Chief Complaints

1. Patient is accompanied by mother
2. "I never needed medications"

History of Present Illness

Depression Screening:

PHQ-2 In last 2 weeks have you been bothered by Little interest or pleasure in doing things No, Feeling down, depressed, or hopeless No.

HISTORY OF PRESENT ILLNESS:

Patient reports of anxiety and poor sleep due to legal case with the probation officer. Patient reports of poor sleep, hard to stay asleep. Patient will like to record the session but Compass doesn't consent. Patient reports that he is not recording this evaluation. Patient reports that he was wrongly diagnosed and was hospitalized five times in the past for it, reports that he has trouble trusting providers. Patient reports that he will be paying out of pocket for a second opinion with a different psychiatry group, where they are consenting for him to record the session.

CHRONOLOGY, ONSET, SEVERITY, DURATION The client was referred for a psychiatric evaluation due past diagnoses of delusions and schizophrenia. REFERRED BY: Probation officer Teresa Nair. Reason For Initial Referral To determine the need for treatment.

SUBSTANCE ABUSE HISTORY:

Patient denies any past use of substances.

PAST PSYCHIATRIC AND MENTAL HEALTH HISTORY:

HOSPITALIZATIONS: Patient reports that he was wrongly hospitalized five times in the past for delusions and schizophrenia and was forced via injection with medications. Patient didn't elabrate any further. OUTPATIENT: Client denies any outpatient treatment for mental health issues. PAST MEDICATIONS: Patient reports that he never took the medications that were prescribed to him in the past by the hospital but was forced through injection during his stay there. Patient didn't state which hospitals. THERAPY: Client denies receiving therapy for mental health issues. SUICIDE ATTEMPT(S): Client denies suicide attempts. RESPONSES TO PRIOR TREATMENT AND DURATION OF TREATMENT: Client had a negative response to prior treatment.

FAMILY HISTORY OF SUBSTANCE ABUSE:

FAMILY HISTORY OF SUBSTANCE ABUSE Client denies family history of substance abuse, Client states that no one in their family uses drugs/alcohol recreationally.

FAMILY PSYCHIATRIC HISTORY:

FAMILY PSYCHIATRIC HISTORY Client denies a family history of mental health issues and/or treatment for any mental health issues.

COMPLETE SOCIAL HISTORY:

EDUCATIONAL LEVEL: Bachelor Degree. VOCATIONAL STATUS: client denies. CURRENT JOB AND EMPLOYMENT HISTORY: The client is currently unemployed. FINANCIAL STATUS: The client is financially supported by his family. CURRENT LIVING CONDITIONS: The client lives with their mother. FAMILY RELATIONSHIPS: Stable relationship with his family. The client states they have no children. PEER RELATIONSHIPS: The client reports that he has hundreds of good friend. SUPPORT NETWORK: Supported by friends and family. LEISURE AND RECREATIONAL ACTIVITIES: Computers, technology, and writing . CULTURAL AND SPIRITUAL INFLUENCES AND IMPACT ON TREATMENT: SPIRITUAL INFLUENCES: The client states they are very spiritual. HISTORY OF ABUSE AND/OR TRAUMA: PHYSICAL ABUSE OR A PHYSICAL TRAUMATIC EVENT:

Client denies any history of physical abuse, client denies experiencing any physically traumatic events in their past, SEXUAL ABUSE OR A SEXUAL TRAUMATIC EVENT: Client denies any history of sexual abuse, client denies experiencing any sexually traumatic events in their past, PSYCHOLOGICAL/EMOTIONAL ABUSE OR AN EMOTIONAL TRAUMATIC EVENT: Client admits, Elaborate the psychological abuse/emotional trauma: being hospitalized against his will. LEGAL HISTORY AND STATUS: the client is post-conviction. PRIMARY CARE PHYSICIAN: The client denies having a primary care physician.

Strength and Weaknesses:

STRENGTH AND WEAKNESSES: ASSETS: Family/Social Support, Independent Living Skills, LIABILITIES: Legal issues.

Suicide Risk Assessment:

Intervention Suicide Risk Assessment Performed 03/19/2018 Patient denies any suicidal ideations, Pt is not a danger to themselves, Depression Screening Findings Negative.

Recent Inpatient Discharge:

(within the past 30 days).

Denies : Discharge from HospitalDischarge from other inpatient facility

Current Medications

Taking

- Vitamin C
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Left torn meniscus repair

Family History

No Family History documented.

Social History

Alcohol Screen:

Alcohol Interpretation Negative, Did you have a drink containing alcohol in the past year? No.

Substance Abuse:

CURRENT SUBSTANCE USE AND LEVEL OF SUBSTANCE ABUSE : Patient denies.

Tobacco Use:

TOBACCO USE/SMOKING Patient is a nonsmoker.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

five hospitalizations for delusion and schizophrenia

Review of Systems

PSYCHIATRIC:

Denies Agitation. Admits Anxiety. Denies Delusions. Denies Depressed mood. Admits Difficulty sleeping. Denies Eating disorder. Denies Hallucinations - auditory. Denies Hallucinations - visual. Denies Homicidal thoughts / ideations. Denies Hyperactivity. Denies Loss of appetite. Denies Mental or Physical abuse. Denies Mood swings. Denies Poor concentration. Denies Poor energy. Denies Poor motivation. Denies Stressors. Denies Substance abuse. Denies Suicidal thoughts / ideations.

RISK ASSESSMENT:

HIGH RISK BEHAVIORS Suicide/Homicide: Client denies suicidal and homicidal ideations at this time; Excess Drug/Alcohol use (injectables?) Client denies excess drug / alcohol use; Sexual Acting Out (unprotected sex with someone other than primary partner) Client denies sexually acting out and denies unprotected sex. HAVE YOU (the client) BEEN VERBALLY ADVISED THAT YOU HAVE Symptoms of Communicable/Infectious Diseases? none reported; TB Testing Results? yes, but negative; HIV Testing Results? yes, but negative. Education discussed: Discussed HIV and AIDS education as well as infection prevention and control education.

Vital Signs
HT 5 ft 10 in, Pain scale 0 (0-10).

Examination
MENTAL STATUS EXAM:

MENTAL STATUS EXAM: Appearance: Groomed, Good Eye Contact,Guarded, Attitude: Irritable, Activity: Normal, Speech: Hyperverbal, Mood: Anxious, Affect: Irritable, Depression Symptoms: Decreased Sleep, Anxiety Symptoms: Anxious, Concentration/Attention Span: Normal, Thought Process: Clear, Goal-Directed, Thought Content/Psychosis: Increased Delusions, Suicidal Ideation: None, Level of Consciousness: Alert/Awake, Orientation: Normal (x4), Memory: Recent Memory Intact, Remote Memory Intact, Language: Normal, Information and Intelligence: Average, Insight: Fair, Judgment: Fair, Reliability: Fair, Gait/Station: Normal, Muscle Strength/Tone: Normal, Abnormal Movements: Absent, Withdrawal Symptoms: None Identified.

Assessments
1. Paranoid schizophrenia - F20.0 (Primary)

Treatment
1. Others

Clinical Notes: Not willing to take medications to aid his diagnosis.

Preventive Medicine
CLINICAL NARRATIVE SUMMARY: Analysis/Interpretation of Assessment: Patient is a 42 year-old Caucasian male who has history of delusions and schizophrenia; patient reports that he was prescribed psychotropic medications in the past but never took them. Patient is now presenting to the office with sleep disturbances and increased anxiety. Patient has denied any manic episodes, acute psychosis and denies any suicidal/homicidal ideations, plan or intent at this time. Patient has a long, detailed complaint involving a school in Morocco where the headmaster tried to sexually molest him, and later was discovered to have child pornography. He believes US government officials are harassing him because of this, and his mother corroborates this. He says he will e-mail proof of this later today. In the meantime, his complaints seem more likely to be delusional in nature. Patient stated that he will receive a second opinion.
RECOMMENDED TREATMENT: Psychiatric Management (weekly, monthly, or other): A treatment plan was discussed but patient isn't willing to take medications to aid his diagnosis. Psychotherapy: The patient was not in agreeance with therapy treatment.
OTHER : Service(s) provided are medically necessary and appropriate to the patient's diagnosis and treatment needs: : yes.

Follow Up
prn

Sheila Rowan MD

Electronically signed by Sheila Rowan , MD on 03/28/2018 at 01:32 PM EDT

Sign off status: Completed

IN THE CIRCUIT COURT OF THE
SEVENTEENTH JUDICIAL CIRCUIT,
IN AND FOR BROWARD COUNTY, FLORIDA

CASE NO. CACE 20-002293 Division 08

[redacted], Plaintiff,
v.
COMPASS HEALTH SYSTEMS, P.A.,
SHEILA M. ROWAN, M.D., Defendants.

AFFIDAVIT OF MARIE DICOWDEN

STATE OF VIRGINIA)
) ss.
CITY OF ALEXANDRIA)

BEFORE ME, the undersigned authority, personally appeared Marie DiCowden, who, first being duly sworn, deposes and says:

1. I am a licensed Psychologist in the State of Florida and the State of Virginia. None of my prior opinions have been disqualified by any State or Federal court. Additionally, I have been accepted as an expert in various court cases in both Florida and Virginia.

2. As a licensed Psychologist, I am qualified to evaluate and diagnose a mental health disorder pursuant to the definitions, specifications and standards promulgated by the American Psychological Association (APA) and the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). The standard to evaluate/diagnose a mental health disorder is the same as both Psychologists and Psychiatrists use the Diagnostic and Statistical Manual-V (DSM-V) published by the American Psychiatric Association. Both psychiatrists and psychologists are trained to diagnose using this resource and the criteria for different diagnoses that the DSM-V lists. The types of treatment both disciplines provide may differ depending on the particular professional's training in psychotherapy and/or medication. Psychiatrists usually prescribe medication and may

or may not provide psychotherapy. Psychologists generally do not provide medication and primarily provide psychotherapy. However, psychologists who are specialty trained in medication for mental health also do prescribe medication in five states.

3. I have devoted professional time during the 3 years immediately preceding the date of the occurrence of this claim (and since) to the active clinical practice of Psychology to include the evaluation, diagnosis, or treatment of the mental health disorders that are the subject of the claim and have prior experience treating similar patients.

4. I met [redacted] on March 21, 2018, after he hired me to evaluate him and provide a diagnosis. I was aware he had been given a diagnosis of schizophrenia issued by Dr. Sheila Rowan. He informed me that my opinion would be submitted as evidence in a court case for which he was on probation. He also informed me that Dr. Rowan agreed to review additional materials as part of his evaluation which he sent her via email. He agreed to provide me the same materials via email that he provided Dr. Rowan.

5. Mr. [redacted] provided me with voluminous materials including copies of letters on letterhead, emails with email verification addresses and newspaper clippings. I also met with Mr. [redacted] alone as well as with Mr. [redacted] and his mother in my office for a direct, face to face interview.

6. As a result of my assessment on March 21, 2018, and record review, I provided Mr. [redacted] a letter on July 14, 2018, with a diagnosis that Mr. [redacted] is suffering from Post-Traumatic Stress Disorder (PTSD).

7. I came to this assessment as a result of my combined 90 minutes of interview with Mr. [redacted] alone and also an interview with Mr. [redacted] and his mother. During that time there were numerous issues that were covered. While these issues were not always covered in chronological

order, it became clear after spending many hours reviewing hundreds of pages of information supplied by Mr. [redacted] in the form of letters on letterhead, emails with identifying email addresses from various persons and numerous newspaper clippings that the many issues that were discussed were not only verified but reflected on one another.

8. Mr. [redacted] met all criteria for a chronic Post-traumatic Stress Disorder as noted by the DSM-V. These included:

A. *Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:*

1. *Directly experiencing the traumatic event(s).*
2. *Witnessing, in person, the event(s) as it occurred to others.*

Mr. [redacted] witnessed actual violence as a young teenager and beyond; he also experienced violence and sexual aggression himself.

[redacted]

[redacted]

9. Since my initial evaluation in 2018, Mr. [redacted] has informed me that he was imprisoned by his probation officer from May 13th, 2019, until September 13th, 2019, for refusing to participate in any further medical procedures being ordered by his probation officer in support of treatment for schizophrenia, a diagnosis with which I do not agree. Mr. [redacted] further informed me that after 4 months of imprisonment, the Federal Judge overseeing his probation eventually held a hearing where she accepted me as an expert that is qualified to dispute the diagnosis of schizophrenia issued by Dr. Rowan. Mr. [redacted] informs me that the Federal Judge further ruled that my diagnosis of PTSD is valid, and the diagnosis of schizophrenia issued by Dr. [redacted] is not. As a result of these rulings, Mr. [redacted] informs me that he was released from the imprisonment on the day of his hearing (September 13th, 2019) and his probation was also terminated over a year early due to the misconduct which resulted in his 4-month imprisonment.

10. Mr. [redacted] subsequently contacted me after filing a PRO SE civil complaint to challenge the schizophrenia diagnosis issued by Dr. [redacted] and the injuries, he has sustained because of it (to include the 4-month imprisonment). Mr. [redacted] further informed me that a

hearing was held on August 25th, 2021 concerning a motion to dismiss his civil complaint, and that the Court is requesting for legal deficiencies pertaining to my letter of July 18th, 2018 to be corrected before the Court will permit Mr. [redacted] claims to proceed. I provide this updated affidavit in order to assist in his efforts to cure those deficiencies.

11. Following the hearing held on August 25th, 2021, Mr. [redacted] provided me a copy of the following three items to evaluate for evidence of negligence (pursuant to the legal standards required by Florida statute for a medical malpractice claim to be permitted to proceed to a jury).

(a) Mr. [redacted] submits a full and complete audio recording of the evaluation conducted by Dr. Rowan in her office on 3/19/2018 at the following YouTube URL: https://www.youtube.com/watch?v=KOnIV5Dma3o
(b) Mr. [redacted] submits a transcript of the recording above, attached as Exhibit 1
(c) Mr. [redacted] submits a copy of the diagnosis issued by Dr. Rowan following her evaluation, attached as Exhibit 2

12. Given Mr. [redacted]'s life history and multi-factorial issues as evidenced in voluminous written materials that verify his accounts, I cannot conclude that a 13-minute interview is adequate nor meets the standard for full examination of Mr. [redacted]'s complicated life.

13. Furthermore, Mr. [redacted] does not meet the criteria for schizophrenia as designated by the DSM-5. The specific *DSM-5* criteria for schizophrenia are as follows:

> *The presence of 2 (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated), with at least 1 of them being (1), (2), or (3): (1) delusions, (2) hallucinations, (3) disorganized speech, (4) grossly disorganized or catatonic behavior, and (5) negative symptoms.*

Review of materials presented by Mr. [redacted] verifies his history and rules out that he is delusional or hallucinating events he reports. While his speech may seem disorganized at times,, he conveys a complicated history, and events are not always presented chronologically. However his reports of events are verifiable to a great degree. He does not display any disorganized or

catatonic behavior. Further he does not evidence any of the criteria of negative symptoms. Negative symptoms in schizophrenia are defined as:

- *A decrease in the ability to emotionally respond to people, events, etc.*
- *A decrease in speaking (alogia)*
- *Difficulty sticking with activities and tasks; the appearance of being unmotivated or withdrawn.*

Additionally, the DSM-V criteria states:

> *For a significant portion of the time since the onset of the disturbance, level of functioning in 1 or more major areas (e.g., work, interpersonal relations, or self-care) is markedly below the level achieved before onset; when the onset is in childhood or adolescence, the expected level of interpersonal, academic or occupational functioning is not achieved.*

[redacted]

Mr. [redacted] does not suffer from hallucinations or delusions. He does suffer from distrust of others due to his chronic and severe Post Traumatic Stress Disorder. He is hypervigilant based on past experiences. Although this may seem like paranoia, his distrust is based in past events that occurred. Further, paranoia is no longer considered a symptom of schizophrenia as the American Psychiatric Association has not used that as a symptom classification or subtype of schizophrenia since 2013 when it published the DSM-5.

14. Based upon Mr. [redacted]'s assertion that the above materials constitute the entirety of his physical interaction with Dr. Rowan and that he supplied Dr. Rowan with the same written

materials through email that I received verifying his traumas, it is my professional opinion that any diagnosis of schizophrenia issued by Dr. Rowan is a misdiagnosis of Mr. [redacted]'s condition.

15. I reviewed the audio recording of Mr. [redacted]'s interview with Dr. Rowan for the first time in preparation for this affidavit, and I previously reviewed the email evidence submitted in 2018 which I relied upon to conclude a diagnosis of PTSD born of exposure to traumatic events occurring in reality (and not schizophrenia born of delusions and hallucinations). I further requested additional records from Mr. [redacted] to supplement his answers to my questions that arose in discussing this affidavit.

16. In my professional opinion, Dr. Rowan's diagnosis of schizophrenia for Mr. [redacted] violates the prevailing medical standards required to diagnose such a condition according to the DSM-V.

17. I reserve the right to amend and/or supplement this affidavit should additional information, documentation or other evidence become available.

****

FURTHER AFFIANT SAYETH NAUGHT.

Marie A. DiCowden, PH.D.
MARIE A. DICOWDEN, PH.D.

STATE OF VIRGINIA)

CITY OF ALEXANDRIA)

I HEREBY CERTIFY that on this 8th day of September, 2021, before me, an officer duly authorized in the State aforesaid and in the County aforesaid to take acknowledgments, the forgoing instrument was acknowledged and sworn before me by **MARIE DICOWDEN,** who is personally known to me or who has produced Drivers License as identification.

S/Hamdi – Sef A. Hamdi

Notary Public
(Affix Seal Below)

Sef A. Hamdi

Typed or printed name of Notary Public

SEF A. HAMDI
NOTARY PUBLIC
REG. # 7801156
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES 12/31/2022