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CASE NUMBER: 2012CR201522

October 13, 2014

Hon. Carlos A. Samour, Jr., Judge
District Court, Arapahoe County
7325 South Potomac Street
Centennial, CO 80112

RE: REPORT: James Eagan Holmes, Defendant; Case No. 12CR1522

Dear Judge Samour:

You have asked for a report with regard to this defendant's mental responsibility under Colorado statute (C.R.S. § 16-8.101.5) for alleged criminal acts committed July 20, 2012, as outlined in the relevant court documents. I am able to supply the opinions and comments below, based upon very extensive materials provided by the court and both parties (defense and prosecution), personal examination of the defendant, interviews with a number of other and corroborating persons, relevant psychological testing, professional literature review, and my training, background and experience. (See below for a summary of items relied upon.) The methods used in my review and report are those routinely relied upon by forensic psychiatrists in matters such as this.

This report includes four Appendices: (1) Dr. Gray's report of recent independent psychological testing, (2) Dr. Rogers's independent expert review of 2013 and 2014 psychological testing data, (3) a list of key references to my video-recorded interview DVDs, and (4) a summary "mental status examination" compiled from my recent interviews of the defendant.

It may be noted that I was ordered to opine specifically on Mr. Holmes's sanity, as feasible considering the available information and situation, and to refrain from offering opinions on mitigation or competency. I was also asked to address a number of other topics, which comments are made separately below. Your April 14, 2014, Order specified, in part:

> . . . another examination of the defendant's sanity on the date of the offenses charged . . . . (also) should address the Court's findings of inadequacy (of Dr. Metzner's report), *see* Order P-68 . . . .
> . . . Pursuant to section 16-8-106(6), the report should include . . . (1) the name of each physician, forensic psychologist, or other expert who examined the defendant; (2) a description of the nature, content, extent, and results of the examination and any tests conducted; (3) a diagnosis and prognosis of the defendant's physical and mental condition; (4) an opinion as to whether the defendant suffered from a mental

> disease or defect or from a condition of mind caused by a mental disease or defect that prevented him from forming the culpable mental state that is an essential element of any crime charged; and (5) if the defendant suffered from such a mental disease or defect or from such a condition of mind, a separate opinion as to whether the defendant was insane, as that term is defined in article 8 of title 16 of the Colorado Revised Statutes, on the date of the offenses charged. . . . the report must also address the defendant's cooperation during the examination. The new examiner shall not consider the defendant's competency to proceed or how any mental disease or defect or condition of mind caused by a mental disease or defect affects any mitigating factor in the death penalty statutes.
>
> (Order C-94, pp. 2-4)

Items of prior "inadequacy," from Order P-68, are listed and addressed beginning on page 13.

This report will not attempt to recreate exhaustively all aspects of the alleged crimes, their planning, the defendant's history, or every item and corroborative item upon which my opinions and statements are based, but adequate explanations for, and discussion of, all opinions are provided. The reader is referred elsewhere in the record and various citations for details. Dr. Metzner's report contains good summaries of much of the record and various examinations; most need not be repeated herein. When my opinions or interpretations disagree with, or add to, those of other examiners, the differences or additions are clearly delineated and supported. *Exemplary citations for quotations from or references to my interviews of the defendant are generally listed in Appendix 3 ("Chart of Interview Examples"), and are not footnoted in the text.*

Finally, the help received from many people in locating and gathering information, and providing access to people and data, should be recognized. They include the lawyers for both parties and their staffs, law enforcement agencies and personnel, Arapahoe County corrections personnel, CMHIP clinical and security staff, University representatives and staff, corroborating witnesses, experts retained by both sides and the Court, and, not least by any means, CMHIP Counsel and Assistant Attorney General Tanya Smith.

OPINIONS

The following **opinions** are offered to a reasonable degree of medical/psychiatric certainty given the information available to me when this report was completed.

1. Sanity

> **As of July, 20, 2012, the defendant, James Holmes, did not suffer from a mental disease or defect, or from a condition of mind caused by a mental disease or defect, that prevented him from forming the culpable mental state that is an essential element of the crimes charged.**
>
> See **Discussion of Opinion 1 (Sanity)**, below (p. 3).

2. Diagnosis

At the time of the July 20, 2012, shootings, the most reasonable diagnostic consideration would have been

Schizotypal Personality Disorder (*DSM-5*[1] 301.22)

with or without

Delusional Disorder, Unspecified Type, Continuous Course (*DSM-5* 297.1) (provisional)

See **Discussion of Opinion 2 (Diagnosis and Prognosis)**, below (p. 5).

IMPORTANT CLINICAL NOTE with regard to the defendant's *current* diagnosis and mental condition: At the time of my July-August, 2014, interviews, Mr. Holmes's psychological testing results strongly suggested substantial risk of suicide. That risk was also documented in July, 2013, based largely on psychological test results at that time (which suggested more suicide risk than did the 2014 tests). **It is thus important that he receive adequate psychiatric care and follow-up for protection from self-harm.** Close safety monitoring is one part of that care; ongoing risk assessment and competent psychiatric treatment are others. I *do not* recommend that he be housed in an Arapahoe County jail "BC" cell ("rubber room," "hole"), because of the strong likelihood that it will worsen his condition.

DISCUSSION OF OPINION 1 (Sanity)

a. The record and my interviews clearly indicate, without significant discrepancy, that regardless of any mental disease or defect that he may or may not have had at any relevant time prior to or during the shootings, the defendant knew and appreciated at all relevant times that the shootings and killings he committed (to the extent those charges are eventually proved) are and were illegal and socially wrong. He knew that others, including psychiatrists and law enforcement personnel, would try to stop him if they realized what he was planning to do. He knew, and appreciated, the likely consequences to others (e.g., death, injury) and himself (e.g., arrest and imprisonment or execution).

b. The record and my interviews clearly indicate, without significant discrepancy, that the defendant knowingly intended to perform the shootings and killings in spite of appreciating their illegality and their likely consequences to others and himself.

c. The record and my interviews indicate that the defendant understood and generally appreciated the moral (as contrasted with legal or "social") wrongfulness of the shootings and killings as he planned them and carried them out.

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[1] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* Washington, DC: American Psychiatric Publishing (hereafter "*DSM-5*").

For example, and without intending to be exhaustive, the record indicates that **the defendant knew the shootings would be highly illegal.** He told people before and after the shootings, and wrote in his "notebook," that he expected to be arrested and/or killed by police, and if arrested expected either to go to prison or be executed. He kept his shooting/killing thoughts secret from almost everyone, and did not divulge plans or details that might have caused others to interfere with their being carried out. Although he broached the subject of wishing to kill people with his girlfriend and his student health service clinicians, he kept the topic abstract, sometimes saying that he did not want to be "locked up" by the clinicians.

His planning and practice were surreptitious, specifically to avoid detection and interruption of the plan or "mission." He purchased and stored weapons, *materiel*, and equipment in such a way that no one would suspect the coming events. He practiced shooting at a far away and unsupervised range. He kept his curtains closed to avoid being observed. He refrained from divulging his preparatory activities or objectives to others.

He planned, considered, and/or implemented methods of distraction and escape, such as the incendiary "booby traps" in and near his apartment, and "road stars" found in his car.

He carefully chose a method of killing that he reasonably believed would result in maximum deaths, with minimal chance that he would be stopped before shooting and killing many people. He planned a contained and crowded killing field (but denied that particular phrase, or "killing chute"), planned ways to incapacitate his would-be victims (such as using tear gas and handcuffing the upper exit doors shut[2]), armed himself with several weapons and a great deal of ammunition, planned ways to keep people away from himself so that he would not be stopped and overwhelmed, and protected himself with body armor and a gas mask.

He carried out the shootings and related behaviors deliberately and methodically. He came to the theater calmly, went through the lobby as if he were an ordinary patron, carried out a planned ruse before exiting to get his firearms and other equipment, put the equipment on in his carefully-parked car with covered windows, re-entered using a pre-planned method of holding the exit door open, and went "on autopilot" with (he said) loud "techno dance music" through iPod ear buds. He did not stop until his shotgun was empty and his rifle jammed, then left the auditorium after unsuccessfully trying to unjam the rifle.

He said that before re-entering the auditorium he would have shot a theater employee who was apparently emptying trash nearby as the defendant was putting on his gear, if the employee had noticed him and tried to interfere with his plan. He considered shooting two policemen whom he saw after he left the theater, but made a decision that it would be safer (for him) to surrender.

He said he knew beforehand that his victims would suffer and would not have wanted to be shot or killed. When considering the potential benefit to himself, he was indifferent to his victims' feelings, pain, other current or future suffering, or the likelihood that they would die. He described a wish to keep the killings "impersonal," but in addition to the planned killing of a specific group of people (those attending the movie), there are elements of direct targeting, including shooting at particular persons because they were trying to escape ("I can't have everybody running away"), shooting at least one person as he looked directly at him (according to one wounded victim, Dion Rosborough [discovery p. 13698]), and being prepared to shoot a particular theater employee who might have interrupted his plan.

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[2] He did not actually lock the doors.

After the shootings, he said that he understood that his victims would not want to be shot or killed. Nevertheless, according to him, he was willing to sacrifice both those who would be killed (as people whose "value" he might accrue and whose deaths might make him feel less depressed) and those who would be injured (as unfortunate "collateral damage" [his term]) in his effort to make himself feel better. He told me that he knew (beforehand) that he was "selfish" in that regard, trading their lives and well-being for a chance that he would benefit. Although he said he believes he increased his "value" by an "arbitrary" "12" (the number of dead), he recalled that before the shootings he thought his chances for feeling better after the killings were "about 50-50," and that his hoped-for improvement in "depression" after the killings did not materialize.

The defendant has never alleged that his arrest was unjustified nor that his acts were somehow legally, socially, or morally acceptable. His statements that he believes in a kind of "moral relativism," with which he continues to justify the killings to himself, have never been extended to suggest that other people would consider them moral. Others, according to his statements, are entitled to have any moral position that they wish; he does not limit them to his view, or imply that others must accept his philosophy.

DISCUSSION OF OPINION 2 (Diagnosis and Prognosis)

My opinion regarding the defendant *vis a vis* the criminal sanity statute should not be construed as indicating that I believe he was free of significant mental illness at the time. The clinical findings and opinions among the various clinicians who have seen Mr. Holmes over the past several years are not as different as they may seem to a lay observer. Whatever his specific diagnosis(es), and taking into account the various differences in symptoms seen or inferred at different times, I have no doubt that he was significantly mentally ill on, and during the months before, July 20, 2012.

Similarly, regarding his condition at present (as of July-August, 2014), whatever his specific diagnosis(es), and taking into account the various differences in symptoms seen or inferred by different clinicians at different times in his life, before and since his arrest, I have no doubt that the defendant is significantly mentally ill.

The above having been said, *sanity, in the context contemplated by the Court, is a matter of ability and function, not of diagnosis*. Whatever Mr. Holmes's diagnosis(es) may have been at the time of the shootings, the evidence is overwhelming that he was not prevented from forming the culpable mental state that is an essential element of the crimes charged, and indeed that he did form that culpable mental state. None of the diagnoses considered by any clinician is *per se* indicative of inability to form the requisite culpable mental state.

The discussion that follows is largely based on professionally-recognized diagnostic criteria as published in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (hereafter *DSM-5*). It should be noted that those criteria are intended for professional use, are not simply to be rotely applied, and should not be used in forensic (legal) settings without appropriate explanation.[3]

Schizotypal personality disorder is characterized by a chronic and pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close

[3] *DSM-5*, p. 25, "Cautionary Statement for Forensic Use of *DSM-5*"

relationships, as well as by cognitive (thinking) or perceptual (perceiving, understanding) distortions and eccentricities.[4] The characteristics may present in different ways and severities. They usually begin by early adulthood (often in childhood or adolescence).

The diagnosis requires that the subject's signs and symptoms include, over a significant period, most (not necessarily all) of the following, *in the absence of a chronic psychotic disorder such as schizophrenia, bipolar disorder, depressive psychosis, or schizoaffective disorder* (see discussion of those diagnoses, below):

- chronic thoughts or delusions that others' words or actions refer to the subject ("ideas of reference" or "delusions of reference") (probably absent in the defendant prior to the shootings);
- odd beliefs or magical thinking that influence(s) behavior and is inconsistent with cultural norms (present in the defendant);
- unusual perceptual experiences, including bodily illusions (present);
- odd thinking and speech (such as, but not necessarily limited to, vagueness, circumstantiality [wandering from the point during conversation], speaking in metaphors, overelaborating, or stereotyped speech) (probably present);
- suspiciousness or paranoid thinking (present to at least some extent);
- inappropriate or constricted (limited) affect (facial and emotional expression) (present);
- odd, eccentric, or peculiar appearance or behavior (present);
- lack of close friends or *confidants* other than close family (present); and
- excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about oneself (present, at least often).

The defendant met the diagnostic criteria as of July 20, 2012, during the several months before the shootings, and probably before that. He did not meet criteria for exclusionary diagnoses (i.e., conditions that would preempt schizotypal personality disorder) such as schizophrenia, bipolar disorder, psychotic depression, and schizoaffective disorder (see below).

The course of schizotypal personality disorder is chronic and lifelong, without known cure. Appropriate medications may alleviate some symptoms in some patients. Long-term, highly specialized psychotherapy by appropriately trained and experienced clinicians may be helpful for some patients.[5] In Mr. Holmes's case, assuming this is the correct primary diagnosis, he appears to be responding marginally to generic treatment for disordered thinking or psychosis (low doses of risperidone [Risperdal®]) and for anxiety and depression (anxiety in this case) (escitalopram [Lexapro®]); any modest chance for improvement is compromised by his situation, environment, and lack of specialized psychotherapy.

The natural course of the disorder is generally stable, without marked improvement or deterioration. Extraordinary stressors (which may or may not be obvious to observers, since they may be idiosyncratic to a particular patient) may be associated with additional symptoms, including brief acute psychosis. Only a small portion of people with schizotypal personality

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[4] *Ibid.*, p.655-658

[5] See, e.g., Stone MH (2007). Cluster A Personality Disorders: Paranoid, Schizoid, and Schizotypal, in GO Gabbard (ed.), *Gabbard's Treatments of Psychiatric Disorders*, Washington, DC: American Psychiatric Publishing, Inc. (pp. 769-772)

disorder go on to develop schizophrenia and similar conditions, but both schizophrenia and schizotypal symptoms occur in their relatives more often than in the general population.

Delusional disorder is characterized by the presence of one or more "delusions" for over a month. Other criteria are required as well.[6] Delusional disorder may coexist with schizotypal personality disorder. The delusion(s) are often expressed in particular ways (such as jealousy, feelings of persecution, or grandiosity), or may be mixed or nonspecific.

A "delusion" is a fixed, but false, belief that does not change when the person is presented with logic or education, and is not a reasonable part of an accepted cultural belief system (such as a religion or philosophical system). Delusions are different from fantasies, opinions, viewpoints, philosophies, and beliefs that arise from ignorance or lack of information. A belief that is within a cultural framework, such as a religion, may be delusional if it is outside the accepted norm for that framework (for example, if a member of a charismatic church truly believes he is Jesus). Similarly, a philosophical belief may be delusional if it is outside accepted norms for that philosophy (for example, if a racially bigoted person truly believes that people of other races came from Mars). Persons with delusional disorder sometimes superficially accept (or simply aver) "factual" insights about the topics of their delusions, but they lack true insight.

The delusions in delusional disorder must not be part of the marked and chronic syndrome associated with schizophrenia, schizoaffective disorder, and related conditions, and must not be due to some general medical or external chemical cause (e.g., substance abuse or toxicity, delirium, or an organic dementia such as from a stroke or Alzheimer's disease).

A person with delusional disorder may experience brief episodes of severe depression or mania, or hallucinations related to the delusional theme, but those are not prominent within the delusional condition. Apart from the impact of the delusion(s) and their ramifications, the person is not otherwise markedly impaired; his or her behavior is not unusual to the extent of being bizarre.

Although delusional disorder is considered a "psychotic" disorder in the psychiatric nomenclature, its delusion-related behaviors are not usually viewed by psychiatrists as psychotic, nor are people with the disorder seen as psychotic most of the time (perhaps never). People with delusional disorder commonly appear normal, or merely eccentric, when their delusional thoughts are not being discussed or acted upon. Their delusions are often well focused and their delusion-related actions are often complex (such as stalking or diatribe-laced letter-writing campaigns). The delusions are usually "encapsulated" (that is, limited to one topic or area of life), although the topic may change (for example, a stalker may shift to another victim). It is common for delusional beliefs to play a significant role in poor psychosocial functioning, but "encapsulation" sometimes allows persons with delusional disorder to carry on their lives, even engage in professions, with relative success, not coming to the attention of psychiatrists or psychologists unless they get into trouble with the law.

Once established, the course of delusional disorder is thought to be chronic and lifelong, with no known cure. Overall function is almost always much better than that seen in schizophrenia; acute psychotic episodes are unusual and characteristically brief, but can occur with particular (sometimes idiosyncratic) stressors. A portion of people with delusional disorder eventually develop schizophrenia, and both schizophrenia and schizotypal personality disorder are overrepresented in the families of delusional disorder patients.

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[6] *DSM-5*, pp. 90-93

As with schizotypal personality disorder and many similar conditions, antipsychotic medication may decrease the seriousness of the delusions, but delusional disorder is notoriously resistant to both medication and psychotherapy (in part because the patient usually doesn't believe treatment is necessary, may not trust it, and/or doesn't cooperate with it).[7] Long-acting medication injections, where available, are more effective than relying on daily pills.[8] In Mr. Holmes's case, his risperidone (Risperdal®) may be decreasing the severity of unusual or delusional thoughts and what some believe are occasional visual hallucinations (his "shadows"), but it probably will not eliminate them altogether.

It is likely that Mr. Holmes's belief that he would accrue for himself some "value" from each of the people he killed does reach delusional proportions, and that it was established long before the shootings. Mr. Holmes's other chronic and unusual thoughts are more characteristic of schizotypal personality. His preoccupation with viewing himself as flawed and his hoping for relief in the act of killing others are consistent with delusional thinking, but also with the broader concept of schizotypal personality disorder (as well as with schizophrenia). Other symptoms and signs appear to best fit schizotypal personality.

During the early Spring of 2012 (March 21 and thereafter), Dr. Fenton considered a diagnosis of schizoid personality disorder, along with "? psychotic level thinking" and anxiety that may have reached diagnostic proportions (obsessive-compulsive traits, social phobia, and somatic concerns). At Mr. Holmes's last student health clinic visit (June 11, 2012), after meeting with him six times, discussing him with Dr. Feinstein, considering a "frank psychotic disorder," and diagnosing schizotypal personality at one point, she recorded a final diagnosis of schizoid personality, with considerations of schizophrenia (see below) and Asperger's disorder (somewhat similar to autism). Her notes describe, and other parts of the record reflect, a number of schizoid traits, including characteristic aloofness, but in retrospect his paranoia and other characteristics make schizoid personality an unlikely primary diagnosis.

Many reviewers and examiners have considered, and some have diagnosed, the more globally psychotic condition of schizophrenia (or schizoaffective disorder [see below]). Although Mr. Holmes's apparent symptoms and behaviors on and prior to July 20, 2012, are in some ways *consistent with* such diagnoses, there is no indication in the record that he met professionally-accepted criteria for those diagnoses.[9] In addition, there is substantial evidence in records and descriptions of his functioning at that time that he did *not* meet those diagnostic criteria. (See discussion several paragraphs below.)

The defendant's longtime symptoms of social difficulty, social anxiety, somatization (focus on imagined or exaggerated physical problems), and obsessive-compulsive traits may or may not have merited a separate "anxiety disorder" diagnosis (such as obsessive compulsive disorder or social anxiety disorder), but those do not explain many of his symptoms and behaviors. His

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[7] Mews MR, Quante A (2013). Comparative efficacy and acceptability of existing pharmacotherapies for delusional disorder. *Journal of Clinical Psychopharmacology* 33(4):512-519.

[8] Gonzales-Rodriguez A *et al.* (2014). Effectiveness of long-acting injectable antipsychotics in delusional disorders with nonprominent hallucinations and without hallucinations. *International Clinical Psychopharmacology* 29(3):177-180.

[9] *DSM-5*, pp. 99-101, 105-107

significant anxiety symptoms can be adequately subsumed under schizotypal personality disorder with social anxiety, somatization, and obsessive *traits*.

In spite of his self-diagnosis of "dysphoric mania" and the concerns he listed in his "notebook,"[10] there is little reliable indication in the record or descriptions from witnesses that Mr. Holmes suffered from severe clinical depression or significant mood instability during the months before the shootings. Various clinicians have speculated about, or diagnosed, mood disorders, but there is no reasonable evidence that he ever met professionally-accepted clinical criteria for major depressive disorder (or any "major depressive episode"), dysthymia, mania, or hypomania[11] prior to the shootings (see below).

There is evidence that the defendant has been significantly depressed since a few weeks after he was arrested. There is also evidence that he felt depressed at various times prior to the shootings. He may or may not have had significant suicidal thoughts before the shootings; but he was very clear with me that he was not conscious of any suicidal impulses. He told me several times, when trying to explain his homicidal thoughts and impulses, that he believes or assumes their purpose was to keep suicidal thoughts from becoming conscious, *but he does not recall having suicidal impulses*. There is no indication that he ever planned or attempted suicide before the shootings.[12] He did not bring up, or endorse, suicidal thoughts with any clinician before his arrest, and neither Dr. Fenton nor Dr. Feinstein recorded any particular concern about self-harm.

"Feeling depressed" is not the same as meeting recognized criteria for a significant depressive diagnosis. When one compares the *pre-shooting* record to the *DSM-5* criteria for the depressive condition that would have had the most impact on his behavior ("major depressive disorder" and its characteristic "major depressive episodes")[13], the evidence is simply not there.

For example, there is no reliable indication that the defendant met the requirement (one of several) that he suffer at least two weeks of clinically-qualifying depressed mood "most of the day, nearly every day" or "markedly diminished interest in all, or almost all, activities most of the day, nearly every day."[14] He had no known period of significant weight loss or gain (his weight in December, 2011, was about the same as his weight upon arrest in July, 2012). He apparently slept adequately (per statements to me), in spite of reporting "insomnia" at one point. No witness has suggested that he had symptoms of "psychomotor agitation or retardation" (specifically defined behaviors *observed by others* and characteristic of some severe depressions). Neither he nor others described chronic or pervasive fatigue or loss of energy (see, e.g., his activities of daily living, shopping [sometimes viewed on store surveillance videos], driving long distances to practice shooting, playing video games, working on his "mission"). There is no reliable indication that he felt particularly worthless or guilt-ridden. He appears to have been able to think and concentrate sufficiently (although he complained to Ms. Roath and Dr. Fenton about trouble concentrating), without particular ambivalence, to carry out complex mission planning and implementation, as well as to attend classes and labs through the end of the

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[10] Noting again that uncorroborated wording in the "notebook" should not be considered accurate, consistent with his views at other times, or necessarily true renditions of what he believed when it was written.
[11] *DSM-5*, pp. 124-125, 160-165, 168-170
[12] Excepting the reported childhood scratches with cardboard, which he described as a "cry for help" when the family left the Salinas, California area, which he liked, to move back to San Diego.
[13] *DSM-5*, pp.160-165
[14] *Ibid*, pp. 160-161, with quotes

school year and sit for his "prelim" examination (although he performed worse than he had several months before).[15] After the shootings, he referred to his homicidal thoughts as psychological defenses against suicidal thoughts, but he made it clear to me that the "suicidal thoughts" did not rise to a conscious level (averring in a sort of circular fashion that the homicidal thoughts kept them from becoming conscious).

Several examiners make a case for a *current* diagnosis of schizophrenia or a similar schizophreniform disorder (such as schizoaffective disorder), based on (perhaps among other things) (a) the defendant's post-shooting descriptions of what some infer were hallucinations (essentially the "shadows"), (b) his apparent symptoms in jail some four months after the shootings, (c) his apparent partial response to antipsychotic medication (low doses of risperidone), (d) something Dr. Gur described as personality "decompensation" over the seven months before the shootings, and (e) an interpretation of his chronic pre-shooting social behavior and affectual difficulties as either prodromal (i.e., before the disorder fully manifests itself) or undiagnosed schizophrenic symptoms.

While schizophrenia should be considered, a number of factors mitigate against that diagnosis. (a) The pre-shooting visual experiences that some imply are schizophrenia-consistent hallucinations have other logical explanations as well (e.g., that they were/are visual illusions exaggerated by schizotypal obsessiveness, hypnogogic [pre-sleep] phenomena, and/or brief "micropsychotic" episodes), none of which is diagnostic for schizophrenia. (b) The defendant's acute symptoms in jail in November, 2012, may not have been due to schizophrenia *per se*, but instead related to post-shooting stressors in an already anxious and paranoid schizotypal person (such as the memory of killing and injuring many people, his marked isolation in jail [particularly in the "hole," where the isolation, deprivation, and primitiveness of his environment were extraordinary], anticipating trial and sentencing [including a possible death sentence], and the metabolic effects of his apparently-paranoia-related lack of eating and drinking).

(c) The defendant's apparent marginal response to low doses of risperidone (Risperdal®, an antipsychotic medication) and a moderate dose of escitalopram (Lexapro®, an antidepressant) over some 21 months has little diagnostic significance. Risperidone (Risperdal®) is generically antipsychotic (i.e., it can reduce paranoia, hallucinations, and/or other psychotic symptoms found in many different conditions); therapeutic response to it does not suggest any particular diagnosis. The November, 2012, acute psychotic episode having subsided, the defendant's thinking and behavior (primary indicators of psychosis) over the past 18 months do not appear greatly different from his condition at the time of the shootings (as inferred from the jail logs, his various psychiatric examinations, and psychological tests), except for comments that his depression is worse and the "shadows" a bit less prominent. Finally, although no "on-med *vs.* off-med" comparison has been attempted, his examinations and psychological testing suggest little response to the antidepressant escitalopram (i.e., he manifests significant depression and suicide risk, whatever the diagnosis).

(d) Although there appears to have been a deterioration of graduate school performance, and changes in some behaviors, over Spring and early Summer of 2012, there is insufficient

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[15] Both Mr. Holmes and his graduate school examiners (e.g., Prof. Restrepo in my September 30, 2014, interview) described his not studying and not passing the oral exam as a matter of choice and of not knowing the material, not as a matter of poor concentration during the exam. He passed his final lab course (contrary to some experts' understanding), although with a mediocre grade. He did not report any indecisiveness about dropping out of school and pursuing his "mission."

evidence to define those as "decompensation" in the psychiatric sense (that is, moving from quiescent or controlled psychotic symptoms into acute psychosis). There is no reliable indication that the defendant manifested acute psychotic signs in any of his pre-shooting interactions, in many different contexts with clinicians, friends, former friends, professors, or other people. He was able to perform school duties (albeit less effectively), shop, drive, go to and shoot at the distant Byers Canyon range, order a complicated array of equipment, set up the attempted incendiary "diversion," carry out usual activities of daily living, and prepare and implement his complex ruse and shooting procedure at the Century 16 theater, all apparently without significant impairment.

One should also note that the defendant was diagnosed with infectious mononucleosis ("mono") in late December, 2011. He continued to attend classes and labs in spite of probable fatigue, listlessness, and other symptoms of that illness, receiving no treatment after his January, 2012, return to school. The usual course of mono is about eight to 12 weeks, assuming the patient avoids exertion and follows other physician instructions, but the symptoms can last much longer. Although there is no reliable information about symptoms or the continuing presence of the virus in late Spring, 2012, it seems likely that some or all of any deterioration in the defendant's school performance during at least January and February was associated with his mononucleosis. Mono-related problems at that time could also have set back his overall performance for the rest of the school year.[16]

With regard to schizoaffective disorder, there is no reasonable clinical evidence that the defendant met professionally-accepted diagnostic criteria for that diagnosis before July 20, 2012, nor that he meets those criteria at present. Diagnosis of schizoaffective disorder requires clear evidence that the subject has met *both* the primary accepted criteria for schizophrenia ("Criterion A"[17]) and those for either a "major depressive episode" or a "manic episode,"[18] *and* that one of the latter has coexisted with an acute schizophrenic episode. There is no reasonable indication in either the record or any examination that this was ever the case.[19]

(e) If a diagnosis of schizophrenia is confirmed, my schizotypal personality diagnosis would reasonably be seen as a "prodromal" condition. That would have no effect on my opinions about the defendant's criminal responsibility.

The requirements for diagnosis of schizophrenia[20] begin with "the clear presence of delusions, ... hallucinations, ... or disorganized speech." It is likely that Mr. Holmes's stated beliefs or philosophy with regard to "human capital" reach a level of "delusion," but he consistently described his human-capital beliefs as coming entirely from him, often using the term "arbitrary," and denied that they represent any particular "truth." He made it clear (to the extent that his statements can be accepted as accurate) that they exist because he believes them, and that they are irrelevant to those who do not. He also acknowledged that although he feels better believing he is somehow "worth more" because he killed 12 people, the "worth" he feels is

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[16] Further comment about infectious mononucleosis is outside my expertise.
[17] *DSM-5*, p. 99
[18] *Ibid.,* pp. 105-110, 124-125
[19] Dr. Woodcock, a defense psychiatrist who interviewed the defendant within one to four days of his arrest, stated in his notes that Mr. Holmes's primary diagnosis is schizoaffective disorder (apparently based upon the defendant's statements and self-diagnosis of "dysphoric mania"). I disagree (see "Discussion of Opinion 1 [Sanity]," above). Dr. Woodcock also diagnosed antisocial personality disorder (I disagree) and an "anxiety disorder."
[20] American Psychiatric Association, *op.cit.*, pp. 99-105.

arbitrary and idiosyncratic (i.e., it is whatever he decides it is), and it does not make him stronger, imbue him with special powers, extend his life, etc.

In addition, whether considered delusional or not, the fact that his human capital thoughts/beliefs are extremely well (psychologically) encapsulated is more consistent with delusional disorder than with schizophrenia. They have shown no signs of expanding or generalizing to other topics, and have never *per se* interfered with Mr. Holmes's functioning in the various areas of his life.[21]

Although some examiners may view Mr. Holmes's pre-shooting "shadows" (which he did not describe until November, 2012, after which he said he had similar experiences in mid-2012) as "hallucinations," his descriptions are not typical of the hallucinations usually seen in schizophrenia. First, they are described as visual phenomena, with an absence of the far more common auditory hallucinations (e.g., "voices"). Second, they often appear(ed) in a manner more indicative of "illusions" (inaccurate perceptions created from existing things) or hypnogogic phenomena (dream- or hallucination-like experiences that arise as one is entering sleep, but which are not considered hallucinations for purposes of a schizophrenia diagnosis) than of schizophreniform hallucinations. It is interesting that he said he sometimes summons the "shadows" himself when he is bored, can consciously control their form and behavior, and often enjoys their presence. Such activity is unusual but is, in my experience, more associated with a sophisticated imagination, obsessiveness, or defensive soothing behavior than with schizophrenia.

Except for the November, 2012, period in which he was apparently metabolically delirious and experiencing extraordinary isolation and sensory deprivation at the jail, Mr. Holmes has never demonstrated disorganized speech or grossly disorganized or catatonic behavior.[22] The November, 2012, episode cleared rapidly after metabolic correction, medication, and environmental change.

Trichotillomania is a form of obsessive-compulsive behavior/diagnosis in which the compulsive behavior is chronic and recurrent pulling out of one's own hair.[23] Although diagnosed by at least one of his pre-shooting treating clinicians (Dr. Fenton), Mr. Holmes probably did not (and does not) meet criteria for the separate diagnosis, in part because it did not appear to cause significant distress or impairment. Even if accurately diagnosed, it has no particular relevance to the shootings or his psychiatric condition when they occurred.

The defendant expressed several physical concerns consistent with, but not diagnostic of, a "somatization disorder" such as body dysmorphic disorder[24] or illness anxiety disorder.[25] These disorders or syndromes are sometimes characterized by excessive worry about mild or non-existent physical symptoms, or erroneously-assumed medical conditions (and sometimes psychiatric ones, despite the word "somatization"). For example, the defendant's "notebook" contains a list of illnesses and apparently exaggerated symptoms that he was worried about, most

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[21] Neither his social anxiety, his obsessive behavior, nor what may or may not have been psychiatrically-related deterioration in his mid-2012 grades appears directly related to his "human capital" thoughts.
[22] Although he mentions "catatonia" in his "notebook" and elsewhere, his descriptions do not suggest actual catatonic behavior.
[23] *DSM-5*, pp. 251-254
[24] *Ibid.*, pp. 242-244
[25] *Ibid.*, pp. 315-316

or all of which do not appear to have been present (or present to a clinically-significant extent): "Catatonia . . . ; Excessive fatigue . . . ; Brief periods of invincibility, actions are in hyperspeed . . . ; Tiredness . . . for about an hour . . . ; Quick fleeting movements in peripheral vision . . . ; Proclivity to scan environment . . . ; Recurring return to mirror to look at appearance . . . focused on hair styling . . . ; Concern with teeth . . . ; Concern with nose. Often drippy . . . ; Concern with cock . . . ; Inability to communicate what I want to say although I can understand it . . . ; Difficulty in concentrating or focusing on anything longer than 15 minutes . . . ; Odd sense of self. View myself as divided . . . the real me is fighting the biological me . . . ; Can't fall asleep when I want to . . . ; Random . . . stabbing back pain . . . ; The obsession to kill."

In addition, there was a long list (p. 31 of his "notebook") of psychiatric or quasi-psychiatric conditions that he considered in a sort of "self diagnosis" apparently based largely on Internet searches (which I could not find in the record) and his own assumptions: "Dysphoric mania; Generalized anxiety disorder/social anxiety disorder/OCD (Obsessive Compulsive Disorder)/PTSD (chronic) (parentheses his); Asperger syndrome/autism, ADHD (Attention Deficit Hyperactivity Disorder); schizophrenia; Body dysmorphic disorder; Borderline, narcissistic, anxious, avoidant and obsessive compulsive personality disorders; Chronic insomnia; Psychosis; Trichotillomania; Adjustment disorder; Pain disorder; Restless leg syndrome."

None of these conditions should be assumed to have been present simply because the defendant listed it in his "notebook." One logical inference is that he was trying to make sense of his feelings and mental experiences, which is common and understandable. Such searching and assumptions are sometimes associated with mental illness and sometimes not, and occasionally reflect delusional thinking but usually not.

Finally, some observers and examiners have mentioned the possibility of a dissociative disorder. Those hypotheses were apparently prompted by comments to the effect that he viewed himself as "divided . . . the real me is fighting the biological me,"[26] that he was "on autopilot" during the shootings, and that he may have wanted to view the part of him that was planning the killings as separate from the rest of him (e.g., in some comments about dyeing his hair). I found no reliable evidence for any dissociative disorder (e.g., depersonalization/derealization disorder, dissociative identity disorder,[27]) in any record, interview or psychological test.

ITEMS ADDRESSED FROM ORDER P-68

The following **statements** are offered in response to other requirements of the Order, and refer to page numbers in Order P-68. Each is expressed to a reasonable degree of medical/psychiatric certainty and may be considered an opinion, unless otherwise noted, to the extent allowed by Order C-94.

NOTE: The accuracy of the defendant's statements made since the shootings, and particularly weeks, months or years later, is affected by many things, including (but not necessarily limited to) time, his state of mind when the described events occurred, his state of mind when he made

[26] Defendant's "notebook," p.35
[27] *DSM-5*, pp. 291-307

the statements, the inherent fragility and changeability of memory, and the ways in which his psyche protects him (and protected him in the past) from intolerable information and feelings (i.e., psychological defenses). In addition, his oral or written statements made prior to the shootings may or may not be accurate, or accurately represent events or his mental condition, particularly as he "explains" those statements months or years later.

Thus, "facts" gotten from the defendant himself should not be assumed to be accurate or representative without adequate corroboration. Some may be accurate or partially accurate; others honest but inaccurate; others honest but incomplete; others some combination of the above, and still others purposely erroneous, incomplete, or misleading (intentionally or not). The mere consistency of his statements, their superficial "logic," or the ease with which he conveys them should not be assumed to be highly correlated with accuracy, which, in turn, should not be confused with "honesty."

Many of the above limitations on the accuracy of statements and memories apply also to witnesses and other informants.

1. With regard to ascertaining **the onset and evolution of the defendant's "human capital" belief and "how this belief compared to the defendant's childhood homicidal ideology"** . . . "further exploration is necessary." (pp. 17-19 of Order P-68)[28]

   The defendant stated that his first thoughts of the "human capital" concept[29] began during graduate school. There is no independent corroboration of those comments or of any direct comparison to his early thoughts or beliefs.

   His thoughts about the concept just before the shootings (according to his after-the-fact statements) were that he receives an arbitrary "one point" of value for every person he kills. That is consistent with his statements to me in July and August, 2014, that, for example, his own life has a value of "one" and the shootings gave him an additional 12. Those "values" are abstract; although he likes having the "points," he did not, and does not, associate them with any measurable advantage, increase in anything, longer life, more enjoyable life, additional lives, or the like. When asked whether or not others can gain similar value from killing, he responded that that depends on what they believe.

   As already noted, Mr. Holmes stated on several occasions that his concept of human capital, the values he places, and their meanings are all from his own thoughts and came from "inside me" (i.e., not from some external source, voice, "higher power," or particular philosophical writings). He was somewhat aware of similar-sounding philosophies, and acknowledged that things he may have read at some point might have influenced his thoughts, but he denied they came directly from any philosopher (such as Nietzsche), movie (such as *Highlander*), television program, or game.

   The defendant said that accidental killings don't, in his version of his belief, count toward one's value. Children convey the same value to their killers as do adults.[30] Wounded or injured persons don't count. If he were to be executed, the executioner

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[28] Page numbers in this section refer to Order P-68 unless otherwise noted.

[29] That purposely killing others results in his accruing some kind of value, which may or may not be related to their assumed individual worth (depending on when he made the statements).

[30] The only deceased victim under 17 was a six-year-old child; some other children were injured.

would get one point and others associated with his execution may get a point (but he was clear that the benefit applies only to people who believe as he does).

I found no indication that Mr. Holmes's "human capital" belief (accruing value from killed victims) is directly or consciously associated with any childhood thoughts of killing people (to the extent that he actually had formed homicidal ideation in childhood, as contrasted with occasional vague thoughts of killing people that are common in children). There is no indication that any childhood thoughts about killing others represented an "ideology" (i.e., a systematic body of concepts, either idiosyncratic or shared) at the time.

2. With regard to "inquir(ing) into whether or not **the defendant's statement that there is 'no right or wrong' related to the writings of Friedrich Nietzsche" and general issues of (nihilistic) philosophy *vs.* psychotically delusional belief.** (pp. 20-21)

Mr. Holmes conveyed to me several times, and implied to others, a clear view that moral "right" and "wrong" are matters of individual choice and belief, and that one person's view is as valid as another's (i.e., right and wrong are whatever an individual thinks they are). Thus, he sometimes said, the shootings were not "wrong" *vis a vis* his personal philosophy. At other times, he made it clear that he knows (and knew while planning his "mission") that the shootings were not only legally but morally wrong in society's eyes.

He did not, in his interviews with me, attribute his "moral relativism" to Nietzsche (or any other philosopher or external source), although he acknowledged that the idea might not be original. His views/beliefs on this topic appear to be part of an entrenched philosophy rather than any significant mental disorder, and are quite separate from his understanding of *legal* and *socially-accepted* right and wrong. This does not, in itself, suggest a significant mental disorder, and is consistent with simply an uncommonly-held moral philosophy and antisocial traits.[31]

With regard to nihilistic philosophy *vs.* "psychotically delusional belief," etc., in the Order, there is no indication that his "moral relativism" *per se* is psychotic (i.e., associated with a break with reality that is relevant to intent), although such thoughts or beliefs are sometimes used to rationalize irreconcilable thoughts or actions (which may or may not themselves indicate psychosis).

The point is that both severely mentally ill and non-mentally-ill persons may employ thoughts and behaviors such as Mr. Holmes's – unusual, and appearing non-empathic – in order to justify, both in their own psyches and to others, some (unconsciously-based) rationalization.

3. With regard to issues of **whether or not, and why (if applicable), the defendant "believed he was crazy and delusional, and thought killing people was crazy" prior to the shooting. . . . "The defendant's insight into whether he was having psychotic symptoms before the shooting** is an important aspect of the nature and progression of his mental condition." (p. 22)

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[31] Note that this does not imply that Mr. Holmes is otherwise "antisocial" in the psychiatric sense, or that he meets diagnostic criteria for antisocial personality disorder (he does not).

First, there is some doubt that Mr. Holmes's comments to others about his purported mental condition before the shootings accurately reflect his thoughts (certainly not all of them) or any true "insight" into his mental condition. The record reflects, and his statements are consistent with, his own concerns about his thinking, which sometimes reached a level of seeking explanations (e.g., in his Internet searches and the diagnoses he proposed for himself) or help (i.e., his appointments with Ms. Roath and Dr. Fenton). He said, to Ms. Roath, in his pre-shooting notebook, and in after-the-fact interviews, that he went to the student health clinic for help with anxiety. It is reasonable to assume, and he was willing to consider, that a part of him also wished for his violent impulses to be controlled or eliminated.

I see no firm indication that the defendant consciously thought that killing people in the ways he imagined or planned was "crazy."[32] He appears to have believed at various times (but not at others), including years before 2012, that there was something "wrong" with him (including his anxieties and social impairments). He referred in his "notebook" to "the mind of madness," but it seems likely that such verbiage was a kind of literary hyperbole, meant to be read by others, rather than any particular insight into being delusional or otherwise "psychotic" (to the extent that he may have been either).

Although Mr. Holmes was emotionally troubled at times, and tried to find psychiatric explanations (diagnoses) for his discomfort, *there is only modest, at best, indication that he consciously "thought killing people was crazy" in a psychiatric sense.* He did not indicate to me, nor does the record convincingly reflect, any consistent view that killing others was a sign of psychosis[33]; however, there is good evidence in his behaviors, writings, and communications before and after the shootings that he knew his "mission" to kill was "wrong" and that part of him believed it should not be carried out (consider, e.g., his thinly-veiled hope that Dr. Fenton would somehow recognize the danger, his belief [or hope] that the FBI would stop him at the last minute, and his last minute call to the University hotline). He told me that the part of him that wanted/needed to carry out the "mission" was simply stronger than the part that wanted to stop it.

There is little indication that the defendant truly believed he was "delusional." Mr. Holmes may have used the word "delusional" or "paranoid" from time to time to describe himself, but there is scant evidence that he was somehow aware that a thought was delusional while engaged in it (to the extent that he was ever engaged in a delusion prior to the shootings). That is not to say that he did not think about the *possibility* that some of his thoughts or beliefs were delusional (thinking or pondering being an intellectual exercise, not an insight).

Since the shootings, Mr. Holmes has often said that his homicidal thoughts and impulses, the "mission," planning and preparing for the killings, and the killings themselves were there to alleviate his purported depression and keep him from killing himself (one of only two main purposes that he described[34]). He appeared to believe that explanation/rationalization. Nevertheless, he did not, or could not, describe any memory of actually feeling very suicidal, or of symptoms of severe depression, during the months before the shooting. His explanation was circular: in effect, "I know I was suicidal because I was homicidal to protect myself from knowing I was feeling suicidal."

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[32] He apparently used that word with Dr. Metzner, but it is not at all clear that he meant "psychotic."
[33] Although he accurately believed that revealing his plans might get him "locked up."
[34] The other being to gain the "value" of the deceased.

Some of the images and fantasies that Mr. Holmes described from his past, and which appear honest in his description, suggest a correlation with something other than personality traits (but occur in some personality traits as well). His description of images of people's limbs and flying saws, for example – described clearly as *thoughts*, not hallucinations – during periods in which he occasionally felt "frozen" and unable either to respond to anxiety-producing conversation or to escape from it, appears to reflect fantasies of an unconscious solution to the immediate situation, which he never pondered very much and upon which he never acted. That is, although the mental image sounds macabre, such thoughts are common in both children and relatively healthy, nonviolent adults as their minds do the work of protecting them from both internal discomfort and inappropriate behavior.

What Mr. Holmes described to some as obsessive thoughts, beginning in early adolescence, of hating mankind and killing masses of people are more ominous, and may be associated with, or consistent with, the psychological conditions that would eventually lead to the shootings. However, it would be inappropriate to assume those thoughts were indicators *per se*, much less harbingers, of future psychotic illness (such as schizophrenia and related conditions). Their source is a matter of speculation, as is the question of whether or not they are associated with any Mr. Holmes's adult diagnoses or behavior (see below).

4. With regard to **"explor(ing) the defendant's longstanding hatred toward mankind as a potential motive"** . . . "This deficiency is relevant to the question of sanity." . . . "Further exploration of this critical issue is necessary." (p. 22)

Although there is a reference in the defendant's pre-shooting "notebook" to hatred as possibly associated with his plan to kill people[35], he consistently denied (in his interviews with me) "hatred" as a significant motivator. He described his "hating mankind" as referring to something noxious or to be avoided, "like hating broccoli," and not as anything vicious or malevolent. When carefully asked – once again well after the shootings and under circumstances very different from those that existed before the incident – he firmly and repeatedly said that if there was any motivation in the "hatred," it was small (e.g., "10%") compared with what he said were the two (roughly equivalent) main motives: to alleviate depression and suicidal impulses, and to gain "value" points from the deceased victims.

The defendant's discussions with me ratified his many earlier statements about images of killing people, generally in some vague and global way such as "nuclear winter" (meaning nuclear explosions), but he always described those as images or fantasies, never as overt wishes or even naïve childhood plans. They appear to have been similar to the images that sometimes arose unbidden when he was very anxious and "frozen" in minor verbal confrontations, and perhaps had a similar purpose of dealing with anxiety and unconscious aggressive impulses (psychologically "binding" and dissipating them) to decrease his emotional conflict.

NOTE that such emotional "defenses" should not be confused with overt plans or threats of violence without good reason; no discernible direct connection exists in this

[35] p. 36: ". . . to face death, embrace the longstanding hatred of mankind and overcome all fear in certain death."

case. While important childhood characteristics and experiences often have a greater or lesser bearing on adult behaviors, and child development is relevant to adult outcome, there is little indication that the plans and acts of 2012 were part of some chain of prophetic events that began in the defendant's childhood.

5. With regard to "inquir(ing) into **the meaning of the defendant's references to his two different selves.**" . . . "(Dr. Metzner) failed to delve deeper into this area . . . to **determine whether there is evidence of depersonalization phenomena, delusions about identity, metaphorical speech, or efforts at manipulation.**" (p. 23-24)

There is no reasonable indication that the defendant has, or ever had, "two different selves." Nothing in the record or any of his many clinical examinations or psychological tests, including my specific questioning for symptoms of significant dissociative events and dissociative identity disorder ("multiple personality"), suggests any such conditions, delusions about identity, or true depersonalization (separate from ordinary isolation of affect or the defendant's mention of "going on autopilot").

The defendant's comment that he was "on autopilot" during the shootings is easily misconstrued. Whatever he meant by "on autopilot," his descriptions of the events inside auditorium nine of the Century 16 cinema indicate that he was quite aware of (and remembers many of) his surroundings and actions, including his cellphone ruse, returning to the auditorium after putting on his gear, being aware that he dropped one of his tear gas canisters and it rolled under his car, deploying the other canister, choosing some of the victims he would shoot, aiming and firing, hearing at least some screams, being aware of the "techno" music he said was playing through his iPod ear buds, dropping his shotgun when it was empty, moving to a lighted area to try to un-jam his AR-15, working on the weapon itself, deciding to stop shooting, and leaving the auditorium.

"Metaphorical speech" is a term sometimes used by mental health professionals to infer a relationship between a psychotic person's "crazy" words and their putative psychodynamic or real-world meaning(s) (i.e., some otherwise unintelligible, psychotic speech may contain metaphor that can be translated into more coherent communication). For example, a psychodynamically-oriented psychiatrist or psychologist might interpret a psychotic patient's comment such as, "The house is on fire and the children will burn," as communicating the patient's feeling that his emotions are out of control and threatening.

Such interpretations are speculative, and their usefulness generally lies in ongoing treatment of some severely disturbed patients by psychotherapists or psychoanalysts who are very familiar with them. With regard to this defendant, there are a number of interesting possibilities for interpreting his various statements, some of which may indeed be metaphorical, but if offered to a trier, they should be considered speculation.

"Efforts at manipulation" is a phrase more complex than it might appear. First, after extensive exploration and psychological testing that would be expected to reveal malingering, *there is no reasonable indication that the defendant is malingering in any substantial sense*. Defendants can fool examiners and investigators, particularly when an examiner bases his or her opinions solely on interviews. In this case, however, (1) there is good (but not perfect[36]) correlation and consistency among the defendant's many

[36] See, e.g., comments by some CMHIP nursing staff (Appendix 4 [attached], footnote 2).

statements, statements and descriptions by persons who interacted with him during the weeks and months before the shootings, the various examiners' experiences with the defendant, and relevant psychological and neuropsychological testing. (2) Well-validated and reliable tests and scales designed to reveal evidence of malingering or other falsification have all been negative. And (3) the defendant expresses little wish to avoid even the most serious potential consequences for his acts (such as being executed).

Having said the above, virtually every defendant – and every evaluee – manipulates, "shades," "plays down," or exaggerates to some extent. In this defendant, many of his circular explanations and much of his reluctance to elaborate appear to be efforts – often involuntary – to protect himself psychologically (that is, to protect the psychological defenses that he needs in order to feel reasonably comfortable in his current environment, within himself, and in his current legal setting). Nevertheless, and separate from the apparent validity of his test results, I cannot determine the amount of nuance – if it is present – that he may be controlling as we talk.

It may be noted, although I don't believe it applies to Mr. Holmes, that many truly mentally ill defendants try to appear *less* mentally ill when accused of crimes. Even facing extended incarceration or a possible death penalty, some persons with potentially exonerating or mitigating symptoms want so badly *not* to be psychotic (for example), that they try to convince others that they are normal. The stigma of being "bad" is, for them, better than the stigma of being both "bad" and "mad."

6. With regard to "**explor(ing) potential delusions identified by other mental health professionals . . .** (and) **ascertain(ing) whether or not the defendant ever had any ideas of reference or delusions of reference** . . . ." (p. 24)

As already noted, "delusions" are fixed, false beliefs unshaken by facts to the contrary and not held by reasonable others. There is some indication in the record that Mr. Holmes had "ideas of reference" or "delusions of reference" (a situation in which one unreasonably believes that others' actions or comments, such as in conversations or news broadcasts, refer particularly to oneself) prior to the shootings, but the record is far from conclusive about their forensic significance. There was no known consistent or pervasive referential delusion before the shootings.

Dr. Fenton described Mr. Holmes as "paranoid," and noted three brief referential misinterpretations that may or may not reasonably be called "delusional." He (Holmes) suspected that the reason he found her office door locked one day was that she was afraid of him; at the same appointment, he suspected that a box behind her desk was related to his visit, and at a later appointment he suspected that a cast or brace on Dr. Feinstein's arm was a "test" to see if he (Holmes) would be empathic, or that the doctor might have a weapon in it. (All the events were actually coincidental.)

Mr. Holmes's comments that the FBI may have been surveilling him as he implemented his "mission" plans were somewhat ambiguous, and consistent with simple caution and worry about getting caught (as well as with a wish to be stopped – see above). The record indicates that there actually was a marked FBI SUV at or near the Byers Canyon shooting area while he was there. He also recalled wondering if unmarked police cars near his apartment held officers who were monitoring him, but offered (and was amenable to) the explanation that they were merely watching for drunk drivers

leaving a bar across the street.[37] He said he kept his curtains closed to avoid being observed preparing for the shootings, but did not use any unusual or extraordinary measures to avoid detection.[38]

The ideas of reference described by the defendant during his November, 2012, delirium and psychotic episode are consistent with a pre-existing psychosis or predisposition to psychosis, but they do not establish one, nor do they suggest earlier ideas or delusions of reference. Delirium, with or without other psychosis, often includes ideas of reference but, as already discussed, the November, 2012, episode occurred under very unusual conditions, and may or may not have represented some combination of metabolically-related delirium and chronic psychotic disorder (as contrasted with brief psychotic episodes that can occur in some severe personality disorders and other nonpsychotic diagnoses).

7. With regard to **"(c)onfront(ing) the defendant about a discrepancy between statements he made regarding thought broadcasting (which is) . . . relevant to the true nature and progress of the defendant's psychotic symptoms"** (to the extent that psychotic symptoms were present prior to the shootings) (parentheses mine). (p. 24)

   Neither the record nor the defendant's interviews suggests pre-shooting "thought broadcasting."

8. With regard to **exploring and/or explaining any relationship that exists between "Dr. Metzner's 'very clear' opinion that the shooting 'was a direct result of [the defendant's] chronic psychotic illness,' without which 'these crimes could not have occurred.'** . . . (E)xplain(ing) the causal relationship between the defendant's psychiatric symptoms and the shooting . . . is critical to the issue of sanity." p. 25

   First, Dr. Metzner himself can best explain his opinions regarding the issue of sanity.

   For most people, most of the time, even severe mental disorders do not interrupt voluntary adherence to the law, with or without a "policeman at one's elbow." I do not see an exception in Mr. Holmes's case. Although the chain of events that eventually led to the shootings was no doubt affected (and "caused" in some ways) by his psychological symptoms, *(a) there is little or no reasonable psychiatric evidence to suggest that his symptoms affected his ability to form the requisite "culpable mental state" as I understand that phrase in Colorado* (knowing and appreciating legal, social, and moral aspects of his acts), *and (b) the totality of the record, examinations, etc., simply does not suggest direct causality in any sense that interferes with the voluntariness of his acts.*

   It is logical that "but for" the way the defendant was thinking on July 19-20, 2012, delusional or not, he would not have carried out the shootings. That is different, however, from saying that some psychiatric condition "caused" those events in the sense in which I believe the Court contemplates criminal responsibility (a matter best left to the

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[37] That explanation could have been the product of an improved, less delusional psyche, since it was offered after he had been taking antipsychotic medication for over a year.

[38] For example, he purchased his weapons and equipment using his own name and credit card, had many of them delivered to his apartment, and did not use a proxy server or even delete his browser history when visiting "mission"-related websites.

triers). Mr. Holmes had one or more mental disorders during the weeks and months before the shootings. Their specific nature(s) may be in dispute, but it is fair to say that his mental condition affected his thinking during that period, and during the shooting. However, *considering exculpation simply because his behavior was a "product" of his thinking is another matter entirely*, and one that I would opine against in this case, citing the points described elsewhere in this report.

Any person's state of mind (disordered or not) before and during a voluntary act (criminal or not) is associated with that act and generally allows it to occur. A significant change in one's thoughts or state of mind is likely to give rise to different behavior. It is fair to say, without eviscerating the important psychiatric details of this matter, that any substantial and lasting change in the defendant's psychiatric or psychosocial condition during the weeks or months prior to the shootings would probably have altered the chain of events that led to the July 20, 2012, shootings, and those shootings would not have occurred on the date and in the way that they did. The same could be said of changing any number of other things in Mr. Holmes's history, such as his deciding to apply to the CU graduate school or his making the excellent grades required to be accepted.

9. With regard to **exploring "other, equally plausible and reasonable explanations for keeping the killing impersonal" (in addition to a decreasing capacity to tell the difference between right and wrong).** "Further exploration of this issue is necessary to assess the defendant's sanity." (p. 25)

First, I am not convinced that "impersonal" is the relevant term, nor that Mr. Holmes "(kept) the killings impersonal" in the way that he appeared to convey.

The defendant generally used the term "impersonal" to describe a lack of direct relationship with his victims. On the other hand, there are substantial indications that some of his killing or wounding behavior on July 20, 2012, *was*, to some extent, direct or "personal" (or at least individual). Perhaps more important, at least some of what he described as "impersonal" seems to me actually to have been *indifferent*.

With regard to personal-seeming behaviors, the defendant contemplated and carried out the shootings and killings at close range. Although he cites not personally knowing the victims, listening to loud music through ear buds, and having trouble seeing through his gas mask in the theater,[39] he sometimes picked out certain victims (e.g., some who rose to escape when he started shooting), specifically tried to kill people before they could escape, and in at least one instance was described by a victim in a front row (Dion Rosborough) as walking up to him and shooting him face-on at very close range.

When I asked about his considering other, arguably more "effective" ways to kill many people, often at longer and less "personal" range (such as bombing, sniping, or simply repeatedly shooting strangers from ambush), he had sometimes-circular

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[39] Although it may be the case, and earbuds were observed, I found no other corroboration for Mr. Holmes's statement that he was listening to very loud music, or that the music was so loud and continuous that it drowned out all external sound (indeed, he recalled hearing screams early in the shootings). Similarly, informal tests and information about visibility while using a full-visor gas mask and a Strikefire Red Dot close quarters sight (apparently with night vision) on one of his weapons in a movie theater environment suggests to me – noting that I am not expert in such matters – that he was able to see well enough to follow human targets and aim at them if he chose to do so.

rationalizations for choosing the relatively intimate, crowded small-auditorium site, then going through a crowded lobby and sitting with or near some of the audience members he would later shoot (see his "notebook" writings as well).

Mr. Holmes said at least once during my interviews (August 27, 2014) that how the victims felt about dying was irrelevant to his "mission." He speculated (at my request) that if he had been asked *before* the shootings about the victims' feelings, he would have replied that "dying would probably matter a great deal to them."

In addition, and without intending to be exhaustive, he described a willingness to shoot a specific theater employee if the employee had come closer to his car or otherwise tried to interrupt the "mission."[40]

With regard to "indifferent" *versus* (or in addition to) "impersonal," the defendant made it clear to me that he had planned to kill the persons in the audience (and did so) without regard to their rights, their feelings about dying, their wishes, their genders, their ages, or other individual characteristics (such as higher or lower "value" of some kind). He has commented since the shootings that he regrets killing and wounding children; however, he includes the six-year-old victim he killed as one of his 12 "points" accrued. Except for choosing a midnight showing and a PG-13 movie (which he said was done intentionally to screen out children), he made no apparent allowances to exempt them in the planning or execution of the "mission."

10. "Further inquiry" into "**Dr. Metzner's finding that the defendant's 'appreciation of the wrongfulness of his actions [was] significantly impaired'** is relevant and necessary in order to properly address the issue of the defendant's sanity." (p. 26)

First, Dr. Metzner himself can best explain his opinions regarding the issue of appreciation of wrongfulness, as well as other aspects of his findings.

Neither my review of the available records and reports nor my several recent interviews and review of new psychological testing suggests that the defendant was unable to appreciate, in every reasonable sense of the word, the legal wrongfulness and social disapproval or abhorrence of the shootings and their foreseeable consequences to the victims.

With regard to what some might consider personal or moral views of the wrongfulness of his actions, I have already discussed Mr. Holmes's stated philosophy that, in essence, "right" and "wrong" are whatever a person wants them to be (a strict "moral relativism" philosophy). *I do not believe his philosophy in that regard defines, reflects, or characterizes a delusion or other potentially exculpatory mental disorder.*

During my interviews, after some circular-sounding rationalization, he appeared to agree that a society whose members can do anything that they "believe" is right, or expedient, would be very problematic, but he stuck doggedly to his premise. The firmness with which he adhered to that "self"-centered moral philosophy or belief in the face of logical pathways to chaos (or, at best, a savage world) is a little reminiscent of the unshakeable beliefs of a "delusion," but it is not delusional, since it is not a belief about how the world *is*, but about how he feels and how he may think the world *should be*.

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[40] After putting on his gear behind the theater, he became aware of an employee emptying trash. At least twice during my interviews, the defendant said that if the employee had noticed him, he was prepared to shoot the employee with the handgun in the passenger door.

It is fair to note that Mr. Holmes's comments about how he believes others view(ed) him after the shootings may be construed as reaching delusional proportions, but those comments more likely reflect a resilient but nonpsychotic psychological defense (e.g., against feeling almost universally hated). For example, when asked how his former friends Ben, Gargi, Tim, and Hillary may feel about him now, he said that they probably still feel friendship for him, are too busy to write, are moving ahead with their own lives, and would support him if they could. He appeared to interpret the many cards and letters he received from various (primarily) women and some other inmates – communications commonly received by persons arrested for heinous acts – as true support. His sister has never written to him and has visited (with their parents) only once in two years; however he said that she loves him and he is not concerned about her lack of communication. He (perhaps accurately[41]) didn't relate her lack of contact to the shootings, viewing it as simply a routine dearth of communication coupled with caution about any letters being used against him by the prosecution. When asked about the public's obviously negative perceptions of him, he said that "they don't have all the facts."

This apparent misreading or misunderstanding of people's reactions does not, in my opinion, significantly affect the issues of his pre-shooting mental state.

11. With regard to exploring **"the concept of 'warrior mentality'** in order to gain a better understanding of the alleged crimes . . . (and) 'goes to whether [the shooting was] delusionally based.' . . . **(A) complete understanding of any violent fantasies the defendant experienced, their origination, and how they developed and changed** . . . is important in analyzing the defendant's sanity on (July 20, 2012)."

In my view, the forensic psychological concept of "warrior mentality" is irrelevant to this defendant or his sanity. Further, if it were personally relevant to Mr. Holmes, the presence of "warrior mentality" traits would not be particularly probative in the question of his sanity. (That is, and without suggesting that I am well-versed in the concept, some people with such "warrior" traits and behaviors – mentally ill or not – are responsible for their acts; others do have mental disorders that are relevant to their intent and criminal responsibility).

A few of the photos the defendant took of himself before the shootings give a "macho" or "warrior" impression, as well as an image of how he would like to be perceived and remembered. He denied any "warrior" intent during detailed questioning and discussion, but did say that his image in the photographs conveyed someone who can defend himself, a person to be reckoned with, and sometimes a "bad person"[42] (as contrasted from imagining being remembered as a "good person" earlier in college).

One cannot understand every violent fantasy the defendant has had and its origin, development, and evolution. With the preface that everyone has violent fantasies, and that very, very few people act on those fantasies in the way that the defendant did, it is important to note that the fantasies themselves did not "cause" the shootings. It is, however, reasonable to infer that some of his fantasies came from the same psychological sources as did his "mission" plans and implementation.

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[41] His sister, five years younger, did tell me that she still loves him and that the two reasons she has not written are that she doesn't want to harm his defense, and they rarely communicate in any event.

[42] Cf. his thoughts of sending a photo to the New York Times or Denver Post.

The kinds of images or fantasies that the defendant described as occurring in childhood, of "nuclear winter" for example (which apparently did not involve specific killing), are not uncommon in children, but are often not remembered or made conscious in adulthood. The defendant reported mental images (which may or may not have been accompanied by fantasies) during some socially uncomfortable experiences as he became an adult. It is my speculation – there is insufficient corroborated data for an "opinion" – that the images of things like "saws" and "body parts" that he said he sometimes had in mildly confrontational social situations (such as when asked questions he found difficult to answer) represent emotional defenses, not a prediction of things to come.

It is tempting to hypothesize a sort of evolution of Mr. Holmes's violent or "homicidal" thoughts over the years between his childhood and 2012, and to use his memories and descriptions of images and fantasies as markers of that evolution. Any such interpretation relies greatly on speculation, however, and depends on limited information from only one, potentially unreliable, source (the defendant himself).[43] Similarly, to infer "complete understanding" of any violent images or fantasies would be inappropriately speculative.[44]

Having said the above, there are elements that suggest some delusional basis (but not, in my opinion, exculpatory insanity) for some of the defendant's plans and allegedly criminal acts (e.g., the plan to kill people in order to make himself feel better and gain "value"). I have already said that I do not consider Mr. Holmes's stated moral stance delusional, but he appears to have used (and currently uses) it to justify, primarily to himself, the knowingly extremely injurious, often lethal, behaviors that he carried out with what I believe to have been indifference to victims, whom he viewed as irrelevant to his objective(s). The presence of delusions or other psychiatric symptoms, in the absence of evidence that they actually controlled his behavior and intent, is insufficient to imply a lack of sanity in the context apparently contemplated by the Court.

OTHER RESPONSES TO ORDER C-94

Defendant's Cooperation During the Evaluation

The defendant was cooperative at all times during the evaluation, with all interviews, examinations, psychological testing, and related activities.

Examinations Conducted

My specific examination of the defendant consisted primarily of nine evaluation interviews conducted over three days (July 30-August 1, 2014) at the Colorado Mental Health Institute – Pueblo (CMHIP) and two days (August 27-28, 2014) at the Arapahoe County Sheriff's Detention Facility (ACSDF). The defendant was cooperative at all times, during all sessions. The total interview time was about 22 hours, 40 minutes.

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[43] As already discussed, I am not implying that the various sources of unreliability in Mr. Holmes's memories, observations, and interpretations of his own thoughts and behaviors are associated with "malingering."
[44] See also the discussion of "metaphorical speech" in item 5.

The interviews included oral interchange that was extensive, but not necessarily exhaustive, since extensive records, notes and reports from prior forensic interviews by Drs. Metzner and Gur, a clinical (perhaps quasi-forensic) interview by Dr. Woodcock, and forensic psychological testing and interviews by Drs. Hanlon, Gray, and Manguso were available. In addition to oral interviews, I made the usual observations of the defendant's appearance, demeanor, interactions with me, etc., and briefly examined his eyes and pulse at various times.

My examination also included observing Mr. Holmes in his CMHIP sitting area and walking in the CMHIP "yard"; overhearing parts of his conversations and verbal demeanor as he interacted frequently with CMHIP staff; observing him just before and after the recorded interviews at both CMHIP and ACSDF, watching hundreds of hours of monitoring videos from ACSDF (July 20, 2012, and later[45]) and Denver Health Medical Center (November, 2012); watching defense-produced videos taken at Denver Health Medical Center (November, 2012); listening to and/or watching law enforcement interviews/interrogations and the defendant's behavior in an interrogation room; watching very brief news-media-produced video from a court appearance (July, 2012); observing the defendant briefly during our initial introduction at the jail (mid-July, 2014), and examining his 2012 pre-event "selfie" photographs.

Between July 30 and August 1, 2014, Dr. Gray performed, scored, and interpreted three psychological tests (including his own interviews): the Structured Inventory of Reported Symptoms (SIRS-2, to assess likelihood of malingering), the current edition of the Minnesota Multiphasic Personality Inventory (MMPI-2), and the Personality Assessment Inventory (PAI). Dr. Gray's results are generally included elsewhere in this report, and his detailed results are found in **Appendix 1**. Independent forensic psychologist Dr. Richard Rogers reviewed that and other testing and provided "second opinion" interpretations of the 2013 and 2014 test data (**Appendix 2**).

Description of My Interviews[46]

I examined the defendant in nine interviews on five separate days. Six of the interview sessions and all psychological testing took place July 30-August 1, 2014, at Colorado Mental Health Institute, Pueblo (CMHIP), Pueblo, CO, in a secure dayroom. Three took place August 27-28, 2014, in a secure classroom at Arapahoe County Sheriff's Detention Facility (hereafter "the jail"), Centennial, CO. The 2014 physical examination was done at CMHIP.

The interviews were conducted in generally comfortable, private settings; only the defendant and I were in the room. After determining that the setting was safe and secure, security and other staff were able to observe through a large window, with the defendant's back to them; they could not hear our conversation nor see the defendant's facial expressions. At CMHIP, the defendant was without restraints; at the jail, he wore leg shackles. There was ample opportunity for brief breaks; no interview lasted more than three hours and 20 minutes.

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[45] I did not watch all available hours of jail video, but covered his first 3 days in jail, then randomly chose others (7/30/12, 8/16/12) and all available video of the day his "fall" and time in the "BC" cell. All other jail video had been erased except 7/10/14, which I requested in advance to observe a representative recent day of monitoring.

[46] See also Appendix 4 ("Mental Status Findings").

At the beginning of the first interview in each location, the defendant was provided with written information about the nature and purpose of the examinations, my role and agency, limitations on confidentiality, the video and audio procedure (which was open and visible to him), and the like. He clearly understood and remembered that information, which was occasionally reiterated, and appeared to participate willingly.

Although somewhat structured in order to cover necessary content, the interviews were generally open-ended and allowed considerable deviation into details and peripheral topics. The content included relevant forensic topics, items mentioned in the Court's Order, many items addressed in prior examiners' interviews and reports, and the usual topics of a psychiatric evaluation (as relevant to the situation). The defendant was alert and reasonably cooperative during all interviews.

All interviews (but not psychological testing) were completely and continuously video-recorded by a professional videographer and preserved on DVDs. The recorded field included most of the defendant's body, but – for security reasons – omitted any staff or information that might reasonably identify staff or location details. The video equipment was unobtrusively placed; it was turned on before each session, then left unattended. After each session, the videographer verified the recording quality and created a copy of that session's DVD; before the next session, he checked the recording field, audio quality, etc. All recordings were retained by me; the videographer did not peruse the content nor keep any of the recordings. My assistant later transcribed (in uncorrected draft form) the nine interviews.

Psychological and Other Testing

The psychological testing done July 31 and August 1, 2014, consisted of the Montreal Cognitive Assessment (MoCA), Minnesota Multiphasic Personality Inventory (2nd edition, MMPI-2), Personality Assessment Inventory (PAI), and Structured Interview of Reported Symptoms (SIRS-2[47], to assess likelihood of malingering). Routine blood tests and general physical examination by Dr. Brantley at CMHIP were not primarily for forensic purposes, but yielded some relevant information (e.g., regarding the defendant's eyes and thyroid status).

Names of Examiners

I performed all of the above examinations and interviews except the overall physical examination and the administration and interpretation of psychological testing. Routine physical examination was performed by Dr. Brantley of CMHIP. Psychological testing was administered by B. Thomas Gray, PhD, ABPP, of CMHIP. Psychological testing data were interpreted by Dr. Gray and, separately, by independent forensic psychologist Richard Rogers, PhD, ABPP.

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[47] Order P-68, p. 47, refers to a preference for the SIRS-1. The SIRS-1 and SIRS-2 contain exactly the same items, and the SIRS-2 [redacted] SIRS-1, [redacted] for the SIRS-2 [redacted] SIRS-1. Dr. Richard Rogers, who developed the test and wrote (with others) the interpretation manual, stated to me by telephone (10/9/14) that [redacted].

SOURCES RECEIVED AND/OR RELIED UPON IN MY REVIEW AND CREATION OF THIS REPORT

- Written materials, photographs, audio and video materials received

(NOTE that almost all of these materials are already held by both parties. Summary lists of both DVD/CD/other storage media contents and the contents of the cartons of paper records are available upon request. Some materials received from defense counsel may not have been provided to the prosecution at the time they were sent to me. Some materials listed as "additional" may have been included with the initial discovery materials, but were requested and/or sent for my convenience in finding them. Not all materials received were reviewed, or reviewed in detail; they were prioritized for relevance to my task.)

Email and/or hand delivery from Tanya Smith, Assistant AG:

Order Forwarding to the New Examiner Order C-94 and Redacted Copy of Order P-68 (C-96)
Attachment 1, Order C-96 – Order Regarding Further Sanity Examination (C-94)
Attachment 2, Order C-96 – Order Regarding People's Motion for Further Examination Pursuant to C.R.S. § 16-8-106(1) (P-68)
Amended Order RE Motion to Limit Pre-Trial Publicity (D-2a)
Order addressing requests in July 7, 2014 letter from Colorado Mental Health Institute at Pueblo (C-113)
Order setting deadline on any request for an instruction to the second examiner (C-115)
Notice re: the setting of a hearing on Motion D-221[D-222] Certificate of Conferral
Notice re: Order C-117 [suppressed]
Reply in support of Defendant's Motion for Court Order prohibiting the new sanity examiner from videotaping Mr. Holmes's second sanity evaluation [D-221]
Order re: Defendant's Motion for Court Order prohibiting the new sanity examiner from videotaping Mr. Holmes's second examination (D-221-A)

Hand delivery by investigators of the Office of the District Attorney:

Binder: People's Motion P-68 and All Responses, Replies, & Attachments
Motion for Further Examination Pursuant to C.R.S. § 16-8-106(1)
Response to People's Motion for Further Examination Pursuant to C.R.S. § 16-8-106(1)
People's Reply in Support of Motion for Further Examination Pursuant to C.R.S. § 16-8-106(1)
Revised Response to People's Motion for Further Examination Pursuant to C.R.S. § 16-8-106(1)
People's Reply to Defendant's Revised Response to Motion P-68
Binder: Transcripts and Exhibits from Hearings Regarding People's Motion P-68

Sanity Evaluation Report, Jeffrey L. Metzner, MD, Consulting Psychiatrist, CMHIP, 9/3/2013
Reporter's Transcript (January 27, 2014) – Motion Hearing (P-68)
Reporter's Transcript (January 28, 2014) - Motion Hearing
Reporter's Transcript (January 29, 2014) – Motion Hearing
Reporter's Transcript (January 30, 2014, Morning Session) – Motion Hearing
Defense Exhibits: D-PT-2, D-PT-3, D-PT-4, D-PT-5, D-PT-6
Office of the District Attorney, 18th Judicial District - Media Log: Notice Re: Existence of Media in Case (Discs Received through 05/15/14)
DVD1 – DVD265 [**DVD15 not included; no longer part of discovery]
BLU-RAY1 – BLU-RAY4
CD1 – CD318 [**CDs 19-20 not included; no longer part of discovery]
Flash Drive1 – FlashDrive4
External Drive1 – All Files from APD regarding this case (APD's "K Drive")
Discovery Disc – Scanned .pdf discovery pages, discovery pp. 1-75,656
Boxes 1-16: Printed discovery pages 1 – 75,656
CD324 – Records from TMobile
CD325 – Photos from Victim Joshua Nowlan (injuries)
CD326 – Analysis by Agent Eicher 7/14/14
CD327 – Prescription bottle photos by Inv. Heylin

USPS Delivery from the Office of the District Attorney, 18th Judicial District, Lisa Teesch-Maguire, Attorney:
CD – Clip from CD #3 (911 Call #1: Caller Kevin Quiz___z)
CD – Preliminary Exhibits by Exhibit #
DVD – Clip from CD #47 (Theater surveillance clip: defendant entering theater)

FedEx delivery from the Office of the District Attorney, 18th Judicial District:
Discovery pages 75,657-76,344 [via email from Amy Jorgenson on 7/2/14, a Page Discovery Log for pages 75,878-76,344]
CD319-CD323
CD with People's Motion P-68, responses & replies; transcripts & exhibits from hearing; Dr. Metzner's report (a request was made on 7/8/14 for the CD; the documents were provided in 2 binders on 5/16/14)
CD (converted from Blu-Ray 2) – Ben Garcia phone download; also provided the CD contents in paper format "Report from phone download of Ben Garcia's phone: printed from Blu-Ray 2"
Explosives Report, discovery pages 41,232-41,293
Color photos printed from CD312: 3D Model of Theater 8 and 9
Discovery pages 76,345 – 76,883
Preliminary Hearing transcripts and exhibits
Disc containing Preliminary Hearing transcripts
DVD 266 (Holmes 071014) – Video pulled @ 1329 by Dep. S. Kraus 01070 on 071114 (MC1 0000-235)
DVD 267 (Holmes 071014)- Video pulled on 071114 @ 0634 by Dep. S. Kraus #01070 (MCI 000-2359)

Discovery pages 76,884-78,721
CDs 328-333

Hand Delivery by Tamara Brady, Daniel King, & John Gonglach of the Office of the State Public Defender:

Videos or Media
DVD – DHM videos (three they took from the PD)
DVD – DHM videos taken via closed circuit (two videos)
DVD – ACJ videos of use of force and trust fall video (five clips)
Hard Copies
James Holmes Social History
JH Computation Book (condensed) with transcribed pages
JH writings: Galactic Colonization with transcribed pages
Report by JG regarding collection of these writings
Complete set of current jail records (July 20, 2012 – April 21, 2014)
Pod Logs (July 20, 2012 – May 30, 2014)
Letter from Ben Rice re Betty Holmes
Denver Health Medical Staff Interviews:
Defense interview of Jennifer Griffith, 3/26/14
Defense interview of Craig Holland, 4/30/14
Defense interview of Rachel Davis, 3/26/14
Defense interview of Kimberly Indovina, 4/7/14
Arapahoe County Jail Interviews:
Defense interview of Nurse Sandy Paggen, 12/31/13
Defense interview of Russell Martens, 12/30/13
Defense interview of Susan Sylvander, 2/3/14
Defense interview of Deputy Triska, 12/31/13
Defense interview of Deputy Hubbell, 5/8/14
Defense interview of Deputy Robinson, 5/8/14
Defense interview of Dr. Jason Grope, 2/3/14
Defense interview of Deputy Goodyear, 5/8/14
Medical Workers:
Defense interviews of David Muldonado, 6/25/13
Defense interview of Claudia Barros, 6/25/14
Defense interview of Tara Fornier, 6/23/13
Defense interview of Jose Sanchez-Lopez, 8/29/13
Ambulance Drivers
Defense interview of Patrick Herr, 5/8/14

Emails from the Office of the State Public Defender:

Affidavit of Dr. Elizabeth L. Sather, Clinical Psychologist, dated 11/16/2012
Dr. Woodcock's notes
Personal transcription of rough notes by Jonathan H. Woodcock, M.D. during interview of James Holmes, July 24, 2012
Handwritten notes of Dr. Gur re: Jail Visit 8/5/14

Transcribed interview of Dr. Karl Pfenninger, 8/15/12 (interviewed by Detective Fredericksen)
Kaiser Permanente - Medical records for James Holmes (12/23/2011 office visit; 12/24/2011 mononucleosis diagnosis; 12/29/11 follow-up visit)
Handwritten notes of Dr. Gur – 12/19/12, 2/9/13, 2/24/13, 2/25/13, 2/26/13, 5/1/13, 5/2/13, and 11/18/13

FedEx delivery from John Gonglach, Investigator, Office of the State Public Defender:
Defense created transcript of Ben Garcia interview w/law enforcement 8/23/12
Defense created transcript of Ben Garcia interview w/law enforcement 1/17/13
Printed page of Holmes Family Tree (date of birth and death)
CD containing the media's video footage of the first appearance 7/23/12 published by the media (The Denver Post)

Facsimile from Paul D. Cooper, Attorney, for Dr. Erwin Mozer:
Dr. Mozer's handwritten notes re: James Holmes

FedEx delivery from Arapahoe County, Office of the Sheriff
Holmes 071014 – Video, MCI 0000-2359 (Copy Disc #151-2)

Current CMHIP chart (through July, 2014), received on-site 7/30/14

- Direct Examination of defendant Holmes (unchaperoned contact visits, video-recorded)[48]

7/30/14, CMHIP, two sessions totaling 4 hours, 10 minutes[49]
7/31/14, CMHIP, two sessions totaling 5 hours, 19 minutes
8/1/14, CMHIP, two sessions totaling 4 hours, 57 minutes
8/27/14, ACSDF, two sessions totaling 5 hours, 1 minute
8/28/14, ACSDF, one session, 3 hours, 21 minutes

- Psychological Testing and Interpretations (associated with my own examinations, in addition to prior psychological and neuropsychological testing in the record)

MMPI-2 (Minnesota Multiphasic Personality Inventory), PAI (Personality Assessment Inventory), SIRS-2 (Structured Inventory of Reported Symptoms), MoCA (Montreal Cognitive Assessment), administered 7/31 – 8/1/14 after clinical interview, scored, and interpreted by Dr. Thomas Gray (See APPENDIX 1.)

Independent second opinion/consultation by Richard Rogers, PhD, ABPP, regarding 2013 and current 2014 psychological testing (3 telephone consultations 9/29/14 & 10/9/14); report received 10/8/14) (See APPENDIX 2.)

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[48] I was briefly introduced to Mr. Holmes by one of his lawyers during a jail tour on 7/18/14, but no formal examination was conducted and the meeting was not recorded.
[49] Times include a few minutes of non-interview activity.

- My Interviews with persons other than defendant Holmes

  Jeffrey L. Metzner, MD, judge's expert (telephone), 6/10 & 6/23/14; (in-person), 7/17/14
  Phillip J. Resnick, MD, prosecution expert psychiatrist (telephone), 6/23/14
  Kris Mohandie, PhD, prosecution expert psychologist (telephone), 7/1/14
  Raquel Gur, MD, defense expert psychiatrist (telephone, two interviews), 7/1/14, 8/15/14
  Robert Hanlon, PhD, defense expert neuropsychologist, (telephone), 6/25/14
  Jonathan Woodcock, MD, defense expert and treating psychiatrist (telephone), 7/3/14
  Erwin Mozer, MD, jail psychiatrist (brief telephone), 6/24/14; (in person), 7/18/14
  Elizabeth Sather, PsyD, jail psychologist (telephone), 6/30/14
  Margaret Roath, MSW, treating counselor (telephone), 7/7/14
  Lynne Fenton, MD, treating psychiatrist (telephone), 7/25/14 (with Dr. Feinstein)
  Robert Feinstein, MD, treating psychiatrist (telephone), 7/25/14 (with Dr. Fenton)
  Robert House, MD, Denver Health Medical Center (DHMC) (brief telephone), 6/27/14
  Rachel Davis, MD, DHMC (brief telephone), 7/1/14
  Elizabeth Lowdermilk, MD, DHMC (brief telephone), 7/2/14
  Philippe Weintraub, MD, DHMC (brief telephone), 7/3/14
  J. Craig Holland, MD, DHMC (brief telephone), 7/3/14
  Detective Craig Appel, law enforcement investigator (in person), 7/18/14
  Richard Pounds, MD, CMHIP (in person), 7/30/14
  Birgit Fisher, PhD, CMHIP CEO (in person), 7/30 – 8/1/14
  Thomas Gray, PhD, CMHIP (in person), 7/30 – 8/1/14
  John Brantley, MD, CMHIP (in person), ~8/1/14
  Louis Archuleta, Security Chief, CMHIP (in person) 7/30 – 8/1/14
  Nursing staff, CMHIP (various, in person), 7/30 – 8/1/14
  Lori Wickstrom, ACSDF Watch Commander (tour facilitator & chaperone), 7/18/14
  Corrections staff, ACSDF (brief interactions, in person), 8/27-28/14
  Lyle Sidener, Director, Byers Canyon Shooting Range (brief telephone), 7/14/14
  Robert & Arlene Holmes, parents (telephone, two interviews), 7/29/14 (2nd date unk.)
  Chris Holmes, sister (telephone), 8/22/14
  Tim Tapscott, grad school friend (telephone), 9/18/14
  Sukumar Vijayaraghavan, PhD, graduate advisor & professor (brief telephone), 9/30/14
  Diego Restrepo, PhD, graduate school professor, examiner, (brief telephone), 9/30/14
  Defense counsel team (various, telephone and in person), various dates
  Prosecution team (various, telephone and in person), various dates

- Physical visits/tours

  Aurora police lockup, holding, booking, & interrogation (with Det. Craig Appel), 7/18/14
  Arapahoe County Sheriff's Detention Facility (ACSDF) (jail), including Holmes's cell and current contents, "BC" cell ("hole) (with Watch Commander Wilson), 7/18/14
  Century 16 Cinema (exterior only) 7/18/24
  Colorado Mental Health Institute, Pueblo (CMHIP), 7/30 – 8/1/14

- Reviews of relevant professional literature (lists and available data will be produced)

- Various references (e.g., *DSM-5*) and Internet searches (e.g., re: diagnoses, mydriasis, Diablo III and Skyrim video games, "warrior mentality," Vortex Red Dot sights, other merchandise the defendant purchased) (Saved materials will be produced.)

- Limited informal experience in aiming and shooting visibility (e.g., through a short-range telescopic sight reticle on an AR-15 rifle while wearing a gas mask)

- My background, training, and experience in medicine, psychiatry, and forensic psychiatry

QUALIFICATIONS

I am a psychiatrist with training and experience in general psychiatry and forensic psychiatry. My practice has included retention by defense, prosecution, and courts in criminal matters, including many involving capital murder allegations. I am certified in general and forensic psychiatry by the American Board of Psychiatry and Neurology. My qualifications are further outlined in the *curriculum vitae* provided with this report.

* * *

Thank you for the opportunity to comment.

William H. Reid, M.D., M.P.H.

Clinical Professor of Psychiatry
Texas Tech University Health Science Center

Adjunct Professor of Psychiatry
University of Texas Health Science Center, San Antonio
and
Texas A&M College of Medicine

WHR/br

Attachments: Appendices 1-4
cc: (with DVD enclosures previously supplied, via the office of Alicia, Calderon, First Assistant Attorney General)
Defense Counsel
Arapahoe County District Attorney
encl.: Complete video record (DVD) of James Holmes's psychiatric examinations by Dr. Reid
Curriculum vitae

Appendix 1: Dr. Gray's August 12, 2014, Report of Psychological Testing

(Attached)

Appendix 1: Dr. Gray's August 12, 2014, Report of Psychological Testing

(Attached)

PSYCHOLOGICAL EVALUATION

Patient Name: James Eagan Holmes HIMS No.: 100936
Dates of Testing: 07/31/2014 – 08/01/2014
Date of Report: 08/12/2014

Identifying Information and Reason for Referral:
James Eagan Holmes is a 26 year old White male who was transferred to CMHIP for a sanity examination pertaining to multiple felony charges of Murder 1 and Attempted Murder 1 in Arapahoe County. He was referred for evaluation by William H. Reid, M.D., the psychiatrist conducting the sanity examination, to clarify Mr. Holmes' psychological status.

Sources of Information:
Mr. Holmes was seen for approximately 1 hour 25 minutes on 07/31/2014, during which time his personal history was reviewed, and the Montreal Cognitive Assessment (MoCA) and the Minnesota Multiphasic Personality Inventory – 2nd edition (MMPI-2) were administered. He was seen again for approximately 1 hour and 15 minutes on 08/01/2014, at which time the Structured Interview of Reported Symptoms – 2nd edition (SIRS-2) was administered, and he completed the Personality Assessment Inventory (PAI).

I consulted with Dr. Reid, and with ward staff familiar with Mr. Holmes; I also spoke briefly with Richard Pounds, M.D., the attending psychiatrist. I reviewed numerous additional documents, including:

- Records from Family Service Agency of the Monterey Peninsula, dated 01/19/1996 to 04/26/1996
- Limited records from PsyCare pertaining to therapy session in 2001 and 2002
- Records from Action Care Ambulance Inc., dated 11/13/2012 and 11/15/2012
- Mr. Holmes' Journal (also referred to as "The Notebook")
- Medical and mental health records from Arapahoe County Detention Facility, dated July 2012 through May 2013
- Medical records from Denver Health pertaining to events in November of 2012
- Medical and mental health records from University of Colorado Student Health Service, dated March through June 2012
- Transcript of Preliminary Hearing, 01/07/2013 – 01/09/2013
- Neuropsychological Evaluation authored by Robert Hanlon, Ph.D., ABPP, dated 06/08/2013
- Neuropsychiatric Evaluation Report authored by Raquel E. Gur, M.D., Ph.D., dated 06/17/2013
- Sanity Examination authored by Jeffrey Metzner, M.D., dated 09/03/2013
- Psychological and Neuropsychological Examination authored by B. Thomas Gray, Ph.D., ABPP, and Rose Manguso, Ph.D., ABPP, dated 08/26/2013

Notification of Purpose:
At the beginning of our first meeting, on 07/31/2014, Mr. Holmes was informed:

- of the nature and purpose of the evaluation;
- of the absence of a therapeutic relationship;
- of the absence of confidentiality;
- that a written report would be submitted to Dr. Metzner and would become part of his medical record; and further that the report would likely be obtained by his attorney and the District Attorney prosecuting his case; and,
- that I might be called to testify, and that data gathered could be considered at any point in the proceedings against him, including the penalty phase if he is found guilty.

This information was repeated at the beginning of our subsequent meeting. He stated he understood what he had been told, and each time he agreed to continue with the evaluation.

Background:
Mr. Holmes' personal history has been presented in detail by others. The information contained in the report by Dr. Manguso and me in August of last year was reviewed with Mr. Holmes at the beginning of our session on 07/31/2014, and he stated that he believed it was accurate. The interested reader is referred to the report by Dr. Metzner for a more thorough accounting of Mr. Holmes' past.

Mental Status:
James Holmes is a well-nourished White male of average stature who appeared his stated age of 26 years. He was attired for each session in a dark-green institutional-issue jumpsuit with a white t-shirt beneath the top. Grooming and hygiene were good. His appearance was distinctive for a full beard and moustache that were more carefully maintained than when he and I had met approximately a year earlier, and his hair was shorter. He wore contact lenses during all meetings. Gait, posture, and other psychomotor activity were within normal limits. He used his right hand for all drawing and writing tasks. His verbal output remained rather limited, and as he had before, he offered little in the way of spontaneous statements. Speech was normal for pace, tone, and volume. He was fluent and articulate, and could be readily understood, with no behavioral indicia of expressive or receptive language deficits.

Mr. Holmes' affect was somewhat brighter than when Dr. Manguso and I had seen him before, although he remained rather distant and reserved. He was polite and cooperative, willingly responding to all questions asked of him and undertaking testing tasks without complaint. He described his mood as "relatively stable," and attributed his apparent improvement, however modest, to the effects of medication. He indicated that he has continued to sleep "a lot," up to 16 hours a day, and that his appetite is "considerable." He denied experiencing symptoms of depression of late. Mr. Holmes also initially denied any current thoughts of killing himself, but during our last meeting he acknowledged recurrent thoughts of self-harm. He was terse in denying currently having symptoms of psychosis, including hallucinations (auditory, visual, olfactory, or tactile) or maintaining odd beliefs consistent with

common delusional themes (e.g., mind reading, thought broadcasting, thought insertion, referential thinking).

Mr. Holmes was alert and was well oriented: He knew who and where he was, he knew the date and day of the week, and he understood his current situation. His performance on the MoCA was well within the unimpaired range. Insight was intact; he reported he was taking risperidone for psychotic symptoms and escitalopram for depression, and that these medications were helping him by "keeping me like sedated." When asked directly, he indicated that if he were not sedated, "I'd have a lot of pent-up energy."

Psychological Test Results:

As noted above, Mr. Holmes' performance on the MoCA [redacted] was in the unimpaired range. The only point he missed was on [redacted] where he was able to [redacted] that had been presented to him. There was thus [redacted]

Because of questions/concerns that were raised about the previous evaluation that was done at CMHIP, the SIRS-2 was administered. Application of [redacted] or [redacted] yielded no data giving concern that [redacted] This was consistent with previous findings and with his clinical presentation both in 2013 and 2014, when he effectively denied experiencing significant symptoms of serious mental illness.

Mr. Holmes [redacted] for the MMPI-2 and the PAI that were [redacted] with his overall patterns of responding being very similar to those obtained approximately a year ago. There remained a [redacted] on the PAI, but the [redacted] and did not preclude meaningful interpretation. His scores on [redacted] on the MMPI-2 [redacted] and was thought to reflect honest responding to questions regarding [redacted] there was no indication of [redacted].

His MMPI-2 and PAI profiles both showed notable indications of ongoing psychological disturbance. The MMPI-2 [redacted], although his PAI [redacted]. It is interesting that his score on scales [redacted] from last year to the present assessment on the MMPI-2, [redacted] PAI. The other notable difference was a [redacted] as reflected on the PAI [redacted].

Despite these differences, the overall interpretation of Mr. Holmes' test data remains largely unchanged, as [redacted] on each test were the same between the 2013

[1] MMPI-2 and PAI [redacted]

assessment and the one reported here. Depressive symptoms continue to play a prominent role in his presentation, with difficulty concentrating and substantial feelings of hopelessness, low energy, and self-doubt. Avoidance of social interaction and close interpersonal relationships is common in persons with similar profiles, as is frequent suicidal thinking and behavior, and a proclivity to episodes of psychosis.

Discussion:

James Eagan Holmes is a 26 year old White male who was remanded to CMHIP for evaluation of his sanity on multiple serious felony charges in Arapahoe County. He was referred for psychological and neuropsychological evaluation by William Reid, M.D., the psychiatrist who is completing the sanity examination. It is important to note that he has now been maintained on antipsychotic and antidepressant medication for well over a year, and this has quite likely had an important impact on the nature of his responses to test stimuli.

Neuropsychological testing has consistently revealed above-average intellectual functioning and generally normal overall neurocognitive functioning. During the evaluation conducted by Dr. Manguso and me in August 2013, the data available indicated "evidence of subtle neuropsychological dysfunction relative to expected levels for Mr. Holmes, based on his demographic norm group," although

> relative to the average individual from the general population... the large majority of his scores are within normal limits and are not reflective of any basic impairment in the ability to [redacted]

Mr. Holmes' personality testing revealed significant psychological disturbance. There continued to be indications of marked symptoms of anxiety and depression, along with a proneness to psychoticism. During our previous evaluation, Dr. Manguso and I outlined the description he provided of a progressive development of his psychiatric symptoms, beginning with a tendency to "zone out sometimes," and appearance of significant anxiety and suspiciousness of others and their motives by the time he entered high school. Feelings of paranoia continued throughout his undergraduate schooling, and somatic symptoms began to appear. He said that in graduate school his anxiety became increasingly problematic and he became increasingly depressed, with heightened paranoia.

Given the data at hand, I find no compelling evidence to change the diagnostic possibilities that were provided by Dr. Manguso and me in 2013, which included the presence of a depressive illness with psychotic symptoms. I remain uncertain as to whether these would best be categorized as independent conditions (e.g., schizophrenia together with major depression), or a mood disorder with psychotic features, or a schizoaffective illness. Regardless, the clinical picture is complicated further by considerable anxiety and by possible personality pathology. Although he reported experiencing some consequences as a result of his use of alcohol, there is insufficient information to warrant a substance use diagnosis.

It must be pointed out that Mr. Holmes has consistently reported ongoing suicidal thinking, including during the evaluation reported here. There is only one known instance of overtly suicidal behavior, that

having occurred in November 2012 while he was housed at the Arapahoe County Detention Facility. It remains quite possible that thoughts of killing himself will increase as the stresses of the adjudicative process and potential lengthy incarceration accrue. It is strongly recommended that he be routinely monitored for such ideation, and that appropriate preventive steps be taken.

Thank you for the opportunity to participate in the evaluation of this interesting man. Please contact me at (719) 546-4087 if you have any questions or if I can be of further assistance.

B. Thomas Gray, PhD, ABPP
Training Director, Court Services Department
CMHIP
Board Certified in Forensic Psychology
American Board of Professional Psychology

[redacted]
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DIPLOMATE IN FORENSIC PSYCHOLOGY

LICENSED PSYCHOLOGIST
TEXAS #24820

October 7, 2014

William H. Reid, M.D., M.P.H.
P.O. Box 4015
Horseshoe Bay, TX 78657

Re: Independent Interpretation of Multiscale Inventories for JEH

Dear Dr. Reid:

It is my understanding is that you would like for me to provide you with an independent review and interpretation of two multiscale inventories, the Minnesota Multiphasic Inventory-2nd edition (MMPI-2) and the Personality Assessment Inventory (PAI). The dates of the administrations are summarized:

- PAI: 8-12-2013 and 8-1-2014
- MMPI-2: 8-12-2013 and 7-31-2014

As noted subsequently, I reviewed the results of the Structured Interview of Reported Symptoms-2[1] (SIRS-2) as it relates to [redacted]. I also briefly read the summary that you provided me prior to my interpretations. I noted that you were concerned that over-interpretations may have occurred with another psychologist. Of course, I will not be addressing that issue since I am unaware of his interpretations. Finally, you requested a summary of findings, but not an extensive report. Before presenting my interpretations, four key points affecting interpretations of multiscale inventories are outlined.

Key Points

Multiscale inventories are effective psychological tests for identifying response styles, such as [redacted], and providing some [redacted]. Nonetheless, the following key points must be considered with their interpretations:

1. The MMPI-2 and PAI [redacted] have [redacted] Despite the similarities, it is critically important to recognize that these scales [redacted] Patients often have [redacted].
2. MMPI-2 and PAI [redacted] do not provide [redacted] At best, certain [redacted].[2] As an

[1] The undersigned is its principal author (i.e., Rogers, Sewell, & Gillard, 2010).
[2] Rogers and Shuman (2005) in *Fundamentals of forensic practice: Mental health and criminal law* referred to these as [redacted]

important consideration, these [redacted]. For example, many persons with [redacted] will have [redacted] but they are typically outnumbered by persons with other diagnoses, who are [redacted] [3]

3. The primary interpretation of [redacted] involves what are described as [redacted] These [redacted]; however, [redacted]. The [redacted] Therefore, psychologists need to be careful not to overstate their certainty about the [redacted].
4. Interpretations are based on the presence of [redacted] and [redacted]. In other words, [redacted]. As a clear example from the MMPI-2, [redacted] although [redacted] [4]

PAI Interpretation

Both the 2013 and 2014 PAI administrations include the [redacted]. In my professional experience, these [redacted]. To be [redacted], [redacted] PAI Professional Manual.[5] For the PAI, [redacted] Each interpretation summary will begin with a paragraph about response styles based on validity scales.

PAI 2013

JEH completed the entire PAI without omitting any items. He clearly attended to the content of the items and did not endorse items [redacted] There was [redacted]; however, his score would be interpreted as [redacted] [6] No evidence of [redacted]. His [redacted]. The [redacted].

To my knowledge, the PAI [redacted] A search of the American Psychological Association's PsychInfo, the

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[3] On occasion, psychologists may make a statement that [redacted]. Although unintentional, such statements may be misleading to those untrained in psychological testing. In most instances, the [redacted]

[4] See, for example, Greene (2011), *The MMPI-2/MMPI-2-RF Interpretive Manual* (3rd ed.).

[5] Morey (2007) *Personality Assessment Inventory (PAI) Professional Manual.*

[6] Morey (2007), [redacted]

[7] Morey (2007); also Rogers, R., Gillard, N. D., Wooley, C. N., & Ross, C. A. (2012). [redacted].

main search engine for psychologists, [redacted] As a result, I do not provide any interpretation or comments with respect to [redacted]

In my estimation, the [redacted] provide the [redacted] As noted, [redacted]

1. [redacted]
    a. Significant depressive experience
    b. Likely has hopelessness and personal failure
    c. Feelings of sadness, lost of interest in normal activities, and a loss of sense of pleasure in things that were previously enjoyed
    d. The symptom picture appears to be relatively free from of changes in energy, appetite, and sleep patterns
2. [redacted]
    a. Experiencing specific fears or anxiety surrounding some situation
    b. Fairly rigid individual
    c. Likely experienced a disturbing traumatic event in the past—an event that continues to distress him and produce recurrent episodes of anxiety
3. [redacted]
    a. Concern about physical functioning and probable impairment arising from somatic symptoms
    b. Feels his health is not as good as that of his age peers and likely believes his health problems are complex and difficult to treat successfully
    c. His interactions and conversations tend to focus on his health problems
4. [redacted]
    a. Peculiarities in thinking
    b. His social isolation and detachment may serve to decrease a sense of discomfort that interpersonal contact fosters.
5. [redacted]
    a. Suicidal thought at a level typical of individuals placed on suicidal precautions. The potential for suicide should be evaluated immediately and appropriate interventions should be implemented without delay.
6. [redacted]
    a. His responses suggest an acknowledgement of important problems and the perception of a need for help in dealing with these problems.

PAI 2014

Similar to 2013, JEH did not omit items and [redacted]. His [redacted] falls in the [redacted]. As before, his [redacted] are consistently in the range found with [redacted]. The [redacted] cautions about [redacted]

[8] Psychologists are ethically responsible for their interpretations, which is difficult when [redacted]

[redacted] which is apparently based on [redacted]. Although consistent with the test manual, this score is better categorized as [redacted] Also the [redacted] fell in the [redacted], further [redacted].

The 2014 PAI profile, while similar to the 2013, [redacted] First, [redacted] Second, [redacted] though still [redacted]. Finally, [redacted]

The stable interpretations remain the same for the following: [redacted], and [redacted] Interpretation of the [redacted] changes to the following: [redacted]

MMPI-2 Interpretation

Unlike the PAI, the MMPI-2 interpretations can be examined via multiple interpretative systems. The psychologist utilized the [redacted]. It is widely used and is published by Pearson, which also publishes the MMPI-2. My own preference is [redacted], which [redacted] and relies closely [redacted]. [redacted] recent text[10] will be [redacted]. As with the PAI, I focused primarily on [redacted].[11] For the MMPI-2, [redacted] are considered [redacted].

MMPI-2 2013

JEH completed the MMPI-2 consistently without any omissions. Interpretations are [redacted].

1. [redacted].[12]
2. [redacted]
   a. [redacted]
      i. General sadness and depressed mood
      ii. Evaluate for suicidal behavior
      iii. Negative view of the world
      iv. Withdraws and avoids social interaction

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[9] [redacted]

[10] Greene (2011).

[11] In contrast, [redacted].

[12] Greene (2011); see also Rogers, R., Sewell, K. W., Martin, M. A., & Vitacco, M. J. (2003). [redacted]

b. [redacted]
   i. Depressed, feels hopeless, feels life is a strain
   ii. Anxious
   iii. Pessimistic
   iv. Sleep disturbance

c. [redacted]
   i. Depressed
   ii. Worthless and inadequate
   iii. At times, he may feel desperate
   iv. Seem to have difficulty concentrating
   v. Should be assessed for suicide [redacted]

3. [redacted]

a. [redacted]
   i. [redacted][15]
   ii. Alienated and remote from his environment

b. [redacted]
   i. Depressed
   ii. Feels hopeless

c. [redacted]
   i. Mistrust of others
   ii. Unusual thoughts

4. [redacted]

a. [redacted]
   i. Introverted, shy, and socially insecure
   ii. Withdraws from and avoids significant others
   iii. Likelihood of acting out is low, and the likelihood of ruminative behavior is high.

b. [redacted]

c. [redacted]
   i. Vulnerable to being hurt by others
   ii. Very insecure in close relationships
   iii. Introverted
   iv. Somewhat rigid and over-controlled in social situations
   v. Reclusive behavior and a tendency toward interpersonal avoidance

---

[13] The [redacted] For comparisons, [redacted]. As noted, this analysis focuses mostly [redacted].

[14] Described by Greene (2011) [redacted]

[15] [redacted].

MMPI-2 2014

This outline generally parallels 2013 MMPI-2 summary, noting similarities and differences.

1. [redacted]
   a. [redacted]
      i. While the MMPI-2 [redacted], it may reflect some [redacted].
      ii. Rogers comment: [redacted].
   b. [redacted]
      i. [redacted] He is acknowledging [redacted] more than the typical person. The [redacted] reflects the extent and severity of his psychopathology and how he has adjusted to his psychopathology
      ii. [redacted]: He either is experiencing and reporting a significant level of emotional distress or is making a self-unfavorable reporting of the severity and extent of his psychopathology.
      iii. Rogers comment [redacted].
      iv. Rogers comment [redacted].
2. [redacted]
   a. [redacted] and [redacted]
      i. Same interpretation as 2013
   b. [redacted]
      i. Depressed
      ii. Helpless and alone, inadequate
      iii. Hopeless
      iv. May have seriously contemplated suicide ([redacted])
3. [redacted]
   a. [redacted]
      i. likely to be suspicious, hostile, and overly sensitive, and he will likely overtly verbalize these qualities
   b. [redacted]
   c. [redacted]
      i. See the world as a threatening place [redacted])
      ii. Unjustly blamed for others' problems [redacted])
4. [redacted]
   a. [redacted]

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[16] Described by [redacted] as "[redacted]"

[17] Described by [redacted] as "[redacted]"

i. Worried, tense, and indecisive
ii. Agitation may develop, and overt anxiety

b. [redacted]
i. Depressed
ii. Anxious

c. [redacted]
i. Overwhelmed with anxiety and tension
ii. Attempts to control his worries
iii. Insecure
iv. Elevated stress level

5. [redacted]
a. [redacted] and [redacted]
i. Same interpretation as 2013

b. [redacted]
i. May be preoccupied with obscure religious ideas
ii. Extreme and bizarre thoughts, suggesting the presence of delusions and/or hallucinations ([redacted]
iii. Mystical powers [redacted])

6. [redacted]
a. [redacted] and [redacted]
i. Same interpretation as 2013

b. [redacted]
i. Similar to the 2013 report, but described as "very introverted" and having "problem-filled relationships"

Conclusions

The clinical findings, outlined above, can be utilized for cross-sectional (2013 or 2014) and longitudinal (across both times) perspectives. Focusing on a single time, greater weight can be given to those [redacted] that are consistent across [redacted]. Looking across times on the same [redacted] provides valuable insights regarding consistencies and changes in [redacted]

Five important themes emerge from these test data. First, [redacted]—including the SIRS-2—[redacted]. Second, [redacted] depression and suicidal ideation are very prominent. Third, [redacted] are noted that frequently involve detachment and withdrawal from others with concomitant discomfort (e.g., anxiety, insecurity, or mistrust) likely to be experienced when involved in relationships. Fourth, anxiety related to a traumatic event deserves a careful evaluation. Fifth, oddities in thinking should be examined closely. On this final point, [redacted]. However, the fourth key point on page 2 must be underscored: [redacted]

As a final consideration, you raised an important question about whether the 2013 and 2014 test results could inform us regarding JEH's pre-shooting status in and before July, 2012.

Two points are worth considering. First, [redacted] the MMPI-2. In clinical populations, these [redacted] [18] Therefore, [redacted] are likely to have occurred with JEH. Second, according to your summary, JEH has experienced dramatic changes in his environment since his arrest, including continuous isolation for more than 2 years. Such pervasive environmental changes are likely to have a major impact on JEH's psychological functioning, and consequently, [redacted]. Taking these two points into account, it would be highly speculative to make any inferences about JEH's functioning prior to his arrest.

I appreciate the opportunity to consult with you on the independent interpretation of these multiscale inventories. Please let me know if I can be of further assistance.

Best regards,

Richard Rogers, Ph.D., ABPP
Diplomate, Forensic Psychology

[18] See [redacted].

Appendix 3: Chart of Interview Examples

This is a chart of some dates and approximate times during my (Reid) interviews at which the defendant referred to particular items or concept cited in this report, in the general context implied. **These are examples.** ***They are not the only references that could be cited, and may not be the most illustrative; not every reference is listed herein.*** Times are in hours:minutes, measured from the beginning ot the particular session. Please refer to the interview videos (included with this report and supplied to the parties) or to my searchable "Draft Master Transcript" of those videos (not included, but available upon request) for complete examples, context, and additional occurrences of these and other statements.

Word/Phrase/Concept	Date & AM/PM	~~Time Marker	Draft Master Transcript Page
collateral damage (victims)	7/31/14 PM	02:23	273
selfish (Holmes)	8/28/14 AM/PM	00:30	592
moral relativism, individual choice	8/27/14 PM	00:29	519
people may take any moral position they wish	8/27/14 PM	00:30	519-521
moral wrongness (Holmes self-view)	8/27/14 AM	01:40	485
transfer of suicidal feelings to homicidal	7/31/14 PM	02:43	283
increased self-worth after killings	7/31/14 PM	02:12	281
minimizing risk to children	7/31/14 PM	02:26	276
dying/injury mattered to those injured	7/31/14 PM	02:24	274
aiming at victims	8/1/14 PM	01:00	401
remembering scream, jamming of weapon, etc.	8/1/14 PM	01:00	401, 405
autopilot	8/1/14 PM	00:43	387
being stopped or prevented from carrying out the mission	7/30/14 PM	02:09	127
being stopped or prevented from carrying out the mission	8/1/14 PM	00:15	375
impersonal, indifferent	7/31/14 PM	00:30	220
victims' feelings about dying, relevance to mission, pre-shooting	8/27/14 AM	01:06-9	472-473
wrong to kill children	8/28/14 AM/PM	00:18	587
"points" for killing children	8/28/14 AM/PM	00:19	587
avoiding killing children	8/28/14 AM/PM	03:07	653
direct targeting, "I can't have everybody running away. "	8/1/14 PM	00:20	388
shooting at those trying to escape	8/1/14 PM	01:00	400-401
trash-emptying employee, prepared to shoot him/her	8/1/14 PM	00:16	378-379
depression, pre-shootings, severe, evidence or lack thereof	7/31/14 AM	01:17 >>	167 >>
suicidal thoughts, pre-shootings, tautology of assumption	7/31/14 PM	00:18	213
mania, evidence or lack thereof	8/1/14 PM	02:00	431
transfer suicidal thoughts to homicidal thoughts	7/31/14 AM	01:17	167
"mono," infectious mononucleosis	7/30/14 PM	01:28	107
human capital, value, "arbitrary"	7/31/14 PM	02:38	280
human capital, value, "incremental"	7/31/14 PM	02:41	282
human capital, first thoughts	8/27/14 PM	00:26	517
earliest thoughts of killing people	7/31/14 PM	01:23	244-245
"frozen," thoughts or images when "frozen"	7/30/14 PM	01:18	101
"flying saws," limbs images, pre-shooting	7/30/14 PM	01:18	101
"shadows"	8/1/14 AM	00:32 >>	303-310 >>
earliest thoughts that he was mentally ill, "broken brain"	7/30/14 PM	01:48	118-119

Nietzsche, *Highlander*, etc.	7/31/14 PM	00:26	218-220
paranoia about being watched, lack of, pre-shooting	8/27/14 PM	00:55	532
paranoia about being under surveillance, pre-shooting	7/30/13 PM	02:09	126-127
FBI/police surveilling, pre-shooting, as possibly delusional	8/1/14 AM	00:25	298
paranoia/suspiciousness, pre-shooting (Fenton/Feinstein visits)	8/27/14 PM	02:30	575
getting "locked up" pre-shooting	8/28/14 AM/PM	00:26	590-591
hating mankind, pre-shooting (not a motivator)	7/30/14 PM	01:45	116
hating mankind as a motivator for the shootings ("10%")	8/27/14 PM	02:38	577
different selves, personalities	8/27/14 PM	00:50	527-528
ideas/delusions of reference, pre-shooting & post-shooting	8/27/14 PM	00:53	533-534
thought broadcasting, pre-shooting & post shooting	8/27/14 PM	00:53	533-534
belief (himself) that he was/is delusional	8/27/14 PM	00:51	529-530
expectation of being caught, killed, imprisoned, executed	8/1/14 AM	01:59	344
friends' feelings about him post-shooting	7/31/14 AM	02:20	200-201
sister's feelings about him post-shooting	7/31/14 AM	02:18	198
"supportive" cards & letters post-shooting	8/1/14 AM	00:55	314-315
"warrior" self-image, absence of (cf. "warrior mentality")	8/1/14/AM	02:00	345-346
"selfie" photos, meanings, being remembered	8/1/14 PM	01:15	408
defensive weapons/intent, pre-shooting	8/28/14 AM/PM	02:02	629
"nuclear winter," childhood image pre-shooting	7/30/14 PM	01:18	101
examiner pre-interview notifications, defendant acceptance	7/30/14 AM	00:01	1-2
pupil size, pulse during interviews	7/31/14 AM	00:02	133

APPENDIX 4: Mental Status Findings as of July, 2014, and August, 2014

The following is a brief summary of a standard psychiatric "mental status examination" for Mr. Holmes, as compiled from my nine interviews during July and August, 2014. The complete interviews are provided in the accompanying video DVDs.

NOTE: These interviews occurred over two years after the events in which he is charged. Although the findings may be discussed in forensic and clinical contexts, they *should not* be assumed to reflect the defendant's condition during or before the shootings.

Situation: The Court ordered an evaluation related to questions of sanity, criminal responsibility, and diagnosis and prognosis. The defendant had been incarcerated for over two years, all in strict isolation, awaiting trial on multiple counts of murder and attempted murder. He had been taking low doses of risperidone and moderate doses of escitalopram for about 20 months.[1] His condition during the past several months was generally described by jail observers as stable.

Locations & Interview Conditions: Six sessions took place in a CMHIP day room, then three in a jail classroom a few weeks later. They were private contact visits with security very closely available, without leg shackles at CMHIP but with them at the jail. They were recorded using an obvious video camera and microphones. Juice or water was provided; breaks were available.

Dates & Times: July 30, 31 and August 1, 2014 (CMHIP); August 27 and 28, 2014 (jail). Morning and afternoon sessions at both sites, generally 2-3 hours each.

Disclaimers/Caveats: The defendant was provided with written information about my name and position, my role in the case, and other information and disclaimers about lack of confidentiality, potential recipients and uses of the interview results, the fact of the video-recording, etc. He appears to have no difficulty understanding and remembering all of the information provided.

Presentation/Understanding/Cooperativeness: The defendant arrived and participated willingly, generally interacting actively, even enthusiastically, during the interviews. He had very good knowledge and understanding of his current situation and of the interview purpose and process. He was cooperative throughout, and appeared to make reasonable efforts to participate.

Appearance and Demeanor: Mr. Holmes is a Caucasian, English-speaking man of medium build who appeared about his age (mid-20s) and had a moderately-trimmed, dark beard and moustache. He was fairly neatly dressed and kempt in institutional garb, sometimes freshly showered, often with tousled hair. He was slightly overweight for his height, but not obese. His eyes were generally widely-opened, almost (but not quite) "buggy." His pupils were always somewhat enlarged and usually markedly dilated. He had good eye contact and attended well to the examiner, although often with an unusual affect (see below). There were no visible tattoos, piercings or other marks or stigmata. His other physical features, as viewed without close examination, appeared normal.

His demeanor was polite and respectful, friendly to a point, and not particularly aloof. Physical interchanges (such as shaking hands, greetings while approaching the interview area

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[1] He may also have been taking benztropine (Cogentin®), sometimes prescribed for certain medication side effects (perhaps stiffness or tremor).

were a little stiff and slow but otherwise unremarkable. Verbal interactions were often slowed to varying degrees, with some pauses before responding and often limited responses (see below). Some of his stiffness and slow responses may or may not have been related to his medications; he exhibited no other apparent medication effects that might have interfered with the interviews.

The defendant showed a variety of affects and demeanors, but their range and intensity were somewhat restricted (see below).

When observed in the secure hospital "yard" (being followed by several staff for security), he appeared to have a slightly stiff gait and carriage but otherwise walked normally.

Posture/Tolerance: The defendant appeared to sit comfortably during all interviews, sometimes a little stiffly but not rigidly, with an open posture. He tolerated the interviews well. He did not ask for breaks, sat throughout all sessions, and did not fidget or shift unusually in his chair.

Movements: Except for the slight slowness and stiffness described above, no unusual movements were observed. He did not appear to have Parkinsonian or tardive stigmata symptoms. (I did not do a complete "AIMS" test.)

Affect: The defendant's facial expressions and other indicators of affect showed some variety and range (e.g., smiling appropriately for the most part, although sometimes nervously; chuckling at small jokes; being serious with serious topics), but were consistently restricted or blunted (no tearing of his eyes, expressions of significant anger, or deep laughs).[2] He never appeared truly "flat," and did not exhibit bizarre affects. He never showed very *much* emotion, even when prodded a bit. Except for limited intensity of, for example, sadness or loss (e.g., on topics of depression, separation from family, loss of his future, possible imprisonment or execution), his affect was generally consistent with the topics discussed.

Although the *form* of his affect often appeared consistent with his (somewhat bland-appearing) moods, there was considerable evidence that his affectual intensity was blunted, and sometimes isolated from the mood that an observer would expect. For example, when he spoke of loss, depression, or suicidal thoughts, his face did not show particular sadness, tears, pain or angst, and his posture remained unremarkable. Similarly, his pupil size and heart rate sometimes suggested autonomic signs of anxiety even though he did not outwardly appear anxious.

His limitation of outward emotion did not come across as characterologically antisocial or "cold," but as an impairment or *deficit*.

Mood: The defendant described feeling depressed, and even suicidal, at times, but did not appear outwardly depressed or anxious in any of the interviews (see Affect, above). Consistently bland, he never exhibited other moods very much (such as anger), either.

Interestingly, Mr. Holmes didn't express particular pleasure at being in CMHIP for several days during the earlier interviews (where, in spite of similar security and similar isolation from other patients/inmates, he had much more comfortable living conditions, interacted much more often with interested [often female] staff, had more access to videos and games [often with nursing staff], and had a much nicer exercise yard). He said he liked the CMHIP food better, but that overall he preferred the greater isolation and separation from staff found at the jail.

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[2] Some CMHIP nursing staff said that during his mid-2013 and 2014 stays there he enjoyed, and spontaneously initiated, conversation and games with familiar staff (some of whom he remembered from a year earlier). His smiles were odd ("smirk," "kinda creepy"). Some said he became much more reserved when he saw "deputies."

Although played down during his interviews, the defendant's July, 2014, psychological testing raised substantial concerns about suicide risk. Those concerns are conveyed in the attached Report, with important clinical recommendations.

Speech/Communication: The defendant often – but not always – had noticeable delays in speech or responses to questions. Once he began responses, his rate and volume were generally normal (perhaps a little soft), but his comments and answers were usually short (but not terse), and when I waited for expected additional comments they were either much delayed or absent. This appeared not to be an issue of speech difficulty, but of the process of formulating responses and/or choosing words (that is, thought blocking and/or guardedness). Inflection was present but sometimes blunted. Complexity and completeness of descriptions (e.g., of activities, relationships, feelings, or events) was routinely lacking, and usually required considerable encouragement (sometimes successful and sometimes not). There was no problem with vocabulary, sophistication, nuanced humor, or idiom except when psychological factors (e.g., thought blocking) seemed to intervene.

Thought Process (largely inferred from speech): There were indications of defensive thought blocking, some of which may have reflected conscious guardedness. There was limited indication of mild paranoia. There was no significant looseness of associations, otherwise disorganized speech, or other indication of frank or florid psychosis. (Although appearing mild, the extent of any paranoia could not be estimated from these interviews, except to say that it was not so severe as to cause looseness of associations or other obvious signs of acute psychosis.)

Thought Content: There was clear evidence of odd thoughts, some of which may reflect delusions (e.g., concerning the "human capital" "points" that he said he has accrued). There was no description of, or evidence for, hallucinations occurring during the interviews themselves. He denied indications of current ideas of reference,[3] thought broadcasting, thought insertion, thought control, or the like. Suicidal ideation and risk are addressed above. When asked if he believed that additional killings would add to his "value" (cf. "human capital"), the defendant implied that he might kill others if allowed to do so.

Some of the defendant's thoughts about his current situation included considering whether he would prefer a life sentence or execution. He assumes that he would be isolated from other inmates in prison, but believes (perhaps rightly) that if he were among other inmates, they would try to kill him. That, and thoughts that his life is "over" anyway, he said, make him think that execution may be his preferred sentence.

Negative Symptoms: The defendant's blunted affect, limited spontaneity of speech, difficulty experiencing pleasure and forming emotional attachments, etc., are consistent with "negative symptoms" (i.e., of a schizophreniform diagnosis), but also with other conditions.[4]

Insight/Reality Testing: Superficial reality testing appears intact; general understanding of his environment and situation appeared normal or near-normal. More complex functions may have been impaired during the interviews (e.g., as reflected in subtly delusional thinking).

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[3] He believes, reasonably, that other inmates sometimes talk about him; he is not allowed contact with, or even to see, other inmates. His cell window is covered when other inmates are nearby.

[4] Diagnostic interpretations are outside the purview of this descriptive Appendix. See the attached Report.

Judgment: Superficial judgment appeared intact. Judgment with regard to the reality of subtle, potentially delusional material may have been impaired. His judgment with regard to current homicidal thoughts (and sharing them with me) appears impaired. His judgment with regard to suicidal thoughts or impulses may or may not be impaired, depending upon whether those thoughts are predicated on realistic "life is over" fears and assumptions.

Cognition/Concentration: The defendant's verbal expression speed in the interviews was impaired, but apparently not his processing speed. He may misperceive some cues, but appeared to understand and reason well during our interviews. He had flaws in some aspects of his thinking (e.g., limited ability to consider alternatives to odd or potentially delusional thoughts). There was no apparent memory deficit. He was able to focus and concentrate well on most of the topics addressed in the sessions, and carry them forward to later sessions, but appeared to avoid – and perhaps have difficulty concentrating on – some sensitive subjects (e.g., his family, some things related to the shootings). There was no indication of delirium or dementia.

Impulse Control (during interview): He appeared able to control various mental and physical impulses during our interviews (sometimes overly controlling his verbal responses). The extent to which some of those controls were aided by external factors (e.g., nearby clinical and security support) is unclear.

Orientation: The defendant was fully oriented to person, place, time, and situation.

Memory (reflex, recent, remote): Although not specifically tested, his comments and responses during the interviews appeared to reflect good short- and long-term memory, with no indication of memory deficit. Reflex memory was not tested.

General Knowledge/Intellect: His general knowledge was very good, in spite of apparently limited exposure to current events. His intelligence and general ability to think both concretely and abstractly are excellent, so long as the subjects are not encroached upon by psychologically sensitive or potentially delusional material.

Lability/Stability: There was no indication of emotional lability (wide, rapid swings of emotion without apparent reason).

Limited Physical Examination: Pupil size and reaction to light and accommodation were tested at various times, and his pulse taken periodically. As already mentioned, his pupils were uniformly enlarged, and often markedly dilated. The dilated pupils reacted to both bright light (but did not constrict completely) and accommodation. He denied experiencing unusual brightness subjectively, or blurred vision, even when his pupils were dilated, saying that he doesn't know when they are dilated without looking into a mirror. His pulse was somewhat elevated (about 110 bpm) when his pupils were very dilated, even after sitting quietly for some time. When the pupils were only slightly enlarged, his pulse tended to be about 72-80 bpm.