psychiatry staff will provide ongoing assessment,*

prescribe medication as needed and make necessary referrals.

Goal(s): *Mr Vanhook will participate in clinic appointments as well as the ongoing assessment and referrals.*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 2. *Medication management*

AEB: *As evidenced by a need to maintain medication compliance to avoid decompensation and a decrease in functioning.*

Date identified: *12/29/2015*

Intervention(s): *Staff will monitor medication compliance and provide support and education as needed*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 3. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Mental Health Education / Support / Crisis Intervention on an as needed basis. As well as one on one contact at least once per month to ensure stability.*

Goal(s): *Mr Vanhook will identify when his mood begins effecting his daily functioning and will seek out mental health support.*

Responsible staff: *RN/MD/CNP/LISW/LSW/Psychology Assistant/Psychologist*

Target date *12/29/2016*

Target date 12/29/2016

Progress: *Some*

Problem 4. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *06/28/2016*

Intervention(s): *Staff will provide insight oriented groups utilizing a cognitive behavioral approach.*

Frequency of Intervention(s) *Weekly*

Goal(s): *Go to Notes Mr Vanhook will participate in weekly group sessions, complete assignments, and report decrease in anxiety.*

Responsible staff: *Psychologist, PA, LSW, LISW*

Target date *12/29/2016*

MH SOAP NOTE:

Mental Health Enounter Note

SOAP note date: *06/28/2016*

Treatment Plan Review

SUBJECTIVE: *Record reveals that the inmate has been compliant with his treatment plan including medications. There have been no significant issues or concerns voiced by the inmate or staff. The inmate has begun to participate in MH Group.*

OBJECTIVE: *Treatment plan has been effective in addressing the inmate's mental health needs.*

ASSESSMENT: *Problem #4 has been added to address MH Groups as part of the overall regime. No other changes needed.*

PLAN: *Review plan again in 90 days*

Electronically signed by Kevin Littler-LISW-S on 06/28/2016 at 10:13 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 06/28/2016

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

EXHIBIT 39

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

07/05/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

ITP INSTRUCTIONS *7/5/2016*
Individual Group Designation: *Outpatient Psycho-educational*
Facilitator(s): *Kevin Littler, LISW(s) SW2*
PsyEd Group Note Summary: *Group session was a review of CBT and a discussion of disputing irrational thinking.*
Behavioral Observations: *Appropriate*
Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 07/06/2016 at 01:42 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 07/05/2016

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

EXHIBIT 40

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

07/26/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

7/26/2016

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW SW2*

PsyEd Group Note Summary: *The group discussion covered disputation of irrational thoughts (CBT)*

Behavioral Observations: *Appropriate*

Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 07/27/2016 at 10:33 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 07/26/2016

EXHIBIT 41

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

08/09/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

Individual Group Designation: *Outpatient Psycho-educational*

Facilitator(s): *Kevin Littler, LISW(s) SW2*

PsyEd Group Note Summary: *Group discussion of self talk as related to disputation of irrational thoughts.*

Behavioral Observations: *Appropriate*

Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 08/10/2016 at 09:44 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 08/09/2016

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

EXHIBIT 42

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

08/16/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH GROUP

History of Present Illness
MH GROUP INTERVENTION SOAP NOTE:

Group Therapy Intervention Notes

Individual Group Designation: *Outpatient Psycho-educational*
Facilitator(s): *Kevin Littler, LISW(s) SW2*
PsyEd Group Note Summary: *Group discussion of CBT and daily habits.*
Behavioral Observations: *Appropriate*
Participation: *Active*

Electronically signed by Kevin Littler-LISW-S on 08/17/2016 at 09:34 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 08/16/2016

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

EXHIBIT 43

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 411
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

08/19/2016 **Progress Note: Kevin S Littler-LISW-S**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Treatment Plan Review

History of Present Illness
MENTAL HEALTH TREATMENT PLAN:

Problems, Treatments and Recommendations

TX plan date: *08/19/2016*

Symptom Management *Good (within 90 days)*

REVIEW *3RD REVIEW*

Problem 1. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Psychiatry staff will provide ongoing assessment,*

prescribe medication as needed and make necessary referrals.

Goal(s): *Mr Vanhook will participate in clinic appointments as well as the ongoing assessment and referrals.*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 2. *Medication management*

AEB: *As evidenced by a need to maintain medication compliance to avoid decompensation and a decrease in functioning.*

Date identified: *12/29/2015*

Intervention(s): *Staff will monitor medication compliance and provide support and education as needed*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 3. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Mental Health Education / Support / Crisis Intervention on an as needed basis. As well as one on one contact at least once per month to ensure stability.*

Goal(s): *Mr Vanhook will identify when his mood begins effecting his daily functioning and will seek out mental health support.*

Responsible staff: *RN/MD/CNP/LISW/LSW/Psychology Assistant/Psychologist*

Target date *12/29/2016*

Target date 12/29/2016

Progress: *Some*

Problem 4. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *06/28/2016*

Intervention(s): *Staff will provide insight oriented groups utilizing a cognitive behavioral approach.*

Frequency of Intervention(s) *Weekly*

Goal(s): *Go to Notes Mr Vanhook will participate in weekly group sessions, complete assignments, and report decrease in anxiety.*

Responsible staff: *Psychologist, PA, LSW, LISW*

Target date *12/29/2016*

MH SOAP NOTE:

Mental Health Enounter Note

SOAP note date: *08/19/2016*

Treatment Plan Review

SUBJECTIVE: *Inmate voiced no issues or complaints with his treatment plan. The record reveals that he has been compliant with the plan including MH Groups.*

OBJECTIVE: *Treatment plan has been effective in addressing the inmate's mental health needs.*

ASSESSMENT: *No changes needed with this review.*

PLAN: *Review plan again in 90 days*

Electronically signed by Kevin Littler-LISW-S on 08/19/2016 at 01:38 PM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Kevin S Littler-LISW-S 08/19/2016

EXHIBIT 44

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 408
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080
Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

11/09/2016 **Progress Note: Jennifer M Kutys-Psych**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH TREATMENT PLAN

History of Present Illness
MENTAL HEALTH TREATMENT PLAN:

Problems, Treatments and Recommendations

TX plan date: *11/09/2016*

Symptom Management *Good (within 90 days)*

REVIEW *INITIAL*

Problem 1. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Psychiatry staff will provide ongoing assessment,*

prescribe medication as needed and make necessary referrals.

Goal(s): *Mr Vanhook will participate in clinic appointments as well as the ongoing assessment and referrals.*

Responsible staff: *MD / CNP / RN*

Target date *11/09/2017*

Progress: *Some*

Problem 2. *Medication management*

AEB: *As evidenced by a need to maintain medication compliance to avoid decompensation and a decrease in functioning.*

Date identified: *12/29/2015*

Intervention(s): *Staff will monitor medication compliance and provide support and education as needed*

Responsible staff: *MD / CNP / RN*

Target date *12/29/2016*

Progress: *Some*

Problem 3. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Mental Health Education / Support / Crisis Intervention on an as needed basis. As well as one on one contact at least once per month to ensure stability.*

Goal(s): *Mr Vanhook will identify when his mood begins effecting his daily functioning and will seek out mental health support.*

Responsible staff: *RN/MD/CNP/LISW/LSW/Psychology Assistant/Psychologist*

Target date *11/09/2017*

Target date 11/09/2017
Progress: *Some*
Problem 4. *Anxiety*
AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*
Date identified: *06/28/2016*
Intervention(s): *Staff will provide insight oriented groups utilizing a cognitive behavioral approach.*
Frequency of Intervention(s) *Weekly*
Goal(s): *Go to Notes Mr Vanhook will participate in weekly group sessions, complete assignments, and report decrease in anxiety.*
Responsible staff: *Psychologist, PA, LSW, LISW*
Target date *11/09/2017*
MH SOAP NOTE:
Mental Health Encounter Note

SOAP note date: *11/09/2016*
SUBJECTIVE: *Inmate seen on rounds this morning by MH. Voiced no complaints.*
OBJECTIVE: *Treatment plan has been effective in addressing the inmate's mental health needs.*
ASSESSMENT: *No changes needed with this review.*
PLAN: *Review plan again in 90 days. Inmate maintained on caseload solely due to the fact that he is prescribed medications and, per policy, cannot be an "N" with medications prescribed.*

Electronically signed by Jennifer Kutys-Psych Super on 11/09/2016 at 07:58 AM EST

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Jennifer M Kutys-Psych 11/09/2016

EXHIBIT 45

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 408
56 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

11/22/2016 **Progress Note: Teresa Y Gray-BHCP II**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH LIAISON CONTACT

History of Present Illness
MH SOAP NOTE:
Mental Health Encounter Note

SOAP note date: *11/22/2016*
SUBJECTIVE: *Patient stopped worker and asked if the mental health groups were going to be restarted because "I was enjoying learning about Rational Emotive Therapy and all that from Mr Littler."*
OBJECTIVE: *Pt alert and oriented x4. Behavior cooperative, speech tone, rate and quality normal; mood euthymic, affect reactive and appropriate to the situation. No hallucinations present; no SI/HI stated. Thought content logical, no*

memory impairments evident.

ASSESSMENT: *Advised that worker was not aware that groups had been discontinued and would have to ask about them. Will follow up during next round.*

PLAN: *Asked Dr Kutys about groups; she stated that a fire in the group room had occurred, making it unsafe to occupy the room for group. She stated that after the work order to repair the ceiling is complete, we can begin groups again. Pt to kite with future needs.*

Electronically signed by Teresa Gray-BHCP II , TYG on 11/22/2016 at 03:25 PM EST

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 46

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 408
57 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

08/30/2017 Progress Note: Default Group A-Mental Health

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH 1:1 CONTACT

History of Present Illness
MH SOAP NOTE:
Mental Health Encounter Note

SOAP note date: *08/30/2017*
SUBJECTIVE: *Met with Inmate VanHook to discuss Mindfulness & Meditation. Started with handing him an article titled "Getting Started with Mindfulness Meditation" which explains the basics of Mindfulness. Inmate VanHook was very interested in Mindfulness Meditation and how it would increase his overall quality of life both mentally and physically.*
OBJECTIVE: *Inmate VanHook was alert and cooperative during the 1 hour encounter*

ASSESSMENT: *Inmate VanHook appeared to be stable.*

PLAN: *Follow up as needed*

☒

Electronically signed by Stephen Beeler-AT , SCB on 09/13/2017 at 11:18 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Default Group A-Mental Health 08/30/2017

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 408
57 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

09/15/2017 Progress Note: Default Group A-Mental Health

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH LIAISON CONTACT

History of Present Illness
MH SOAP NOTE:
Mental Health Encounter Note

SOAP note date: *9/14/2017*
SUBJECTIVE: *Met with inmate Vanhook and discussed Mindfulness and Meditation. Talked with him on the article I gave him on the last encounter on the basics of Mindfulness. We discussed how daily mindfulness practice would help him handle daily emotions. The encounter was ended with a 20 minute body scan meditation and a discussion on pre and post meditation emotions.*
OBJECTIVE: *Inmate Vanhook was alert and cooperative during the 1*

nour encounter

ASSESSMENT: *Inmate appeared to be stable*

PLAN: *Follow up as needed*

☒

Electronically signed by Stephen Beeler-AT , SCB on 09/22/2017 at 09:16 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

Patient: VANHOOK, ROBERT DOB: 01/14/1960 Progress Note: Default Group A-Mental Health 09/15/2017

EXHIBIT 47

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 408
57 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

10/05/2017 Progress Note: Default Group A-Mental Health

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH LIAISON CONTACT

History of Present Illness
MH SOAP NOTE:

Mental Health Encounter Note

SOAP note date: *10/4/2017 @ 9:30 am*

SUBJECTIVE: *Met with Inmate Vanhook to discuss Mindfulness and Meditation. Talked briefly about his emotions over the since my last encounter with him. He seemed very positive. I gave him 2 articles on Mindfulness in regards to meditations to help him become more mentally aware. We then did a 20 minute breathing and body scan meditation.*

OBJECTIVE: *Inmate was alert and cooperative during 1 hour*

encounter

ASSESSMENT: *Inmate appeared to be stable*

PLAN: *Follow up as needed*

Electronically signed by Stephen Beeler-AT , SCB on 10/13/2017 at 09:02 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 48

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR1B 125
57 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

10/19/2017 Progress Note: Default Group A-Mental Health

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH 1:1 CONTACT

History of Present Illness
MH SOAP NOTE:
Mental Health Encounter Note

SUBJECTIVE: *Met with Inmate Vanhook for a Mindfulness and Meditation session. Started group discussing the previous week and reading information that was given to him. He seemed motivated to becoming more mindful and meditated several times inbetween our sessions. I walked him through a 10 minute breathing meditation and then proceeded to talk on his emotional state. He stated "I am mentally in a good place.". I handed him 2 articles on anxiety and breathing in regards to mindfulness.*

We finished the session with a 5 minute meditation

OBJECTIVE: *Inmate Vanhook was alert and cooperative during the encounter*

ASSESSMENT: *Inmate Vanhook appeared to be stable*

PLAN: *Follow up as needed*

Electronically signed by Stephen Beeler-AT , SCB on 12/14/2017 at 09:27 AM EST

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 49

VANHOOK, ROBERT

BCI: B070911
InmateID: A186347
Facility Code: CCI Housing Area: DRDR2 408
57 Y old Male, DOB: 01/14/1960
P.O. BOX 5500, CHILLICOTHE CORRECTIONAL INSTITUTION, CHILLICOTHE, OH-45601
Home: 740-774-7080

Guarantor: VANHOOK, ROBERT
Appointment Facility: Chillicothe Correctional Inst.

10/24/2017 **Progress Note: Jennifer M Kutys-Psych**

Current Medications
None

Mental/Medical History
Hep C d/c'd
right knee ACL tear
Lipids d/c'd
BPH
Hypothyroid
Hypertension
Hypertension

Allergies/Intolerance
Serotonin Reuptake Inhib: 1009-1-: Allergy

Chief Complaint
1. MH Treatment Plan Review

History of Present Illness
MENTAL HEALTH TREATMENT PLAN:

Problems, Treatments and Recommendations

TX plan date: *10/24/2017*

Symptom Management *Good (within 90 days)*

REVIEW *INITIAL*

Problem 1. *Anxiety*

AEB: *Feelings of anxiety related to a history of relational instability and subsequent emotional insecurity.*

Date identified: *12/29/2015*

Intervention(s): *Psychiatry staff will provide ongoing assessment,*

prescribe medication as needed and make necessary referrals. MHL to provide Mental Health Education / Support / Crisis Intervention on an as needed basis.

Goal(s): *Mr Vanhook will participate in clinic appointments as well as the ongoing assessment and referrals.*

Responsible staff: *MD / CNP / RN*

Target date *10/24/2017*

Progress: *Some*

Problem 2. *Medication management*

AEB: *As evidenced by a need to maintain medication compliance to avoid decompensation and a decrease in functioning.*

Date identified: *12/29/2015*

Intervention(s): *Staff will monitor medication compliance and provide support and education as needed*

Responsible staff: *MD / CNP / RN*

Target date *10/24/2018*

MH SOAP NOTE:

Mental Health Encounter Note

SOAP note date: *10/24/2017*

SUBJECTIVE: *Inmate sleeping when this writer attempted to review his treatment plan with him. Chart review indicates he has been regularly attending mindfulness programming and is in positive spirits. Inmate scheduled to see prescriber related to medications.*

OBJECTIVE: *Treatment plan has been effective in addressing the inmate's mental health needs.*

ASSESSMENT: *No changes*

ASSESSMENT: *No changes needed with this review.*

PLAN: *Review plan again in 90 days.*

Electronically signed by Jennifer Kutys-Psych Super on 10/24/2017 at 10:45 AM EDT

Sign off status: Completed

Chillicothe Correctional Inst.
15802 Ste Rt 104 N
Chillicothe, OH 45601
Tel: 740-774-7080
Fax:

EXHIBIT 50

INTERDISCIPLINARY PROGRESS NOTES

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.	Dept. or Discipline
5/30/91	I went over Mr. VanHook's psychiatric chart at Dr. Vermeulen's request to see if anything in his history pointed toward an Axis I diagnosis that would likely warrant our need to provide services to him at this time. Although he has experienced a chaotic life and has been diagnosed as suffering from a Borderline Personality Disorder and Ego Dystonic Homosexuality, I do not see these conditions as requiring OPSC services. Ted [illegible], Ph.D.	
6-14-91	3:45 Mr Van Hook was scheduled for evaluation in clinic c Dr Vermeulen. He was not seen due to lack of time & schedule conflicting c meal [illegible] in K Block. Will reschedule. [illegible signature]	

8/1/91 VANHOOK 186-347

We spent some time with VanHook based on his request and complaints about the need of treatment, which again was based on a diagnosis of Borderline Personality. The reason for the delay is that there is quite a bit of material in the file and some time was necessary to review it. Also I have requested Dr. Strickland and the psychological department to review the material to get some idea about the problem and treatment needs.

Mr. VanHook presented with a rather peculiar hairdo but otherwise good grooming and hygiene. He talks freely and rationally except for a couple of ideas initially, such as wanting to be a spiritual leader, that might not be quite inside the range of what one would expect. His need for treatment is expressed mostly as a concern that he has been getting into situations where he has not been able to control his temper and has become assaultive as he says he has been in the past.

Van Hook # 186-347

(continue on reverse side)

INTERDISCIPLINARY PROGRESS NOTES

Date & Time	Document significant events during clients course of treatment; implementation of treatment plan and response to treatment. Sign and title all notes.	Dept. or Discipline

When he explains those situations it seems that at least some of them have been provoked by himself, as when he explains that he got into a fight with somebody with whom he had made a "sexual contract." Mostly what it came down to was that he would like to see somebody with some regularity that he could talk to and confide in and discuss everyday problems that he runs into.

The impression certainly is of a personality disorder, just possibly an impulse control disorder, and there may be some borderline aspects. Although from this interview I couldn't determine whether he has ever had psychotic episodes. He does seem to have a genuine need for some contact with a trusted person and normally one would expect that this need be met by unit staff. However, he complains that before he can see somebody on the unit staff, he has to send a kite and I would certainly agree that the process would consume more time than he may have patience.

My conclusion is that he does not have a need for ongoing psychiatric treatment. I do accept his need for regular counseling contact and I told him that I would present him to the treatment team and ask for the presence of somebody from the psychology department and let the treatment team decide what his treatment plan should be.

J.H.V.

John H. Vermeulen, M.D., Consulting Psychiatrist
JHV/dw - Trans. 8/6/91 11:05 AM

9/11/91 VANHOOK 186-347

I saw VanHook some time ago and made a referral to the treatment team to include psychological services to discuss assignment. Following that recommendation I am told that this was not appropriate and that it was up to me to determine whether he was appropriate for our services.

Since I did indicate that he is in need of regular counseling and since without a firm commitment from psychology I am convinced that he would not receive the counseling that I feel he needs, I now state that he would be appropriate to our services and that counseling can be provided to him through Psychiatric Services to Corrections.

JHV

John H. Vermeulen, M.D., Consulting Psychiatrist
JHV/dw - Trans. 9/16/91 12:25 PM

9-27-91 10:00 AM — Vanhook was seen today on routine recall. Psycho-Social Assessment and Psychiatric intake completed.

June Marucm LSW

June Marucm LS.W.

DMH-MedR-1007

EXHIBIT 51

DEPARTMENT OF REHABILITATION AND CORRECTION

OFFICE COMMUNICATION

TO: Arthur Tate, Jr., Warden DATE: 6-7-91

FROM: William W. Gilbert, Ph.D., Psychology Supervisor

SUBJECT: VAN HOOK #186 347

....Necessary Action	....Prepare Reply	....For Your Information	....Approval	....Note and Return	....See Me
....Investigate	....Signature	....Per Conversation	....Comment	....Note and File	....As Requested

21 OSR

My interview analysis reported to you on 5/31/91 did not include diagnostic or program planning information. As I conducted the brief screening interview I determined that there were no indications of serious mental illness and no need for individual therapeutic intervention from us or from OPSC.

If, as he states, he is an individual with a borderline personality disorder, the recommended treatment would be a firm and predictable program of experiencing appropriate consequences for his behavior.

SOUTHERN OHIO CORRECTIONAL FACILITY

William W. Gilbert, Ph.D.
Psychology Supervisor

WWG:ha

cc: File

EXHIBIT 52

TREATMENT PLAN AND CONTRACT FOR INDIVIDUAL THERAPY
(Individual / Group)

MANSFIELD CORRECTIONAL
Institution

Name VAN HOOK Date of Preparation 4-23-96

Number 186-347 Therapist KATHLEEN ISGRO, PH.D.

Presenting Problem: VIOLENT IDEATION WITH HX OF AGGRESSIVE ACTING-OUT

Goal or desired behavior:

I MAINTENANCE OF BEHAVIORAL CONTROL OVER VIOLENT IMPULSES

II COMPLIANCE WITH MEDICATION REGIMEN

III IDENTIFICATION/UTILIZATION OF EFFECTIVE STRATEGIES FOR ANGER AND STRESS-MANAGEMENT

IV ↓ IN FREQUENCY OF VIOLENT IDEATION AND EMOTIONAL OVER-REACTIVITY

Frequency of Sessions and Duration of Therapy 15 MINUTE 1:1 CONTACT PER WEEK

Methods used in Therapy MEDICATION, COGNITIVE-BEHAVIORAL METHODS, LIMIT-SETTING, SUPPORTIVE PSYCHOTHERAPEUTIC CONTACT

Evaluation Process TREATMENT TEAM TO MONITOR PROGRESS ON MONTHLY BASIS BEGINNING END OF MAY, 1996.

Goal	Date	No Progress	Some Progress	Accomplished Goal
I				
II				
III				
IV				

I agree to the above treatment plan which I helped develop and which shall remain in effect until it is either revised, completed or terminated.
Therapy can be terminated for the following reasons:

1. Successfully completing treatment.
2. Progress toward goals - continued treatment recommended at later date.
3. Administrative discharge due to: excessive absences, leaving institution, inadequate progress on goals, inappropriate behavior in therapy.
4. Inmate/therapist agree on another modality for treatment.

I agree to attend all therapy sessions.
The only information released from this therapy will be the number of sessions contracted for, and the number of sessions attended; unless I sign a release of information granting the therapist permission to write a progress report for placement in the Master Pocket. This does not grant me the right to read the report as it is considered a type of psychological evaluation.

Client Signature A186347

Kathleen Isgro, PhD.
Therapist Signature

cc. Inmate
Psychology File
Master Pocket if release is attached

Supervisor (Date) 5/3/96

EXHIBIT 53

Rec'd 6/1/2005 NARRATIVE SUMMARY Typed 6/4/2005
Dict. 6/1/2005

Present History, Past History, Physical Findings (Include Lab, and X-Ray), Diagnosis, Course of Treatment, Recommendations and Plans, Disposition.

Date of Admission	Date of Discharge or Release	No. of Days Hospitalized
5/9/2005		

(Dr.Carder:ps) DISCHARGE NARRATIVE SUMMARY June 4, 2005

Pt. Name: VANHOOK, Robert
DRC # 186-347
DOB: [redacted]
Adm. Date: 5/09/2005
Admission Source: ManCI/Death Row – Dr. Patterson

Identifying Information:
Mr. Vanhook is a 45-year-old divorced Caucasian male never before admitted to OCF.

Reason for Referral:
Mr. Vanhook was referred to Oakwood due to self-injurious acts on 5/05/2005, which at the present time seem to be stress related.

History of Present Illness:
Mr. Vanhook is a 45-year-old Caucasian male who has been incarcerated on death row since 1985. He has received intermittent mental health treatment. Previous diagnosis have included borderline personality disorder, atypical bipolar disorder, impulse control disorder, not otherwise specified, polysubstance dependence and a R/O of major depressive disorder. Mr. Vanhook has also had extensive psychological testing due to the nature of his crime. His most recent episode occurred on May 5, 2005 when he became "stressed and upset about a pending transfer to OSP" as well as being upset about family members who are allegedly ill. He states that he was attempting to meditate to Buddha which usually helps to calm him down but during one of his meditations he was overcome by the thought of a Christian-like Satan symbol which told him that if he was going to return to OSP he might as well cut his own throat. He stated that he held a razor to his neck in an attempt to get mental health to respond quickly. When they did not he made

6-07-05 SM

superficial cuts to his abdomen to show people he was serious. He stated once "white shirts" showed up and talked to him, he did calm down significantly. Shortly thereafter, he was started on Risperdal and Benadryl which seemed to have improved the situation greatly. He describes these medications as "force field" which are protecting him and keeping him safe. He has had no further self-injurious thoughts since this episode on 5/05/2005. Prior to this he stated he was doing relatively well. He had not had a self-injurious act since 1981. He does not feel his medication or visions of Buddha are auditory or visual hallucinations. He feels they are just strong thoughts of his, although he had some previous examiners that thought he did have command hallucinations. He does not report any or manic episodes. He did not report any significant depressive symptoms at the present time. His greatest concerns on the day of his evaluation are his privileges and ability to read his legal mail while at OCF. He did not report any side effects to medications but did report problems falling asleep. He reported initially he had trouble "shaking" which the Benadryl has helped with. He states he is concerned about his return to OSP because he had been housed there in the past and had great difficulty there. Review of his file shows that he had "fight his way to earn respect" when last at this institution. He does have some hope for his future and states that his case is under its final appeal. He did not report any significant problems with appetite, energy or interest.

Past Psychiatric History:
Mr. Vanhook had received outpatient counseling through the VA. and inpatient drug rehab. As stated above he has had extensive psychological evaluations due to the nature of his crime. Review of the psychological evaluations shows the prominent diagnosis of borderline personality disorder which is thought to be the contributing factor in his crime. Through the psychological reports he was in a "psychotic rage and homosexual panic which allegedly caused the murder. Previous medications have included Wellbutrin, Sinequan, Haldol and most recently Risperdal and Benadryl. His current dose is Risperdal, 2 milligrams twice daily and Benadryl, 100 milligrams twice daily. He has had numerous diagnosis over the years which are listed above in the history of present illness. His most prominent diagnosis appears to be borderline personality disorder.

Medical History:
Mr. Vanhook suffers from Hepatitis C, Arthritis, and an ACL tear. He is currently taking Motrin for treatment of pain from the Arthritis and ACL tear. He had no known drug allergies. He reports an appendectomy as an adolescent. He reports a history of head injury due to bar fights and an motor vehicle accident. He does not report any seizure activity.

Alcohol/Substance History:
Mr. Vanhook reports an extensive alcohol and substance abuse history starting at the age of two. He reports that his father was a musician and was always drinking in the home and would bring many friends home to use alcohol and drugs. He reports that his father's friends found it humorous to get him drunk when he was a toddler. He started using alcohol and drugs voluntarily around the age of nine or ten. He reports he has used almost every type of drug, but seems to center on marijuana, alcohol and amphetamines. He does report a history of IV drug use. He has received inpatient rehabilitation for his alcohol and drug use and received an honorable discharge from the army due to his alcohol and drug use.

Psychosocial/Developmental History:
Mr. Vanhook was born and raised in the Cincinnati area. He described his childhood as very chaotic. He was exposed to sexual activity by his parents at a very young age. Both parents were unfaithful to one another and often moved around. Once his parents were divorced, he was shuffled between numerous aunts' homes and finally ended up staying with his father. His father became his regular drinking partner and they got into many bar fights together. Review of his mental health file shows that he was often placed in many "double bind situations." For example he was asked frequently who he loved more, his father or his mother, and no matter what his response he would be severely beaten. He only attended school up until the ninth grade but did go on to receive his GED through the prison system. He was not in any special education classes. He was married briefly for less than six months and has never had any children. Review of his mental health file shows that he had many conflicting feelings regarding his sexual identity and has been involved in numerous homosexual relationships. His current offense involves taking a gentlemen home from a homosexual bar and going into a rage when the gentleman attempted to have oral sex with him. Review of his mental health file also shows an extensive fascination, almost fantasy-like obsession with the military with movies depicting very violent, gruesome killings such as the Killing Fields. He did enlist in the army and served four and one half years and was given an honorable discharge. He seemed to be fascinated with the Special Forces and airborne division and would often dress in this type of clothing when going to his VA appointment even though he was never in this branch of the armed forces. Prior to incarceration, Mr. Vanhook supported himself by doing construction work, but also has prostituted himself homosexually to earn money and to support his alcohol and drug habits.

Family Medical & Psychiatric History:
Family history is significant for a mother who has been treated for an unknown type of mental illness. He also thinks a cousin might have committed suicide. There is extensive alcohol and drug use in both his mother and father. His father is now deceased.

Criminal Justice History:
Mr. Vanhook has an extensive history of bar fights. He is currently incarcerated on aggravated murder and lives on death row in Mansfield.

Institutional Adjustment:
Mr. Vanhook has had intermittent involvement with mental health but seems to have adjusted well over the past few years without any major incidents. He has only come to mental health's attention on May 5, 2005 after his self-injurious act.

Mental Status Examination on Admission:
Mr. Vanhook is a 45 year-old Caucasian male who appears his stated age. He is dressed appropriately with no psychomotor agitation or retardation. He sat calmly throughout the interview and was able to maintain appropriate eye contact. Speech was fluent, spontaneous with a normal rate and tone. His present mood appears to be euthymic. His affect congruent and reactive. Thought process was logical and goal directed without any evidence of circumstantiality, tangentiality or flight of ideas. Thought content shows some mild rumination about possible return to OSP but it is not of an obsessional nature and does not appear to be impairing his normal thought process. He is not reporting any present perceptual disturbances although he had reported previously command hallucinations. He is now seeing these as part of his meditation and no different than normal thoughts. He is not reporting any delusional ideation, suicide and violence risk assessment, past ideation attempts. He has had numerous suicidal gestures and attempts over the past twenty-five years. There have been no documented attempts of a serious level of mortality.

Present Ideas and Behaviors: He is denying. He reports that he has not had any self-injurious thoughts s
2005. He is reporting that his current act of making superficial scratch to his abdomen was simply to let s
he was serious about his concerns.

Past Violent Assault Behavior: He has an extensive history of fighting when intoxicated. He is currently incarcerated on aggravated murder. Present ideas and behaviors he is denying. His insight and judgment are fair.

Psychological testing results: His previous I.Q. testing shows an I.Q. of 95.

Admitting Diagnostic Impression: (DSM IV)
Axis I: (S) Polysubstance Dependence, Institutional Admission (304.80)
Axis II: (P) Borderline Personality Disorder (301.83)
Axis III: Hepatitis C, Arthritis

PATIENT'S LAST-FIRST-MIDDLE NAME	STATISTICAL NO.	DRC NO.	WARD NO
VANHOOK, Robert		186-347	

Psychiatric Hospital Units of the Oakwood Correctional Facility

(Name of hospital or other medical facility)

Axis IV: 4-Severe Psychosocial stressors related to incarceration
Axis V: GAF-S = 38-45

Criteria for Hospitalization:
Mr. Vanhook presently satisfies criteria ORC 5120.17, as a mentally ill person subject to hospitalization due to recent self-injurious acts he needs to be observed and stabilized in a hospital setting.

Treatment Recommendation:
(1) Mr. Vanhook was ordered annual laboratory studies including CBC with Diff, Chem. Profile, UA, TSH and RPR.
(2) His medications were continued but changed as follows Risperdal, 4 milligrams in the evening and Benadryl 200 milligrams in the evening.
(3) At the present time there is no ongoing thoughts of self-harm with documented dramatic improvement since the initiation of medication, therefore his close watch is discontinued. He is also receiving 15-minute observation and documentation through his special security status, which will help to ensure his stability and safety.
(4) After a period of observation he will be enrolled in appropriate groups and therapy as deemed appropriate at his first treatment team meeting, which will be done within 72 hours.

Admission Physical Exam:
Mr. Vanhook was examined by Dr. Amin May 11, 2005. The patient had no chief complaints, but noted a history of a right knee injury, a torn ACL, and history of chronic back pain. On exam Dr. Amin noted multiple tranverse abrasions on the front of the abdomen. His impression was Hepatitis C, old injury to right knee and back pain. Mr. Vanhook was admitted to the Hepatitis C chronic care clinic and was ordered Ibuprofen.

Admission Laboratory Studies:
Mr. Vanhook received a complete Chem profile. AFB tumor marker, TSH, CBC with diff, RPR, and U/A. At the time of the dictation his Chem. profile is still listed at "pending" The AFB tumor marker was normal at 2.2 The TSH came back elevated at 23.13; CBC was normal, RPR was non-reactive and the U/A was negative.

Hospital Course:
Mr. Vanhook is a 45 year old male who was sent to Oakwood due to a self injurious act on 5/5/2005. He reported on admission that he had became stressed about a pending transfer to OSP and was upset about family members who were ill. He reported that just prior to the incident he had been meditating to Budda, who in the past has helped him calm down. For some reason

the Buddha like figure turned to more of a Satan symbol, which influenced him to harm himself. He did not see this as a psychotic symptom but rather his thoughts through meditation taking over. Prior to his transfer to OCF he had been started on Risperdal and Benadryl, which improved his clinical situation greatly and on admission he was voicing a desire to continue these medications in reported no ongoing barbs of self harm. Mr. Vanhook was started on Synthroid 0.1 mg. daily on 5/12/2005 (due to the TSH coming back elevated as described above in the laboratory section). Once this medication was initiated, he showed great improvement in his mood and ask to be slowly tapered off the Risperdal. Once the Risperdal was discontinued he had ongoing stability with no recurrence of any visions or delusions. His mood remained for the most part stable other than intermittent dysphoria which quickly resolved with individual counseling. At the end of May, he felt the Benadryl was no longer affective and was causing constipation. He was therefore changed over to Trazadone, which was increased to 150 mg. in the evening. When his treatment team convened on June 1, 2005 all were in agreement that he was no longer needing hospital level of care. Mr. Vanhook did voice his desire to return to his parent institution so that he could restart his exercise regimen. At no time during this hospitalization were there any episodes of self injury, overt psychotic behavior nor medication side effects, other than mild constipation from the Benadryl.

Discharge Physical & Lab:
Remain unchanged.

Discharge Mental Status Exam:
Mr. Vanhook is a 45 year old Caucasian male who appears his stated age. Grooming and hygiene are with in the normal range. There are no psychomotor agitation or retardation. Speech is fluent, spontaneous, of a normal rate and tone. Mood is euthymic with congruent affect. Thought process is logical and goal directed. Thought content is without any overt delusions. Suicidal ideation or homicidal ideation, there is no longer rumination about returning to OSP. Cognitive exam shows that he alert and oriented times 3. Recent, remote and immediate memory are intact. Attention and concentration are within normal range. Intelligence and fund of knowledge are average. His insight and judgment are fair.

Conclusion:
Based on the aforementioned, the patient presently does not satisfy the requirements of ORC 5120.17 as a mentally ill person subject to hospitalization. He is of no danger to himself or others with no impairment in daily functioning.

PATIENT'S LAST-FIRST-MIDDLE NAME	STATISTICAL NO.	DRC NO.	WARD NO
VANHOOK, Robert		186-347	

Psychiatric Hospital Units of the Oakwood Correctional Facility

(Name of hospital or other medical facility)

REPORT
OR
CONTINUATION

Page 7

Final Diagnosis:
Axis I: (P) Adjustment Disorder with Disturbance of Conduct (309.30)
Axis II: (S) Antisocial Personality Disorder (301.70)
Axis III: None
Axis IV: 3-Moderate Psychosocial stressors related to incarceration
Axis V: GAF-S = 55

Treatment Recommendation & Medications:

1. Mr. Vanhook's discharge medication includes Trazadone, 150 mg. at bedtime and Synthroid 0.1 mg. daily.
2. Mr. Vanhook would benefit from ongoing mental health follow up; especially during the possible transfer to OSP as it has been a psychosocial stressor for him. He would benefit from increased mental health liaisons and/or individual therapy sessions during that time to ensure his safety and stability.

[signature] Date: 6/7/05

for Lynnea Carder, M.D.

PATIENT'S LAST-FIRST-MIDDLE NAME	STATISTICAL NO.	DRC NO.	WARD NO
VANHOOK, Robert		186-347	

Psychiatric Hospital Units of the Oakwood Correctional Facility

(Name of hospital or other medical facility)

DMH 0087 REPORT OR CONTINUATION

EXHIBIT 54

Referral to Mental Health Services

Inmate Name: Vanhook		Number: A-186347
Date of Referral: 01/21/2014	Lock: DR1 cell 101/ SEG 2 CW	Unit: DR/ SEG
Referred by Name: C. Branham	Title: Captain	Phone Ext.: 2005

Reason for Referral:
Inmate Vanhook A-186347 had a violent episode after being intoxicated on an unknown substance. He threaten to harm himself and was stating he wanted his life to end.

Seen by both T. Sovacool and J. Gotthardt, white
On watch yesterday and today (1-21/1-22)
Remains MHD.

Date Assigned to AMHP: 1-22-14	
Name of AMHP Assigned to: MH to continue to see	
Title of AMHP: N/A	Phone Ext.:
To be Seen by (date): today	Signature of MHM/MHA or Designee Completing form: R Castro, MHA

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Referral to Mental Health Services

Inmate Name: Vanhook		Number: A-186347
Date of Referral: 01/21/2014	Lock: DR-1	Unit: DR
Referred by Name: C Branham	Title: Captain	Phone Ext.: 2005

Reason for Referral:

While interviewing inmate Vanhook 186-347 in DR-1, he stated to me that he did not want to live any longer. Vanhook further stated that he has done 29 years and did not want to wait until the last 30 days of his sentence to try to get right with God, he said "cut my jugular and let me die".

Seen by both T. Savacool and J. Gollhardt while on watch yesterday and today (1-21/1-22) remains on MHD.

Date Assigned to AMHP: 1-22-14	
Name of AMHP Assigned to: MH to continue to see.	
Title of AMHP:	Phone Ext.:

To be Seen by (date): today	Signature of MHM/MHA or Designee Completing form: R Watts, MHH

DRC5265 E (Rev. 08/08) DISTRIBUTION: WHITE - Mental Health CANARY - Unit File