STATE OF MICHIGAN

COURT OF APPEALS

FARM BUREAU GENERAL INSURANCE COMPANY OF MICHIGAN, Plaintiff-Appellee,	UNPUBLISHED November 25, 2014
v	No. 317674 Hillsdale Circuit Court
GABRIEL WARRINER, Defendant-Appellant.	LC No. 12-000541-NF

Before: BOONSTRA, P.J., and DONOFRIO and GLEICHER, JJ.

PER CURIAM.

In this declaratory action, defendant appeals as of right the trial court's order granting plaintiff judgment. Because the trial court did not clearly err in determining that defendant's need for 24-hour care was not attributable to the August 21, 2003, car crash, we affirm.

This case involves whether defendant's need for care, including 24-hour care, many years after a 2003 motor vehicle accident arises out of that accident. On August 21, 2003, defendant, who was 21 years old at the time, was the single occupant of a car that crashed into a tree at a high rate of speed. One of the injuries that defendant sustained was a traumatic brain injury. At the scene, EMS workers determined that defendant had a Glasglow Coma Scale (GCS) score of 8. Defendant was transported to Hillsdale Hospital but was then airlifted to Borgess Medical Center. The airlift records indicate that at 1:50 a.m., defendant had a GCS score of 7, and at 1:54 a.m., defendant was determined to be "chemically paralyzed" from medications that were given to him. Defendant was also intubated at this time.

The Borgess medical records indicate that defendant was intoxicated at the time of the accident. Even while sedated and intubated, defendant opened his eyes briefly to voice prompts and also exhibited bilateral grip strength of 5/5. On the following day, defendant was extubated. Defendant was to be discharged from Borgess on August 26, 2003. At the time, defendant was noted to have "recovered and done well during admission" and was "walking, eating and carrying on most activities of daily living." But defendant was held over in order to perform plastic surgery on his right zygoma fracture.

In March 2004, defendant underwent a neuropsychological assessment by Firoza VanHorn, a licensed psychologist. Defendant complained of having severe headaches, memory problems, and depression. Defendant's father (erroneously) told VanHorn that defendant was in

a "coma" for five days following the accident. VanHorn noted that defendant appeared disheveled and confused and that most of his responses were inaudible. VanHorn diagnosed defendant as having a "[m]ood disorder due to the severity of the pain following the accident with Mixed Features."

Defendant then saw Dr. Joseph Hornyak, a physiatrist in the Department of Physical Medicine Rehabilitation at the University of Michigan, from August 2004 through May 2010. Dr. Hornyak opined that defendant suffered from a severe traumatic brain injury as a result of the accident. He based his opinion, in part, on defendant's GCS score of 7 after the accident because he stated that a score less than 9 reflects a severe injury. Dr. Hornyak also testified that defendant had reached a maximum amount of recovery for his head trauma by 2010.

Dr. Hornyak stated that defendant's "biggest problems" were disorders in his thought process and hallucinations or hearing voices telling him things to do. Dr. Hornyak opined that these problems were related to the brain injury defendant suffered from the 2003 accident. He explained that a traumatic brain injury can cause one to develop symptoms mimicking schizophrenia. However, Dr. Hornyak admitted that one who suffered a traumatic brain injury could develop schizophrenia independently from that brain injury. Dr. Hornyak also admitted that, as a physical medicine and rehabilitation doctor, he does not diagnose or treat schizophrenia—psychiatrists do.

Dr. James Rowan, a psychologist, first saw defendant in September 2004, when defendant was referred to him by the University of Michigan department of physical medicine and rehabilitation. Dr. Rowan testified that defendant was diagnosed with a traumatic brain injury, a psychological response to the traumatic brain injury, and possibly "a more serious psychiatric injury." Dr. Rowan, however, was unable to render an opinion on whether the car accident caused defendant's current thought disorder. He explained that, because he had no records or information pertaining to defendant's condition before the accident, rendering an opinion would simply be guesswork. Dr. Rowan also testified that he specifically referred defendant to a psychiatrist because psychiatrists are better suited to make such diagnoses related to the thought disorder.

In October 2004 and September 2005, defendant was seen by Dr. Walter Sobota, a licensed psychologist. Dr. Sobota diagnosed defendant with "diffuse organic impairment, with maximal disruption of frontal and deeper temporal zone functioning." Dr. Sobota also noted that defendant exhibited "residuals from a closed head injury," but defendant's clinical status was "complicate[d]" because of defendant's 2004 suicide attempt by carbon monoxide because "there can be delayed sequella from [carbon monoxide] poisoning associated with myelin injury." At his deposition, Dr. Sobota testified that defendant appeared to be responding to internal cues, or in other words, he was hearing voices. Dr. Sobota thought that defendant's condition was consistent with a closed-head injury and psychosis. Dr. Sobota acknowledged that defendant appeared schizophrenic. However, Dr. Sobota opined that one can have psychosis that mimics schizophrenia without having schizophrenia, per se. And in defendant's case, Dr. Sobota thought that defendant's low score in "picture completion" was inconsistent with one who was a paranoid schizophrenic. Instead, Dr. Sobota thought that the test result was more consistent with one who suffered a head injury and was recovering from it and is psychotic. He stressed that schizophrenia cannot be caused by trauma, but schizophrenic-like symptoms can be caused by

trauma. But Dr. Sobota also acknowledged that it is possible for a person to have suffered a traumatic brain injury and independently have true schizophrenia. In sum, Dr. Sobota opined that that it was more likely than not that defendant's condition was related to the accident as opposed to any other factors. But Dr. Sobota also acknowledged that he was relying on much less information and records than other individuals, specifically plaintiff experts Dr. Steven Putnam and Dr. Elliott Wolf.

In April 2005, Dr. Robert Fabiano, a psychologist, conducted a neuropsychological evaluation of defendant. In his report, Dr. Fabiano stated that defendant likely sustained a traumatic brain injury of a moderate to severe magnitude and that there was "a strong premorbid history remarkable for significant psychopatholgy," which he thought was never addressed in the three previous neuropsychologial evaluations. Dr. Fabiano surmised that this preexisting condition accounted for as much as 80 percent of defendant's underlying degree of psychological distress. But Dr. Fabiano clarified that he thought that while the car accident did not cause defendant's deterioration, it nonetheless "aggravated" his preexisting condition:

> I feel that this individual is someone who was struggling in his social adaptive functioning prior to the motor vehicle accident. I do feel that the effects of the traumatic brain injury have greatly aggravated his underlying psychiatric disability which is quite significant at the present time. The relevance of this claimant's premorbid psychiatric history is such that there is a strong potential that this condition may remain chronic and is not entirely causal to the motor vehicle accident.

In his deposition, Dr. Fabiano testified that, although rare, it was possible for someone to develop schizoid symptoms as a result of a traumatic brain injury. But more often those symptoms precede a traumatic injury. Dr. Fabiano also explained that schizophrenia typically manifests in a person when the person is aged anywhere from 18 to 25 years. Dr. Fabiano opined that defendant had suffered a moderate to severe brain injury and that defendant had a preexisting psychiatric disorder. Specifically, defendant had a schizoid personality disorder. Dr. Fabiano also stated that someone with a brain injury similar to what defendant suffered would have gotten better over time instead of gotten worse. In fact, he suggested that a person would recover enough to be independent within 12 to 24 months after being injured. Dr. Fabiano also stated that someone with a thought disorder who did not receive proper treatment would deteriorate over time.

In July 2008, defendant was examined by psychologist Dr. Steven Putnam. But defendant was uncooperative during the meetings, with Dr. Putnam noting that defendant was "clearly psychotic and hostile." Consequently, defendant did not meaningfully participate. But Dr. Putnam interviewed defendant's parents and had access to the voluminous medical records and reports in this case. Dr. Putnam opined that defendant's parents failed to adequately address defendant's psychosis and failed to adhere to virtually any recommended treatments over the course of years. As an example, defendant's parents at every turn have dissuaded or prevented the use of any psychiatric medications. Instead, they believe that defendant's condition was attributable to diet and side effects from medication. Dr. Putnam concluded that although defendant required 24-hour care, "this need relates far more to his psychiatric disorder than to the residuals of a remote traumatic brain injury."

During his deposition, Dr. Putnam described that there is a recognized set of criteria that allows a neuropsychologist to diagnose whether the patient is suffering from a brain injury with schizophrenic symptoms or whether those symptoms are the result of having schizophrenia. He explained that a traumatic brain injury is diagnosed on the basis of "the acute injury characteristics," while schizophrenia is diagnosed on the basis of the "constellation[] of symptoms and thresholds for different types of symptoms." The constellation of symptoms would typically include hallucinations, delusions, disorganized speech, and sometimes depersonalization. Dr. Putnam noted that there is a narrow window when schizophrenia typically develops in people: it emerges when a person is anywhere between late adolescence and the early twenties. Dr. Putnam diagnosed defendant with unquestionably suffering a traumatic brain injury but also suffering from schizophrenia. He further stated that while a traumatic brain injury may cause time-limited episodes of psychosis, there is "no evidence in the world" that suggests that a traumatic brain injury can actually cause schizophrenia. The difference is the "duration of the symptoms and the chronicity of it." Defendant's symptoms presented the classic presentation of schizophrenia. Dr. Putnam noted that defendant's history before the car accident further supported his diagnosis. He noted that defendant's records showed "a lot of hints of a young man who is somewhat eccentric, has difficulty relating to peers, has difficulty being successful in the developmental tasks of childhood, namely, school." As an example, Dr. Putnam noted that there was a succession of letters from the principal of defendant's elementary school that documented defendant's aggressive, disruptive, and destructive behavior. The principal's final letter noted that this was defendant's tenth incident. Dr. Putnam described these incidents as being prodromal for schizophrenia, or in other words, these incidents, while in isolation have no meaning, nonetheless likely were early markers for schizophrenia. On cross-examination, Dr. Putnam agreed that a head trauma can cause symptoms that mimic schizophrenia, but he noted that such symptoms would not last a long time or be chronic in nature.

In April 2010, Dr. Elliot Wolf, a board-certified psychiatrist, issued a report based on his review of defendant's records. Dr. Wolf opined that defendant's symptoms as of "2005 or 2006 were no longer primarily manifestations of a closed-head injury, but instead were symptoms of a different and unrelated psychiatric disorder, clearly psychotic in nature and probably schizophrenic." Dr. Wolf also found that 24-hour inpatient care would not be needed to treat a closed-head injury six-and-a-half years after the injury has occurred unless one has "the residuals of a severe head injury with a widespread degree of impairment." In June 2011, Dr. Wolf conducted an independent psychiatric examination of defendant. Dr. Wolf opined that defendant likely suffered a mild closed-head injury as a result of the accident and that he reached maximum recovery years earlier. He further opined that defendant's psychiatric illness was schizophrenia and was not caused by the 2003 accident. He noted that the onset of defendant's schizophrenia sometime after the car accident facilitated defendant's parents' denial that he had a severe psychiatric illness.

In his deposition, Dr. Wolf indicated that while head trauma can cause psychosis symptoms, those symptoms are distinguishable from actual schizophrenia. He said that there are "qualitative differences" between schizophrenia and trauma-induced psychosis. He explained that there are "certain symptoms which are classically regarded as being if not peculiar to schizophrenia, then clustering together in a schizophrenic individual as opposed to somebody else." The hallmark symptoms of one who is schizophrenic include, but are not limited to the

following: disheveled appearance, autistic preoccupation, auditory hallucinations, delusional, flat affect, ambivalence (acting in a mysterious way, such as standing up, moving around in a meaningless way, only to sit back down again), poor judgment, and being highly anxious. Dr. Wolf further testified that if a person's traumatic brain injury did cause some of these symptoms, the person's behavior would nonetheless have "a different flavor" as opposed to a schizophrenic's behavior: the person would be less animated, more dull, and less variable than one who is schizophrenic. In other words, "there is something qualitatively unique about . . . the psychosis of schizophrenia," which is readily identifiable when you witness it. He also indicated that brain injuries virtually always improve over time, plateauing 18 to 24 months after the injury took place. Thus, if a person's condition regresses or new symptoms appear months or years after the injury, something else is probably going on unrelated to the injury itself. Related to defendant, Dr. Wolf opined that he suffers from schizophrenia, which was unrelated to the vehicle accident. He reiterated that "schizophrenic type of psychosis is not caused by anything other than schizophrenia." Dr. Wolf also concluded that even though defendant had suffered a traumatic brain injury during the vehicle accident, defendant did not exhibit any symptoms related to that brain injury at the time of his report because defendant's schizophrenic symptoms "so shrouded everything else."

Dr. Aurif Abedi, a board-certified psychiatrist, evaluated defendant several times from December 2009 through April 2010. Dr. Abedi was a consultant for the Eisenhower Center, when defendant stayed there. Dr. Abedi's purpose in seeing defendant these several times was for medication management and oversight. Dr. Abedi diagnosed defendant with psychosis NOS (not otherwise specified). He later clarified that this psychosis was indeed caused by the car accident. While Dr. Abedi acknowledged that it is possible for one to have suffered a traumatic brain injury and independently suffer from schizophrenia, he indicated that he did not give a diagnosis of schizophrenia because of the fact that the head injury preceded the psychotic symptoms. He also relied on the fact he was not aware of any preexisting symptoms/conditions or relevant family history. But he also admitted that the source of this information primarily was from defendant and to a lesser extent, his parents. Dr. Abedi described some history that he thought would be relevant: whether the person had reports of any hallucinations or delusions, had very unusual behaviors, did things that stood out from others, was withdrawn from society. In other words, typically, when looking back earlier is a person's life "there are some odd behaviors," such as having problems in school, failing to get along with others, and having odd or different rituals. Dr. Abedi then stated that in order to clarify whether defendant's condition was schizophrenia or psychosis NOS due to the head injury, he would have wanted to review all of defendant's records from early childhood and school, which typically is beyond the scope of his regular assessments at Eisenhower. But from the history Dr. Abedi was provided, nothing was suggestive that defendant "had any sort of problem before the accident." As a result, Dr. Abedi opined that defendant's psychosis symptoms were related to the car accident.

On August 16, 2012, plaintiff filed the instant action for declaratory judgment, seeking a declaration that the treatment defendant received related to his psychosis was not related to the motor vehicle accident but instead related to an unrelated mental disease. The parties agreed to submit 40 joint exhibits in the bench trial. Shortly thereafter, plaintiff learned that defendant indeed had a family history of schizophrenia because his uncle was diagnosed with paranoid schizophrenia and schizoaffective disorder. The parties then amended the joint exhibit list to include several exhibits related to defendant's uncle.

On July 18, 2013, the trial court held a bench trial, where it noted that it had reviewed all of the exhibits. At the trial, no testimony was heard, and the parties gave their closing arguments. The trial court found, in pertinent part:

> There's no question in this case that [defendant] had initially a traumatic brain injury. I think we all can agree on that. At some point, he reached a maximum level of recovery within 18 to 24 months. Clearly, from the testimony of Putnam and [Wolf] and others that I've already attributed to, there is a recovery, there is an improvement period. That maximized approximately two years after the accident.
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> It's expected that a TBI [traumatic brain injury] will result in improvement. That's not the case here. [Defendant], on the other hand, got worse over time, not better over time. A number of observations of different personnel, which I've identified based on the record, clearly indicate an underlying psychiatric problem.
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> It goes back to his childhood. He has a long history of psychological problems. This is a situation where he suffered a traumatic brain injury of a mild to moderate level, not severe. I discount entirely the testimony that he had a severe head injury. It's not supported by the facts. It's not supported by the records, the medical records.
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> Taking into account the evidence that I established, there is no current connection between the automobile accident and [defendant's] condition. He suffers from schizophrenia, a pre-existing condition.

II. ANALYSIS

The sole issue on appeal is whether the trial court erred in making its determination that defendant's psychotic condition was not related to the August 2003 automobile accident. Following a bench trial, we review the trial court's factual findings for clear error. *Ladd v Motor City Plastics Co*, 303 Mich App 83, 92; 842 NW2d 388 (2013). A finding is clearly erroneous when we are left with a definite and firm conviction that a mistake was made. *Chelsea Inv Group, LLC v City of Chelsea*, 288 Mich App 239, 251; 792 NW2d 781 (2010).

Defendant was seeking recovery of PIP benefits under MCL 500.3105 and MCL 500.3107. MCL 500.3105(1) provides that "[u]nder personal protection insurance[,] an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter." MCL 500.3107(1)(a) then provides that personal protection insurance benefits include "[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."

Thus, the dispositive question is whether defendant's condition "arose out of" the 2003 vehicle accident. Our Supreme Court has examined this language and has determined that no-fault benefits can only be recovered "where the causal connection between the injury and the use of a motor vehicle as a motor vehicle is more than incidental, fortuitous, or 'but for.'" *Thornton v Allstate Ins Co*, 425 Mich 643, 659; 391 NW2d 320 (1986). Therefore, there must be a relationship between the injury and the vehicular use of the motor vehicle. *Id.* at 659-660.

Here, the trial court determined that defendant suffers from schizophrenia, which was not caused by the car accident. We are not left with a definite and firm conviction that the trial court made a mistake. The trial court's finding was supported by expert testimony. First, Dr. Wolf, a board-certified psychiatrist, testified that defendant suffered from schizophrenia, which cannot be caused by head trauma. Dr. Wolf also noted that while a head trauma can cause psychosis, the nature of the psychosis from schizophrenia is qualitatively distinguishable from the psychosis as a result of head trauma. And in this case, Dr. Wolf observed that defendant's symptoms were not merely consistent with schizophrenia, they were "pathognomonic, which means classical, customary, jump off the page at you[;] he's the poster boy for schizophrenia type symptoms." Further, as noted by several experts, defendant's age was consistent with when someone starts to exhibit schizophrenia because if schizophrenia is going to manifest in a male, it manifests when the person is aged anywhere between his late teens and early-to-mid twenties.

Second, Dr. Putnam also diagnosed defendant with schizophrenia that was unrelated to the automobile accident. Dr. Putnam also noted that defendant exhibited the classic symptoms of schizophrenia. He further acknowledged that while a traumatic brain injury can cause time-limited episodes of psychosis, those are distinguishable from schizophrenia because of the shorter duration of the trauma-induced symptoms. Dr. Putnam also noted that defendant's history before the car accident, which showed "a lot of hints of a young man who is somewhat eccentric, has difficulty relating to peers, has difficulty being successful in the developmental tasks of childhood, namely, school," was consistent with one who later develops schizophrenia.

Third, Dr. Fabiano testified that defendant had a schizoid personality disorder. Dr. Fabiano also stated that someone with a brain injury similar to what defendant suffered would have gotten better over time instead of gotten worse, like defendant did.

Defendant complains that the trial court discounted the testimony of his expert witnesses. But, being the fact-finder in this case, it was the trial court's role to decide which evidence to afford more weight. See *People v Eisen*, 296 Mich App 326, 331; 820 NW2d 229 (2012). Thus, it was within the purview of the trial court to weigh the evidence and give more credence to certain witnesses over other ones. Here, the trial court gave more weight to plaintiff's witnesses. We perceive no error. We stress that the standard of review for factual findings is for clear error, which is highly deferential. This standard does not allow a reviewing court to reverse the finding of the trier of fact simply because it would have decided the case differently. *Beason v Beason*, 435 Mich 791, 803; 460 NW2d 207 (1990). "When there are two permissible views of the evidence, the factfinder's choice between them cannot be clearly erroneous." *Id.* (quotation marks omitted). In other words, "if the trial court's account of the evidence is plausible in light of the record viewed in its entirety, the Court of Appeals may not reverse." *Id.*

Here, testimony contrary to the trial court's finding was supplied by several of defendant's witnesses. But after reviewing the record, we are convinced that the trial court did not clearly err in discounting that testimony.

Dr. VanHorn did not diagnose defendant with schizophrenia, but at the time she examined defendant in March 2004, just seven months after the accident, defendant was not exhibiting any signs of hallucinations, paranoia, or delusions. Signs of defendant's hallucinations and paranoia would surface later.

Dr. Hornyak opined that defendant's problems were related to the brain injury that he suffered from the accident. But Dr. Hornyak, a physical medicine and rehabilitation doctor, noted that it is not within his area of expertise to diagnose or treat schizophrenia. Thus, the trial court reasonably viewed Dr. Hornyak's testimony cautiously on this matter.

Psychologist Dr. Sobota opined that, even though it is possible for a person to have suffered a traumatic brain injury and independently have true schizophrenia, defendant's condition was related to the vehicle accident as opposed to any other factors. But Dr. Sobota also acknowledged that he was basing his opinion on much less information and records than what Dr. Putnam and Dr. Wolf had access to. Along these lines, Dr. Rowan stated that it was impossible to properly provide a meaningful diagnosis without having records or information pertaining to defendant's condition before the accident.

Lastly, defendant relied on the testimony of board-certified psychiatrist, Dr. Abedi. Dr. Abedi initially diagnosed defendant with psychosis NOS and later clarified that this psychosis was indeed caused by the car accident. However, Dr. Abedi's rationale for supplying this diagnosis was not very compelling. He explained that it was possible for an individual to suffer a traumatic brain injury and independently suffer from schizophrenia, but he then goes on to state that he did not give a diagnosis of schizophrenia because of the fact that the psychotic symptoms were preceded by the head injury. Without any explanation as to why or how the accident caused the psychosis, his mere reliance on the temporal relationship between the accident and the symptoms is at odds with his professed belief that it was possible for one to suffer a head injury and independently suffer from schizophrenia.

Further, Dr. Abedi stated that it was important that he was not aware of any preexisting symptoms or conditions that would be indicative of schizophrenia. But, vitally important, Dr. Abedi admitted that he did not have any records to reference but instead obtained this history primarily was from defendant and, to a lesser extent, defendant's parents. Dr. Abedi explained that when looking back earlier is a person's life, typically "there are some odd behaviors," such as having problems in school, failing to get along with others, and having odd or different rituals. Unbeknownst to Dr. Abedi, this is exactly what defendant's preaccident history indicated. Defendant's school records indicated that he struggled with school, having never graduated from high school, and struggled with interacting with others, as evidenced by the repeated instances of fighting. In just the 1991-1992 elementary school year alone, defendant was sent to the principal's office ten times for a variety of reasons ranging from fighting with other students to disrupting the class. Additionally, once defendant dropped out of school after the tenth grade, he was never able to hold any stable employment.

Moreover, most damaging to Dr. Abedi's "diagnosis" was the fact that Dr. Abedi admitted that in order to clarify whether defendant's condition was schizophrenia or psychosis NOS due to the head injury, he would need to review all of defendant's records from early childhood and school, which typically is beyond the scope of his regular assessments at Eisenhower. There is no dispute that Dr. Abedi did not have access to these or any records and relied upon the assertions of defendant and defendant's parents. Thus, because he lacked the information that he stated would be necessary in order to distinguish between schizophrenia and injury-induced psychosis, the trial court reasonably gave his testimony very little weight.

Defendant also complains that the trial court gave weight to the fact that defendant's uncle was diagnosed with schizophrenia. The trial court noted that one of the submitted exhibits was a death certificate of defendant's uncle, who committed suicide. The certificate stated, "Other significant conditions: paranoid schizophrenia, schizoid affective disorder." Plaintiff had argued at the trial court that because a first-degree relative had schizophrenia, defendant was ten times as likely to contract the disease as well. Defendant points out on appeal that an uncle is only a second-degree relative, which would increase a person's chance of being diagnosed with schizophrenia only from one percent to two percent. But defendant fails to acknowledge that the trial court recognized that the uncle was not a first-degree relative. Thus, any assertion that the trial court gave weight to the "ten-times-more-likely" aspect of having a first-degree relative diagnosed with schizophrenia is misplaced.

Affirmed. Plaintiff, as the prevailing party, may tax costs pursuant to MCR 7.219.

/s/ Mark T. Boonstra
/s/ Pat M. Donofrio
/s/ Elizabeth L. Gleicher