Alex Shunnarah, Psy.D, J.D.

Education

Samford University; B.A. (1982)
University of Memphis; J.D. (1985)
Georgia School of Professional Psychology; M.A. and Psy.D. (1991)
Georgia State University Counseling Center; intership (1992)

Licensing and Experience

Licensed attorney in Tennessee

Licensed clinical psychologist in Alabama, Georgia and Tennessee

Clinical and forensic psychologist in both private and government settings for 23 years

Testified in over 200 trials, all for the government

Alabama Psychological Services, Inc. (1994 – 2002)
- Psychological Evaluations
- Psychological Counseling

Chief Psychologist, Alabama Department of Corrections (2002 – 2013)
- Psychological Evaluations
- Treatment

Albertson & Shunnarah, LLC. (2013-current)
- Psychological Evaluations
- Psychological Treatment
- Treat children and provide custody evaluations for the state of Alabama

Expertise

Specializes in treating children, adolescents and adults with borderline personality disorder, depression, sexual abuse, eating disorders, bipolar disorder and anxiety disorders.

Report of Dr. Alex Shunnarah
August 3, 2017
Psychological Evaluation of Sally Childers

I am paid by the state at a rate of $175 per hour for preparation and trial testimony. Before testifying at trial, I have spent a total of three hours reviewing the evidence and writing the following report. I expect an additional four hours for trial testimony.

Data used to form opinion:
At the request of the state, I reviewed Ms. Childers medical records including the notes from her primary psychiatrist Dr. Hu. I read excerpts of Ms. Childers' journal. I talked with Detective Lloyd at the Maycomb County Police department. I read Detective Lloyd's interviews with Casey Cantrell and Bennie Arnold. I also reviewed the report created by Dr. Hu on behalf of Ms. Childers. I also reviewed Ms. Childers' criminal record. I have seen all of the photographs and the surveillance video of the stabbing.

I did not interview Ms. Childers personally. I have found that in cases such as this a post-arrest, pre-trial interview only increases the likelihood of a patient malingering during the interview. In which case the data gathered would be flawed. I did not read the journal of Patrick Summerfield because he was not the patient and so it was not diagnostically relevant. I also did not review the mood log created by Ms. Childers because like the interview a defendant/patient is apt to lie about their condition.

Opinion:
It is my professional medical opinion that Ms. Childers' bipolar disorder played no role in her actions on May 29/30 when she intentionally stabbed Patrick Summerfield with a knife causing his death. In fact, Ms. Childers used her bipolar disorder to empower herself so she could hunt down Mr. Summerfield. Ms. Childers manipulated the bipolar disorder, not the other way around. Bipolar disorder effects mood, not cognition. Brains do not commit crimes, people do. Reckless behavior is not an insanity defense. In my twenty- three years of practice I have never seen a case where bipolar disorder rendered a patient legally insane. I cannot even image a scenario where it would be possible.

Also, having bipolar disorder does not make a patient more likely to have a legitimate fear of bodily harm even during a manic episode. Ms. Childers fear of the victim was not significant enough for her to use a deadly weapon, especially considering her ability to physically dominate the victim, if necessary, without any weapon. Ms. Childers was athletic and the victim was not. For Ms. Childers to act out with deadly violence shows her intent to kill not an attempt to defend herself. It is evident from the video that her first and only attempt to "defend herself" was with a knife she probably planted in preparation for her deadly attack.

Background on Bipolar I disorder:
Ms. Childers was diagnosed with bipolar I on October 8, 2015. Bipolar I is a mood disorder that is diagnosed when a patient presents symptoms of the disorder. There is no blood test or scan or biopsy to accurately diagnose a mood disorder. Instead you rely on the testimony from the patient and the patient's friends and family. The primary symptoms of bipolar I include periods of severe depression followed by periods of mania repeated over and over.

Bipolar I is the designation for the classic variety of bipolar disorder, characterized by full-blown manic attacks lasting at least a week and deep, paralyzing depression. A schematic representation of the moods of bipolar I appears in the attached chart marked as figure 1. The pattern of abnormal mood episodes seems to vary widely, and the rhythm of the illness is almost as individual as the patient who has it. Symptoms of bipolar I usually begin in the late teens or early twenties although onset at later ages is not uncommon.

Bipolar I is what physicians refer to as a relapsing and remitting illness; during the course of the illness, its symptoms come and go. This feature of bipolar I – it is actually a feature of all mood disorders – makes it difficult to diagnose, difficult to treat, and fiendishly difficult to study.

A depressive mood is noted by severe lethargy and a general lack of interest. Depressive moods tend to cause the patient to have difficulty focusing on tasks. The depressive mood often causes the patient to sleep much more than normal, but it can also cause a patient to listlessly suffer insomnia. When a patient is in a severe depressive mood they generally have am extremely poor self image and may contemplate suicide.

Not all those who suffer from major depression are bipolar. To be bipolar you have to swing from one extreme to the other. The transition from one mood to another is called a cycle. Cycling can occur over the period of days to hours. Typically the depressive moods last longer than the mania but a patient could cycle to both extremes in the same day.

Mania moods are noted by an energy that is far above normal. A patient in a mania mood will often speak quickly and work quickly. They will often move from task to task but at the same time remain focused on their activities. Patients feel as if their mind is racing and they have grandiose thoughts of themselves. A mania mood will often manifest in a patient going on a spending spree or acting out sexually in a way that is uncharacteristic and often unrestrained. The mania mood produces a sense of euphoria with the patient but that can also turn violent. A mania mood may lead a patient to blow things out of proportion and become severely agitated very quickly. In a severe mania a patient may even hallucinate.

With proper medication it is possible for the mood swings to be managed. However, finding the right medications for an individual can be a difficult task. Once a balance of medications is found it is likely that the medications will need to adjusted to meet the varying life events of the patient. For example, if a patient is going through a stressful time their medications may need to be raised and/or lowered to accommodate the patient's life settings. It is critical that a patient speak regularly and honestly with their treating physician.

It is important for bipolar patients to become self-aware to understand when they are cycling and where they are in the cycle. Journaling is highly recommended. It is also very helpful if the patient keeps track of how they are feeling each day using a number scale. Zero would be normal. Ten would mean in an extreme manic state. Negative ten would mean in an extreme depressive state. However, a patient's assessment of themselves should not be the sole means of assessment, it is merely an aid. A licensed doctor must assess the patient to get a true sense of where a patient falls on the mood continuum.

Evidence against Ms. Childers acting under the power of her illness:
There are several key factors that show that Ms. Childers was, at the time of the murder, manipulating her moods:

First of all, in her journal she seems to plan the execution of her boss. She is clearly obsessed with him and has for some period of time wished him harm. There is evidence of that all throughout her journal.

Second, she intentionally did not take some of her medications and overdosed on others to, in my opinion, induce a manic mood. She was abusing her medications to muster up the courage to carry out her devious plans. As evidenced in her journal she numbered her personal assessment of how she was feeling and even when her numbers were positive and climbing she did not take any mood stabilizing drugs that she was prescribed. This is evidenced by the photos and her journal entries. Instead, she only took the antidepressant medication which for a bipolar patient, when taken alone, will exacerbate a manic episode.

Third, she misled her treating physician, Dr. Hu. In her last visit with Dr. Hu she lied about how she was feeling and if she was taking her prescription medications as instructed. Her lies deceived Dr. Hu into again prescribing the antidepressant medication and not increasing the dosage for the mood stabilizing as would have been appropriate. Whatever mood Ms. Childers found herself in on the night of May 29/30 was her intended mood. Her actions were deliberate, methodical and calculating.

Bottom line is that having bipolar disorder is not a license to commit crimes. Bipolar disorder effects mood not cognition. Nevertheless, bipolar I patients often find themselves in trouble with the law as a result of the actions taken while in a manic state. While studies have shown that bipolar patients have a proclivity for criminal behavior it does not excuse it. Ms. Childers' own criminal record shows that she has, from time to time, been out of control and in trouble with the law. Bipolar disorder does not make a patient paranoid. It just makes them act out in ways they desire to act but have held back. A patient in an extreme mania is a patient exposing their inner character.

Drug use and abuse, violence such as getting into altercations, and hyper sexualized behavior are all common activities of a patient during a bipolar I manic episode. That is why it is critical for a diagnosed patient to do whatever is necessary to avoid mania. When a subject, such as

Ms. Childers, intentionally induces mania they cannot then claim they were under the control of the mania they created. It would be like an alcoholic blaming the seven beers he just drank for making him drunk when it was his choice to drink in the first place. While some would say it is theoretically possible that a bipolar I sufferer could be acting at the direction of the illness and not of their own free will, this is not the case here. Bipolar patients can control their cycles so they are not extreme. Ms. Childers' intentionally let her mania get out of control. She is responsible for her actions during the manic state.

Conclusion:

It is my opinion to a reasonable degree of professional certainty that Sally Childers was in full control of her faculties on May 29/30, 2017. Her seducing and then murdering Patrick Summerfield was a premeditated act, not a side effect of a mood disorder that she could not control. She understood her actions and the consequences of her actions.

It is also my opinion that having a manic episode does not change the objective circumstances of a given point in time. Mania does not make a person fearful. It merely elevates their mood to a euphoric state. Ms. Childers killed Patrick Summerfield because it felt good to her to do it. She wanted to do it and she did it. This was not self defense.

/s/ Alex Shunnarah

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Alex Shunnarah

An Hu, M.D.

Education

Tulane University, B.S. (1987)
University of South Alabama College of Medicine, M.D. (1993)
National Naval Medical Center, Psychiatry Residency (1993-1995)
Harvard University, Fellowship in Psychodynamic Psychotherapy (1995-1997)

Licensing and Experience

Board certified in adult psychiatry

Life fellow in the American Psychiatric Association

Past president of the Alabama Psychiatric Society

Member of the AOA-Medical Honor Society

Presented at World Psychiatric Congress and American Psychiatric Association

Residency Training Director and Vice Chair of Department of Psychiatry at Penn State Hershey Medical Center (1997-2009)

Pierce & Associates; Prattville, Alabama (2009 – current)

- Office treats over 500 patients
- Testified in 17 criminal trials, always for the patient

Expertise

Specializes in PTSD and trauma related disorders, bipolar disorder, chronic depression and anxiety disorders in adult and geriatric patients.

Conducts trainings in stress management trainings and cross cultural adaptations

Conducts trainings in the art and science of evidence based modern psychiatry

Report of Dr. An Hu
July 7, 2017
Psychiatric Evaluation of Sally Childers

The State of Alabama will pay me at a rate of $175 per hour for my time spent during the trial. I have spent countless hours with Ms. Childers over the past two years and in preparation for trial I have spent 8 hours reviewing and studying Ms. Childers' unique case. However, I will only be paid by the State for my trial testimony time that takes me away from my practice. I expect that to be about four hours.

Background and Pertinent Medical History:
You have to know Sally Childers and what she has and is going through mentally before you can judge her.

I am Ms. Childers' personal physician/psychiatrist. She has been a patient of mine since September 30, 2015. After the initial consultation and having her complete a few diagnostic tests, I saw her again October 8, 2015, to go over results and give a diagnosis. Ms. Childers filled out eight pages of questionnaires, told stories of wild sexual encounters and lavish spending sprees as well as weeks of severe and debilitating depression. After reviewing the questionnaires I determined that her brain is what is commonly described as a "ring of fire" which is often a precursor to bipolar disorder. That fact, plus hearing her stories of great vacillation between depression and mania, I determined that Ms. Childers was suffering from bipolar disorder, specifically bipolar I.

Her treatment plan was to be combination of therapy, counseling sessions with a licensed therapist, and medications. I would see her once a month to determine how she was responding to the medication and adjust it as needed. Since finding the correct combination of medications is a bit of a hit or miss proposition we started with low dosages to see how she reacted. Because she was bipolar I, I prescribed a mood stabilizer, Lithium 25mg daily. Eventually, once a proper mood stabilizer is found then an anti-depressant will be added. In bipolar patients it is critical not to introduce anti-depressants too soon or it will cause an immediate manic episode. Lithium can be dangerous as the difference between a therapeutic dosage and a toxic dosage is slight. A small dosage was prescribed and if it is well received, then it may be gradually increased.

After two months, in December 2015, Ms. Childers complained of headaches and weight gain. As a woman in her twenties these side effects were not tolerable, so I switched her mood stabilizer to Trileptal 50mg daily. Besides the unfavorable side effects of the Lithium, Ms. Childers did report that she had not had a manic episode in the two months. She did complain about feeling down all the time. This is not an acceptable side effect and another reason to change to Trileptal. She reported that she had found a therapist and that her sessions were going well as she was beginning to understand how her body responds and reacts. She also mentioned dealing with the depression because of the bipolar I diagnosis. She felt ashamed

that she was bipolar and outside of her family and a few close friends had kept her diagnosis private. She mentioned that she had begun journaling as a way to express herself in a discreet fashion.

In March 2016, Ms. Childers said that her vision was declining. She stated that from time to time she would have double vision and that driving was difficult. She also complained of occasional dizziness. The dizziness had been a reoccurring problem that I had hoped would go away once her body adjusted to the Trileptal. But after four months and no change it was time to try a different mood stabilizing medication. I put her on Valproate, specifically Depakote 50mg daily.

In April 2016, Ms. Childers came in and before she sat down she requested to be taken off the Depakote. In fact, she herself stopped taking the Depakote after using it for only four days. She said the Depakote caused her to feel hot or flushed all the time, she would have difficulty breathing and swallowing which then cause to her to have panic attacks. Because she was not under the influence of any prescription mood stablizer she said that she felt herself cycle to extremes. She said she had her first manic episode since her diagnosis in October 2015. She said the episode lasted for five days. She then said she fell into a deep depression and did not leave her the apartment for eleven days. I agreed that the Depakote was not a good fit but warned her not to alter her medications without consulting my office. I told her that she need not wait for her regular monthly visit, but that we could see her anytime she was having problems. At this point I prescribed Lamictal, specifically Lamotrigine 50mg daily. For insurance purpose I already knew that Lamictal was less expensive as 100mg so I gave her a prescription for 100mg but told her to break the pills in half and just take a half pill. I also prescribed Clonazepan 50mg to take as needed if she had anymore panic attacks.

In August 2016, after Ms Childers had no significant complaints about any adverse side effects from the Lamictal, I raised her daily dosage to 100mg daily. Ms. Childers did say that while she was not in a depression she was not herself. She confessed to not knowing what “feeling herself” actually felt like. But there has not been a significant manic episode since changing to Lamictal. She has not complained of panic attacks since April 2016 so I did not renew that prescription.

In January 2017, after Ms. Childers informed me that she had no significant side effects from the Lamictal, I raised her dosage to 200mg daily. Since Ms. Childers had become more in tune with her body she said she could tell when she was cycling. She said she had not been high for a while but did suffer serious depressive period in the middle of the month which caused her to lose her job. I advised her to try to keep of log of how she was feeling each day to see if there was a pattern. If there was a pattern then we could adjust her medications in anticipation of highs or lows. I explained to her that a simple numbering system would suffice. She should treat zero as have neither depression nor mania. If she felt depression she should give a negative number with negative 10 being the most extreme depression. If she felt mania she should give that a positive number with 10 being the most extreme mania. I told her to bring her log with her to each appointment.

On April 24, 2017, after Ms. Childers has shown that the Lamictal agrees with her as a mood stabilizer, I decided to introduce an anti-depressant. Ms. Childers' log numbers were consistent but they were consistently on the negative side. The therapeutic goal is to get her balanced, at zero for a predominant period of a month. An anti-depressant is now appropriate since she is taking, and has been taking, a medically significant amount of mood stabilizers for several months now. I prescribed Wellbutrin at 150mg daily and increased the Lamictal to 400mg to balance out just in case the Wellbutrin was too strong at that dosage.

On May 22, 2017, I saw Ms. Childers for her regular monthly visit. For the first time in my office I could tell that she was in a manic state. According to her log it was a significantly high manic state at a 5. I felt that the Wellbutrin may be too strong so I prescribed a lower dosage. I decreased her prescription to 50mg daily. I stressed to her that if her numbers did not drop close to zero or below zero quickly she needed to immediately cease taking the Wellbutrin. She became agitated when she described her working conditions. She said felt as if her boss, Mr. Summerfield, was sexual harassing her and that he was crossing the line. She expressed a desire to hurt him but when pressed said that she was not serious and just exaggerating. Nevertheless I prescribed an antipsychotic medication, Risperidone 1mg, to eliminate her deviant thoughts and calm her restless mind.

Since I would see Ms. Childers every month I only prescribe enough medication for thirty days. Every prescription I have written for Ms. Childers has been for thirty days worth of medication. Typically that means one pill per day.

May 22, 2017: Nurse notation. The pharmacy called and informed us that because the prescription for the Wellbutrin was 50mg and said one or two pills per day that it was improper to designate 1 or 2 pills. The nurse told the pharmacy to make it one pill at 100mg.

On June 5, 2017, After noticing the nurse notation I felt compelled to visit Ms. Childers in the Maycomb County detention center. Given the extreme reaction to the Wellbutrin, as well as the confusion over her last prescription, I ceased the Wellbutrin prescription and will not add any anti-depressant to Ms. Childers regime for the near future. I increased the Risperidone to 2mg as well.

Data used to form opinion:
To come to my opinion I reviewed the pertinent medical history described above. I read the statements of Casey Cantrell and Bennie Arnold. I read the description of the report produced by Detective Lloyd. I also, for the first time, saw Ms. Childers' journal along with her log of mood numbers. Previously I had not reviewed either her journal or log. I relied on her oral statements of both her journal entries and log numbers during our office visits. Finally, I have seen all of the photographs and the surveillance video of the stabbing.

Opinion and Analysis:
It must be understood that for a person with severe Bipolar disorder, like Sally Childers, the part of the brain involved in emotional responses and decision-making are broken. The result can be impulsive behavior. A patient does not get the feedback that controls their decisions. In other words, they do not have the brakes on their behavior. That is why it is critical that their disorder be tempered with medication so that they can remain in control.

Unfortunately, finding the right balance of medications for bipolar disorder is a trial and error process. At the end of the day it is much like trying to get the water in a shower balanced. There is hot and cold water and it has to mix just right. That perfect temperature differs from person to person. And much like when the hot water starts to run out in a shower you have to adjust the dials mid-shower to try to maintain as close to comfortable as possible, so too with the bipolar medications. It is an individual assessment that takes time. It is not a one size fits all.

When the anti-depressant was added to the mix in April 2017, it created a state of mania in Ms. Childers. It must be understood that mania is when a patient is in a euphoric mood. The patient feels as if they are on a high. They are energetic, engaging, and have periods of heightened concentration and creativity. They often feel a decreased need for sleep; have an erratic appetite, and an increased libido. As a result, bipolar patients crave the mania. It has been described as the greatest "high" a person can achieve. For Ms. Childers, she had not experienced a significant mania period for quite some time as the mood stabilizers had suppressed any significant mood swing upwards. Finally feeling "up" after feeling "down" for so long is like a giving a meal to a starving person. Feelings of indestructibility and grandiosity that come with mania tend to trick a patient into doing or trying things that are extreme, dangerous and sometimes criminal.

So as in the case of Ms. Childers, it is reasonable that when her mood finally rose into a significant manic state of 3 or more, as evidenced by her log, she desired to stay there and would do whatever was necessary to continue the euphoria. It should be noted that even though patients themselves maintain their mood log it can be trusted as reliable because the patient is seeking improve their condition. Lying on the mood chart would only distort that objective.

The mania at level 3 or above can result in increased impulsivity and can significantly impair reasoning and judgment. Ms. Childers' subconscious bipolar brain tricked her into thinking that mania was ideal when her conscious mind would be tempered. Her overdosing on the anti-depressant is reasonable as she rightly connected the manic state to the introduction of the anti-depressant. Also, by not taking the mood stabilizers she exaggerated the manic inducing effect of the anti-depressant.

Unfortunately, this is normal reaction of a bipolar patient that is at this high level of mania. The patient has no concept of right and wrong they simply want to maintain the euphoria. That explains why Ms. Childers was not forthright in our May 2017 appointment. Her statements

were true in how she was feeling, however her neglecting to inform me that she was not taking the prescribed amount of mood stabilizers, while a material misstatement, is typical given the high level of mania she was experiencing at the time. In hindsight, I should not have renewed the prescription for any amount of Wellbutrin given her body's reaction to the drug as evidenced by her demeanor in my office. But there is no way to predict how any amount of any medication will respond in a patient.

Unfortunately, in this case, for Ms. Childers there was a severe chemical imbalance caused by the Wellbutrin. There was also an accidental overdosing by taking twice the originally prescribed amount since May 22. Given her base need to maintain the mania it is predictable that she would overdose. It is reasonable that she did not realize she was overdosing. She may have thought that the pills were 1/3 as strong as before because that is what we discussed in my office on May 22. In fact, they were 2/3 as strong or twice a potent as she would have believed. Ms. Childers thought she was maintain her previous level of medication and not adding more than prescribed even though she was taking more pills. A balanced patient may have noticed that the bottle was clearly marked 100mg but her pattern of taking the anti-depressant indicates that she believed she only had a 50mg prescription as we discussed. As a result instead of taking 150mg as she was the previous month she was, at least at first, taking 300mg per day. At that high dosage her mania would overwhelm her reasoning.

Also, while a person in a severe mania their emotions can turn on a dime and become irritable. Given the energetic and aggressive attitude of a patient during a manic episode this can turn violent. It is not uncommon for a bipolar patient in a manic episode to be set off by some minor infraction and have an overreaction greatly disproportionate to the perceived slight. This is often a precursor for criminal activity be it assault or destruction of property.

In the case of Ms. Childers, as seen from her self-assessment, she was raging in a mania on May 29. She had taken ten times the amount of anti-depressant prescribed and was not taking any counter balancing mood stabilizers. Ms. Childers demonstrated her ability to quickly fly off the handle by overreacting to the catfish incident. She demonstrated her dramatically heightened libido on May 27, by giving her boss, a man she was repulsed by, a lap dance and by having unrestrained intercourse with several strangers. Finally, you can tell that she is not herself by seeing how her language and tone changes in her journal. When she is manic her language is foul, coarse and vulgar. She is not herself.

Ultimately, when Ms. Childers was threatened by Mr. Summerfield and her personal space not respected she struck back. A violent outburst is consistent with her extreme condition. At that time she was not capable of fully understanding the meaning of her actions in punching with a knife. Besides it is clear from the evidence that Mr. Summerfield was sexually assaulting Ms. Childers and she was justified in defending herself regardless of her mental condition.

It is my professional opinion to a reasonable degree of professional certainty that Ms. Childers' severe manic state as a result of her bipolar I disorder made her incapable of understanding the significance of stabbing someone with a knife. In her extreme mania she could not form

criminal intent or perceive right from wrong. She was acting out inhibitions buried in her subconscious mind. She sought only to maintain or heighten the euphoria of the mania. Her overdosing on anti-depressants was a natural consequence of her bipolar I disorder and as a result she could not fully understand the consequences of her actions, her bipolar brain at that time would not allow it.

It is also my professional opinion that given Ms. Childers severely elevated mania she would reasonably and quickly perceive aggressive behavior as a legitimate threat to cause her bodily harm. Elevated mania can create paranoia and sudden agitation which makes her actions to defend herself, while sudden and violent, justified. For her the fear was immediate and real.

Had her mania been a seven or below I would have a different opinion of her mental capacity and her culpability for her action.

/s/ An Hu

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An Hu