AMERICAN BANKRUPTCY INSTITUTE

2021 Virtual Annual Spring Meeting

Dealing with Debtors/Creditors with Mental Health Issues

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CONCURRENT SESSION

2021

Mental Health and The Bankruptcy Process:

Dealing with Debtors/Creditors with Mental Health Issues

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An overview of mental illnesses that often confront bankruptcy courts, and how to handle problems that arise when mental illness is an issue in a case or when a debtor's mental illness affects the administration of a case.

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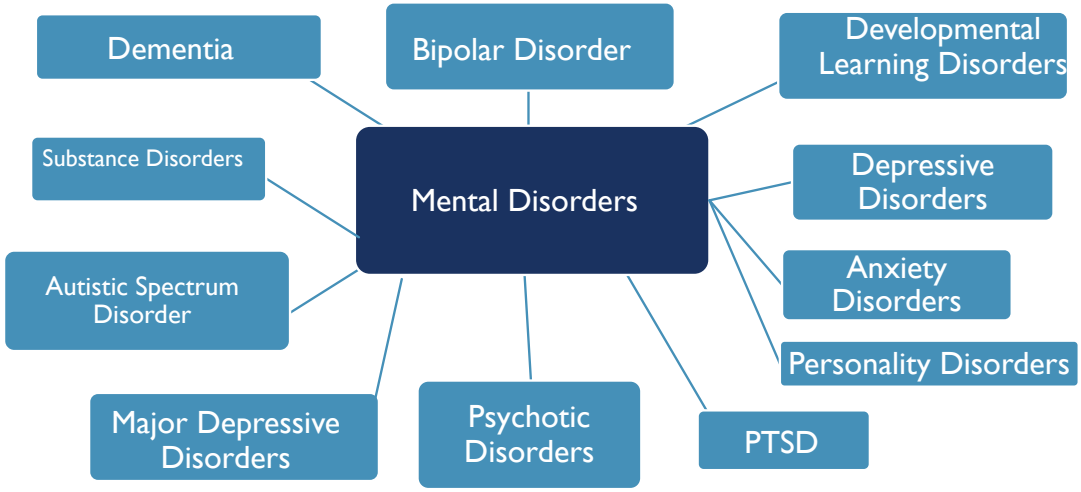
TYPES OF MENTAL HEALTH ISSUES THAT APPEAR IN THE BANKRUPTCY PROCESS



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HISTORY

In Biblical times, mental illness was understood in spiritual terms (demon possession, the work of the devil).

Hippocrates first classified personality types in 400 A.D. based on the relative amounts of the 4 humors he believed our bodies contain:

- Blood-Sanguine (happy, optimistic) Personality
- Black Bile-Melancholic (depressed)Personality
- Yellow Bile-Choleric (angry) Personality
- Phlegm-Phlegmatic (lazy)Personality

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HISTORICAL VIEWS OF MENTAL ILLNESS

- 1840 census reflects stigma in classifying all mental disorders as "idiocy."
- 1840-1887 Dorothea Dix campaigned for humane treatment of indigent people with mental illnesses.
- 1963 Community Mental Health Centers Act made mental health care a right of all citizens, not a privilege of those who could afford it.
- 1980s Health Insurance became "managed care." This limits coverage to "measurable behavioral objectives" in treating "functional impairments." The traditional goals of psychotherapy (insight and change to achieve happiness, relatedness, efficacy, coherence, and sense of purpose) are not regarded as "medically necessary" and are often not covered. Many criticize managed mental health care as "Treating the symptoms—not the person."
- 1999-2001 Mental Health Reform did away with Community Mental Health Centers and reduced public funding for mental health care by privatizing (and under-funding)it with a system of LMEs (Local Management Entities) authorizing payment for services by private provider groups.

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BARRIERS TO COMPASSIONATE CARE OF MENTAL ILLNESS

• **Stigma** ("I don't want people to know that I'm in therapy." "I have problems, but I'm not crazy.")

• **Misunderstanding** ("Just try harder." "Look on the brighter side." "I've got the blues, but I don't think I'm depressed". "I don't want to use medication as a crutch.")

• **Neglect** ("I don't want to pay more taxes for those people's problems.")

• **Us-Them** ("I get down sometimes, but not like those people." "It's mostly low income people who have those kinds of problems.")

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DEPRESSIVE DISORDERS

Depressive disorders are characterized by a disturbance of mood. Everyone experiences mood changes, but one is considered to have a mood disorder only if the mood disturbance impairs functioning and/or causes significant personal distress.

Temporary depression is appropriate and necessary in adjusting to a loss (e.g. death, divorce, job loss). These are not considered a depressive disorder.

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PREVALENCE

Many experts consider Depression the most common mental disorder.

Major Depressive Disorder has a lifetime prevalence of 10-25% of women & 5-12% of men across all races, ethnicities and socioeconomic classes.

Dysthymic Disorder has a 6% lifetime prevalence. Bipolar Disorder has a 1-1.8% lifetime prevalence. Onset can occur at any age with mean of 40 for MDD. Course is chronic and episodic.

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DEPRESSION INVOLVES THE FOLLOWING MOOD CHANGES:

- Sadness
- Irritability
- Pessimism
- Guilt
- Low self esteem
- Lack of initiative
- Anhedonia
- Preoccupation with death
- Suicidal thoughts

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DEPRESSION ALSO INVOLVES PHYSICAL SYMPTOMS:

- Sleep disturbance (insomnia or hypersomnia)
- Appetite disturbance (lack of appetite or comfort feeding)
- Fatigue
- Low sex drive
- Trouble with concentration and memory
- Psychosomatic concerns

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TYPES OF DEPRESSIVE DISORDERS

Depression and/or mania occur in several mood disorders listed roughly from less severe to more severe:

- V Codes or normal reactions to stressful events (e.g. bereavement)
- Adjustment Disorders or temporary but abnormal reactions to stressful events
- Secondary to a medical condition (e.g. thyroid condition, congestive heart failure)
- Secondary to another mental disorder (e.g. schizophrenia, cluster B personality disorders)
- Dysthymic Disorder (chronic, less severe)
- Cyclothymic Disorder (cycling episodes of hypomania and dysthymia)
- Depressive Disorder Other Specified and Unspecified (Premenstrual Dysphoric Disorder, Seasonal Affective Disorder, Minor Depressive Disorder, Recurrent Brief Depressive Disorder, Mixed Anxiety- Depression Disorder, Post-Psychotic Depressive Disorder) • Major Depressive Disorder (severe, episodic)

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TREATMENT

Although depressive disorders are chronic, symptoms can be eliminated or reduced for most people.
- The most effective treatment is a combination of psychotherapy and medication.
- Psychodynamic and cognitive-behavioral therapies have demonstrated effectiveness.

MEDICATIONS

- The most common anti-depressant medications are SSRIs (selective serotonin reuptake inhibitors) (Prozac, Zoloft, Paxil, Lexapro).
- Other medications used include those that act on norepinephine (Welbutrin, Cymbalta),
- Tricyclics (Elavil, Sinequan, Norpramin)
- MAO (monoamine oxidase) inhibitors (Nardil).
- Mood stabilizers are used for bipolar disorder. The most common is lithium carbonate. Some seizure medications (Depakote, Tegretol, Lamictal) are also used for their mood stabilizing properties.

- Severe and life threatening depression: hospitalization may be necessary.
- When other treatments have proven ineffective, ECT (electroconvulsive therapy) or TMS (targeted magnetic stimulation) may "hit the reset button" on mood.

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BIPOLAR DISORDER

- Characterized by cycling from Major Depression to Mania (Bipolar I) or Hypomania (Bipolar II).

- Mania: elevated mood, grandiosity, hyperactivity, reduced need for sleep, pressured speech, flight of ideas, distractibility, agitation, high risk behavior, & irritability. With mania, symptoms are bizarre and sometimes psychotic.

- Hypomania: abnormally elevated mood, energy, activity & confidence. Not bizarre or psychotic and may occur in productive, creative people.

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ANXIETY DISORDERS

Anxiety is a normal reaction to perceived danger. The danger can be psychological (e.g. humiliation) or physical. Anxiety involves both subjective distress (worry, hyper-alertness, hyper-reactivity) and physiological reactions (trembling, sweating, palpitations, flushing, nausea, and shortness of breath). An anxiety disorder is diagnosed when anxiety is severe enough to cause substantial discomfort and/or impaired functioning. Anxiety disorders are common, and people with anxiety disorders often have more than one type.

Types

- Generalized Anxiety Disorder (excessive generalized worry)
- Obsessive-Compulsive Disorder (irrational obsessive thoughts and compulsive rituals)
- Acute Stress Disorder (heightened arousal, intrusive thoughts, and attempts to avoid reminders occurring within a month of a traumatic event such as combat, rape or natural disaster)
- Posttraumatic Stress Disorder (heightened arousal, intrusive thoughts and attempts to avoid reminders enduring more than a month after a traumatic event such as combat, rape, torture, domestic violence or natural disaster) • Panic Disorder (Brief periods of terror and physiological arousal)
- Agoraphobia (irrational fear of public places)
- Social Phobia (excessive fear of public speaking or social situations)
- Specific Phobia (irrational fear of specific objects or activities, e.g. flying, spiders)

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ANXIETY DISORDERS

PREVALENCE

- Anxiety disorders are common. One in four people meet criteria for at least one in their lifetime. • Having a co-occurrence of more than one is the norm.
- Some anxiety disorders are primarily responses to stressors (PTSD). Others (OCD, GAD, phobias) appear to be more endogenous.

TREATMENT

- Most anxiety symptoms can be eliminated or reduced with treatment.
- Behavioral therapies (desensitization) are helpful with symptoms such as phobias, cognitive behavioral therapies with catastrophising thought patterns, and psychodynamic therapies with underlying fears and conflicts.
- Preferred medications are SSRI's, which address anxiety as well as depression and are relatively free from side effects and dependency. Benzodiazepines (Klonopin, Xanax, Valium) also give more immediate relief, but can produce dependency.

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PTSD

• Intrusive thoughts & hyperarousal
• Unstable mood, depression and anger
• Anxiety
• Hypervigilance & mistrust
• Avoidance of potentially triggering situations
• Diagnosed as Acute Stress Disorder if it resolves within a month of the trauma & Post-Traumatic Stress Disorder if it becomes chronic.
• Caused by trauma (sexual assault, combat, torture, natural disaster).

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DEVELOPMENTAL & LEARNING DISORDERS

- ADHD (hyperactive, distractible, impulsive)
- Specific Learning Disabilities (dyslexia or impaired learning in other specific area in a person with otherwise normal intelligence)

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ADHD

ADHD is a life-long condition that is usually first noticed in the toddler stage.
- It is divided into subtypes according to whether hyperactivity, inattention or impulsivity are the predominant feature.
- Symptoms include restlessness, excessive talking, difficulty sticking with activities, difficulty listening, disorganization, losing things, forgetfulness, and interrupting.
- Sometimes ADHD also includes difficulty reading social cues.

ADHD is treated with a combination of stimulant medications, classroom accommodations, and compensatory strategies.
- Stimulant medications (Ritalin, Concerta, Adderall, Vyvanse) activate brain centers for focusing.
- Schools are required by law to provide necessary classroom accommodations (front row seating, untimed test taking, note takers, tutors).
- Compensatory strategies involve list making, distraction-free work space, coaching on organization, and exercise. Books by Edward Hallowell & John Ratey, Russell Barkley and others contain a wealth of suggestions

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AUTISTIC SPECTRUM DISORDERS

• **Autism** involves markedly abnormal development of social interaction and communication skills and restricted interests and activities. It is relatively rare (0.02-0.05 %) and usually develops before age 3.

• **Asperger's Disorder** involves less severe impairment of social interaction, repetitive behaviors & interests, and no delays in language.

• **Autistic Spectrum Disorders** (ASD) Include Autism, Asperger's and 2 rare disorders (Rett's Disorder and Childhood Disintegrative Disorder) characterized by regression after a period of normal development.

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PSYCHOTIC DISORDERS

Psychosis is defined as the inability to distinguish reality from fantasy. It includes hallucinations (false sensory perceptions), delusions (incorrect inferences about reality), and illusions (distortions of sensory perceptions). Psychosis is a symptom of several categories of mental disorders.

TYPES OF PSYCHOTIC DISORDERS

- Schizophrenia; Schizophreniform Disorder; Schizoaffective Disorder
- Bipolar Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Shared Psychotic Disorder (Folie a Deux)
- Psychotic Disorder Due to a General Medical Condition
- Substance-Induced Psychotic Disorder
- Transient psychotic episode in Borderline Paranoid, or Schizotypal Personality Disorder
- Neurocognitive Disorders (Dementia, Delirium and Traumatic Brain Injury)
- Psychotic Disorder Not Otherwise Specified

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SCHIZOPHRENIA

• Schizophrenia is a severe and chronic disorder with onset in late teens or twenties.

• It is characterized by "negative symptoms" (i.e. deterioration of many aspects of cognitive functioning, affect, social skills, and self care, and by "positive symptoms" (i.e. psychosis including hallucinations and/or delusions).

• Functioning ranges from self-sufficient but eccentric to requiring institutional care. Modern anti-psychotic medications (Clozaril, Risperdal, Seroquel, Zyprexa, Abilify) have increased the likelihood of independent living by controlling "positive" symptoms.

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DEMENTIA

• Dementia is an impairment of memory and other cognitive functions without impairment of consciousness.

• It is roughly synonymous with the popular terms, "senility" and "brain damage."

• Dementia is usually irreversible.

• It is most often associated with old age, though it can also occur in younger people as a result of medical conditions such as stroke, traumatic brain injury, poisoning, substance abuse, or early onset Alzheimer's.

Types

• Alzheimer's (most common, cortical)
• Vascular (Multi-Infarct Dementia or "hardening of the arteries")
• HIV (slower, subcortical)
• Parkinson's
• Korsakoff Syndrome (Alcohol-Induced Dementia)
• Stroke
• Traumatic Brain Injury Other less common dementias (Lewy Body, Pick's, Huntington's or "Woody Guthrie Disease , Creutzfeld-Jacob)

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ALZHEIMER'S

- Most common dementia and increasing.
- More common among women (2/3 are women).
- Usually begins in later adulthood, but can begin as early as 40s.
- Earliest symptoms are gradual memory loss, disorientation, and mood changes.
- Later symptoms include paranoia, agitation, loss of short-term and then long-term memory, and eventually loss of autonomic memory (swallowing).
- Hereditary tendencies, but causes not well understood.
- Results from development of plaques and tangles in cortex.
- Until recently, could be diagnosed only by symptoms and autopsy, but recent brain imaging studies show changes years before development of symptoms, opening the way for early detection and treatment.
- Although incurable, early treatment (Namenda, Aricept) can slow the rate of memory loss by about 6 months.

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ALZHEIMER'S

TREATMENT

- Medications (Namenda, Aricept) slow the rate of memory deterioration.
- Antipsychotics are used to address paranoia and agitation.
- Care for the caregiver (respite care, support groups such as Duke Family Support Program) is critically important.
- Some continuing care and assisted living facilities have units specifically for dementia.
- Alzheimer's Association offers a wealth of information about resources

STATISTICS

- Alzheimer's is 6th leading cause of death in US.
- 1 in 3 seniors die with dementia.
- In 2013, nationally 15.5 million caregivers provided 17.7 billion hours of unpaid care valued at more than $220 billion.

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PERSONALITY DISORDERS

- Personality disorders are enduring patterns of feeling, thinking and acting.
- They cause significant distress and/or impaired functioning.
- They have been consistently present at least since adolescence.
- They are present across many situations (not just in crisis).
- They deviate from cultural norms.
- DSM-5 adds that they involve impairment in self (self concept, goals) and interpersonal understanding (other perspectives, close relationships).

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TYPES OF PERSONALITY DISORDERS

- Antisocial
- Avoidant
- Borderline
- Narcissistic
- Obsessive-compulsive
- Schizotypal

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WHEN DO MENTAL HEALTH ISSUES ARISE IN THE BANKRUPTCY PROCESS?

A. Section 341 meetings - Debtors may not be able to attend meetings.

B. Adversary proceedings

C. Objection to Claims

D. Invisible Debtors

E. Mental Illness can cause Debtors' behaviors and errors in judgment.

F. Mental illness can cause Debtors to fail to act.

G. Mental illness plus substance addiction can cause irregular behavior.

H. Mental illness vs evil or angry behavior

I. Others

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WHEN DO MENTAL HEALTH ISSUES ARISE IN THE BANKRUPTCY PROCESS?

A. Proceedings having to do with ability to pay student loans. Debtors often assert that mental illness precludes repayment of their student loans.

B. An excuse for certain conduct (failure to answer a complaint, list assets on a petition, obtain credit counseling, attend 341 meetings, and to take an approved financial management course). Debtors sometimes claim that their illness caused mistakes or omissions in required filings, and ask the court to excuse the omission on that basis. Debtors have also asserted that their behavior should be excused by their substance addiction, but that defense rarely is successful.

C. Any determination of a debtor's ability to understand a contractual arrangement, to get a job, or to keep a job can involve mental health considerations. So, too, can a debtor's ability to attend court, complete paperwork, and participate appropriately. Depression, mania, anxiety, attention disorders, psychosis, personality disorders, and substance abuse all may a be relevant and require accurate diagnosis and proper management. This is why it's useful for the court to have access to mental health assessment.

D. Individuals with anxiety disorders such as generalized anxiety disorder, panic disorder, and social phobia may become frozen with terror at the prospect of having to testify. Measures that may help these individuals include: (1.) a pre-hearing visit to the courtroom, (2.) meeting the judge in advance, (3.)being accompanied by a trusted companion, and (4.) being helped to prepare a written statement in advance.

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BANKRUPTCY PROFESSIONALS WHO MAY ENCOUNTER MENTAL HEALTH ISSUES DURING THE BANKRUPTCY PROCESS

- JUDGES and COURT STAFF
- TRUSTEES
- DEBTORS' AND CREDITORS' COUNSEL
- FINANCIAL ADVISORY PROFESSIONALS

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HOW SHOULD BANKRUPTCY PROFESSIONALS HANDLE MENTAL HEALTH ISSUES DURING THE BANKRUPTCY PROCESS?

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HOW TO HANDLE DIFFICULT LITIGANTS

Helpful Ways to Deal with Pro Se Litigants

- Pro se litigants are not usually difficult people, but trying a proceeding with parties who are not represented by counsel can be difficult because pro se litigants are usually not familiar with legal requirements and basic courtroom procedures.

Pre-trial Conferences – a pre-trial conference at which all parties are present gives the court the opportunity to explain to the pro se litigant the elements that must be proved to maintain the litigant's cause of action or defense. The judge can also explain basic procedure and courtroom protocol. ending an in-court pre-trial conference also gives the pro se litigant a chance to become acclimated to the courtroom, and perhaps to see other matters being tried.

Here is a checklist of some things to cover;

- - where the litigant should sit and who may accompany the litigant
- - what attire is not appropriate for court
- - parties should stand when addressing the court
- - opening statements
- - the order of presentation of evidence
- - the questioning and cross examination of witnesses
- - the introduction of documentary evidence
- - closing arguments

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HOW TO HANDLE DIFFICULT LITIGANTS

Video or Court Provided Checklist - Information regarding court procedures can be made available in written form or by video on the court's website.

Pro Bono Programs for Pro Se Non-Debtor Litigants

- In the Eastern District of North Carolina some members of the bar have agreed to represent non-debtor litigants in bankruptcy proceedings when the party is unable to afford counsel.
- This typically occurs in proceedings such as actions by a chapter 7 trustee to recover preferential transfers.

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HOW TO HANDLE DIFFICULT LITIGANTS

Suicide Threats and Strategy
Suicide threats should be taken seriously, and the court should develop a strategy to deal with threats that are made. For example, court employees should have a hotline phone number to provide to anyone who should make a suicide threat.

Suicide Prevention Hotline:
http://www.suicidepreventionlifeline.org/
1-800-273-TALK (8255)

Are Mentally Ill Litigants Dangerous?
People who have mental illnesses may behave strangely, but they are rarely dangerous. When they are, they are more likely to be dangerous to themselves than to others. There are, however, exceptions.

The primary exception concerns those with antisocial and related personality disorders (e.g. borderline and narcissistic). Such individuals tend toward angry, impulsive, aggressive behavior. They lack appropriate impulse control, regard for others, and conscience. They tend to experience people as either with them or against them. A second exception are people with paranoia. Paranoia can occur in a number of mental disorders, (e.g. schizophrenia, bipolar disorder, major depressive disorder, dementia, delusional disorder, drug-induced psychosis). People who experience paranoia may be dangerous because they feel the need to defend themselves against perceived harmful intentions of others. A final exception are people with substance abuse disorders. Such individuals, when intoxicated, may lack the self-control and judgment that they possess when sober. And, as the condition worsens, their behavior when sober may likewise become more troublesome.

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HOW TO HANDLE DIFFICULT LITIGANTS

Security:
- Some litigants are members of anti-government groups and have a disruptive agenda. Some litigants are just angry and have been inflamed by sentiments appearing on the internet, facebook, blogs and other social media.

- Here are some security measures that might help.
- Alert Everyone in Chambers, Clerk's Office and CSOs (Send an email with a photo)
- Designate a Senior Person in Clerk's Office to Deal with Difficult Litigants
- CSOs Should Accompany Difficult Litigants to Clerk's Office
- Court Order: In egregious cases a court order can be entered outlining, with respect to a specific litigant, what behavior is not acceptable. The order should be sent to all court personnel. Communications from the difficult litigant can be required to be in writing and on the record.

Strict Adherence to Procedural Rules.
- It is always a good idea to strictly adhere to procedural rules, but it is especially helpful when dealing with difficult litigants.

Marshals Service Assistance
- The U.S. Marshals Service is responsible for providing security for federal judges. Obviously, you should report any threat as soon as possible. It is important to get to know and regularly contact the Judicial Security Inspector for your district. Judges and their staffs should keep the emergency number for the U.S. Marshal with them at all times.

Prohibiting Re-filings
- 11 U.S.C. § 109(g)(1) provides that a debtor is precluded from refiling a petition for 180 days for willful failure to abide by orders of the court resulting in dismissal.

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HOW TO HANDLE DIFFICULT LITIGANTS

Civil Contempt - In cases involving disruptive litigants, courts have used their contempt powers to bar parties from the courthouse.
Criminal Contempt - Criminal contempt sanctions are punitive in nature and preserve the dignity and authority of the court when the court's orders are violated.
Dismissal of Chapter 7 Case § 707 - Section 707(a) provides that after notice and a hearing a court may dismiss a case under chapter 7 for cause.
Denial of Discharge § 727 - The court shall not grant a discharge for a number of reasons specified in § 727, including failure to obey any lawful order of the court. § 727(6(A).
Dismissal or Conversion of Chapter 11 Case § 1112(b) - Bankruptcy Code §1112(b)(1) provides that after notice and a hearing the court shall convert a case under chapter 11 to one under chapter 7 or shall dismiss the case for cause. 11 U.S.C. § 1112(b)(2)(E) provides that cause "includes" failure to comply with an order of the court. The types of "cause" specified in § 1112(b)(E) are not exclusive. § 102(3).
Appointment of Trustee or Examiner § 1104 - A court may appoint a trustee or examiner for cause. Because the specified incidents of "cause" are not exclusive, presumably a trustee or examiner could be appointed for failure to abide by an order of the court.

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HOW TO HANDLE DIFFICULT CREDITORS

11 U.S.C. § 523(d)

Where a creditor unsuccessfully objects to dischargeability under § 523(a)(2) and creditor's position is determined to be "not substantially justified," the court shall award judgment for debtor and costs/fees for the proceeding, unless special circumstances render such an award unjust.

Bankruptcy Rule 9011 Sanctions

After notice to and opportunity for offending party to respond, and on motion or court's own initiative, court may sanction an attorney, law firm, or party in violation of requirements governing representations to the court.

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HOW TO HANDLE DIFFICULT ATTORNEYS

Judges are not infrequently confronted by lawyers who misbehave in different ways. Some of these activities are minor, but some are quite serious. Some lawyers are always late to court, while some are rude to litigants and other attorneys. Some lawyers are disrespectful to the court and some are dishonest.

Helpful Phrases

- Counsel, you are not being respectful of the court if you are being disrespectful to each other.
- Mr. Smith, we do not observe Casual Day in this courtroom.
- I have announced my decision, the proceeding is concluded, and if you have other arguments to make, you may make then to another judge should you decide to appeal.
- I appreciate your apology for being late, but you also owe an apology to opposing counsel, and all the parties, including your client, who have been waiting for you to arrive.

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HOW TO HANDLE DIFFICULT ATTORNEYS

28 U.S.C. § 1927- An attorney who "unreasonably and vexatiously" multiplies proceedings may be required by court to "personally satisfy" the resulting excess costs and fees.

Discovery Sanctions

Refer to State Bar or Disciplinary Panel

Professional Obligation to Report Attorney Misconduct

The Model Rules of Professional Conduct (www.americanbar.org), which have been adopted by and serve as the ethics rules for most states, include rules intended to maintain the integrity of the profession.

Among these, Rule 8.3 ("Reporting Professional Misconduct") provides in part: "A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority." Examples of conduct deemed to be "professional misconduct" are set out in Rule 8.4.

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HYPOTHETICALS WHERE MENTAL HEALTH ISSUES AROSE DURING THE BANKRUPTCY PROCESS

HYPOTHETICAL ONE: CHAPTER 13 DEBTOR

Debtor files a chapter 13 case in 2014. Approximately a year later, Bank of America (BA) seeks relief from the automatic stay (RFS) based on her numerous missed post-petition payments, totaling approximately $10,000. Debtor opposes RFS, arguing that BA does not have standing because it holds only the Note and not the Deed of Trust. (This argument has been rejected by state courts in California and numerous bankruptcy and district courts in California). The Court grants RFS under 11 U.S.C. § 362(d)(1), finding "cause" for failure to make post-petition payments. The Bankruptcy Appellate Panel (BAP) affirms. Debtor then files 75 pleadings in numerous cases in the bankruptcy court, before the Bankruptcy Appellate Panel and Ninth Circuit Court of Appeals, and in other state and federal courts, asserting that BA did not have standing to seek RFS because it did not hold the Deed of Trust.

In 2019, after the Judge issues a ruling again disagreeing with the Debtor's position that BA lacked standing to seek RFS, the Debtor:

(a.) Moves to recuse the Judge claiming that Judge's grown son, who is living with the Judge while his house is being renovated, has a bank account with BA.

(b.) Sends a letter to the Judge's chambers with photos of the gym that the Judge frequents, the school her grandchildren attend, and the Judge's favorite restaurant.

HYPOTHETICAL TWO: THE ROGUE CREDITOR

Madeline Manning is a 25-year-old transgender female who worked at the Debtor's retail video game store, Gamepop, in Cleveland, Ohio, for 4 days as a stockperson before she was fired for insubordination and being consistently late. Madeline alleged that during the course of her employment at Gamepop, the manager of the store, Karl "Mine" Kraft, refused to call her by the correct pronouns, "she and "her' and instead kept referring to her as "he" and "him" and by the name that was on her driver's license, Mario. After she was fired, Madeline filed a gender discrimination complaint with the EEOC claiming that she had been discriminated against because she was transgender. At the hearing on the complaint, Madeline failed to show up and the complaint was dismissed.

As the video game market shifted from CDs to online downloads, Gamepop's financial situation became dire and it was forced to file a chapter 11 case in the Northern District of Ohio. The Debtor listed Madeline as a creditor and she received notice of the filling of the case. As a result, Madeline filed an administrative claim for $100,000 based upon her EEOC complaint that "was not settled yet". Unable to reorganize, Gamepop sold most of its assets in a 363 sale and confirmed a Liquidating Plan chapter 11 plan. Amelia Gumby was appointed the Liquidating Trustee and she hired Hammond Egger from the law firm of Freeman & Mason as her counsel. Hammond worked closely with Gumby and filed a series of Omnibus Claim objections.

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HYPOTHETICAL TWO: THE ROGUE CREDITOR – CONT.

After performing her due diligence on Madeline's claim, Gumby directed Egger to file an objection to Madeline's claim. Shortly after the claim objection was filed Egger began receiving weekly emails from Madeline. Many of the emails were incoherent and rambling. The emails included statements that the EEOC lost her paperwork, that she had consulted with the Attorney General for the State of Ohio and the FBI, that she had filed her own complaint against the EEOC for libel, that she was suffering from a series of medical and mental health issues for which she was receiving treatment. In one email. Madeline outlined her entire medical history in detail. In another email she described her experience at Gamepop, where they were rude, had interrogated her about her prior job history (she had been fired from multiple jobs), was treated as "a freak of nature" and questioned about the many medications she was required to take "to treat multiple conditions that she had including Thoracic Outlet Syndrome, Aspergers, Dementia and severe allergies.

In response to the Trustee's claim objection, Madeline filed a 75-page Pro Se pleading with hundreds of pages of emails to the EEOC as an exhibit that described her entire life history and asserted that, "my Father has worked for Scotland Yard as well as the Canadian and Mexican governments and several federal branches, has the highest civilian security clearance in the United States and I can guarantee you coming from a family with knowledge like mine-the law is still the law". Egger, who had recently received a Master's Degree in Counseling, was concerned about Madeline's mental health and how to proceed with the claim objection. He advised Gumby that rather than dragging this situation into court, she should make a reasonable settlement offer to Madeline and resolve the objection. Gumby agreed and authorized Egger to offer Madeline $5,000 to settle her claim. Thinking that this would extricate the Trustee from a difficult and uncomfortable situation and placate Madeline, Egger made the offer.

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HYPOTHETICAL TWO: THE ROGUE CREDITOR– CONT.

As the date of the court hearing on the Trustee's claim objection got closer and having received no response from Madeline to the settlement offer, Egger sent her a settlement agreement and mutual release document. Madeline responded by saying that she would agree to the settlement if the Trustee apologized to her in open Court for the conduct of the Gamepop management, agreed to donate the $5,000 to her favorite charity and declared flatly that she would never sign a settlement agreement and release but instead would refer the matter to her friend, the Attorney General of Ohio.

By this point, Gumby had lost her patience and directed Egger to proceed with the claim objection. Egger went to court, explained the situation to the Judge and the United States Trustee and asked that the claim objection be granted. Judge Gravediggger shrugged his shoulders, noted for the record that Madeline had not appeared at the hearing and granted the Trustee's request to disallow and expunge the claim. Nothing was heard from Madeline for months, then on New Year's Eve of that year, Madeline sent a long email to head and founder of Freeman & Mason, Peter Freemason, stating that a bankruptcy attorney at his firm had cheated her out of a substantial amount of money, had refused to respond to her calls and emails and should be disbarred! Freemason demanded an immediate explanation from Egger and told him that he should deal with the situation and get rid of the problem or he would be fired! Query, how should Egger handle this Creditor with obvious mental health issues.

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HYPOTHETICAL THREE: SMALL BUSINESS OWNER (JOE)

Joe is a proud owner of a small and profitable business which he built over the past 10 years. He employs 5 people who are very loyal to him and have diligently formed strong relationships with the clients. The business provides consulting services and is poised for substantial growth, and Joe spends much of his time trying to find new clients, in addition to reaching out to existing clients to ensure they continue to retain the firm for their growing needs.

In competing for new business, Joe decides to take on a more aggressive business plan, without obtaining substantial input from the employees. He challenges competitors in markets where his firm has no current presence, causes the firm to take on substantial debt, and initiates litigation to challenge other firms whom he believes are engaging in illegal conduct to undermine him. He becomes very obsessed with the litigation, believing that if he "hits a home run" on one of the cases he will obtain so much money for the firm that he will be able to pay off all of the firm's mounting debts and provide himself a handsome dividend.

While pursuing his aggressive growth strategy, Joe experiences substantial stress. The stress, in turn, triggers some mental health issues that he thought he had under control from earlier periods of his life, including depression, obsessive compulsive disorder and a bipolar condition. On top of that, his older brother and mentor, who helped him launch his business, is diagnosed with a serious and potentially fatal cancer, further fueling his depression. Joe's employees, spouse and family grow increasingly concerned that Joe's challenged mental health is impairing his business judgment, causing him to take on risks that the company cannot bear, such as ultra-aggressive litigation and growth strategies against well-resourced competitors. The employees also believe that Joe is developing an exaggerated view of the company's prospects, potentially due to his mental health crisis. However, Joe insists he can "do it all" and that he can still lead the company through this crisis.

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HYPOTHETICAL THREE: SMALL BUSINESS OWNER (JOE) – CONT.

As one of the litigation cases grows more intense and expensive, three of the firm's creditors grow impatient with non-payment and threaten to file an involuntary bankruptcy petition against Joe's company. Despite the increasing stress on the firm and Joe's exaggerated view of the firm's prospects, the employees agree to stay with the company for the time being, and diligently work to maintain the client base and creditor confidence.

In response to the worsening crisis with the company and the mental stress, Joe grows defiant and fails to respond adequately to the creditors' overtures for payment or settlement of their debts. Frustrated, the creditors file the involuntary petition, and seek the appointment of a chapter 11 trustee. Joe is deeply suspicious that his employees conspired with the creditors to encourage a bankruptcy filing and the appointment of a trustee, despite any objective evidence to that effect. The court decides to appoint a trustee, who then proceeds to assume control of the business and manage it for the best interest of the creditors. Joe is furious and vows not to cooperate with the trustee, and watches his every move to undermine him. Joe frequently leaves vitriolic voicemails for the trustee, complaining that he is ruining the business.

In the bankruptcy case, the trustee soon concludes that Joe's substantial experience with the business, client connections and acumen are essential to its recovery, but is under pressure from the employees and creditors to assert more control over its affairs than Joe is willing to voluntarily give him. He sets out to maintain the confidence of the court, the creditors, clients and the employees, while pursuing a strategy to obtain Joe's support for the trustee's recovery plan.

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RESOURCES

Eastern District of North Carolina Bankruptcy Court

http://www.nceb.uscourts.gov/mental-health-project

– The U.S. Bankruptcy Court for the Eastern District of North Carolina has developed a bankruptcy and mental health program consisting of two major components: education and evaluation. The education component seeks to educate legal professionals, their clients, and mental health professionals about the role of mental health in bankruptcy proceedings. The evaluation component seeks to make mental health evaluations more accessible to debtors whose mental health is an issue in their bankruptcy proceeding.

Selected Articles on Finance and Mental Health

http://heinonline.org/HOL/Page?handle=hein.journals/lpsyr33&div=12&g_sent=1&collection=journals

– Katheryn Hancock examines current statutes regarding the discharge of student loans through the lens of mental health issues. Hancock analyzes the problems facing both the debtors and the judges involved in cases where mental health issues must be taken into consideration.

http://www.forbes.com/sites/amymorin/2015/07/21/studies-show-your-financial-health-could-be-a-good-indicator-of-your-mental-health/#2b03e38c1f5a

– Psychotherapist and author Amy Morin discusses the connection between mental health and financial health, explaining that the two are highly interdependent.

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THE END

Faculty

Hon. Sandra R. Klein is a U.S. Bankruptcy Judge for the Central District of California in Los Angeles, appointed in April 2011. Prior to her appointment to the bench, she worked for more than 13 years for the U.S. Department of Justice, most recently as the acting assistant director of the Office of Criminal Enforcement of the U.S. Trustee Program, where she focused nationally on increasing detection and prosecution of criminal conduct in the bankruptcy system. From 2003-09, Judge Klein was a bankruptcy fraud criminal coordinator with the U.S. Trustee Program, responsible for assisting federal law enforcement agents and assistant U.S. attorneys with bankruptcy-related investigations and prosecutions. From 1997-2003, she was a special assistant U.S. attorney in the Central District of California (on permanent detail from the U.S. Trustee Program), where she focused on complex white collar crime cases and bankruptcy fraud cases in particular. Before joining the DOJ, Judge Klein served as a litigation associate with O'Melveny & Myers LLP and began her legal career clerking for Hon. Arthur L. Alarcón of the Ninth Circuit Court of Appeals and Hon. Lourdes G. Baird of the Central District of California. Judge Klein is a member of the Board of Directors of the Federal Bar Association, Los Angeles Chapter, a member of the Board of Governors of Loyola Law School, and a community member of the Girl Scouts of Greater Los Angeles Board Development Committee. From 2010-20, she was a member of the Women Lawyers Association of Los Angeles (WLALA) Board of Governors. Judge Klein has received numerous awards, including the 2018 National Conference of Bankruptcy Judges Public Outreach Award, the 2018 WLALA Distinguished Service Award, and the 2019 Girl Scouts of Greater Los Angeles Woman of Distinction Award. She received her Bachelor's degree *magna cum laude* in music education from the University of Lowell in Massachusetts, her J.D. *magna cum laude* from Loyola Law School in Los Angeles, where she was admitted to the Order of the Coif and served as a senior note and comment editor for the *Loyola International and Comparative Law Journal*, and her M.B.A. with honors from UCLA's Anderson School of Management in Los Angeles.

Richard S. Lauter is a partner in the Chicago office of Lewis Brisbois Bisgaard & Smith LLP and chairs its Bankruptcy & Insolvency Practice. He has nearly 40 years of experience in corporate restructuring and insolvency. Mr. Lauter's legal experience includes reorganizing financially distressed companies in and outside of chapter 11, representing and advising creditors' committees, financial institutions, real estate development firms, bankruptcy trustees, assignees, and receivers in all aspects of creditors' rights and insolvency matters. He has also served as a liquidating trustee, special counsel to the City of Chicago in multiple airline and airport-related cases, counseled chapter 7, chapter 11, and liquidating trustees in numerous cases, and acted as chairperson for and represented numerous chapter 11 creditors' committees. Mr. Lauter is a member of ABI's Board of Directors and is considered one of the leading lawyers for chapter 11 creditors' committees in the U.S. He received his J.D. in 1981 from Northern Illinois University College of Law.

N. Neville Reid is a capital partner with Fox, Swibel, Levin & Carroll, LLP in Chicago and co-chairs its Bankruptcy, Restructuring & Creditors' Rights Group. His principal expertise is advising companies, lenders, receivers, trustees, investors and other clients on a wide array of insolvency-related issues, including restructuring corporations and their relationships with creditors, advising lenders on restructuring loans with distressed borrowers, and structuring acquisitions of distressed

assets for investors. Mr. Reid has more than 30 years of experience in this area, including 25 years as a bankruptcy trustee who is frequently appointed by bankruptcy judges to investigate fraudulent transactions and liquidate assets in bankruptcy cases for the benefit of creditors. He also has served as a receiver appointed by the SEC in a Ponzi scheme case currently pending in Chicago. Mr. Reid is currently president of the National Association of Bankruptcy Trustees, and in 2017 he received the Illinois Harvard Law Society's Role Model Award. He has been rated AV-Preeminent by Martindale-Hubbell and named to the *Illinois Super Lawyers* and *Leading Lawyers* lists. Mr. Reid received both his B.A. *magna cum laude* and J.D. from Harvard.

Hon. A. Thomas Small is a retired U.S. Bankruptcy Judge for the Eastern District of North Carolina in Durham. He served from 1982-2009, and as Chief Judge from 1992-99 and 2006-07). He was recalled from 2013-14. Judge Small chaired the U.S. Judicial Conference Advisory Committee on Bankruptcy Rules from 2000-04, of which he was a member from 1996-99. In addition, he was Bankruptcy Judge Representative to the U.S. Judicial Conference from 2004-07 and a member of the U.S. Judicial Conference Long Range Planning Committee from 1991-96. Judge Small was president of the National Conference of Bankruptcy Judges from 2000-01 and chairman of the NCBJ Endowment for Education from 1993-94. He also served as a board member of the Federal Judicial Center from 1997-2001, on ABI's Board of Directors from 1989-95, and on the board of directors of the American College of Bankruptcy from 2002-05. He has been a member of the National Bankruptcy Conference since 2006. Judge Small has served on the board of editors of *Collier on Bankruptcy* since 2007 and was a contributing editor to *Norton Bankruptcy Law and Practice* from 1987-95. He received his A.B. from Duke University and his J.D. from Wake Forest University School of Law.

Dr. Jay C. Williams, Ph.D., LCSW is a clinical social worker in Chapel Hill, N.C., where he has treated patients for depression, anxiety, trauma and stress, among others. He began practicing in 1978.