Kip Kinkel's Trial: Testimony of Mental Health Professionals

Testimony of Dr. Orin Bolstad (psychologist)

Did he reveal hallucinations he had experienced to you?

A. He did.

Can you describe those or summarize them, and try and describe them in as verbatim a way as he described them to you as you can. So if you need to read from your report, please do.

A. I think I have probably somewhere around nine pages of verbatims from his delusions -- from his hallucinations. I'm not going to read all of that to this court, but I will review the highlights.

If I can stop you for a second, I do want to know when he disclosed to you that he first started experiencing hallucinations and how they initially emerged, and then perhaps you can walk us through the genesis of them.

A. The first day I met with him was February the 1st, and on the very first part of the first day he acknowledged that he heard voices, and he did that on the Child Behavior Checklist. And when I looked at the scores on that result, I noticed that he checked the item that he hears voices.

And when I asked him, does he hear voices, he indicated that he did, but he also told me he didn't want to talk about it. And he told me the reason why he didn't want to talk about it was a fear that if he started talking about it, the voices would come back, and that was something he was intent on trying to avoid.

When did he say he first started experiencing voices?

A. He indicated to me that he first started hearing voices when he was twelve years of age.

And how did that first occur?

A. He told me he remembered the first time he heard voices, he got off a school bus. "I was on my driveway, looking at some bushes, and a voice said, 'You need to kill everyone, everyone in the world.'" He stated to me, "It scared the shit out of me. I was confused. It seemed like something was seriously wrong. I ran into the house and cried in my room. It said other things too. It said, 'You are a stupid piece of shit. You aren't worth anything,' and some jumbled words that I can't understand. I was just standing there, looking at the bushes."

I asked him at that point, "Where do you think the voices came from?" He said "Well, I had some theories. I was an atheist or an agnostic, I'm not sure. Maybe it was from the devil. I also thought that the government might have put a chip in my head. Government satellites might have transmitted to the chip in my head. At first I thought the voices were outside of my head because they were so loud. They were very loud, like Surround Sound."

And then he proceeded to tell me about the different types of voices that he hears. He said, "I often hear two voices at the same time, sometimes a third voice. I know they are different. They sound different. The doctor gave them labels A, B, and C" -- and the doctor referred to here was Dr. Pincus. "One voice always tells me what to do. It's an authoritarian. Loud. The doctor gave that voice a title A. The B voice tells me I'm a piece of shit, I'm like that, a put-down kind of voice."

He said this started in the fall or the winter of the sixth grade, all three of the voices. He said that A is loud, but B is louder. C just repeats what the others say over and over and over again. "They scared the shit out of me. I get pissed. I get angry, hearing these voices. I was very pissed at God, if I believed in him. What is

this? Why do I have these voices?"

Did you discuss with him whether he ever revealed to anyone what he was experiencing?

A. He indicated to me that prior to May 20th-21st, he had never talked with anyone about the voices.

Did you ask him why?

A. He told me he didn't -- he was afraid of the voices. He was afraid that that meant he was mentally ill. He didn't want anyone to think of him as mentally ill. He added he particularly didn't want girls to think that he was mentally ill, because had become interested in girls. He said that there were times that he came close to telling his mother about the voices, and that he wanted to, but that he was afraid to.

He said one time his mother told him that she heard ringing in her ears, and he thought that might mean that she was hearing voices too. And he said, "I came very close to telling her at that point." But he also indicated he was afraid of telling her about things like this because she would get so upset and that she might pull her hair out. So he was reluctant to let anyone know about these voices, and he told me he made it a rule never to tell anyone.

In your experience, are juveniles of this age typically guarded, whether they're mentally ill or not?

A. Oh, very much so.

And did it surprise you that he never revealed the voices to anyone?

A. No.

Do juveniles of this age generally have a fear of being labeled with mental illness as well?

A. Oh, yes.

Did he describe when the voices next occurred?

A. Yes. He told me that the second time he heard the voices was in the sixth grade also. It was December. His family had been to Eagle Crest for the weekend. When they got home from their weekend, there was a referral in the mail from school for some misbehavior. He didn't think he was going to be getting a referral; he thought it had been settled. And he told me that if he would have known he would have gotten a referral, he would have intercepted it.

He said, "When my parents saw the referral, they went off, they really got angry, they were yelling at me." He said, "I went to my room, and the voices came after me, saying the same thing, 'Stupid shit, you can't do anything right.'"

He cried in his room for quite some time. His parents were on the other side of the door, yelling at him. He said the voice was yelling at him too. Later on he got on his bike and he rode down to the river, and he said he was bawling. He tried to ride away from the voice, but he couldn't get away from them. They kept on telling him, over and over again, he was a stupid piece of shit. He said they talked to each other about him, about how stupid he was. And that was the second time he heard voices.

Are auditory hallucinations characteristic of particular mental illnesses?

A. Yes.

Which ones?

A. Well, it's psychotic thinking. It's most commonly associated with schizophrenics, but you also see

hallucinations with some other disorders. You'll see hallucinations sometimes with manic phase for bipolar. You'll see hallucinations sometimes in extreme forms of depression. So it's characteristic of pretty serious mental illnesses.

Are certain auditory hallucinations so-called First Rank Symptoms?

A. Yes, there a Schneider list called First Rank Symptoms.

Where does that come from?

A. Well, from Schneider's research on hallucinations and delusions. And they have been incorporated in the Diagnostic and Statistical Manual. This is the diagnostic book that psychologists and psychiatrists use. And the Schneider list has been incorporated into the diagnosis of schizophrenia such that if people have First Rank Symptoms, that's a very positive sign of serious mental illness.

The DSM is kind of the common language that psychiatrists and psychologists talk to each other in?

A. Yes.

It's the way of understanding diagnosis from one subjective source to another?

A. Yes.

How often did he say the hallucinations recurred after that second time, and can you summarize his later experiencing of similar hallucinations?

A. He indicated to me that it varied. There were days that he heard voices many times a day. There were times that he heard them weekly. He said sometimes he only heard them once a month. It depended on how much stress he was under. It depended on how depressed he was, how angry he was. The voices were pretty persistent from the time he was twelve on, but they varied in frequency as a function of stress.

Did you discuss the relationship between what he was experiencing and what he heard on a rock and roll CD?

A. Yes. He once indicated to me that he had never told anyone about his voices, that he wondered about them a lot, he wondered what they meant. He was curious about them. He indicated to me that he had thoughts like he wondered if deaf people could hear voices, which I found to be a rather intriguing question. But he went on to tell me that the first time he had ever heard anyone mention voices was when he heard a song by Nine-Inch Nails, that described in that song the hearing of voices.

And it intrigued him, from his reading of the lyrics from this song, to know that someone else was like him, someone else heard voices. And I think because of this association, he felt a big connection with the Nine Inch Nails.

The particular verse from Nine-Inch Nails that attracted his attention goes like the following:

"Annie, hold on a bit tighter.
"I might just slip away.
"He won't give up.
"He wants me dead.
"God damn this voice inside my head."

And he indicated to me that that line, "God damn this voice inside my head," shocked him when he first heard it because it fit for him. And he said that over a period of time, he came to say this to himself a great deal. And he said that lots of times, "I would say to myself, 'God damn these voices inside my head.'"

As he described it to you, did the Nine Inch Nails precede the voices or was his connection with Nine Inch Nails the fact that he finally heard someone else who was expressing, experiencing the same things he was?

A. According to what he indicated to me, he had been hearing voices for quite some time before he ever heard the song by Nine-Inch Nails.

Did you find him to be an accurate and truthful reporter, generally?

A. I was astonished by how meticulous he was in his recollection of events. I went over my notes with him at one point, and one time I quoted Voice A when I was incorrect; it should have been Voice B in my writing. And he was very upset with me about that, and was emphatic that I got that wrong, and he wanted to make sure that I got that corrected. He didn't want himself misrepresented. He had a particular fascination with being correct about these matters.

I also made a mistake in my history-gathering in my notes. I said something about one of his professors was black, and I must have misheard that. And he was very clear with me that I got that wrong, that the professor was not black.

And when I would go over the history with him, I found that he was very meticulous, very accurate, and extremely consistent from one reporting to the next over the many hours that I saw him. . .

Did you discuss with Mr. Kinkel the psychologist he went to see during the beginning of 1997 and through June of '97?

A. Yes. Dr. Hicks. ... He indicated to me that while he was seeing Hicks in that summer, the voices were less frequent. He also indicated to me that after seeing Hicks, he was put on antidepressant medications. And he felt like he had a good summer. He wasn't sure if the reduction of voices had to do with being on this medicine, Prozac, or just because there was very little stress in the summer. He was not clear about that.

The Prozac or the combination of the Prozac and his summer activities did seem to help abate the voices though; is that correct?

A. He indicated to that he only heard voices a few times during that summer.

Did he indicate why he discontinued the medication?

A. He indicated to me that he thought he was better at the end of the summer. He indicated to me that -- the way he put it was, as a result of his meeting with Hicks, he felt like he didn't need to be on the medicine anymore, so he was taken off the medicine.

Did he describe to you ways he tried to get the voices to stop?

A. Yes.

What did he tell you?

A. There were a variety of different things that he would do to try to get the voices to stop. One was exercise. Riding his bike. He would try to distract himself. He would watch TV. He told me that he wished he would have tried alcohol or drugs to get rid of the voices, especially when they were bad, but he never really was successful at that either.

He also told me that sometimes he would punch himself in the head when he was hearing voices. While he was incarcerated in jail, he had an incident where he punched himself in the head to the point of getting a black eye. So he said he tried that to get rid of the voices, but he said basically nothing worked. He used to tell them to shut up, but he said that didn't help either. He said it just made them get louder.

Are you aware of any time he reported the voices to others?

A. The only incident that I'm aware that he made any kind of a public statement or a statement about voices was in class. I think about two or three weeks before May 20th, he blurted out in class, "God damn this voice inside my head."

And have you seen the so-called respect sheet or discipline write-up that was in Mr. Rowan's class that was generated from that?

A. Yes, I've seen that.

Showing you what's been marked as Defendant's Exhibit 107, can you identify that?

A. Yes. This is the a copy of the same respect sheet that I had seen earlier.

And can you describe what it says.

A. Well, the respect sheet has his name on the top. The name of the class, literature. The date, which is April 24th, 1997. And the first question that he's asked to fill out reads: "What were you doing that was disrespectful in the classroom?"

And the statement that is written here is, "Saying 'God damn, I've got to get these voices out of my head' is inappropriate in class."

That's crossed through. What's crossed through is "God damn, I've got to get these voices out of my head," and over on the left hand margin it is rewritten and it says "God damn this voice inside my head."

I asked Kip to explain this to me. And what he indicated to me is that the teacher got it wrong, the teacher was inaccurate. "He said, 'I've got to get these voices out of my head,' and I never said that." He said, "What I said was, 'this voice.'"

And this is an example of his precision. Kip has a very strong thing about being precise, and he wanted this respect sheet to be accurate, so he crossed through the original phrase and substituted the accurate phrase, "God damn this voice inside my head."

Looking further down the sheet, it says, "The expected behavior for the situation was," and what does that describe, meaning he was disciplined for what?

A. It says, "What is expected behavior for this situation?" And it says, "Not to say 'damn.'"

It doesn't say anything about God; correct?

A. No.

"In the future, what could you do differently to prevent the problem?" It says, "Not to say damn"?

A. Correct.

What's the date of the respect sheet?

A. April 24th, 1997 -- 1998.

It appears as if both Kip and Mr. Rowan signed it on that day, and then Kip's mom signed it on the 27th of April?

A. Yes. . .

. . . Can you distinguish hallucinations and delusions for us?

A. Hallucinations pertain to auditory or visual distortions of reality. They are the hearing of a voice that's not really there, or the seeing of an image that's not really there.

A delusion is a false belief. It's a false belief that is distorted, often twisted in a negative direction, and it's very resistant to change in the absence of medications. People who have delusions typically are hard to talk out of their opinion or their strange notions, and even in the face of data to the contrary they are reluctant to change their minds about such things.

Did Mr. Kinkel relay to you a history of delusions?

A. He didn't put them that way. He didn't say, "I have a history of delusions," but he did tell me about a number of things that I think could easily be classified as delusions.

Could you describe those for us.

A. Yes. In talking with him about his feeling that he needed to arm himself and protect himself, I asked him why, and he indicated to me that he had fears that the Chinese were going to invade, like after a bombing with a nuclear weapon. He felt that he was particularly worried about the second wave of an attack. He thought he would survive the first wave because he lived where he did.

He was very concerned about how the Chinese -- and I quote: "They brag that they have a billion people, and 200 million in the military. They are so huge. They have nuclear weapons. Seemed like I would end up fighting them. I had lots of fantasies about fighting the Chinese."

So he was also very concerned about a plague, like "The Stand," by Stephen King. He felt like he needed to accumulate food, supplies. He thought he would have liked to have built a bomb shelter. If he had the money, if he had had the stuff to build a bomb, he would build a bomb. He wanted to learn how to build bombs in case he would need it. He also thought about the end of the world. He thought about society falling apart, and he worried a lot about that.

When I interviewed his sister, she clued me in to how he had some peculiar notions about the Disney Corporation. So I asked him about Disney, and he became animated. And it was the first time I had ever seen him animated. Up until this point he had been pretty flat in his affect.

And he told me that over the next fifteen years, the Disney dollar would take over the American dollar. He says they're also taking over the news industry, entertainment, ABC News. It's a monopoly. They use a fuzzy mouse as a mascot. It lets them get away with all kinds of stuff. If Iraq would just use a fuzzy mascot, they would have a better image. No one goes after Disney because of Mickey Mouse. And then he told me, "Disneyland, the happiest place on earth." And he said that in a very cynical, agitated, irritated manner.

He also had a lot of concerns about censorship. He felt like music was being censored. He made references to how censorship works, and he referenced Castro, Mao Tse-tung, Stalin. He said, "Consult the experts. Censorship works."

And then he told me that they are putting chips in the backs of sex criminals. He says that, "I don't need to worry about that, because I'm not a sex criminal, but I think about that the government could take control of us. If someone put a chip in me, I would take it out. The government is experimenting right now. Look at "The X Files." And they told me, when they did an MRI, I thought they would find a chip or something in my head put there by the government."

And then he told me the chip can produce voices, and he said, "Maybe that's the way they're controlling me." And he went on to tell me that the government was controlling Hinckley, maybe. And then he told me he thought the Disney thing probably sounded stupid to me, because it sounds stupid to criticize Disney, but behind it there are greedy corporations taking over America. And he went on and on about this.

And somehow the Disney Corporation and government were caught up a censorship collaboration to censor lyrics in music. He told me that sometimes he would tell people at school about Disney, but he gave up on doing that because they thought he was weird. And he could talk with his mother about it and his sister a little bit, but he didn't really find himself talking about it with other people.

And I noted with emphasis in my report that he had a way of saying things. A delusion isn't just a disordered thought; it's more than that. It has to do with the way things are said sometimes, not just the content of what is said. And I will give you an illustration.

He said to me with the kind of emphasis that I'm going to try to mimic that he did. He told me, I can see what Disney is doing. I can see the government as well. And then he asked me if I saw it, and I told him I didn't see it that way. And he became animated. He wanted to argue about it. And then he finally said to me, "No one of average intelligence sees it with the Disney. You have to be smarter. Happiest place on earth, ha-ha."

So it's not just the content of what's said, it's sort of the way it's said. And that's said with a conviction that is characteristic of delusions. It's also said with a quality of grandiosity. When he said " I can," he is distinguishing himself from most everyone else in a grandiose way. That clustering of symptoms I think illustrates delusions quite well, as well as grandiosity. And these are symptoms of psychotic thinking.

Did he relate another delusion about an individual who pursued him for an incident by the roadside near his home?

A. Yes.

Can you tell us about that.

A. He told me about a man who had been following him around. He said that one day, I think it was around Thanksgiving of the preceding year, prior to -- I guess that would be Thanksgiving of '97, he told me that he was riding his bike along the road, and there was a man parked alongside the road fixing his tire. And he had put a triangle out as a safety indicator, just a small little triangle on the road.

And he says as he was riding along the road, he kicked the triangle over. And he said the man came up to him afterwards and was very upset. He said this car that the man was working on had bullet holes in it. And he said this man came up to him and told him, he kicked his triangle. He said the man looked all drugged out.

He said, I know where he lives. He lives in a trailer on the road that was on the way to school. He came up to me and demanded that I give him $40 for kicking his triangle, as if it was a fine or something. Kip said, "I told him I didn't have $40. He asked for my address and my phone number. I gave him a fake address, and I mixed up my phone number. And then he got his gun out from a glove compartment and he threatened me, and I rode off."

After this, Kip indicated he kept on seeing this guy. He would go to school on the school bus, and he would look over at this guy's house, and he would see him, watching him. He would see him following him in the brown car after the bus went by. He said, "I was afraid he would come to my house and that he would bring his friends to my house and take over our house." And he said, "I had to have a plan to get rid of this guy. That's why I needed the gun." I said, "Which gun?" He said the one I bought from Corey. He said, "I needed a pistol. My dad had the other pistols in his locker, so I needed this one in case he came after me."

He told me he was driving with his mother, and they pulled into a gas station. And he said this same car with the bullet holes came into this gas station. And a guy got out who wasn't the same fellow who he claimed met him at the triangle. And he said this other man came up to him and said, "You're Kip Kinkel, aren't you? You kicked my triangle. We'll see you later. We'll get you for kicking my triangle." He said he was really upset because it wasn't even the same guy, and he didn't know how this guy could have known his name.

And this whole story has a quality of disbelief to it. It's an odd story. It's a strange story. I questioned that this is an accurate story about what happened. I think it's delusional. I think he's incorporated a lot of features into this story that are his fears and his projections, and it's an example of another delusion.

Have you stated your conclusion that these delusions are good indication of psychotic processes?

A. Well, there's one type of delusion that he manifested that is on Schneider's list of high-risk symptoms for schizophrenia, and that's the kind of delusion in which someone is trying to take control of your mind. And his delusion about a microchip having been placed in his brain by the government that communicates with satellites -- he indicated that one satellite gave voices to the microchip, and that's where the voices came from, and another satellite followed his every movement. So there's a good example of a Schneider First-Rank Symptom. But he has many other delusions besides that.

Dr. Bolstad, can you turn to page 32 of your report. I'm looking at the last paragraph there. At some point a ways into your clinical interview you discuss with Mr. Kinkel the events of May 20th and May 21st of 1998; is that correct?

A. Yes.

And did you detail those as accurately as you could in your report?

A. Yes.

I wonder if you could just read from the report, starting with that last paragraph and up to the top of page 34.

A. I asked him if he had been hearing voices around the time of the incidents on May 20th and 21st. And specifically I asked him if he had heard any voices around the time that he was caught with the gun in his locker.

And he says, "No, they didn't start until I was at the Burger King. My dad picked me up at school, and we were at the police station for a while. I had been told by someone that I would get expelled, something about two felony convictions on my record. I got in the car with my dad to go home, and he said to me, 'You're only 15 and you've already got two felonies.' We stopped at the Burger King on the way home, and we ordered two Whoppers. We sat down. My dad said to me, 'You disgust me,' and he got up and went to the car to eat his hamburger.

"I couldn't eat because the voices had started. I just sat there. I threw the Whopper away and started to walk out, but then realized that there was too little time to have eaten it. And so I went to the bathroom for a while before I went back to the car. I didn't want my dad yelling at me for not eating the Whopper, wasting money.

"In the car, we drove home. I don't remember what my dad said. The voices were all over me at that point, all three. It's a fifteen-minute ride home. B was saying, 'Look at what you've done, you stupid piece of shit, you're worthless.' The A voice said, 'You'll have to kill him, shoot him.' C was repeating this over and over. They got louder and louder. I went into the house. I was crying. I went in my bedroom, up to the loft. There were two guns in the trunk, the .22 pistol and the sawed off shotgun. I took them and hid them because I thought Dad might look. Hid them in the attic. The voices kept saying, 'Get your gun, shoot him, shoot him.' I got the .22 rifle."

As Kip was saying this, he was crying and sobbing. His head was down on the table, much like it is now. The rest of the account that he told me took place on the table, again, sobbing. He said, "My dad was sitting at the bar. The voice said, 'Kill him, shoot him,' so I did. I had no choice. The voices told me, 'You have no choice.' I had never heard that before, 'You have no choice.' His back was to me."

I said, "Why didn't you refuse the voice?"

He said, "I don't know. They were getting louder and louder. I had to be right there. Like the time I held the scissors, because the scissors were in my hand."

"Any thoughts just before the shooting?"

"I said to myself, I had no other choice. They kept saying it to me. It didn't seem real."

I asked him what he was thinking after that.

He says that, "I hate everybody, myself especially. I hated the voices most of all. B kept on saying to me, 'Look at what you've done now, you stupid shit.'"

Then I asked him about his mother. And he said when she came home, they said, 'Kill her. Look at what you've done. You have no other choice.' So I killed her too. I just wanted to kill myself."

"The voice said later, 'Get guns and bullets. You have no other choice. Kill everybody. Go to school and kill everybody. Look at what you've already done.'"

He said, "I argued with them. I told them to shut up. They ignored me. All night long, I didn't sleep. It seemed like a short time. The night went by fast. I had the same clothes on all the next day. I put on the coat. I took the .22 pistol and the .22 rifle and the Glock. I switched stocks for the rifle. The stock -- I took the stock that was sawed off, I switched it that night. I switched it so I could hide it better.

"I taped bullets to my chest." I asked him why he did that, and he said something about he saw it on TV or something, so he could kill himself if he ran out of ammo. I asked him if the voices told him to tape the bullets to his chest, he said, "No, it was my idea." I said, "Did you have any thoughts on the way to school?" And he says "No, I don't remember."

He told me about getting to school and walking down the corridor. He saw three kids in front of him. He heard a voice that said, "Shoot them now," another voice said "Wait, wait." He heard, "Look at what you've already done, and it's their fault. You have no other choice." He heard that over and over. "You have no other choice."

"I knew people would be in the cafeteria. I just started shooting. It was all rolled together, the voices saying, 'Look what you've already done. You've ruined their lives. Shoot them. You've got no other choice.'"

I think that's enough. Did you reach diagnostic conclusions on the DSM axes?

A. Well, I did with some of the same qualifiers I've already said earlier. I think diagnosing adolescents is difficult. Adolescents' symptoms change as they develop and get older. What I'm clear about is he has psychotic symptoms. I'm clear that he has a mental illness. I believe that most of his symptoms are consistent with schizophrenia, paranoid type. Although I can't yet rule out schizoaffective disorder; I think that's a real possibility. Schizoaffective disorder is a combination of schizophrenia with depression.

I also can't rule out a bipolar type of affective disorder, because he has a lot of manic symptoms as well. So it's still a bit confusing as to exactly the nature of his diagnosis, but I am confident that he is mentally ill. I am confident that he is psychotic. He also has a learning disorder. He has generalized anxiety disorder, and major depressive disorder.

Perhaps we discussed this before, but I want to be certain. First Rank symptoms, did you notice those?

A. Yes.

Which ones?

A. In diagnosing schizophrenia, you have to satisfy what's called Criterion This criterion requires either hallucinations or delusions, and there's a lot of different requirements about those delusions and hallucinations. But if you meet Criterion A First Rank Symptoms, it satisfies all of Criterion A.

And he met two First Rank symptoms. The first was he heard voices that communicated with each other about him. That's a first rank symptom. And the First Rank delusion that he has is the delusion in which he thinks there are parties that are controlling his mind. And either one of those would satisfy First Rank symptoms, but he has both, so he like doubly qualifies.

Did you bring with you the chapter on the DSM related to schizophrenia and psychotic disorders?

A. Yes.

And you've gone through that and isolated particular portions that you think are significant and pertinent to Kip Kinkel and his diagnosis and his behaviors; is that correct?

A. Yes.

Can you just share a few of those with the court. I'm looking at page 281.

A. Page 281 has a particular statement on it that I find that's very characteristic. It reads, "The onset of schizophrenia typically occurs between the late teens and the mid-thirties, with onset prior to adolescent rare, although cases with age of onset at five or six years of age are reported. The essential features of the condition are the same in children, but it may be particularly difficult to make the diagnosis in this age group. In children, delusions and hallucinations may be less elaborated than those observed in adults."

And I think his delusions are less elaborated -- and what elaborated means is, his delusions are not as tightly organized as you see in adult schizophrenics. They are not as convoluted or as layered. As people get older with schizophrenia with delusions, their delusions kind of become organized, become developed like a well-developed story. And he is not well developed yet in his delusions. He has multiple delusions, but he doesn't have like one delusion that is highly organized and systematized.

Page 282, there's a description of the course of schizophrenia. And it talks about how the onset may be abrupt or insidious, but the majority of individuals display some type of prodromal phase, early phase, manifested by slow and gradual development of a variety of signs and symptoms. Social withdrawal, loss of interest in school or work, deterioration of hygiene and grooming, unusual behaviors, outbursts of anger.

Family members may find this behavior difficult to interpret and assume that the person is just going through a phase. Eventually, however, the appearance of some active phase symptoms marks the disturbance of schizophrenia.

Individuals with an early age of onset are more often male and have poor premorbid adjustment -- meaning poor adjustment prior to the onset. They have often more evidence of structural brain abnormalities, more evidence of cognitive impairments with neurological testing. So that was one of the reasons why I was particularly interested in getting a report from a pediatric neurologist.

And then in terms of diagnosis, on page 287 --

Paranoid type, yes?

A. They talk about the paranoid type of schizophrenia. And what's a distinguishing feature of the paranoid -- and I think this is very important -- is that the paranoid type of schizophrenia is characterized by the presence of prominent delusions or hallucinations in the context of a relative preservation of cognitive functioning and affect.

What that means is you can have these symptoms of hallucinations and delusions and at the same time have well preserved cognitive thinking in most other areas of your life. The thing we know about people with paranoid symptoms is they often do well in school, adults do well in their businesses, until someone touches a button that is related to a delusion or until they start hearing voices. But otherwise their behavior can look pretty normal.

And the paranoid type of delusions, they're mostly persecutory, although they're sometimes command. And the associated features of these symptoms are anxiety, anger, aloofness, and argumentativeness. There's often a formal quality in interpersonal interactions. And the persecutory themes may predispose the

individual to suicidal behavior, and the combination of persecutory and grandiose delusions with anger may predispose the individual to violence.

Individuals with this disorder show little or no impairment on cognitive testing and most neurological testing. And so what we see in the paranoid type of schizophrenia is that none of the following are prominent: disorganized speech is not prominent, disorganized or catatonic behavior is not prominent, and flat or inappropriate affect are not prominent. What's prominent are the auditory hallucinations and the delusions.

So I think his symptomatology is very consistent with this diagnosis, but as I've already indicated, he also has signs of schizoaffective disorder and bi-polar.

Doctor, there are a number of issues that emerged yesterday from the state's presentation that I want to go through with you, and I want to ask you to comment on them based on your workup of the case, your diagnostic conclusions, some of the records you have reviewed, and your discussions with Mr. Kinkel as well. The first is this notion of explosives and his fascination with explosives. Do you find this to be characteristic of the disease in this individual?

A. Well, certainly not all paranoid schizophrenics are fascinated with explosives. I think in Kip's case, he was fascinated with explosives, and I think it had a peculiar quality to it. It related, I think, to delusional fears. Fears of an invasion. Fears that were of a persecutory nature, that he needed to protect himself.

What did he tell you about his experimenting with explosives and when he stopped?

A. I don't remember what he told me about when he began, but I do remember he told me he quit experimenting with explosives around the end of the time that he was seeing Dr. Hicks. He told me that Dr. Hicks had convinced him that explosives were very dangerous, and he could hurt himself or someone else.

And he said about this time he became more interested in guns. And he told me that what he did was, he didn't want to get rid of the explosives that he had accumulated; he had wanted to store them in case there was an invasion. And so he told me he put the explosives in the crawl space in his basement, and that's where he was planning to store them. . .

Moving on to the knife collection, can you comment on that. Is there something about the knife collection and the way that it was preserved and ordered that is significant in terms of his diagnosis?

A. Well, people with paranoid symptomatology are often very compulsive. One of the supervisors at our medical school used to have a saying that paranoia is compulsivity taken to an illogical extreme. And I think the layering of the knives in the perfect order and very organized is a very compulsive side of this young man that you often see in paranoid people. It also goes along with his precision. He wants to be very precise.

How about his journal writing?

A. His journal writing intrigued me. I was intrigued by how small his handwriting was. I mean, it was tiny. Microscopic, practically. And it filled the page. It absolutely filled the page, completely. And I think the only time I've ever seen anything like this before is with manic patients. So there is this side of him which has these manic features, this manic quality, and that struck me as somewhat manic.

The last couple of times that I interviewed Kip Kinkel, he wouldn't sit in a chair and talk to me. He had to pace while we talked. And he would pace in a very compulsive way in the cell. His left shoulder would

always touch the same spot on one side of the cell, and his right shoulder would touch the same exact spot on the other side of the cell. And he would go back and forth while he was talking with me. And that is a behavior that's called pacing, and it's very characteristic of mania. But it's also characteristic of schizophrenia.

Is the content of the journal writing significant in any way?

A. Well, yeah. It's thematically centered around hatred, about hating others, but also hating himself. I would characterize a lot of his writings as projection. He projects his own negative feelings onto other people. The hate that he feels toward himself, he projects onto other people. I think that's very thematic in his writings. There's a lot of self-loathing that gets manifested in hating other people.

He also characteristically in many of his writings talks about there being something wrong with his mind. And that's probably one of the more common themes in a lot of his writings, that there's something wrong with him, that he's not normal, that he's sick.

I want to discuss with you periods of seemingly lucid or ordered behavior that he had, or it's reported that he had on the night of May 20th and even as he walked into the school on May 21st. And what I'm thinking about are the phone calls with Mr. Rowan that we heard about in court yesterday, and the warning about Adam Pearse walking down the hallway in the school. Are these consistent or inconsistent with your diagnosis?

A. They're not inconsistent. The thing we know about paranoid symptomatology is that people can appear very together, very logical one minute, and the next minute can look very illogical.

Their behavior also can be planful. People with paranoid symptomatology can premeditate. They can plan out a course of action, and they can complete it. That doesn't mean that they are logical. A lot of times they're planning, and their thinking is so disordered, so distorted by their delusions, that it's really crazy kinds of thinking. But at the same time it's intentional, it's premeditated, it's planful. But it's also twisted, it's illogical, it's irrational.

But I think Kip is capable of at times looking coherent, looking cognitively nonimpaired. And that's consistent with what I read earlier out of the Diagnostic and Statistical Manual. That is a unique quality of the people with this illness. These people are cognitively together most of the time.

Can you comment generally on the reports of his secretive nature, his ability to go years with what one would think were pretty severe torments and not discuss that with anyone?

A. I would say that's fairly typical of people with paranoid symptomatology. They tend to be private. They tend to be the kind of people who don't want people to know how crazy they are. They have a strong tendency to be private, especially until or unless they're on medicine. When they're on medicine, in my experience, they give up a lot of their private nature.

How about the suggestion that he may have eaten a bowl of cereal at the house on the night of the 20th or on the morning of the 21st. Did that indicate anything to you?

A. Probably that he was hungry.

Is it inconsistent with your diagnosis?

A. No. . .

. . . At my request, did you prepare a validity analysis regarding your study of Kip Kinkel?

A. I did.

I want to be quick with this. Why did you do that?

A. Well, I think any time you raise the issue of mental illness in a case of aggravated murder, I think it's incumbent upon an evaluator to explore the possibility that someone is malingering. I just think it's incumbent upon anyone who wants to do a thorough job to see if that's the case.

Have you had experiences with young people you evaluated for serious criminal conduct to feign mental illness?

A. I have.

And you've had certainly bona fide findings of mental illness with similar evaluations; correct?

A. Yes.

Did you do a review of the research on malingering?

A. I did.

Can you summarize that for us.

A. I've written a rather lengthy report on it. I will try to give you a quick summary. I know we're approaching the end of the day.

There are general research findings on malingering and mental illness. There are people that have looked into -- they've done research on deception and whether or not people are able to be deceptive.

The most famous person in the series is a Guido DePaulo. And he's found that people who lie tend to give a higher pitched tone to their voice when they're lying. They tend to be more hesitant when they give answers. They make more grammatical mistakes, more slips of the tongue, more irrelevant statements, more vague statements. More self-manipulating gestures, like rubbing or scratching. They blink their eyes more. And DePaulo has noted that introverted and anxious people are less successful in concealing their lies.

There has been a lot of research like this in the area that Resnick has reviewed. And generally, I think it's the case that when you have college sophomores who are asked to lie versus college sophomores who are not asked to lie, and you ask psychiatrists and psychologists and police detectives to figure out who is lying, generally speaking, they can't do it. They're not good at doing that on the basis of interviews, especially short interviews. But yet we have learned a fair amount about lying from DePaulo's research. A general finding is that people aren't able to sort that out, the lying.

What's more important, I think, is to look at other things, like how someone reports their symptoms. Do they report symptoms in ways that are consistent with true psychotic people, or are they trying to claim symptoms -- do they depart from what we know about the phenomenology of hallucinations and delusions?

And in brief sum, I would just say -- and I have a lot of pages that address this -- but Kip's description of

hallucinations and Kip's descriptions of delusions are classical in form. They conform precisely to the literature and to our research on schizophrenics and psychotic people. They're very in accord. He doesn't do the kinds of things that people do when they're trying to fake these symptoms.

And to give you a couple of examples, what we know about true hallucinations, true voices is that they are typically very short. They are not lengthy. They are typically ego dystonic. And by ego dystonic, I mean they're upsetting to the person. They don't like hearing them. People do things to try the get rid of the voices.

People who are faking voices don't know these things about true schizophrenics, and they typically give very inaccurate reports about voices. One person once told me that he had long conversations with his father, who was deceased; he had killed him. And that's not the way voices work. Voices don't -- they don't come in the form of long conversations.

So in short sum, his hallucinations and his delusions are very typical with the research on the phenomenology of delusions and hallucinations.

Did you also conduct a validity analysis based on the MMPI?

A. I did.

I have some exhibits on that too, 21A or B.

A. Exhibit 21A. There has been a body of research conducted by a number of scholars in the area, chief among which would be the research team of Watter. Watter has asked people to pretend like they're mentally ill, college sophomores, and he asked them to pretend like they were paranoid schizophrenic. And he gave them information about paranoid schizophrenia and asked them to read it. And after they had finished reading it, he gave them the MMPI to take, and he asked them to take this test as if you were schizophrenic of a paranoid type.

And so with those instructions, this is what was generated. The "S" refers to the simulator group. Simulator means they're simulating mental illness. And you had throughout that, on the validity scales for the MMPI, they have an extremely high score. The F scale on the MMPI is the number of times you endorse rare, unusual symptoms. Schizophrenics endorse some rare symptoms, but not that many. But people who are trying to feign mental illness don't know what are true, rare symptoms. And so they score a lot of them. And you can see the score here is off the map. It said a hundred and twenty.

Actual paranoids, called bona fide paranoids, when they're given that test, their scores hover around 77. So they do see more rare symptoms than the normal population of fifty, but nowhere near the amount that someone does who is faking a mental illness.

You will note that Kip Kinkel's scores are well below even the average paranoid schizophrenics. He's not faking mental illness. He's not endorsing rare symptoms at a rate anywhere close to the fake group, the simulator group, and not even as high as the group of true paranoids. So that's a pretty good clue that he's not malingering. In fact, it's an excellent clue that he's not malingering. . .

. . . Doctor, you conclude your validity analysis with a section on a relationship between psychotic symptoms and some of the critical behaviors that are at issue. Is there a certain commonsense analysis you apply to the conduct with psychotic breaks being the only reasonable explanation for the conduct?

A. Dr. Philip Resnick, who is a psychiatrist who has written most extensively in this area, and I attended a

conference by him just last August. And he makes I think an eloquent point about the relationship between psychotic symptoms and the critical behavior, in this case, murders and attempted murders.

He says that to the extent that you can explain the critical behavior -- or in this case the murders and attempted murders -- to the extent you can explain those behaviors with more or less rational, reasonable reasons -- even though those reasons might be jaded. Can you make sense out of them? Are they rational? Do they make sense?

And he offers as an example, some people might murder out of revenge, someone might murder as part of a gang crime. When they shoot -- someone is shooting at them, you can sort of understand why they're doing it, it makes rational sense even though it's perverse. But it makes sense, intuitively.

And Resnick says you have to look at the critical behavior -- in this case, the murder and attempted murders -- and ask yourself, does it make sense? Did Kip have a reason to shoot his parents? Were his parents abusive towards him? There's no evidence of that. Did he hate his parents? I don't think there's any evidence of that. Why would he shoot his parents? And as I explored this question with Kip, I could not find a rational reason for why he would shoot and kill his parents.

In fact, I was intrigued by the note he wrote on the same evening, May 20th. After shooting his parents, the note, if I recall correctly, says words to this effect: I just killed my parents, exclamation point. I don't know why. I love my parents. They were wonderful people. I'm not getting this exactly correct, but those are the main messages. I'm sorry I did this. I don't know why I did this. I had no choice.

And I think that paragraph is a beautiful illustration of what Resnick is talking about. He thought his parents were wonderful. So why did he kill them? He doesn't know. And I think that's consistent with Resnick's argument that when you can't find a reasonable reason, then you need to look for the possibility of an irrational reason, a psychotic reason.

I noted with interest that Detective Warthen and Dr. Suckow both pursued an area of questioning with him that was audiotape recorded. And the nature of the questions they asked Kip were centered around the issue of, did you shoot them to protect them from the embarrassment of being kicked out of school? And that seemed to be the theme of Dr. Suckow's interview, as well as Dr. Warthen's. And so I found that kind of interesting that they pursued that as a rational reason.

And it may be that's the closest you can get to a rational reason. I understand why they pursued it. But it occurred to me if that is the reason why he killed his parents, it doesn't explain then why he shot people at the school. He would have to have another reason. So we would have to have two separate theories about or two separate reasons as to why he did these shootings. And I don't know what the reason would be that he shot people at the school.

There was no inquiry into that area by Dr. Suckow or by Detective Warthen. When I inquired into that area what Kip said to me was simply, I had no other choice. The voices told me I had to do it. They said kill everybody. Go into the cafeteria and kill everybody. The voices compelled me to do it.

So what Resnick says is, if you can't find a rational reason, look for an irrational reason and see if that's there. And I did, and the irrational reason is, quite precisely, that he was hearing voices that commanded him to do these killings, and he felt like he had no other choice, partly because the voices told him he had no other choice.

By the way, then I went back and reexamined this question of, well, did he kill his parents to save them the embarrassment? And I think when you analyze that question carefully, that's not a particularly rational or logical reason to kill your parents. I mean, would you kill your parents because you're saving them the

embarrassment? That strikes me as fundamentally irrational.

So the long and short of it is, borrowing from Phil Resnick's logic and his voluminous research, I think that kind of analysis points clearly in the direction that Kip, his behavior was dominated at the time by psychotic thinking, by mental illness. And I think that's the explanation for the murders; I don't find any other explanation that's particularly compelling.

Can you state your degree of confidence about Kip as a nonmalingerer in a percentage?

A. I would put it at over 95 percent confidence that he's not malingering. . .

. . . I want to back up and digress from a theme that you just brought up. Are you aware of attempts at Lane County jail to medicate Mr. Kinkel and whether they have been successful?

A. Yes, I am.

And what can you tell us about that?

A. Well, in my opinion, we haven't really had a good period of time to test his response to medication. During the period of time that I evaluated him, I did not want him on any medicine, because if he was on medicine, I wouldn't get an accurate assessment of him. So during the entire time that I was evaluating him, he was not medicated.

Then after I finished my evaluation, and before the state's experts began evaluating him, there was a period of time where he was on an antipsychotic medication, Zyprexa, spelled Z-Y-P-R-E-X-A. That's the trade name for the generic drug which is olanzapine, O-L-A-N-Z-A-P-I-N-E. And that's an antipsychotic drug.

He was also on an antidepressant. I don't remember at the moment which of the many antidepressants he was on.

Was it Celexa?

A. That's correct, he was on Celexa.

Kip indicated to me that he was very eager to get on the medicine. He wanted anything that would help him get rid of his voices. He indicated to me that during that period of time that he was on the olanzapine -- I can't remember exactly how long it was, it seems to me like it was six weeks, two months, somewhere in there -- he told me that during that period of time the voices were greatly diminished. They were only -- he only heard voices a few times during that period. He also told me that he felt less angry.

But he was curious about which drug was having which effect on him. He would ask me lots of questions, like is the olanzapine doing this? Or is the Celexa doing this? And he was very confused about that and kind of intrigued by that.

I learned recently at one point that he tongued his medicine. I believe he tongued the olanzapine. By tonguing it, I mean he was deceptive, he didn't swallow it; he was probably going to save it.

And I don't know exactly why he did that. I have not had a chance to interview him about that, but judging from our prior discussions, I'm guessing that he wanted to see -- he wanted to find out the effects of one medicine against the other, and he probably wanted to see what one was like in the absence of the other.

The other very plausible hypothesis that I would like to ask him at some point would be if he was tonguing the medicine in hopes of saving it up so he could accumulate enough to kill himself, and I think that's also a real possibility. But generally speaking, he had a good response to the medicine. He told me he liked the effects of the medicine. He told me it reduced his voices.

When he went off the medicine so the state's experts could evaluate him, I heard from him several times about how much he wanted to get back on the medicine. He wanted it to hurry up so he could get back on. So I think he's had a good, positive response to the medicine. . .

. . . Doctor, can you advise this court with any certainty how dangerous or whether or not Kip will be dangerous at some remote time in the future?

A. Not really. I think that it would be irresponsible to try to make a prediction twenty-five, thirty, forty years hence about someone's behavior. I don't think I'm capable of doing that as a psychologist. I don't think anyone is really capable of making that kind of prediction.

It's important to note that you're talking about a prediction of low base rate events. Suicide and homicide -- and for that matter violent behavior -- are pretty low frequency events in society, and they're very hard to predict. And to try to predict something thirty years hence, I would say that's virtually impossible. So I would be reluctant to even try to guess about a prediction such as that.

Are you aware of some positive prognostic indicators of the potential that he may successfully rehabilitate? And I don't mean cure; I mean treat.

A. Yes. I would say that this is a positive prognostic indicator in the form that I think he's had a positive response to antipsychotic medications, and that's good. Not all patients do. And so the fact that he has benefited from it -- I think that he is likely to benefit from it more once we can fine tune it -- I think that's a positive sign.

Frankly, in my experience, people with his kind of symptomatology who benefit from medicine, they can do quite well. The delusions go away. The voices go away. And in Kip's case, when the delusions and the voices have gone away, he can be pretty normal.

And I think that's another related prognostic indicator. He's capable intellectually. I think he's capable of finishing high school. He can do that at SITP. He's capable of earning college credits. And I think if he's not troubled by his delusions or his voices, he's going to function pretty well. And I think that's a positive indicator.

I think it's also a positive indicator that he has not been a management problem the whole time he has been in jail. As far as I know, from having reviewed the records, I don't know of any serious management problem that he's posed. . .

. . . Another positive sign is that the nature of his delusions is still immature. His delusions are not well organized. They're not systematized, they're not layered, they're not convoluted. They're early-stage delusions. And I have found that antipsychotic medications help people in early stage with delusions quite a bit.

But people who have had delusions for twenty or thirty years as adults and then they are medicated, it's very hard to ever get rid of the delusions, even under antipsychotic meds. So I think it's a positive sign that we're going to get to him at a young age with the right kind of medicine. . .

Now, as I understand it, you're saying that you acknowledge Mr. Kinkel is a mass murderer. He's killed a multitude of people, attempted to kill a lot more; correct?

A. Yes.

He has an obsession with violence.

A. He has had an obsession with violence in the past, yes. I don't know if he currently has an obsession with violence.

Did ask him about that?

A. Oh, yes, I did. It's not clear that he currently has an obsession with violence.

That he exacts revenge upon people who he believes, perceives correctly or incorrectly, have crossed him.

A. In the past, he's done some of that.

That he advocates or writes of and believes in the necessity of destruction of others who displease him or cross him.

A. Well, he certainly has written about that, no doubt. That's part of his psychosis.

And you're aware of specific acts that he has committed against classmates who he perceives as having crossed him or displeased him or disrespected him in the past; correct?

A. I'm aware of I think two specific acts, yes: one that he threw a pencil at someone, and another time that he kicked someone.

Did the defense provide you with their investigator's report about the time when David Scott, when Mr. Kinkel was only six years old, he was playing with a twelve-year-old boy with a piece of rebar -- you know what rebar is.

A. Yes.

And that Kip was playing with the rebar, and the twelve-year-old boy asked him if he could play with it. Kip said no. The twelve-year-old boy asked again, can I have it to play with it for a while? Kip again says no. The twelve-year-old reaches over to take it, and Kip flies into an uncontrollable rage, chases down the twelve-year-old boy, backs him into a corner, raises the rebar over his head, brings it down upon the boy -- who brings up his hand to protect himself -- hits him, causes injury to the arm, or he still has injury eleven years later [sic], and after he hits him the first time, he raises the rebar again and tries to hit him a second time. You're aware of that incident?

A. I'm aware of it. And I'm also aware of the aftermath of that incident. I'm aware from having read about the incident that Kip cried a great deal afterwards, that he cried as much as the other boy, that there are indications that he was very sorry about that event. This is a six-year-old child. . .

. . . You're aware of the incident at the McCown residence where about one month prior to the shooting, Mr. Kinkel misplaces a knife at Tony McCown's house. He forms the belief that one of his

friends had taken it and tells them, if you will just give it back, I won't be mad.

He became frustrated and confused, his face gets red, he becomes increasingly upset and agitated while looking for the knife because he can't find it, and ends up throwing a bottle and putting a hole in the wall because he can't find the knife.

A. Yes, I'm very well aware of that incident. I've gone over it with him in depth. I'm aware that he was hearing voices in that particular incident and he was quite psychotic.

That's what he tells you?

A. Yes.

You're aware of the incident at the McCown residence again, during the freshman year, a totally separate occasion, where he's just playing around with his friends, and they're doing typical freshman high school teasing each other, egging each other on, and they gang up on Kip a little bit, and actually I guess have him down on the bed. And he becomes upset about that, and he becomes angry, breaks away from them, runs to the kitchen and gets a knife.

They lock Mr. Kinkel out of the bedroom when he runs to get the knife in the kitchen. Mr. Kinkel starts shouting obscenities, hitting the bedroom door with a knife. Then he goes outside, still yelling obscenities, gets a golf club, puts it through the window, was swinging the golf club back and forth, trying to strike the people. They back away from the window. He also puts the knife through the window, making stabbing motions, and eventually he calms down and comes back in the bedroom. Are you aware of that incident?

A. Yes.

You're aware of his dislike and threats to kill a kid named Josh Metzger?

A. Yes.

And that Kip would verbally harass him, put him in a headlock -- this was around spring break of 1998, in the freshman year -- Joshua was able to get away. Are you aware of that incident?

A. Yes, I'm aware of it.

Let me go on a little bit. You're aware of Rocky Montgomery, and the animosity that Mr. Kinkel felt towards Rocky?

A. I can't recall that name.

Floyd is his birth name. Floyd Montgomery?

A. You would have to tell me the story. I don't remember the names.

That Kip would always be antagonistic and verbally abusive towards him, yell obscene words at him and friends such as "faggot," "slut," "whore," "you disease-carrying people." He and Kip got in several fights during seventh and eight grade, where Kip would approach him in the hallway, antagonize him, get into his face, verbally challenge him, put him in headlocks?

A. Yeah, I vaguely recall that. . .

. . . Okay. What about Brian Havelock? You know about him, don't you?

A. Yes.

And in fact, after he had killed his father, and while waiting for his mother to come home to kill her, and carrying on conversations with several of his friends in a three-way phone conversation, he tells -- and not telling his friends that he's killed his father -- he talks about that there's one person that he really hates and wants to kill, and that is Brian Havelock. And this is after he's just committed a murder. You are aware of that, aren't you?

A. No.

You didn't read the reports of Tony McCown and Nick Hiaasen, his two friends?

A. Yeah, I did read those reports.

You don't recall that section where he reports wanting to kill somebody after he's just killed his father?

A. I don't recall that, no.

And that somebody being one of the students at his school?

A. I don't recall that specifically, no.

Wouldn't that be something that would be cause for concern, for someone who you say is supposedly in one of those lucid moments after he has killed his father, is once again threatening to kill somebody else who isn't even a threat to him?

A. I'm not willing to characterize that as a lucid moment.

You don't think that carrying on conversations over an extensive period of time with a multitude of people, where you're lying, deceitful, and manipulative about where your father is, where you're covering up the fact that you've just killed your father and are waiting to kill your mother -- you don't call that a lucid moment?

A. No. I think there were plenty of points in those discussions in which he was hearing voices, in which he had very disturbed kinds of thinking. I think it's altogether possible that he could have a very lucid moment at one part of the telephone conversation and be quite crazy in another part of the conversation.

You're aware that he says that the voices stopped as soon as the phone calls started, and that he was not hearing voices during those phone conversations? Are you aware of that?

A. No, I'm not aware of that. In fact, that contradicts what he told me.

Are you aware that's what he told Dr. Lewis?

A. I'm aware of having read that, and that's why I inquired about it.

And you're aware that with all of these, you talked to a -- Vicki Ramsey, I believe her name is, who is a teacher at LCC or the -- coordinates the instructors at LCC, where she calls up to inquire about the whereabouts of Mr. Kinkel at 4:40 in the afternoon. And he quite calmly tells her, oh, my father forgot to call you and tell you that he wasn't going to be there tonight, there's been a family emergency and he will not be able to teach tonight. Is he hearing voices at that point that tell him to say that?

A. Oh, I think he's very much in part of a delusional state. He may not hear a voice at that particular moment, but I think that the general application of his delusional thinking is very much a part of what he's doing.

I think it's important to understand that the public, generally speaking -- and I think for that matter, often our legal system doesn't understand the nature of paranoid schizophrenia. It's altogether possible for someone to be lucid one minute and very crazy the next minute. That's characteristic of paranoid schizophrenia. In fact, I read that out of the Diagnostic Manual. That's not an uncommon feature of this illness.

Is the manipulative, cover-up nature of his behavior over several hours consistent with a paranoid schizophrenic?

A. Absolutely, it is. Paranoids are quite capable of being clever, manipulative, deceitful, calculating -- they're quite capable of that. They are often very clever people. They anticipate things down the road. They can be very smart, very clever. There's many examples of paranoids throughout the literature who have committed heinous crimes and who have been inordinately clever, very bright, and very calculating.

I believe the Unabomber is an example. He was very clever, very paranoid, and very calculating. So it doesn't surprise me that he is capable of doing these behaviors it's consistent with my understanding of paranoid schizophrenia.

You mentioned the Unabomber. You're aware that Mr. Kinkel has told several people that he saw himself as the next Unabomber.

A. I am.

So is that one of those delusional --

A. Oh, yeah. I think it's part of the way he's attracted to the news and the media.

And you're aware that -- and you said that he is like the Unabomber in the sense that he can be very organized and controlled and still have this paranoid thought process?

A. I think that can be part of his psychic structure, yes.

And the Unabomber is spending the rest of his life in prison, isn't he?

A. Yes.

Where he needs to be?

A. Oh, I personally disagree with that. I think he should have been in a mental hospital, because I think he's profoundly mentally ill. . .

You said something about that he engages in irrational thought process, and this is part of his core. So apparently there is something in him that, where he lacks the basic moral code to tell him that killing is wrong?

A. Oh, no. He has a moral code that killing is wrong. He argued with the voices. He told the voices he didn't want to do this. He begged the voices not to make him do it. He knew it was wrong.

How did the voices make him take a gun and kill his father? Besides telling him to do it.

A. Yeah, well, you know, I wish I could give you a good explanation for that. I can't tell you exactly how that came about. But when I can say is that, depending on the study, between 10 and 80 percent of people who hear command hallucinations follow through with them. So there are people who hear command voices to do things -- they might argue with the voice, they may not want to do it -- but sometimes they comply with what the voice demanded.

What I can tell you about that, from my experience and from the experience of my colleagues, is that to the extent that the voices are very loud, very persistent, and to the extent that he is under a great deal of stress and level of upset, he is much more vulnerable to acting out what the voices tell him to act out. If he's not under high stress and he hears voices commanding him to do things, he's far less likely to act that out. We know that on the basis of a lot of research with schizophrenics with command hallucinations. . .

That brings me to an interesting point with regard to what you just described. The killing of Mr. Kinkel's father, the killing of Mr. Kinkel's mother, and the killing of the students at Thurston High School and the attempted killing of all those other students at Thurston High School, the attempted killing of Detective Warthen -- none of them are involved this any of those delusional systems that you've talked about that he has.

A. I totally disagree.

What does his father have to do with his fear of Disneyland money taking over the world?

A. His delusions are not confined to Disney. He has delusions that are manifest in large ways. He hears voices that say kill everybody. Those delusions are associated -- I mean, those voices are associated with lots of fears about him being evil, about other people being evil, about society falling apart, about society being filled with evil. It's not as if you can separate his hallucinations from his delusions. They're all interwoven. It's not as if you can tease them out and hold them out as separate and unique.

What is it about any of those people that he killed or attempted to kill that would represent a threat? In his delusional and paranoid psychotic state, that would cause him to believe that he needs to kill them?

A. I think the primary thing that was operating in his feeling and need to kill them were the voices. I'm not sure that I can identify a particular fear or a particular threat that he was experiencing from any of these parties.

So in other words, he's the type of paranoid schizophrenic that if someone says -- either an external voice or a real voice that says, kill him, he does not have the ability, because of his core personality, to resist that order?

A. I'm not saying that. I'm saying most of the time he probably could resist. But if he's under a state of highly intense voices, if he's in a state of great stress -- which I'm sure he was on the day of May 20th, the day he was caught with the gun at school -- I'm sure that when you put together that degree of stress, and the voices being very persistent, that he was uniquely vulnerable at that moment.

I am aware that there were other times that he resisted command hallucinations, when he was under less stress.

That's what he tells you?

A. That's what he tells me.

And the bottom line is, you believe that what he tells you is the truth. I believe you said that he is an accurate, meticulous, and truthful reporter.

A. I'm not going to say that Kip Kinkel is truthful in all aspects. I think there are times he is intentionally deceptive, but I do think that in terms of his voices and his delusions, I think his reporting is accurate. I think he's been consistent. He conforms to all of the criteria for not malingering. I have no reason to believe that his description of his hallucinations and his delusions is inaccurate.

Then you are aware of the intentional deceptions that he engaged in with you during his interviews?

A. The intentional deceptions he engaged in with me?

Yes?

A. No, I'm not aware of those.

Well, he gave you a very vivid description of how he killed his father.

A. Yes.

And you're aware that that's not accurate, aren't you?

A. Well, I'm aware that there are some inaccuracies, but I think it's largely accurate. I don't see any great discrepancy between his report and what I read in the police reports.

Certainly you're aware that he didn't kill his father with a rifle; he killed him with a Ruger pistol.

A. Yes, I'm aware of that.

You are aware of that?

A. Mm-hmm.

That's a pretty significant difference, isn't it?

A. Not really. He killed him with a gun.

Well, there's a difference. He says that he went into his bedroom where he had a rifle, his rifle, and loaded it up and went down and shot his father. The Ruger of his father's, which was not his and which was not available to him -- it's a very different and much more calculating act, isn't it? It's a choice?

A. I'm sorry. I don't really see the distinction you're making. I don't see it as any more calculating. I think the fact is, he shot him with a gun. And I'm not sure it makes much difference which gun it was. . .

. . . You think that because he's a paranoid schizophrenic that is why he is a killer?

A. If he were not a paranoid schizophrenic, I do not think he would be a killer.

And what do you base that on?

A. Because I think his act was based on delusions and voices that are consistent and long-standing.

How do you reconcile that with all of his past violent behaviors and threats of violence?

A. I rather suspect a lot of his past behaviors that are violent related were part of delusions, part of hallucinations. You know, I think the picture is pretty complete. He started hearing voices at the age of twelve. A lot of his misbehaviors in school were after the age of twelve. I don't think you can tease out acts as being separate from voices.

Although in some cases you can. For instance, he committed a delinquent act of knocking the rocks off of the overpass over by Bend. I asked him, did the voices tell you to do that? He said no. No voices told me to do that. I asked him, did he steal the CDs because the voices told him to steal the CDs? No, he said.

So he's not purporting that every deviant act is based on voices. He's not trying to suggest that. If it were, that would be a sign of malingering. He's very clear that a lot of his deviant acts were very much related to hearing voices. Certainly the example you gave awhile ago of the boy who, when he lost his knife, he became very upset that night. I spoke with Tony and I spoke with him clearly about that, and he thought that Kip scared him that night. He found him very bizarre. He frightened him.

And he didn't know about the voices, but he knew that Kip was acting in a very bizarre fashion that night. So I think a lot of these acts that you're referring to are very much part and parcel of a mental illness. . .

. . . You know, for someone to do something as bizarre and crazy as kill people, it's not necessary that it be part of a delusion. It's sufficient that it's part of command hallucinations.

I do think, however, that delusions were folded into a lot of his voices. I think that they are not easily separate-able. I tried to find ways to separate them in my interviews, but I find a lot of them are very convoluted.

But to answer your question more precisely, it doesn't -- it's not necessary to invoke the inclusion of delusions to explain his behavior. It's sufficient to acknowledge that he was hearing command hallucinations.

You don't find it significant that he would hear a command hallucination to -- as he reports it -- to kill his father, and that he would wait for an appropriate time to kill his father?

A. I find that totally consistent with my understanding of paranoid schizophrenia. Like I've told you before, they can be calculating, they can be intentional in their behavior, they can be conniving -- I have no trouble with this.

And then have moments of lucidness where they carry on these telephone conversations and threaten to kill other people, and that so when he's -- as I understand it, when he is talking about killing people, or actually killing people, then he's operating under the delusions of paranoid schizophrenia; and when he is at the very next moment lucid and calculating and manipulative and deceitful and covering up his crime, that that's different.

And then the voice will come back when he decides -- when it's time to kill someone else. And his mother shows up and the voice comes back and says kill, and he'll act on the kill; and then it stops again so he can carry on a two- or three-hour conversation with a girl that he's on the phone with and pretend that nothing has happened.

A. Ms. Tracy, I believe we've gone over this before. And my answer hasn't changed. It would be the same answer as I gave before.

That's the nature --

A. I'm not absolutely convinced that he is paranoid schizophrenic; I think it's most likely that he is. I have not fixed my diagnosis.

So it could be that he kills just because he kills.

A. Oh, I'm quite clear he's psychotic. I don't think he's a killer, separate or apart from his mental illness.

How do you explain when you say that there's no rational reason for going to school and killing, the fact that he has verbalized and planned going to the school and shooting it up or bombing it, and targeting certain people for quite a period of time?

A. Ms. Tracy, I think you're mixing apples and oranges. There's a distinction between the reason why he kills, okay, and the process by which he kills. The process by which he killed was, in my opinion, consistent with paranoia. It was -- it was intentional. It was planful.

But the reason why he killed is quite another matter than the process by which he killed. And I cannot find a rational reason why he would kill these people at school. I have read through all these medical reports. I've read through a lot of different materials. And I can't find -- in talking with him, I can't find anywhere in any report that anyone has proposed a viable explanation for why he killed. And if there is one, I would like to hear it.

Well, doesn't his writing provide a reason?

A. Yes. And his writing is psychotic. His writing is very psychotic. I mean, it's filled with references that are bizarre. "I am evil. I am sick. I am not normal. My mind isn't working correct" -- he says all of these things. He telling you that his thinking is troublesome.

And so, you know, I still have yet to hear anyone give me an explanation for why he would have gone to school and killed people, separate from or apart from his mental illness. I can't find one. I mean, if you want to propose one, I would be glad to comment on it.

I guess I just have one more question for you. Given the fact that he's a mass murderer, obsessed with violence, destruction, he's angry, he's got distorted thinking, he's got internal character flaws, he needs a structured environment, he engages irrational thought processes that override his basic moral code "Thou Shalt Not Kill," that he would choose to kill others rather than to kill himself although he claims he's suicidal -- how do you fix him?

A. Yeah.

How do you make us safe?

A. Ms. Tracy, I personally don't think there is any way of curing this disorder. There's not a cure for it, okay? I do think he can be managed. I think the principal way you manage this kind of mental illness is with psychotropic medicine.

And I am awestruck by how much people change once they are given appropriate medicine. The gentleman that I've been evaluating at OSH tells me now, six months after his crime, [said to me], "Dr. Bolstad, I was really delusional, I had crazy thoughts back then." And he can say that because he has been on medicine, and the medicine has helped him a lot. It squared away his thinking.

So I think people are very different when they're in his condition. Real frankly, I would not want to see Kip Kinkel out on the streets, ever, with this condition, okay? Without medicine and without an awful lot of structure and support services arranged for him.

Testimony of Dr. Richard Konkol (neurologist)

At my request did you conduct a neurologic examination of Kip Kinkel?

A. Yes, I did…

What did that exam consist of?

A. It consisted of two hours of interview with Kip in a one-way observation room. There were deputies adjacent to that room that I could hear across the one-way mirror. It consisted of an interview, the kinds of questions that I ask about neurologic function, some background activity, some developmental history, a review of systems where one checks out various parts of the nervous system and determine whether there are any signs of trouble or dysfunction, and then I conducted a neurologic examination. The neurologic exam consists of several parts. It consists of a mental status evaluation. This is where one, in a face-to-face, paper/pencil paradigm scans certain kinds of functions like language, constructional abilities, concentration, processing. It consists of a cranial nerve examination, which is a unique part of the nervous system. Each cranial nerve has its own designated function. The motor examination, a strength test, a test of tone and muscle function, coordination testing, sensory testing, and a reflex testing.

Tell me what the results of those examinations were.

A. Well, I found abnormalities on the examination. They were in several of the subparts of the exam. Just looking at Kip, there was a slight asymmetry of his body habitus. That is how he is structured. The left side was smaller, slightly smaller than the left ... Excuse me, the left is smaller than the right. And I could see this on his face and on his hands.

There is a rule in pediatric neurology that if there is trouble in the brain in what we call the super segmental or the part above the foramen magnum, or the opening where the spinal cord comes up, it can produce

atrophic effect or a growth effect on the body, so that the earlier this trouble is manifest in the brain, the greater the degree of asymmetry of growth you will see in the body. So that is just one of the elements that I found is that there seemed to be an asymmetry with the left side being slightly smaller than the right.

Then I found that Kip's language in his mental status part of the exam was not normal. He had difficulty with word production, writing, spelling -- remarkable difficulty. Some naming difficulty, some intermediate verbal memory troubles, and some disfluency in reading, particularly when there were words that he hadn't been familiar with. So that was one category.

And in that, I also had some assessment of his attentional abilities, and I had him do serial sevens, which is starting with a hundred, subtracting seven to get ninety-three, subtracting seven from that and so on down the list until you run out of numbers. It's a standard neurologic test of ability to focus. He had some troubles on that. He lost his place a couple times. So the mental status exam suggested that there were difficulties in higher-level processing.

On the motor part of the examination there were abnormalities. He had a very specific pattern of weakness. The weakness is what we call the parameter pattern or the upper motor neuroparity. By that I mean that when there is weakness in the body, the specifics of what that weakness is very important. If you have a foot drop, it could mean he just had a lesion in one nerve. If you have more than a foot drop and you can't step with your foot, you may have a higher level lesion up that nerve. If you have both legs weak, you may have a spinal cord lesion. If you have a pattern of weakness which fits with the distribution of the input from the brain to the lower centers in the spinal cord, you can identify an upper motor neuropattern of weakness. And he had that, and it was on the left side. So that means the reference is to the right side of the brain. The right side of the brain controls the left side of the body; the left side of the brain controls the right side of the body. And he had a very specific pattern of weakness. He didn't have weakness in all of his muscles. He didn't have weakness in most of his muscles, but he had weakness in a specific pattern of his muscles called the upper motor neuron distribution.

Then on the sensory part of the examination, he also had troubles there. He extinguished when I touched him on the right side proximally and distally. And he didn't recognize when I touched him distally on the right side, but he did recognize that on the left side. And so there was a form of a very mild neglect that I saw, again, referable to the right hemisphere -- this is all on the left side. I don't know if I said that correctly. The left side was the side that that was found on.

Meaning left side body corresponds to...

A. To the right side of the brain, right. And then his deep tendon reflexes were easier to elicit. These are reflexes that are held in check by the neurons coming down from the brain to the spinal cord, and when the brain is in trouble or when there is a lesion, these reflexes are disinhibited or they become more active. In Kip, this same right-hemisphere related, left-sided asymmetry was seen. So I found subtle neurologic abnormalities in several dimensions.

What you're testing for is brain abnormalities, correct? ...What's a lesion?

A. A lesion is an abnormality. It can be acquired, it can be developmental. By acquired I would mean something like getting hit in the head, having a contusion, having a bleed, having a stroke. It can be developmental in that you can have malformations that occur in normal development that don't affect the whole brain, but just affect very specific parts of the brain....When there is a lesion, there is usually a dysfunction. And when the dysfunction becomes so troubling that it prevents a person from doing what he should do, what he wants to do, what he would be expected to do in the course of his life and his development and his schooling, that reaches a level of importance that in my practice I pay attention to.

From your motor and mental status examinations, you could draw conclusions about brain abnormalities?

A. What we're finding now from things like the PET, positron emission tomography, is we can look at the brain and we can see during the ongoing behavior what is actually happening and where. We can compare that with a normal [brain], and we can see what is wrong with somebody, what part is not working in somebody who has a lesion.

Can you show us on the model what abnormalities you noted in Kip Kinkel based on the motor exam and on the mental status exam?

A. ...Most of the findings on the left side would be related to the parietal lobe that would be the atrophic influences...but would be related to the motor output, the development of motor execution, with the weakness in very specific patterns related to the brain. And that would be related to the right frontal hemisphere.

And then problems with language, and as I said before, language in the vast majority of individuals is -- particularly right-handed individuals, which Kip is -- is left-sided in the brain. And so we would have troubles in the left parietal frontal area, in the temporal area, I would predict, from my examination. And also troubles in the right front, based on my examination in the bit of the lobe of the parietal are

Did you also conduct a scan on Mr. Kinkel's brain, SPECT scan?

A. Yes, I did.

What is the SPECT?

A. SPECT is an abbreviation for Single Photon Emission Computerized Tomography... I think the best way to explain it is to talk about the procedure itself. This is a radionucleii study where an injection of a compound which is a substance that disintegrates -- and the patient is hooked up to a computer -- the compound suritech, that takes it with the circulation into all parts of the body. And the parts of the brain that are active at the time of the injection for about two minutes are the ones that light up, or take up, the suritech compound. And so that area that was active at the time of injection is bright. That area that was inactive that was not functioning is depressed, or is decreased in activity. So the procedure then, after getting the injection, is to sit underneath a hair dryer-like arrangement, or a set of rotating detectors that pick up the radiation coming from out of the brain and feed it into a computer. The computer has a logarithm that will formulate a three-dimensional picture of where those disintegrations came from in the brain and derive a total picture, a map, so to speak, of where these active areas and inactive areas on the brain are. That map can be then sliced, just like a real brain. If I had this brain, and it was scanned, it should have a continuous pattern of activity throughout the cortex. The activity is linked to the blood flow, and they are in a one-on-one relationship in almost all areas of the brain. So if the brain was normal, one would expect to see a continuous pattern of activity reflecting the anatomy of the brain. And if there was a lesion, it would show it as an area of decreased activity.

And you obtained a scan of Kip Kinkel's brain, ... can you interpret that for us or explain what it is.

A. ...What we have here are five...views of the brain. The center one here is looking straight down on the brain, as if we were holding it like this. The node is up, and the back of the brain is here. So this is the right, this is the left. This view up here is the straight-ahead view, looking like this. Here we have a rotated view, so we're looking at the right side, particularly the temporal lobe here, the parietal lobe and the frontal lobe. Then rotating to this side we have the left side of the brain, the frontal part here, occipital, temporal lobe, cerebellum down here. The top of the brain here. And then the rotation is all the way around, and we're

looking at the underside of the brain like this. This represents here the frontal lobes, looked at from underneath. And this represents the temporal lobe, the right side -- this is the left side here, and this is the right side here. And here we have the cerebellum, and that represents the arrangement on the illustration.

And on this illustration, there are several major abnormalities that are apparent.

A. In the orbital frontal area, the prefrontal area here, there are areas of decreased activity. These are not physical holes; these are areas of brain that are not working the same as the rest of the brain. So they are showing up as areas of deficit. They are showing up as holes, with this standardized view setting for the brain study.

When you look at the side of the brain, the right side, you see that this area here, this parietal area, this temporal area is not smooth; it also has areas of decreased activity. And then, it is not that there is a lesion -- a structural part that's missing, a chunk gone; it just means that part is not working, and it's not taking up the dye.

What the SPECT is showing is a decrease in blood flow or an absence of blood flow?

A. And that correlates to activity in the brain. And the same thing on the left side here. Parietal, frontal, temporal deficits. And when you look at the underside, you can see that the temporal lobe, particularly here on the left, is very ratty, very uneven in its appearance in this scan. That means that what should be a continuous structure and a smooth surface has a lot of areas that are not working, comparable to the rest of the brain. And the same thing here, on the right side of the -- the right temporal lobe. And then we have this huge deficit in the orbital frontal are

And can you correlate your findings on the SPECT with your findings on motor exam and mental status exam and describe to the court what abnormalities you find in Kip Kinkel's brain?

A. Yes. Well, the frontal lobes up here have been labeled by psychologists and neurologists as the seat of the executive function. The executive function of the brain is, as the name implies, it's where the orders and the structure of behavior come from. It is the agenda-setting region of the brain. You don't see agenda in young children. This is an area of the brain that matures late. Myelinization and development, as I indicated earlier, is a constantly occurring event, and frontal lobes are probably the last areas of the brain to develop in the human. They are also -- they also contain cortex called the prefrontal cortex. The prefrontal cortex is extremely important. It's the largest in phylogeny. That is, if you look at amphibians, reptiles, mammals, chimpanzees, dogs, and cats -- you put a progression on that size and correlate it with a phylogenic placement of these animals, and it gets bigger and bigger the higher up the phylogenic tree you get until it's at its most elaborate and most developed form in the human. It comprises a huge portion of the frontal lobe.

And this is the area of the brain that makes us what we are. That is the basis of our personality. And it has intimate, if not critical, relationship to our abilities to be ourselves and to have our own individual strategies. Without this, frontal lobotomies used to get rid of individual strategies by disconnecting that part of the brain. If that happens, one becomes passive and does not develop strategies, or loses the strategy.

The frontal lobes develop in an adolescent?

A. Yes. It comes into its own in adolescence. It continues past adolescence, and myelinization continues in this area even into the thirties.

And so, just to be certain we're understanding here, the deficiencies that you've described in the frontal lobe one would expect in an adolescent to be filled in and smooth as you described in the normal brain you showed us; correct?

A. Correct.

What are the implications of the prefrontal lobe that you describe?

A. When you have a lesion in a prefrontal lobe, executive function is disrupted, that is, the ability to strategize, to plan, to prioritize, to choose between extrareceptive input -- that is, stuff coming from the outside versus my own motivation coming up from the inside -- is impaired. One cannot, neurophysiologically -- this has been studied -- there are certain neurons that fire just before you have to make a choice, and they seem to be correlated to holding a variety of choices that are available before you actually have to execute and choose something. And when the frontal lobe is damaged, you lose that ability to follow a strategy, to follow a plan, a timeline, a course of individual action and goal direction.

Can you tell us with medical certainty that Kip Kinkel has this deficit, based on your examination?

A. He has -- there is no way that I can do one test and say that this is a clear-cut, 95 percent abnormality. But taking the totality of the medical method, the history, the review of systems, the family history, the examination, and then the paraclinical testing -- everything seems to point -- when you put the pieces of the puzzle together -- to damage in that are

Let's move down to the temporal lobes. And can you describe what you're seeing there?

A. Temporal lobes are involved in memory, emotion. They are probably related -- well, on the left side in particular, to language. The right side to relational abilities. Constructional abilities. Your coordination. And when they are damaged, you have troubles with memory. You can have troubles with language. You can have troubles with emotional control.

And so you describe damaged areas in the temporal lobes...And that relates to inhibitions or the failure to properly control emotions and other things?

A. Yes. Emotional instability, distortions of sensory perceptions, illusions, delusions, visceral sensations -- things that you feel from your gut. And it's often an area of instability in the brain in people with neurological problems like seizures or epilepsy.

And what can you tell us about occipital and parietal?

A. Well, the occipital lobes here are affected. And this is, again, the sensory processing for vision, primarily. And as I indicated before, that as you go anterior, these perceptions are transfigured and are recombined into more complex experiential units.

The parietal lobe is particularly unique in that it has the primary input from our senses, our sense of touch. We have what we call parietal lobe tests such as touching, drawing figures on hands, putting an object in the hand to see whether somebody recognizes it.

What I did with Kip was draw numbers on his hand while his eyes were closed and see if he could recognize what I was doing, and he had troubles there. And that was again on the left side of his body, referable to the right parietal lobe.

Any other conclusions you draw based on your exam and the SPECT?

A. Well, what I found was a coincidence of or a congruency of information that pointed and supported the

clinical method and clinical conclusions that I had.

I do not rely on the SPECT scan as a sole determinant of a diagnosis; that is in my head after I do the examination. And I do a test, like an EEG, bloodworm, MRI, SPECT scans, to make sure I wasn't wrong.

Summarize your conclusions about Kip Kinkel.

A. I think that with these multiple areas of problems in his brain, both the left and right side are affected. The frontal part more than the posterior part of the brain is affected. The right frontal part has been shown to be particularly unique in inhibition and inhibiting planned activity, inhibiting ongoing activity, delaying responses. That was the most markedly decreased area of function that I found clinically, and that was also supported by the SPECT scan. He also had marked specific language difficulties that refers to the left temporal parietal, frontal loops that are there for those functions, and was also confirmed here on the SPECT scan.

And then, if I had to conclude as to whether this was an acquired or a developmental lesion, I would probably come down in favor of saying that this was a developmental lesion because of asymmetry on the left side. The right side of his brain had more of the decreased function, and the left side of the body showed more of a hemiatrophy, relative hemiatrophy. And you don't see that in late-acquired lesions; you see that in early developmental events.

So what's the cause of the abnormality... is it something that is secondary to trauma or it's something that is genetic that he inherited or...?

A. The cause of the abnormality is underlying dysfunction of specific circuits in the brain....I cannot say with absolute certainty that it's one or the other, but if I had to come one way or another, I would say it was probably developmental.

Does the abnormality rise to the level of a mental defect?

A. Yes... Cognitive defect. A defect in thinking, yes.

Neurologic function is impaired?

A. Correct.

Would it make him more susceptible to a psychotic episode?

A. I think it could. As a matter of fact, one of the other sessions that I attended that I found very interesting was the presentation by Dr. Judith Rapoport from the National Institutes of Mental Health. She showed, in the ongoing study that they are conducting at the National Institutes of Mental Health, their imaging results. And what they showed was that there was in childhood onset schizophrenia a presence of neurologic findings that preceded the onset of the symptoms, that there was an effect of a delay in the growth curve of the brain -- just as there has been shown in many, many studies in the adults that schizophrenics have smaller brain sizes -- the effect is greatest in the frontal and in the temporal are These are the areas where the gray matter is most affected in Kip's SPECT scan, and this is seen by the decreased perfusion, decreased activity in the frontal temporal region.

So a number of the criteria fit your conception based on your workup of Kip Kinkel; is that correct?

A. Correct. There were others as well, if I can recall. One was that there was an unusual, three-fold increase in incidence of other familial neuropsychiatric diseases. I think that is suggestibly present here. And the IQ had to be above 70, and certainly that would fit here too.

And the other history that you reviewed, in terms of the psychological testing Dr. Bolstad did later, on Dr. Bolstad's report, how does that overlay with your neurologic exam?

A. I think it was consistent with it, but it was -- it was different from my approach. And it was another piece of the puzzle, but not related directly to mine. But it would have fit.

And what's the prognosis for someone with the deficits he has?

A. Based on my experience, with children who I've had similar to Kip -- not exactly the same, because I don't think anybody is exactly the same -- I would be hopeful. Mainly because the effects of proper management, that is, setting up a proper environment, where there is a recognition of a deficit, where there is a bypass strategy around the deficit, where there is development of positive reinforcing habits and behavior to sort of train the mind -- this is everything a parent would do with a normal child, but you have to do this more laboriously and with smaller steps with a child with a lesion. There is great hope that medication could help. In my experience, at least 75 percent, and depending on how hard you push and how meticulous you are, you can maybe get that up to 80, 90 percent in some groups, children, to get a positive response from medication. And then I think counseling, to deal with the broader issues that surround a neurologic dysfunction.

Testimony of Dr. William Sack (psychiatrist)

What did your clinical interview of Kip reveal as far as his history of mental illness or psychosis, if there was one?

A. Well, Mr. Kinkel qualifies as a classic individual with psychosis. The content of his psychosis has a great, strong paranoid flavor. It also has a strong connection to affective illness. He becomes sicker when he's depressed. So there are components of both paranoia and depression in his clinical presentation.

And did you do a mental status workup or question him about hallucinations or delusions?

A. Yes.

And what did you learn in that regard?

A. Well, I focused on those issues twice. The first time in March, and then again in the second time in May, I found that he began to hallucinate with voices when he was in the sixth grade. He describes the initial hallucinatory event in a very specific manner. He knew quite where he was. He was on the driveway after school. He was very specific about its onset. And then I wanted to trace it over the next three years, and attempted to do that up until the -- up and through May 20th and into the present time. So I found him to be hallucinating pretty consistently over a three-year -- at least a three-year period. And in addition, there were several delusions of a paranoid nature that I discovered.

Can you describe those briefly?

A. He had an idea that Disney World was going to take over, that we would not have a dollar bill with a president on it, but it would have a picture of Disney and a Disney mouse. This, to him, was a very sinister, evil symbol, and he had quite an elaborate delusion of how this was going to happen.

The second delusion was that he thought that China would invade the United States, and he had to be ready

for that. That's why he stocked up weapons, explosives over a period of time. As he told me, there are two hundred million soldiers in China, more than the population of the United States, and we've got to be ready. I think he told me that he wanted his dad to buy gas masks and tents and meals and things to get ready for this.

Third delusion was that he thought he had a chip in his brain that was -- this was a delusion that came out of the initial hallucinatory experience. He tried to make some sense of why these voices were intruding on his otherwise logical thought processes. They were male voices. They were putting him down, calling him names, telling him to kill people. He was trying to make sense out of that, and he thought, well, maybe this is a chip in my brain that maybe the government or somebody has implanted there.
The fourth delusion was something that happened during my second interview with him. He was very upset that when he was imprisoned, people were allowed, visitors were allowed to walk past his cell and look at him. And he had the thought that maybe they had cameras in their glasses and they were photographing him as well as just peering in his cell.

There is one more hallucination -- I mean, delusion. The fifth one is, he had some worries that the medication that we started him on could be containing poison and might be harmful to him. That's a classic paranoid delusion. You see it all the time. Sometimes they think food is poisoned, but he didn't worry so much about the food. But he did worry initially about the medication.

I want to return to a discussion about the medication, but you mention the hallucinations and a period of time that he discussed that they prevailed. What was the content specifically that he discussed with you of the hallucinations?

A. Well, these were three voices. The initial voice would put him down, call him names, make fun of him, deride him. The second voice would tell him to kill. And the third voice would kind of comment on the two other voices, so there were three different voices. They were male voices. They tended to come when he was either stressed or depressed. And he did have symptoms of depression, both a longstanding, chronic depression as well as a more severe major depression during his freshman year in high school that lasted about three months during the fall of -- I believe it was '97.

Was there anything about the content of his hallucinations that was diagnostic of schizophrenia?

A. Yes. They were persistent, they were command hallucinations, and they were hallucinations commenting on his behavior. Those are all classic for -- as part of the profile or syndrome of paranoid schizophrenia.

What was his affect, and was that a consideration in your diagnosis?

A. ... He was tense. He didn't like to talk about the voices. He did talk about them, and when he did, he was subdued, anxious, with a real severe, stricken look on his face when he had to go into some of these details about the voices. It was not obviously a pleasant experience for him to be sharing this.

Is it your experience generally that it's easy to diagnose fifteen- and sixteen-year-olds?

A. No. Fifteen- and sixteen-year-olds are in the process of -- they're in a developmental process, and they are an emerging adult, and so symptom pictures can change. And they are not a fixed -- that's why we avoid -- we tend to avoid making personality diagnoses with adolescents because they don't yet have a formed personality. So teenagers are emerging adults, but their symptom profiles can change as they continue to develop.

So as I understand it, the full extent of the pathology hasn't revealed itself and onset doesn't occur until into adulthood; is that a fair statement?

A. I think that's a fair statement, yes.

Can you discuss a little more the schizoaffective component and what you mention in your report as a major depression component to your observations of his mental illness and help us understand with best certainty your diagnosis.

A. Well, as I say, I can't be absolutely sure whether he might eventually fall into the schizoaffective category. That simply means he has schizophrenic symptoms that are often accompanied with depressive symptoms or manic symptoms. He does not have any mania that I was able to determine, but he does have depressive symptoms.
In order, technically, to be diagnosed with schizoaffective, you have to have a period of psychotic symptoms where you were not depressed, but you often have symptoms of a mixture of the depressive and psychotic symptoms. And I thought that he probably would qualify for that diagnosis, technically, as well.

The reason I lean more to the paranoid schizophrenia was the content of his illness was so classically paranoid. But I think he falls somewhere in between those two domains. And whether this is simply a psychiatric technicality, I don't know. Certainly he was psychotic, floridly psychotic, whether he falls into one of these groups or the other.

Do you have an opinion as to what effect, if any, his mental disease had on his conduct on May 20th and May 21st of 1998?

A. I feel that his crimes and his behavior on those two days were directly the product of a psychotic process that had been building intermittently in him over a three-year period and suddenly emerged and took over control of his ego, and he became a very dangerous individual.

Have you had the opportunity and have you been presented with data on Mr. Kinkel's family history of mental illness?

A. Yes.

And did you find that significant in terms of converging with your diagnosis or contributing to your diagnosis?

A. It certainly substantiated the fact that this boy had some genetic loading that moved him towards a psychotic process. This obviously wasn't the only factor that resulted in his psychosis, but it certainly could have been an important contributing factor. He had major mental illness on both sides of his family tree.

Can you help the court understand to what extent that might have contributed to his potential to inherit a gene for mental illness? As I understand it, in the general population, the rate is one in a hundred are mentally ill. And although I stated this wrong the other day, in our community of 200,000, that would mean there are 2,000 people who are mentally ill. How would his odds have changed? And perhaps you can't put a number on it, but describe what the implications are.

A. I think, Counsel, one in a hundred means the prevalence of schizophrenia in our population is one in a hundred, you're right.

Oh, I see.

A. And with a positive family history, it goes up. I can't give you a percentage. If one parent has schizophrenia, the child has a tenfold increase of a chance of inheriting that. It's not a hundred percent, and so it falls somewhere between one percent and ten percent. But there is an increased likelihood of a mental illness.

Did you conduct a validity analysis on the research that you obtained and the clinical data that you obtained regarding Mr. Kinkel?

A. Well, I kept asking myself, am I -- you know, am I getting a story of this boy's real inner life or is this a

fabrication? Is this an elaboration? And I found a number of factors that made me feel comfortable that I was getting an accurate picture.

First of all, as I mentioned before, Dr. Bolstad's information and mine converged towards the same diagnosis. We had lunch together. We both said "paranoid schizophrenia" practically simultaneously at lunch as we began to discuss the case together. That's one factor. The second was internal validity: watching his facial gestures, his mannerisms, and seeing if they squared with the content of his information. And of course, since I've done a lot of sexual abuse interviews, I'm very aware that people can fabricate sexual abuse for a variety of secondary gains, so I'm alert to -- I'm looking to see what the non-verbal gestures and mannerisms are in addition to the content of what I hear. Third, the thing again I mentioned is the other interviews subsequently done later this year were very, very similar to what I obtained.

And then finally, I sent my interview notes, typewritten interview notes to you, Mr. Sabitt, and I think you showed them to Mr. Kinkel. And he went over them and he corrected some minor errors that I had made during the interview in a way that was not favorable to himself. He said -- I had taken a history of alcohol use, and I think I put in my notes that he was drunk twice. He crossed that out and said no, I was drunk more like eight times. I had not gotten a full history of his stealing, and he included that in his amended critique of my interview notes. So I didn't think this was a boy who was trying to paint a rosy picture or cover over something else. I think he was trying to be almost too scrupulously honest in giving me this information.

Those are some of the factors. And of course I had Dr. Bolstad's information on his very elaborate analysis of malingering. He sent me his 40-page discussion of that issue from his test data, which were also compatible with my clinical observations.

Have you helped to recommend medications for Kip?

A. Yes. It was right after the Littleton incident. Mr. Kinkel heard of that while he was incarcerated, and his psychologist counselor I think discussed it with him.

Upon hearing of that incident, he -- his voices exacerbated. He became very troubled. The voices told him, "Now see what you've done. You've killed another 25 people." They became very accusatory. He became much sicker, and I felt at that point, even though all the evaluations had not yet been completed, it would be ethically wrong not to treat him with medication.

So I recommended an antipsychotic and an antidepressant medication, and I think it was in June when those were started. And I had not been managing the medicine. I made an initial recommendation. I have not been involved in monitoring or managing the medication, but I did concur with those medications.

What medications were those?

A. Olanzapine and Zyprexa, I believe. It's our newest antipsychotic. It's called an atypical antipsychotic medication, yes.

And are you aware of how he has responded to those meds?

A. He had been on the olanzapine ten days when I saw him the second time. And he reported to me that the voices had come back one time since he was started, but they were more muted. They were less screaming and reproachful. And he was pleased that he was getting some relief. And that was -- but that was only ten days after the medications started.

Are you hopeful about the treatment perspective for Kip?

A. Well, his illness is a treatable condition. I can't claim that it's curable, but it's certainly treatable. And I think if I can just quote our bible here, DSM-IV, which we use to make diagnoses and which guides us in our treatment plans, the DSM-IV says: Some evidence suggests that the prognosis for paranoid type of

schizophrenia may be considerably better than for the other types of schizophrenia, particularly with regard to occupational functioning and capacity for independent living.

My footnote to that would be the tragedy of his illness is that, on the one hand, it allowed him to plan in a methodical way, because his cognitive structures were relatively intact compared to other forms of schizophrenia. I think our common notion of schizophrenia is a disheveled person walking down the street, talking incoherently. That is schizophrenia, but we're talking about a different kettle of fish here. This is paranoid schizophrenia. These people can look very normal.

So on the one hand, the illness had caused him to commit these tragedies. Also, it's the illness that responds better to treatment and has a better prognosis in general than the other forms of schizophrenia. That's the ironic tragedy of the whole thing.

Have you noted some positive prognosticators regarding his potential for successful future treatment?

A. Yes. I would say the positive prognostic factors are, one, his IQ score. He's cognitively bright, above average. Even though he has a learning disability, his overall IQ is high, and we know that high cognition is a good protective factor, a good prognostic factor.

Secondly, he has -- now that the voices are known -- we know that paranoid schizophrenics are secretive. They don't like to talk about voices, and particularly teenagers, because teenagers think in terms of their own identity. "If I tell somebody this, that means I'm crazy." And I think that was one of the reasons he couldn't tell anybody is, he was a teenager. And I've seen this in other cases of teenage psychosis. It can go on for years before it becomes apparent.

So I think he's open now. He's using counseling. He's taking the medication. His symptoms are improving. He is cooperative. He is not a behavior problem. And all of those things I think bode well for his future.

Can you tell this court with medical, at least, optimism that at some remote time in the future -- twenty-five or thirty years from now -- you think there is a potential for Mr. Kinkel to be a safe member of our community?

A. Yes, I think that if Mr. Kinkel takes medication, is consistently cared for by a psychiatrist that he trusts, in 25 or 30 years, I think he can be safely returned to the community. I would be happy to have him as my next-door neighbor if those conditions were met, that he was under good psychiatric care and that he was taking medication and his symptoms were obliterated. I don't think he would be a danger to society.

I want to backtrack a little bit, Doctor, and ask you about some of the issues regarding Mr. Kinkel's conduct on May 20th and May 21st of 1998. And there has been evidence presented to this court that in the interim, between the deaths of his parents and going to school the next morning, he had what appeared to be some lucid moments when there were telephone conversations he was involved in and some conduct around the home. Can you comment on that behavior and relate it to the mental illness you diagnosed and the symptoms of that mental illness generally?

A. Let me start by -- in response to your question, Mr. Sabitt, by reading the first sentence from the description of paranoid schizophrenia that exists in our DSM manual: The essential feature of the paranoid type of schizophrenia is the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect.

It's possible for a paranoid schizophrenic to plan and execute awful things because his cognitive processes aren't as affected as they are in some other forms of schizophrenia. That's point one.

Point two, Dr. Bolstad, who took him through this time and in a much more specific fashion told me this week that Mr. Kinkel was hearing voices while he was on the phone with his friends -- that is secondhand information; I did not ask Mr. Kinkel specifically those questions. So I think it's quite possible -- I think --

my personal, clinical opinion, he was quite psychotic during that time, even though he was able to carry on a phone conversation with peers and schoolteachers.

Some seemingly ordered behavior during the course of a psychotic episode?

A. Yes. He could look so normal and be so sick inside. And this was true not only on the two days of the awful events of May 20th and 21st, but it was true for three years, that he was fighting off an inner mental illness and nobody knew it.

Do you think the shootings of May 20th and 21st would have taken place were it not for Mr. Kinkel's mental illness?

A. I don't think he would have killed anybody had it not been for the mental illness, no.

Is there another possible explanation for these acts? And what I'm thinking of is psychopathy. Is this kid -- based on your meetings with him and the data you have reviewed and the information you have learned about him -- a psychopath?

A. Well, as I mentioned earlier, I took him through the section on conduct disorder from the Kiddie-SADS, and he did not qualify for a conduct disorder. Truly he has had some antisocial behavior, and I am aware of that, but he does not reach threshold for a conduct disorder that I could find, talking with him. Now, I didn't have all the information. But secondly, there is no evidence that this person was in the juvenile system prior to his -- I mean, he was in the juvenile system briefly had he had -- with the rock-throwing incident. I've seen about two or three hundred kids at MacLaren. A lot of those are sociopaths or psychopaths. They leave a trail of consistent behavior, antisocial behavior, in their pathway. That was not true with Mr. Kinkel. And so I don't feel that he is a psychopath. And I'm sure that at times he wasn't a hundred percent honest, but I could not -- the crimes themselves are so bizarre that psychopathy doesn't help me, and I found no evidence of it.

If Kip Kinkel would have probably been identified as mentally ill and properly treated for mental illness several months prior to these acts, in your opinion, would he have committed these acts?

A. I think if he could have been under treatment with appropriate medication and appropriate follow-up, he would not have committed these acts. That's my impression, yes.

If a parent brought a child in to see you and described that there had been some issues regarding a fascination with explosives and a fascination with firearms and some violent behaviors and some law-breaking behaviors and a problem with the folks in relating at home, what would your response to that have been in terms of the workup you would have done on him?

A. I think in listening to such a story, I would have had an internal shiver up my spine. I think I would have done a very thorough mental status exam and possibly hospitalized somebody. Because those are all danger signs, signals that something more than the average distressed youth was facing me here.

Did Mr. Kinkel explain to you why he chose, when he was shooting at the school, not to kill his friends?....What did that imply -- knowing that he had warned off his friends immediately prior to executing Ben Walker, to stay away from the cafeteria, don't go to school today, and picking a friend to tell that to, and then immediately killing another youth at the school in the presence of his friend -- imply that he still has control, some control over who he chooses to kill and not kill?

A. Well, I mean, it would certainly imply that -- as I had mentioned to the court before, this is the awful, tragic thing about paranoid schizophrenia. They have full, functioning, cognitive processes at work here. It's not like he is just out of touch completely with reality. He is out of touch in the sense that he is terribly paranoid, but he can make those kind of choices and still be very psychotic. And beyond that, I can't tell you why he picked one and not the other. I don't know.

...let me back up a minute, Counsel. If you've been hearing voices -- and you know, it's hard for us to empathize; we've never heard voices ourselves. It's hard to understand what an experience is like to have a voice saying kill, kill, kill, and for that to go on for three years, and to be more persistent and louder and louder, and you're feeling depressed -- I mean, it's very difficult to understand what a psychotic person is going through.

We would like to explain it on a rational basis. And I can't explain it on a rational basis. The crime itself is so bizarre, and it so fits with what we know about paranoid schizophrenics, who are dangerous people.

So what happens if you take away his self-reporting that he has had voices for the last three years, saying over and over again, kill, kill, kill? What happens if you, just for the moment, take that out of the equation?

A. Well, I think if we took away the voices and we're taking away part of his psychotic process, that I don't think he would have killed anybody.

So you're saying that but for the voices --

A. Voices, the whole paranoid scheme that was developing over time, this idea that the world is hostile, he has to be on guard -- I mean, all this process was building in him over a period of time. And the voices were certainly the most prominent feature, because they were the most painful aspect of it, I think.

What if he were lying about voices saying kill, kill, kill -- not to say maybe he was lying about hearing voices, but voices that commanded him to kill?

A. If he were lying, then he would be the best actor that I have ever seen. I've seen people try to play psychotic, psychosis on stage -- they're not convincing. I mean, real schizophrenia on psychiatric wards is nothing like Ophelia in Hamlet. You know, this -- I've tried to answer your question, Counsel, that I did not think this boy was lying. And I tried to lay out the reasons why I didn't think so. But if he were lying, he fooled me.

My question is a little more pointed. Not that he is lying about hearing voices or that he is definitely mental -- there is a mental process going on, but that he is lying about the content of the voice, that the voice said over and over again, kill, kill, kill, and had been saying that over and over again over the three years. What if he was lying about that?

A. Well, Counsel, all I can say is that on that driveway in the fall of the sixth grade, when he first heard the voice, that voice said "kill." And that was the very first voice he heard. It was three years prior. I mean -- you know, it was -- it would be a very elaborate fabrication for him to have invented that and to tell that story so consistently and with such appropriate affect. Anyway, if he -- all I can answer your question, Counsel, is that if he were fooling me, I stand fooled. And that's the best I can do with it.

Testimony of Dr. Jeffrey Hicks (psychologist)

What was the focus of the referral and the nature of the problem that was expressed when [Kip] came in to see you?

A. The primary concern was a fascination with guns, knives, and explosives, and antisocial acting out.

And was there a particular event or series of events that precipitated the referral that you were aware of?

A. An increase in activity of playing around with explosives. I think there was an incident in Bend, Oregon, of throwing a rock at a car . . . January 20th of '97.

And what history did you take when you met with him first?

A. A developmental history, mental status exam, interview with his mother, interview with Kip.

How often did you see him thereafter?

A. It was about every three weeks. It varied a bit.

Did he always attend those sessions with his mother?

A. Yes.

Did you meet with her generally during the sessions independent of meeting with Kip, or together with Kip?

A. It happened both ways.

So she was part of the meetings; it was a family counseling kind of event?

A. That's correct.

Did dad participate in these meetings at all?

A. No, he did not.

Was it ever explained to you why?

A. Yes. Kip's mother told me that he wasn't particularly supportive of counseling and didn't think it would be helpful, didn't want to come in.

Was a strained relationship with dad part of the reason that brought him to see you --

A. Yes.

-- that was expressed by mom?

A. Yes.

Tell me what you concluded from the medical history that you took.

A. Well, he had had difficulty learning in school, had difficulty managing anger, some angry acting out, depression. And I did not find evidence of a thought disorder at that time.

Did you do anything in the way of a full psychological evaluation?

A. No. That wasn't my contract. It was to address the specific presenting problems the family brought in.

Your history doesn't mention a mental status exam. Is that something you routinely do on an intake?

A. It is.

And what does that involve?

A. That involves asking a person about their memory, their concentration, attention, screening for hallucinations and delusions.

So how would you screen for hallucinations and delusions?

A. You would ask a person if they were hearing voices when there weren't people there, you would ask them if they feel like they are being plotted against, if they have any unusual powers, that sort of thing.

Did you pose those questions to Kip?

A. I did.

And you never made notes that -- is that something you just routinely do and you recall it in that fashion, or do you have a specific recollection of having asked him those questions?

A. I don't have a specific recollection. Whenever I enter a statement in the chart that there was no evidence of thought disorders or delusional thinking, it means I've asked the specific questions to be able to say that.

After the intake, would the hallucinations and delusions have come up again in your discussions? Would it have been a continuing source of information you would have sought from him? Would you have asked him those questions again?

A. No, not unless I saw evidence in my interviews with Kip of reality testing problems, difficulty with concentration, or seeming that he was easily distractible, something odd, and I didn't see that. ...

Tell me how your treatment of him proceeded.

A. Well, I saw him nine times, and he responded pretty well to counseling, I thought. His -- according to his report and his mother's report, the playing around with explosives, setting off explosive charges stopped. His mood improved. He was more communicative with family members. And according to Kip and his mother, his father was making a stronger effort to be supportive and communicative. ...

Toward the end of your treatment you made an evaluation that perhaps it would be helpful to suggest to his family physician a course of antidepressant medication; is that correct?

A. That's correct.

What led you to that opinion?

A. The continuing irritability, mood problems, feeling tired in the morning, food wasn't tasting good, nothing that he was particularly looking forward to. He met criteria for a major depressive disorder. ... On June 2nd, 1997, I made the recommendation that they consult [the Kinkel family physician] for him to determine whether a trial of antidepressants was indicated.

I next saw him on June 18th, and he had been taking the Prozac, 20 milligrams, for twelve days at that point. He was sleeping better. No temper outbursts, taking the medication as prescribed without side effects.

The last time you saw him was on July 30th of '97?

A. That's correct.

And what did you note on that occasion?

A. He was continuing to do well. No side effects from medication that I observed. Did not appear

depressed. Denied depressive symptoms. Faith reported that his moods had been good, quite good, and on a recent trip to San Diego he had related well to other family members.

Did you formulate a plan with the family at that time for continued treatment or consultation?

A. No. At that point Kip and his mother were feeling that he had made sufficient progress that they could manage things at that point, and given that he was no longer appearing depressed, I certainly honored that. He wasn't a mandated client.

Dr. Hicks, you indicated that the mother actually filled out a form when she came in, Mrs. Kinkel did?

A. Yes.

And in her own handwriting, she is asked to briefly describe the presenting problem, why they've come to see you?

A. Mm-hmm.
And she indicates, inappropriate decision-making regarding behavior, extreme interest in guns, knives, and explosives.

A. That's correct.

So that's what the mom says that they're there for?

A. Yes.

When you were talking with Mrs. Kinkel, and in your notes, you indicate that Mrs. Kinkel tells you that her son would often lie to his parents about his interest in explosives and the parents no longer felt that they could leave him at home?

A. That's correct.

Home alone, I should say.

A. Yes.

Did she also tell you in her statement that her son -- describing her son as having a hot temper and sometimes kicking holes in the walls at home?

A. Yes. ...

When Mr. Kip Kinkel comes in on January 20th of 1997, you talk with him one-on-one about what he perceives his problems to be?

A. Yes.

And during that interview you find no -- again, that's where you note no evidence of delusional thinking or other thought disorder symptoms?

A. That's correct. His thinking was clear.

And that he was logical, coherent, and goal directed?

A. In his speech, yes.

How did he describe himself as far as his anger and how he dealt with feeling angry?

A. He described himself as often feeling very angry, and he found some stress relief by setting off -- detonating explosives.

You described that as the way he would vent his anger was to --

A. Yes.

-- set off explosives?

A. Mm-hmm.

How did he tell you he would react when he had a bad day at school? What would he do to make himself feel better?

A. He would often go to a local quarry and detonate explosives, and that would help him feel better.

Did you get some sort of a commitment from him, I guess it would be the following week, with regard to whether or not he would use explosives anymore?

A. I certainly encouraged him not to. I don't recall that he contracted with me not to.

You note on April 4th that, again, apparently he still has an ongoing interest in explosives. Did you talk to him about it at that point?

A. Yeah. Whenever that would come up. I mean, that's a pretty alarming symptom, and whenever it would come up, I would certainly discourage him from doing that. ...

Were you aware that between the time that he had been on Prozac, starting June 1st, and July 9th of 1997, that on June 30th of 1997, his father went out and bought him the Glock?

A. He told me that, yes.

What did he tell you about that?

A. He told me that his father had purchased a handgun for him, after some persistence on his part. And it was kept out of his reach and to be used only under his supervision.

Did you have any concerns at that point, given his behaviors and his interest in explosives and firearms and just starting on a regimen of Prozac, as to the appropriateness of his parents' purchasing a Glock?

A. No one consulted me about that decision. Yes, I have concerns about that.