CALDWELL REPORT
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June 22, 2016

NAME: Dan Doran

AGE: 50

SEX: Male

EDUCATION: 11 years

MARITAL STATUS: Widowed

REFERRED BY: Daphna Slonim, M.D.

DATE TESTED: June 21, 2016

TEST ADMINISTERED: Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

TEST TAKING ATTITUDE

Attention and Comprehension: His score on the Variable Response Inconsistency scale (VRIN) was unelevated; his item responses were self-consistent throughout the inventory. This suggests that he was clearly able to read and comprehend the test items, that he was attentive in considering his responses, and that he consistently matched the item numbers in the booklet to the corresponding numbers on the answer sheet. He does not appear to have had any difficulties in understanding the content or responding to the format of the inventory.

Attitude and Approach: He was very guarded, denying, and self-favorable in his approach to the inventory. The clinical scale elevations he obtained may be suppressed and incomplete and the pattern somewhat distorted. Considering just scales L, F, and K, the interpretive statements are probably accurate, but they may understate the severity of his problems and his level of disturbance.

He made a considerable number of atypical and rarely given responses to the items occurring in the last half of the inventory (scale F-back). This was in contrast to the relative absence of atypical responses to the earlier MMPI-2 items (scale F). It may be significant to clarify whether, during the latter part of the inventory, he began: (1) to struggle to sustain his attention, (2) to overstate his level of disturbance, (3) to respond carelessly to some items, or (4) otherwise to make errors in recording his responses to these later items. His moderately elevated score on the F-back

scale recommends some caution in the interpretation of deviant scores on the supplemental scales reported on the second page of extra scales (page 2, MMPI-2 subscales).

Socio-cultural Influences vs. Conscious Distortion: The supplemental validity scales suggest that his self-favorableness in responding to scale K derived largely if not almost entirely from an intentional effort to "look good" on the MMPI-2. He showed a moderate level of conscious defensiveness, responding "too positively" to many of the MMPI-2 items. In contrast, his score on the scale (Ss) measuring his currently attained, recently experienced, or self-perceived socioeconomic status was below average. He appears to be someone of less than average socioeconomic status identification who deliberately tried to make a favorable and controlled presentation in responding to the MMPI-2. Some of his clinical scales are apt to be significantly under-elevated, and the following report may significantly understate his level of disturbance. His elevation on the L scale, like his elevation on K, reflects considerable guardedness and denial, a conscious avoidance of admitting any faults or improper actions that might be held against him. The elevation on L should not be interpreted as reflecting more than a mild amount of ingrained properness or characterological self-control. These scores strongly suggest the possibility that he had to take the MMPI-2 "against his will" and that he was very cautiously self-protective as to how the test results might reflect badly on him or be used against him.

An additional contradiction must be noted. In contrast to his high needs to make a good impression, he showed a slightly above average willingness in some areas to emphasize his symptoms and complaints (scale Ds). This would not rule out some confusion in making his responses or uncertainty about how the results of the testing are to be used. This atypical approach to the items would add some doubt as to the validity of his profile, and the level of severity reflected in the following interpretation may need a careful area-by-area evaluation in interviews.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile indicates that he would readily become preoccupied with a wide variety of causes of physical pain and suffering. At least some aspects of localized pain, general malaise, weakness, and fatigue are apt to be seen as beyond medical expectations for his current physical status. Such symptoms as G.I. pain or other G.I. complaints, hypertension, vasomotor instability, and headache are often associated with this profile. If there were a back injury, his complaints are likely to be seen as increased by psychological factors. Various issues involving his eating habits would also be typical. Many patients with similar profiles have shown intractable pain syndromes especially postoperatively. Spells such as fainting, crying, or dizziness are suggested along with other symptoms involving the head or disturbances of consciousness. At times he would show an unexpected acceptance of his physical symptoms and indifference about their consequences in his life. The secondary depression tests as moderate to

severe, as limitedly denied and covered over, and as extensively expressed through the physical apprehensions. There may be "smiling depression" elements and from time to time open breakthroughs of anguish. Crying and loss of appetite are likely expressions of his depression. The current level of his day-to-day coping and immediate practical self-sufficiency tests as severely disorganized in many areas.

He denied many minor faults and trivial moral deficits that most subjects readily admit. Others may see him as "straightlaced", perhaps with rural or "small town" values. These may derive from a strictly religious, foreign, or otherwise culturally atypical upbringing. He could "follow the rule book" in literal and unbending ways and be seen as "rubbing elbows poorly" with coworkers.

Similar patients often developed anxiety symptoms or acute panic attacks. They became phobic about physical illnesses, fearful of leaving home, and had other specific points of focus for their acute anxieties. Unable to accept aggressiveness in themselves or others, they reacted to stresses with clinging and petulantly demanding behaviors. They were unrealistic about money with childish fears over managing responsibility. Changing homes and other environmental and work changes were especially threatening to them.

Talkative about his physical symptoms and concerns, he tests as repressive of internal feelings, as inhibited and avoiding of his conflicts, and as poorly facing his personal problems. His symptoms may gain him reassuring attention and consideration, or effectively allow him to avoid or to say "no" to unwanted demands. He tests as naive and lacking in insight, and his acceptance of his angry feelings and sexual wishes appears poor. Others are apt to see him as much more self-centered, demanding, irritable, and emotional than he sees himself. Others may see him as having simplistic if not Victorian values; these may derive from a strictly religious, rural, foreign, or otherwise provincial childhood upbringing. Outbursts of anger are likely to be infrequent but dissociated. He is also prone to frustration with his place in life, but he would have serious difficulties in facing this.

His efforts to be contented, cooperative, friendly, and cheerful would reflect his ideals but cover over his strong emotional reactions to rejections, to frustrations of his demands and wishes, and to losses of emotional support. He would be especially vulnerable to the death of a family member or other separation from an emotionally supporting person, tending to idealize the lost person and to reject criticism of them. The pattern indicates serious emotional isolation from loved ones, emotional immaturity, distrust of self and others, and confusion in his self-image. His explanations of his symptoms and of bodily functioning are apt to be odd if not confused. These trends may be part of a psychotic reaction or a vulnerability to such a development. Such characteristics as immature, egocentric, and manipulative of others are indicated. He would be seen as stereotyped and inflexible in his handling of emotional problems. He tests

as mildly shy socially. His overall balance of masculine and feminine interests is within the normal range for his age and education.

Similar patients have been described as being at a "throw in the sponge" phase of their lives at the time of testing. Multiple childhood rejections and deprivations were reported, including poor or alcoholic fathers, emotionally ill parents, fathers or mothers who had died during the patient's childhood, and families that lacked affection either because of strict and rigid attitudes or through an immoral and disorganized pattern. As children these patients handled stresses by repressiveness and by learning passive and dependent roles. However, their emotional reactions became attached to strong psychophysiologic reaction patterns as well as being expressed through symbolic conversions of their anxiety. It has been speculated that these life-long conditioned autonomic reactions directly contributed to their high incidence of organic breakdowns and psychophysiologic disorders. They tended to marry adaptable and well-liked wives on whom they depended in subtle if not open ways, but they rejected their children's demands rather as they had been rejected in their own childhoods. The onset of symptoms then appeared to follow an upheaval of their balance of negative input over positive gratifications, especially if such an upheaval coincided with physical symptoms that produced a large increase in the person's sense of vulnerability.

DIAGNOSTIC IMPRESSION

Diagnoses of conversion, pain, and hypochondriacal disorders and of psychophysiologic disorders are the most common with this pattern. Some of these patients were seen as having depressive disorders with a strong somatic emphasis. However, the clinical and diagnostic picture appears more mixed and severe than usual. It should be re-emphasized that his generally guarded and self-favorable responding together with his understatement of his problems and his idealized self-presentation make his profile more ambiguous than most.

TREATMENT CONSIDERATIONS

He is disposed to repeated medical contacts for physical complaints; his symptoms could persist for years with little change in their severity and an unduly ready acceptance of the medical patient role. The polysurgical risk is severe, and in most similar cases surgical procedures were followed by very temporary benefits and persistent postoperative pain. Similar patients have often had prolonged and complicated surgical recoveries with needs for extended postoperative pushing in order to resume functioning; a great deal of caution would be indicated in hospitalizing him for medical treatment or in arranging extensive physical workups if the indications were unclear and equivocal.

Psychotherapeutic intervention is difficult where the patient is so strongly oriented toward physical illnesses and somatic explanations of his difficulties. Family consultation can be quite beneficial to evaluate the

secondary gains and to arrange to minimize them. It can be beneficial to inform them fully as to his current physical status, treatment needs, and capacity for work and activity. Stresses should be minimized if feasible, and work with the family may improve currently frustrating or rejecting relationships even if he does not identify them as such. His responses suggest a careful review of his sexual history.

The profile anticipates that he would be markedly cautious in interviews about any possibly improper reactions he felt he was being asked to reveal if not at times concrete and morally simplistic. Any public occasions in the past when he seriously lost self-control, openly violated his own moral self-expectations, or felt judged by others to be "crazy" could have contributed to his vulnerability to shame. If he is currently going through an intense life crisis, then he may show fairly rapid and extensive emotional changes. Subsequent retesting is apt to be more than usually informative for reevaluating such shifts and for updating treatment directions and goals.

A few similar patients have been able to benefit from the release of stored-up emotions. Often their personal conflicts were identified in part by what they specifically denied to be problems. Emotional catharsis is apt to relate to past rejections, hurt feelings, and unsatisfied needs for care and protection. Frequently this opened up around a loss of emotional support through separation from a loved one or unresolved grief over a loss such as the potentially permanent defeat of a crucial personal goal or the death of a parent or other family member. Similar patients had great difficulties in working through the anger phases of grief processes. Awareness of his self-centered wishes and inhibited impulses is apt to come very gradually, as also would an increased acceptance of the intensity of his emotional reactions and of limitations in himself and others. Termination typically has involved some "face-saving" against the implication that his problems were all psychological; efforts to make such a face-saving adaptive rather than surgically self-destructive or otherwise self-defeating have been reported as beneficial.

Thank you for this referral.

Alex B. Caldwell, Ph.D.

Alex B. Caldwell, Ph.D.
Diplomate in Clinical Psychology

The preceding analysis is basically actuarial and probabilistic in nature in that the symptoms and personality characteristics presented in the

report have been identified as disproportionately frequent among individuals obtaining similar scores and patterns of scores on the MMPI-2 (tm). The diagnosis of any individual, however, needs to be based on the integration of information from personal contacts, the person's history, other test results, and whatever independent data are relevant and available.

This report has an overall focus on psychotherapy intake, differential diagnosis, treatment planning, and related personality-dependent determinations. It provides assistance in the diagnostic process by providing an extended set of clinical hypotheses, the largest part of the basis for which is data from traditional psychiatric settings. The application of these hypotheses to an individual requires independent confirmation of them by the clinician and an allowance for the specific context of testing if it differs substantially from the primarily psychotherapeutic database.

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THE ADAPTATION AND ATTACHMENT HYPOTHESES SUPPLEMENT:

The following paragraphs present my current hypotheses as to etiologic and developmental factors that likely contribute to the behaviors associated with the codetype to which this profile best conforms. The following description characterizes a relatively serious if not severe level of disturbance. Typically an individual with a moderate although not severely elevated profile will show an intermediate level of sensitization so that the adaptive responses to the aversive shaping experiences described below are demanding of but not overwhelming of the person's attentional energy and somewhat less disruptive of day-to-day functioning. THIS DESCRIPTION IS NOT MODIFIED OR ADJUSTED TO THE LEVEL OF DISTURBANCE OR SECONDARY VARIATIONS OF THIS PERSON'S PROFILE: IT IS AN ETIOLOGIC PROTOTYPE FOR ANYONE WITH THIS GENERAL PATTERN TYPE. It is intended to generate hypotheses as to how the individual "got this way". This prototype material will always be the same for any profile corresponding to his code type. At least three fourths of the reports currently processed will have these paragraphs--the other quarter are of more or less rarely occurring codes, and for want of code-specific data they will not have these paragraphs at this time.

My belief is that all behaviors are adaptive given the person's biologic/constitutional makeup and life experiences. An awareness of adaptational benefits is potentially helpful: (1) in understanding the origins and adaptive self-protections of the person's present behaviors, (2) in providing test-result feedback to the client as well as in explaining the person's conduct to judges and any other parties appropriately involved, and (3) in guiding psychotherapeutic intervention. These inductive hypotheses are based on an extensive searching for developmental information on pattern-matched cases. Some interpretations are supported by published data (e.g., Gilberstadt & Duker, 1965, Hathaway & Meehl, 1951, Marks & Seeman, 1963), etc., and others are based on clinically examining any cases I have been able to access on whom pertinent information has been available. Your feedback to me will be much appreciated regarding: (1) whatever in the material that follows is clearly a misfit to this individual, (2) more precisely targeted word choices, phrasing, and especially the person's own words for crucial experiences, and (3) behavioral characteristics that are likely to generalize to the code type but are missing here. For everyone's sakes, don't hesitate to send me a note.

PROPOSED DIAGNOSIS: INTENSIFIED PAIN-FEAR CONDITIONING
ADAPTATION TO: experiences of simultaneous intense fear and acute bodily pain and suffering
TRADITIONAL DIAGNOSIS: pain and conversion disorders (which latter clinically have been mainly complaints of pain, much less often other more esoteric, "classical" symptoms)
PROTOTYPIC CHARACTERISTICS: persisting physical distress concerns with a related focus on personal hopes as well as on potential medical and emotional sources of pain and distress relief. Especially when emotionally

upset, the range of physical discomforts and/or the intensity of reported distress are greater than medically expected, even though there may be well-defined and understandably distressing organic medical disorders from which the person is suffering.

The individual frequently presents as very trusting: "I am a very friendly, reasonable person to whom this painful malady has befallen. I've had to be so brave". Pollyanna attitudes mark the avoidance of the pain of face-to-face anger. Always being "nice" increases the hope for solace when suffering. Failures to anticipate or "see" interpersonal conflicts or other imminently negative and upsetting outcomes can become a sort of "emotional blindness". At the extreme, e.g., 3-Hy over 85 or 90, this blindness seems unbelievable to many observers, who then think it must be faked, "nobody could be that unaware!" But the shifts of attention described below can be quite total. At age 12 my own mother lost her mother; she could never understand my sister's enjoyment of mystery programs on TV: "Somebody always dies".

CONTRIBUTORY SHAPING HISTORY: In those cases with health issues dating back to early age levels (perhaps minimized or denied by the person but confirmed by family members), such factors as multiple rejections and deprivations, poor families, rigid family values, and emotionally disorganized families can set the stage for the inhibiting of any negative emotional expressions, of always "looking the other way" in order not to make a painful situation worse. Note the incidence of pre-pubertal parental deaths in Marks & Seeman (1963): 60% of their 13/31 patients reported a "parent death" which was more than any other code type (the related 231 was at 55%; all of their other codes were at least somewhat less). My hypothesis is that familial inhibition of open expressions of emotional anguish (e.g., your father just died and you are told, "Be quiet--You must be brave") would tend to orient attention onto how badly your body feels, perhaps establishing or considerably enhancing a fear/distress to body pain association.

The intense fear can also be contiguous with bodily sensations. Repeated or extreme associations of fear with a specific sensory input can lead to an alteration of the perception of that input. For example, repeated exposure to terrifying sounds can lead to a reduction of hearing and "hysterical deafness". Caldwell Report will soon have available CD copies of a radio dramatization of Starke Hathaway's treatment of hysterical deafness in an adolescent girl (on a isolated Minnesota farm, the other three family members were all deaf but could lipread, and a suggestible 15 year old girl was the only source of warning and alarm for dangerous sounds during the night). A conditioned activation, night after night, of the olivocochlear bundle that inhibits transmission from the cochlea to the central nervous system would offer a potential explanatory mechanism for a valid perceptual reduction of what is heard. A selective deafness (what activated her fears and hence the neural bundle) eventually spread, and she "discovered" that she was deaf but could "lipread". Thus the conversion metaphor, her fears "converted" her desperate need not to hear into

hysterical deafness. Note that hypothesizing the same distress-fear conditioning etiology for pain disorders as for conversion disorders makes the DSM separation seems a superficial if not arbitrarily symptomatic distinction.

In adult onset cases this profile pattern is often seen after a terrifying injury or other bodily trauma. This is usually physically dramatic to the individual, e.g., a large object falls, crashing down on one's head (with little more than a momentary loss of consciousness), or in a health-dangerous environment a soldier falls ill or is in acute physical pain in the anticipation or midst of horrifying combat, e.g., Gulf War Syndrome. THE SIMULTANEOUS EXPERIENCING OF ACUTE BODILY PAIN WITH AN EXTREME FRIGHT CONDITIONS THE ASSOCIATION OF THE TWO, i.e., UNEXPECTED PAIN AROUSES A STRONG SENSE OF FEAR, AND OCCASIONS OF FEAR ACTIVATE DISTRESSING BODILY SENSATIONS. For example, the threat of a tragic loss or of an angry confrontation, when one has become acutely pain-fear sensitized, can quickly arouse fear-associated physical symptoms and thus an immediate sense of danger to the person's sense of physical well-being. Conversely, an increment of pain or other somatic distress can arouse a heightened if not intense level of fear; so much fear can generate a misattribution of the perceived seriousness and the cause of the pain or an increased sensitivity and awareness of any concurrent and previously mild or unnoticed discomforts. For example, fear due to the experience of an unexpected increase in a particular pain can set the stage for an at least transitory "conversion" symptom (e.g., an accelerated heartbeat when threatened with a major loss or someone's sharp attack, "Oh, my heart doesn't feel right. Did I have some kind of a heart attack? I don't know if the tests the doctor made were good enough"). Toward the extreme, some who are strongly pain-sensitized seem to lose the basic ability to distinguish emotional pain from bodily pain, so that an acute or potentially overwhelming emotional pain is only experienced and expressed as physical anguish.

The longer-term impact of such conditioning is the suppression of the healthily normal range of emotional expressions of anguish and grief at the time of an emotional upset as well as the confounding of subsequently self-owned anger (consider, "That hurt me, and I am p..... off. I don't want you to say that to me again". In contrast to, "What you said wasn't real nice; it wasn't as sensitive as I know you can be"). Focusing on points of hope operates to mitigate or inhibit upsets. I believe the shift of attention toward a focus of hope (however faint and tenuous) is reinforced not only by reduced annoyance and social avoidance by others at an interpersonal level but also at a neurophysiologic level by conditioned metenkephalin/opioid synthesis. Especially strong or autonomically dominant peripheral vasoconstriction responses may have a significant connecting effect between fear and the somatic focus, that is, peripheral vasoconstriction in response to a fear threatening stimulus would focus the attention on "what is happening in my body". To my awareness, whether injuries enhance subsequent peripheral vasoconstriction is not known.

I believe these heightened sensitivities to any perceived threats to

the person's hopes or sense of well-being lead to AUTOMATIC SHIFTS OF ATTENTION lest a surge of pain become overwhelming. Over time these shifts become so automatic and smooth as not to be noticed by the person (nor even by many professional observers if not attuned to watch for them). Specifically, I consider REPRESSION be the outcome of innumerably repeated shifts of attention away from some painful memory whenever a cue of that memory is even remotely approached. The repetitive opioid reinforcements of these shifts of attention away from the threat of the painful memory can progressively make that memory inaccessible and hence "repressed". For example, a woman in her early 70's presented with complaints of declining memory and impaired attention, which did not test as neuropsychologically nor neurologically explainable. A year or so earlier, a bit before the time of the onset of her symptoms, her husband had choked to death at the dinner table. She had not recalled that, at age 5 she was looking out a window of her home and saw her father run over and killed by a truck, for many decades until the too-similar tragedy precipitated obtaining treatment for her symptoms; treatment eventually led to the memory. Thus, her distress appeared to have been sharply intensified by the prior unresolved but inaccessible grief, and successful treatment focused on resolving that accumulated grief.

A persisting CONVERSION symptom is the outcome of a repetitive shifting of attention away from a distressing threat onto a familiar and habituated physical pain, e.g., pressure to do something stressful is seen as somehow a danger to physical systems such as an undue strain on one's vulnerable heart. Belle indifference is the absence of emotional/fear arousal due to the habituation together with the effectiveness of the automatic shifting of attention in blocking the distress response to an imminent interpersonal threat.

DENIAL is the shift of attention away from an immediately distressing input. A postoperative patient was asked about her husband who rarely visited her in the hospital. Without a pause she said, "Oh, he was here two days ago. Look at those beautiful flowers over there. Mrs. Freund brought those from her garden. Aren't they gorgeous!" Or, after a noticeable pause, another 31/13 patient reacted to Rorschach card VIII, "Such beautiful colors! What do other people see in them"? It can be instructive to be alert to such shifts in an interview, and possibly in therapy to immediately ask, "You just made a shift in what we are talking about. Did something just cross your mind?" Thus, the person adapts to the threat of a surge of pain by reflexive and classically conditioned shifts of attention that mitigate or avoid hope-breaking inputs.

The Hy scale readily partitions into two limitedly correlated halves. The degree of emphasis can vary widely from one person to another. Some can have high elevations on the somatic part (Hy Obvious or Hy3 + Hy4) without much elevation on the interpersonal part: the person is body suffering-focused and consolation--and care--needy. Others can have high elevations on the interpersonal trust part (Hy Subtle or Hy1 + Hy2 + Hy5) and be problem-denying, Pollyanna, and approval-needy; a singular conversion

symptom can emerge in a period of intense stress and perceived threat. In the preceding, I have attempted to illuminate the underlying connections between these halves. The subscales give us this balance.

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Prokop, 1988.

Name: Dan Doran

Date: 06/21/16

MMPI-2 CRITICAL ITEMS

Only the items shown in boldface were answered in the critical direction.

Distress and Depression

5. I am easily awakened by noise. (TRUE)
24. Evil spirits possess me at times. (True)
73. I am certainly lacking in self-confidence. (TRUE)
130. I certainly feel useless at times. (TRUE)
140. Most nights I go to sleep without thoughts or ideas bothering me. (FALSE)
146. I cry easily. (True)
165. My memory seems to be all right. (FALSE)
170. I am afraid of losing my mind. (TRUE)
180. There is something wrong with my mind. (True)
233. I have difficulty in starting to do things. (TRUE)
299. I cannot keep my mind on one thing. (True)
301. I feel anxiety about something or someone almost all the time. (True)

Suicidal Thoughts

71. These days I find it hard not to give up hope of amounting to something. (True)
75. I usually feel that life is worthwhile. (False)
150. Sometimes I feel as if I must injure either myself or someone else. (True)
215. I brood a great deal. (True)
234. I believe I am a condemned person. (True)
246. I believe my sins are unpardonable. (True)
303. Most of the time I wish I were dead. (TRUE)
454. The future seems hopeless to me. (TRUE)
506. I have recently considered killing myself. (True)
520. Lately I have thought a lot about killing myself. (True)
524. No one knows it but I have tried to kill myself. (True)

Ideas of Reference, Persecution, and Delusions

42. If people had not had it in for me, I would have been much more successful. (True)
99. Someone has it in for me. (True)
138. I believe I am being plotted against. (True)
144. I believe I am being followed. (True)
162. Someone has been trying to poison me. (True)
228. There are persons who are trying to steal my thoughts and ideas. (True)
314. I have no enemies who really wish to harm me. (False)
333. People say insulting and vulgar things about me. (True)
336. Someone has control over my mind. (True)
361. Someone has been trying to influence my mind. (True)
466. Sometimes I am sure that other people can tell what I am thinking. (True)

Peculiar Experiences and Hallucinations

32. I have had very peculiar and strange experiences. (TRUE)
60. When I am with people, I am bothered by hearing very queer things. (True)
96. I see things or animals or people around me that others do not see. (True)
198. I often hear voices without knowing where they come from. (True)
298. Peculiar odors come to me at times. (TRUE)
311. I often feel as if things were not real. (TRUE)
316. I have strange and peculiar thoughts. (True)
319. I hear strange things when I am alone. (True)
355. At one or more times in my life I felt that someone was making me do things by hypnotizing me. (True)

Aggressive Impulses

37. At times I feel like smashing things. (True)
85. At times I have a strong urge to do something harmful or shocking. (True)
134. At times I feel like picking a fist fight with someone. (True)
213. I get mad easily and then get over it soon. (True)
389. I am often said to be hotheaded. (True)

Authority Problems and Poor Control

35. Sometimes when I was young I stole things. (True)
50. I have often had to take orders from someone who did not know as much as I did. (TRUE)
84. I was suspended from school one or more times for bad behavior. (True)
105. In school I was sometimes sent to the principal for bad behavior. (True)
240. At times it has been impossible for me to keep from stealing or shoplifting something. (True)
266. I have never been in trouble with the law. (False)

Sexual Difficulties

12. My sex life is satisfactory. (FALSE)
34. I have never been in trouble because of my sex behavior. (False)
62. I have often wished I were a girl. (or if you are a girl) I have never been sorry that I am a girl. Male: (True) Female: (False)
121. I have never indulged in any unusual sex practices. (FALSE)
166. I am worried about sex. (TRUE)
268. I wish I were not bothered by thoughts about sex. (TRUE)

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Date: 06/21/16

MMPI-2 CRITICAL ITEMS

Only the items shown in boldface were answered in the critical direction.

Alcohol and Drugs

168. I have had periods in which I carried on activities without knowing later what I had been doing. (True)
229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (TRUE)
264. I have used alcohol excessively. (True)
487. I have enjoyed using marijuana. (TRUE)
489. I have a drug or alcohol problem. (True)
511. Once a week or more I get high or drunk. (True)
527. After a bad day, I usually need a few drinks to relax. (True)
540. I have gotten angry and broken furniture or dishes when I was drinking. (True)

Family Discord

21. At times I have very much wanted to leave home. (True)
83. I have very few quarrels with members of my family. (False)
125. I believe that my home life is as pleasant as that of most people I know. (FALSE)
190. My people treat me more like a child than a grown-up. (True)
195. There is very little love and companionship in my family as compared to other homes. (True)
217. My relatives are nearly all in sympathy with me. (FALSE)
288. My parents and family find more fault with me that they should. (True)

Somatic Concerns

2. I have a good appetite. (FALSE)
10. I am about as able to work as I ever was. (FALSE)
18. I am troubled by attacks of nausea and vomiting. (TRUE)
47. I am almost never bothered by pains over the heart or in my chest. (FALSE)
101. Often I feel as if there were a tight band about my head. (True)
111. I have a great deal of stomach trouble. (TRUE)
141. During the past few years I have been well most of the time. (FALSE)
164. I seldom or never have dizzy spells. (False)
175. I feel weak all over much of the time. (TRUE)
176. I have very few headaches. (FALSE)
224. I have few or no pains. (FALSE)

8087

M
Male

Male

MMPI-2™

The Minnesota Multiphasic Personality Inventory-2™
Starke R. Hathaway and J. Charnley McKinley

MMPI-2 code: 3 1 2 * 7 8 " ' 4 0 - 6 5 / 9

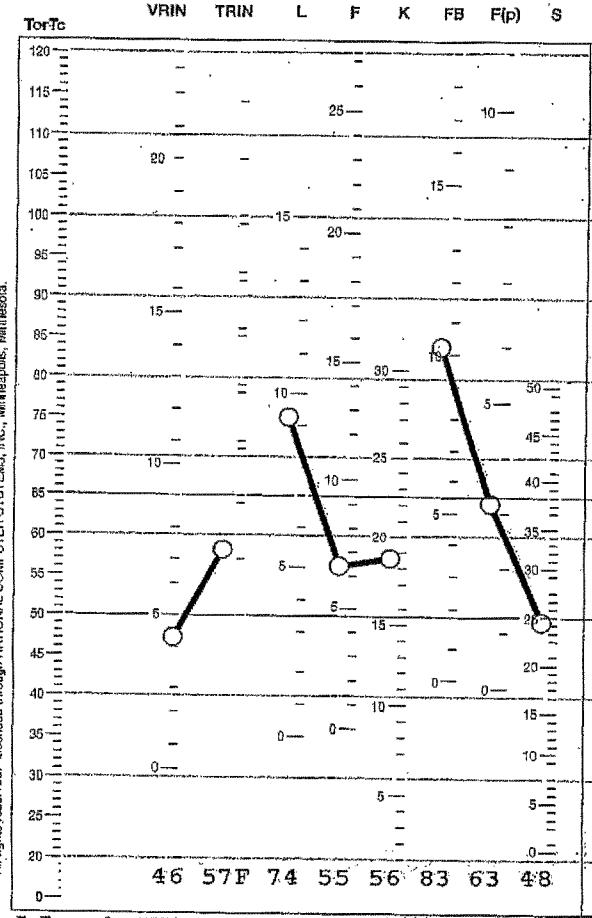
Name Dan Doran Age 50

Marital Status Widowed Education 11 years

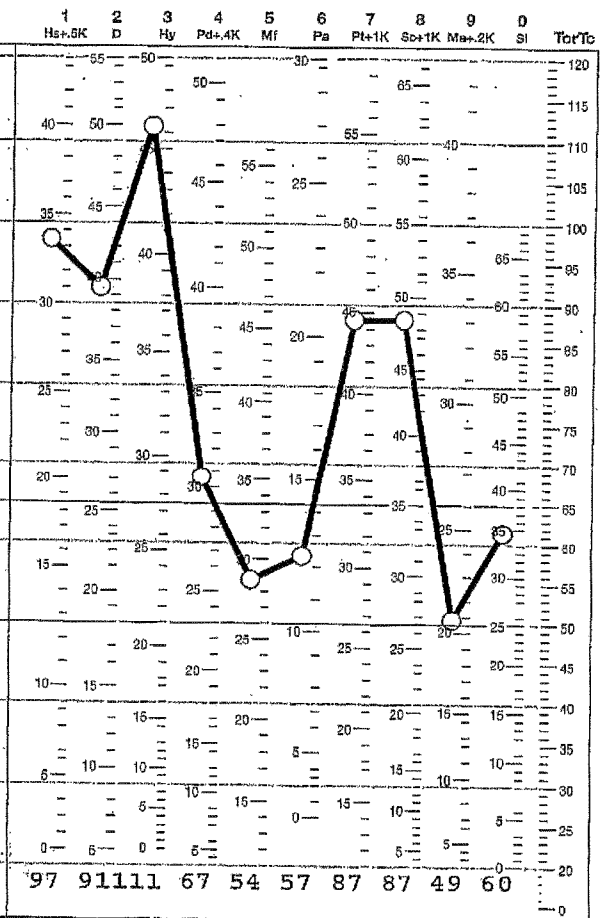
Date Tested 06/21/16 Date Processed 06/22/16

Referred By Daphna Slonim, M.D.

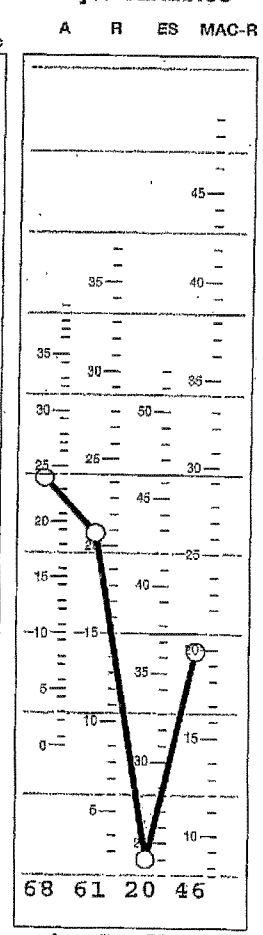
Validity



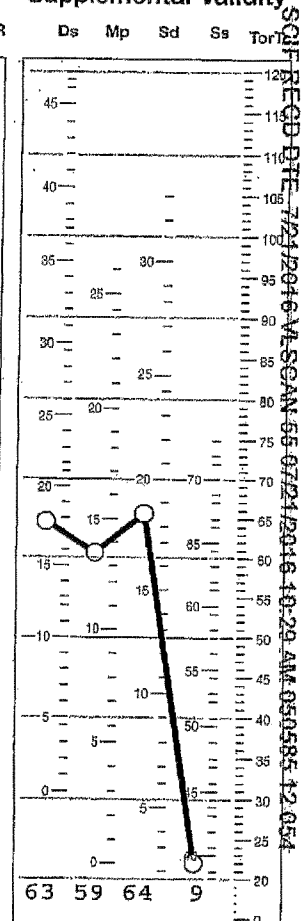
MMPI-2 Basic Scale Profile



Major Variables



Supplemental Validity



TorTc	?	VRIN	TRIN	L	F	K	FB	F(p)	S	1 Hs+.5K	2 D	3 Hy	4 Pd+.4K	5 Mf	6 Pa	7 Pt+1K	8 Sc+1K	9 Ma+.2K	0 Si	TorTc
Raw Score	0	4	8	9	6	18	10	3	23	24	39	46	23	28	12	26	30	16	34	
K to be added										9			7			18	18	4		
Raw Score with K										33			30			44	48	20		

A	R	ES	MAC-R
23	20	23	19

Ds	Mp	Sd	Ss	TorTc
17	13	18	31	

Name: Dan Doran
Referred by: Daphna Slonim, M.D.
Date Tested: 06/21/16

2-D and Subscales

		RAW	T
D	(full scale)	39	91
D1	Subjective depression	20	85
D2	Indecision-retardation	10	76
D3	Health pessimism	8	91
D4	Mental dullness	11	91
D5	Brooding, loss of hope	5	68

6-Pa and Subscales

		RAW	T
Pa	(full scale)	12	57
Pa1	Persecutory ideas	2	52
Pa2	Poignant sensitivity	4	62
Pa3	Moral righteousness	4	46

3-Hy and Subscales

		RAW	T
Hy	(full scale)	46	111
Hy1	Denies social anxiety	6	61
Hy2	Need for affection	7	51
Hy3	Lassitude - malaise	14	102
Hy4	Somatic complaints	13	101
Hy5	Inhibits aggression	4	55

8-Sc and Subscales

		RAW	T
Sc	(full scale)	30	87
Sc1	Social alienation	2	47
Sc2	Emotional alienation	4	78
Sc3	Ego defect, cognitive	7	84
Sc4	Ego defect, conative	8	82
Sc5	Defective inhibition	1	47
Sc6	Sensorimotor dissociation	12	99

4-Pd and Subscales

		RAW	T
Pd	(full scale)	23	67
Pd1	Family discord	3	58
Pd2	Authority problems	3	47
Pd3	Social disinhibition	5	57
Pd4	Social alienation	5	56
Pd5	Self-alienation	5	58

9-Ma and Subscales

		RAW	T
Ma	(full scale)	16	49
Ma1	Opportunism	1	42
Ma2	Psychomotor acceleration	3	39
Ma3	Imperturbability	5	59
Ma4	Ego inflation	3	50

5-Mf and Subscales

		RAW	T
Mf	(full scale)	28	54
GM	Gender masculine	26	30
GF	Gender feminine	27	48

0-Si and Subscales

		RAW	T
Si	(full scale)	34	60
Si1	Shyness and self-consciousness	1	39
Si2	Social avoidance	6	62
Si3	Alienation - self and others	10	65

Name: Dan Doran
Referred by: Daphna Slonim, M.D.
Date Tested: 06/21/16

Major Clinical Variables

		RAW	T
ES	Ego strength	23	20
MAC-R	Potential alcoholism	19	46
SAP	Teen drugs/alcohol	14	63
AAS		2	46
Mt	College maladjustment	31	81
N-P	Neurotic-psychotic profile balance		20

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	13	36
EC-5	Ego control	13	57
ORIG	Need novelty	26	55
INT	Abstract interests	39	34
Do	Need for autonomy	13	38
Dy	Need reassurances	22	60
Pr	Intolerance	14	61
Re	Value rigidity	19	47
Et	Ethnocentrism	10	48
St	Status mobility	18	51
R-S	Repression-sensitization	63	68
Lbp	Low back pain	15	79
O-H	Overcontrolled hostility	16	62
Ho	Cynical hostility	22	54
Ba	Good teamworker	42	41

Distress-Control

		RAW	T
A	Level of distress	23	68
R	Emotional constriction	20	61
Ca	Caudality-distress	22	80
Cn	Control-facade	20	48
So-r	Life as desirable	25	39
Th-r	Tired housewife	25	80
Wb-r	Worried breadwinner	18	70
PK	PTSD	22	73

Validity & Stability

		RAW	T
VRIN	Response inconsistency	4	46
TRIN	T-F inconsistency	8	57F
F-back	Rare answers - back	10	83
F(p)	Psychiatric infrequency	3	63
S	Superlative self-presentation	23	48
Ds	Overemphasize-fake sick	17	63
Mp	Consciously fake good	13	59
Sd	Consciously fake good	18	64
Ss	SES identification	31	9
Response Bias Scale		16	62
Rc	Retest-consistency	14	31
Ic	Retest-item change	32	64
Tc	Retest-score change	22	62

Content Scales

		RAW	T
HEA	Health concerns	27	95
DEP	Depression	16	71
FAM	Family problems	9	60
ASP	Antisocial practices	6	46
ANG	Anger	8	56
CYN	Cynicism	11	51
ANX	Anxiety	16	75
OBS	Obsessiveness	7	56
FRS	Fears - phobias	9	67
BIZ	Bizarre mentation	4	57
LSE	Low self-esteem	10	64
TPA	Type A	8	48
SOD	Social discomfort	8	50
WRK	Work interference	12	59
TRT	Negative treatment indicators	12	69

PSY-5 Personality Psychopathology Scales

		RAW	T
AGGR	Aggressiveness	10	56
PSYC	Psychoticism	2	44
DISC	Disconstraint	9	35
NEGE	Negative Emotionality/Neuroticism	12	55
INTR	Introversion Low Positive Emotionality	22	74

BECK DEPRESSION INVENTORY
SELF-RATING SCALE
by Aaron T. Beck

Name DAN DORAN Birthdate 06-04-1966 Current Age 50 Sex: M X F ___

Date of Evaluation 06-21-2016

Instructions: On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
   1 I feel sad.
   (2) I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   (1) I feel discouraged about the future.
   2 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   (1) I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   (2) I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   (2) I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel particularly guilty.
   1 I feel I may be punished.
   2 I expect to be punished.
   (3) I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   (2) I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   (3) I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   (1) I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    (3) I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    (1) I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    (2) I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    (2) I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    (3) I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    (2) I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    (1) I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    (2) I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    (3) I have no appetite at all anymore.

19. (0) I haven't lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.
    I am purposely trying to lose weight by eating less.
    Yes ☐ No ☐

20. 0 I am no more worried about my health than usual.
    (1) I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    (3) I have lost interest in sex completely.

HMP Form 19

Hamilton Anxiety Rating Scale

Patient's Name DAN DORAN

Date of First Report 06-21-2016

Diagnosis

Date of This Report

Current Therapy

Instructions — *This checklist is to assist the physician in evaluating each patient with respect to degree of anxiety and pathological condition. Please fill in the appropriate rating.*

0 None
1 Mild
2 Moderate
3 Severe
4 Severe, grossly disabling

Item	Rating	Item	Rating
Anxious Mood — Worries, anticipation of the worst, fearful anticipation, irritability.	3	Somatic (Sensory) — Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, picking sensation.	3
Tension — Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.	3	Cardiovascular Symptoms — Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.	1
Fear — Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.	2	Respiratory Symptoms — Pressure or constriction in chest, choking feelings, sighing, dyspnea.	2
Insomnia — Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.	3	Gastrointestinal Symptoms — Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, loosness of bowels, loss of weight, constipation.	3
Intellectual (Cognitive) — Difficulty in concentration, poor memory.	3	Genitourinary Symptoms — Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.	3
Depressed Mood — Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.	3	Autonomic Symptoms — Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.	2
Behavior at Interview — Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos.		Somatic (Muscular) — Pains and aches, twitchings, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.	2
		Total Score	33

DANIEL DORAN
6/21/16

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Print out this test, fill in your answers and see where you stand.

Situation	Chance of Dozing or Sleeping
Sitting and reading	0
Watching TV	1
Sitting inactive in a public place	0
Being a passenger in a motor vehicle for an hour or more	0
Lying down in the afternoon	0
Sitting and talking to someone	0
Sitting quietly after lunch (no alcohol)	1
Stopped for a few minutes in traffic while driving	0
Total score (add the scores up) (This is your Epworth score)	2

TOMM: Score Sheet

by Tom Tombaugh, Ph.D.

Name: Dan [redacted] Date: 6/21/16

Age: 50 Gender: Male: X Female: ☐

Name of Administrator: Ray [redacted] RN

Instructions:

Each trial lists both correct (**bold**, underlined) and incorrect (regular text) responses. While running the test, *circle the name of the item* that the respondent chooses. After administering the test, put a checkmark in the box beside each number that has a circled **bold** and underlined response. Add up the number of checkmarks in both columns to obtain the total number of correct responses and record it at the bottom of each trial.

TOMM Score Sheet: Trial 1

No.	A	B	
1.	**spinning wheel**	cookie	☑
2.	tent	**tissue box**	☑
3.	dustpan	**mouse**	☑
4.	**quill pen**	teepee	☐
5.	birdbath	**can**	☑
6.	**suitcase**	comb	☑
7.	**pennant**	boat	☑
8.	gas pump	**musical notes**	☐
9.	ring	**guitar**	☑
10.	**hat**	Christmas tree	☑
11.	**muffin pan**	train	☑
12.	mailbox	**paintbrush**	☑
13.	wheat	**axe**	☑
14.	**jack o' lantern**	coat hanger	☐
15.	wallet	**scissors**	☑
16.	safety pin	**elephant**	☑
17.	**saw**	door	☑
18.	**butterfly net**	lawn mower	☑
19.	pullout bed	**candle**	☑
20.	**motorcycle**	knife	☑
21.	fishing pole	**sewing machine**	☐
22.	**jack-in-the-box**	rocking chair	☑
23.	**bench**	fence	☐
24.	screw	**stool**	☐
25.	**toaster**	bow & arrow	☑
26.	T.V.	**light bulb**	☑
27.	**maple leaf**	boat	☑
28.	crutch	**wrench**	☐
29.	hoe	**cake**	☑
30.	**key**	sock	☑
31.	cloud	**rose**	☑
32.	**racket**	pencil	☐
33.	corn	**ladder**	☐
34.	**wheelbarrow**	fire hydrant	☑
35.	**whistle**	grapes	☑
36.	toilet paper	**birdhouse**	☑
37.	**shopping cart**	teddy bear	☐
38.	cigarettes	**ice cream**	☑
39.	**roller skates**	glue	☐
40.	cherries	**umbrella**	☑
41.	**life preserver**	mountains	☑
42.	wheelchair	**stapler**	☐
43.	**swing set**	bunk bed	☑
44.	soup ladle	**pail & shovel**	☑
45.	dice	**iron**	☐
46.	**carrot**	book	☑
47.	drum	**dart**	☑
48.	**paper clip**	bird cage	☑
49.	**vest**	telescope	☐
50.	end table	**mask**	☑

TOTAL Correct for Trial 1 = 36

TOMM Score Sheet: Trial 2

	A	B		A	B	
1.	scissors	clock	☑	26. yest	baseball bat	☐
2.	banana	musical notes	☑	27. string of pearls	stapler	☑
3.	hobbyhorse	tin can	☑	28. window	spinning wheel	☑
4.	ice cream cone	lock & key	☑	29. iron	lipstick	☑
5.	sewing machine	bird feeder	☐	30. shoe	butterfly net	☑
6.	chair	toaster	☑	31. notebook	roller skate	☑
7.	light bulb	eggs	☑	32. mouse	pine cone	☑
8.	elephant	batteries	☑	33. basketball net	maple leaf	☐
9.	ceiling fan	jack o'lantern	☑	34. stepladder	filing cabinet	☑
10.	wrench	ashtray	☑	35. felt marker	candle	☑
11.	suitcase	spray bottle	☐	36. wishing well	muffin pan	☑
12.	container	saw	☑	37. hat	mustard bottle	☑
13.	carrot	chair & table	☑	38. guitar	hot dog on fork	☑
14.	saltshaker	birdhouse	☑	39. telephone pole	key	☑
15.	eyeglasses	rose	☑	40. pennant	bell	☑
16.	clothespin	motorcycle	☑	41. hairbrush	jack-in-the-box	☑
17.	swing set	needle & thread	☐	42. playing card	life preserver	☑
18.	racket	light switch	☑	43. tissue box	stump	☑
19.	knife	pail & shovel	☑	44. picnic basket	dart	☑
20.	onion	bench	☐	45. axe	anchor	☑
21.	lighter	umbrella	☑	46. fishhook	paintbrush	☑
22.	quill pen	mirror	☑	47. shopping cart	sack	☑
23.	cake	purse	☑	48. wheelbarrow	thermos	☑
24.	fire	paper clip	☑	49. mask	cross	☑
25.	whistle	bricks	☑	50. oven mitts	stool	☑

TOTAL Correct for Trial 2 = 44

TOMM Score Sheet: Retention Trial

	A	B		A	B	
1.	light socket	wrench	☑	26. tissue box	wagon	☐
2.	stapler	fudge	☑	27. cheese	dart	☑
3.	jack-in-the-box	gondola	☑	28. rose	shoe	☑
4.	tree	mask	☑	29. coat	shopping cart	☑
5.	maple leaf	peanuts	☐	30. bench	fence	☑
6.	jack-o'-lantern	carton	☑	31. extension cord	umbrella	☑
7.	mailbox	carrot	☑	32. mill	wheelbarrow	☑
8.	skip rope	light bulb	☑	33. can	snowman	☑
9.	paintbrush	candy	☑	34. zipper	ice cream cone	☑
10.	life preserver	bird	☑	35. package	motorcycle	☑
11.	elephant	lamp	☑	36. muffin pan	trophy	☑
12.	water faucet	musical notes	☑	37. swing set	pipe	☑
13.	loaf of bread	scissors	☑	38. diving board	whistle	☑
14.	stool	cup	☑	39. sewing machine	necktie	☑
15.	slingshot	birdhouse	☑	40. cone	toaster	☑
16.	butterfly net	lighthouse	☑	41. saw	sign	☑
17.	clown	racket	☑	42. roller skates	scales	☑
18.	wagon	pail & shovel	☑	43. drill	spinning wheel	☑
19.	quill pen	footstool	☑	44. iron	plant	☑
20.	cake	dinner bell	☑	45. electric fan	key	☑
21.	candle	church	☑	46. pennant	rolling pin	☑
22.	windmill	vest	☐	47. phone	mouse	☑
23.	flat	kite	☑	48. suitcase	needle	☑
24.	airplane	guitar	☑	49. clipboard	axe	☑
25.	stepladder	water fountain	☑	50. paper clip	scarf	☑

TOTAL Correct for Retention Trial = 47

Daphna Slonim, M.D.
Diplomate American Board of Psychiatry and Neurology

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July 18, 2016

William Green, Esq.
3419 Via Lido, #607
Newport Beach, CA 92663

Amber Thomas, Claims Adjuster
State Compensation Insurance Fund
P.O. Box 3171
Suisun City, CA 94585-6171

PSYCHIATRIC QME REPORT

Re:	Dan Doran
Employer:	Benedict & Benedict Plumbing Company
D.O.B.:	06/04/1966
D.O.A.:	07/11/12
D.O.E.:	6/21/16
WCAB #:	ADJ 8760713
Claim #:	05814232

Mr. Doran was seen for a comprehensive psychiatric evaluation at the Covina office on 6/21/16 for 3 ½ hours, plus two hours of testing.

Mr. Doran is a 50-year-old Caucasian male who reported that he was involved in an industrial injury on 7/11/12, while employed by Benedict & Benedict Plumbing Company.

The examination consisted of a clinical psychiatric interview. No physical examination was conducted.

The following tests were administered and scored by me in conjunction with this evaluation:

1. The Beck Rating Scale for Depression
2. Hamilton Anxiety Rating Scale
3. Epworth Sleepiness Scale
4. TOMM (Test of Memory Malingering)
5. MMPI-II

Mr. Doran was employed by Benedict & Benedict as a plumber since 2009 until his injury on 7/11/12.

HISTORY OF INJURY:

On 7/11/12, Mr. Doran cut through a wall with a saw. A chunk of the wall came down from above and struck him on the right wrist and hand. He had an open wound on the right thumb. He cleaned it himself and taped it. He was in pain, and he left to go home, as it was the end of his shift. Mr. Doran reported the injury to the owner. He could not sleep because of the pain. The next day, they gave him a helper to finish the job.

On Friday, 7/13/12, Mr. Doran drove himself to ER at Memorial Hospital in Pasadena. X-rays were taken, and he was told he had a fracture on his right thumb. They splinted it and taped it.

Mr. Doran went to see an orthopedic surgeon, who put a cast on it. He then had physical therapy and EMG. "It hurt terribly." So, he decided to get an attorney and was referred to the office of Dr. Haronian and Dr. Kohan. Dr. Kohan diagnosed RSD because of severe persistent burning pain in the right forearm. Dr. Kohan gave him an injection in the neck, which did not help. In August, 2014, Dr. Kohan installed a spinal cord stimulator.

Synapse Orthopedic Group included Dr. Haronian, an orthopedic surgeon, and Dr. Kohan, an orthopedic surgeon, but also a pain management specialist who did the surgery to install the spinal and stimulator. Dr. Hinze, the psychologist, was also a part of the same clinic. Mr. Doran stated that most of the time he saw physician assistants at this clinic.

Dr. Kohan released Mr. Doran from under his care in September, 2015, and stopped his SDI without even notifying him. Only in February, 2016, was the attorney able to refer Mr. Doran to Dr. Baker for treatment.

Mr. Doran saw a psychologist, Dr. Hinze, about 2-3 times over a couple of years. He only received group therapy once a week, with different therapists. He did not receive any individual psychotherapy. He felt it was "informative," but did not help much.

Mr. Doran was released by Dr. Hinze around May, 2015, around the same time he saw QME orthopedist, Dr. Aval. Mr. Doran reported that he was never referred for psychiatric evaluation nor received any psychotropic medications, other than Elavil.

Mr. Doran reported that when the spinal cord stimulator turns high it takes the burning pain in the right forearm from 10/10 to 5-6/10. But he also has a buzz in his knees, ankles, and hips. The stimulator was placed on 8/28/14.

Since the work accident, Mr. Doran has a jerky tremor of the left upper and lower extremity. He was told by one of the PA's at Dr. Kohan's office that it could be the side effects of Neurontin. He takes 800mg four times per day, and when the dose was cut down, the pain increased.

Dr. Baker, his pain management doctor, also prescribed Elavil, 50mg, in the evening. Other than Dr. Baker, Mr. Doran only sees his general practitioner, Dr. Bao Thai, under MediCal. She treats him for his diabetes. Metformin, 1000mg, twice per day. He also gets Lipizide, 5mg, twice per day, as well as a low dose of medication for high blood pressure, name unrecalled. Both blood pressure and diabetes has been under control.

Mr. Doran sees Dr. Baker once a month. Workers Compensation paid temporarily total disability checks for two years. He then was getting money from State Disability until August, 2015. When Dr. Kohan cut him off, he then got welfare and food stamps. Mr. Doran then was again put on SDI by Dr. Baker.

He applied for Social Security in January, 2015, and it was denied. He appealed it with an attorney and is scheduled for a hearing on September 12, 2016. He'll have to go back on welfare. Mr. Doran lives with his girlfriend of eight years. She has been supporting him. She has been on Social Security Disability, as well as her late husband's Social Security.

Because of financial problems, he had to sell most of his belongings, including his truck. He has been living in constant fear that his girlfriend would kick him out.

CURRENT PHYSICAL COMPLAINTS:

Mr. Doran has a burning pain in the right forearm up to his elbow, rated 6/10, with the stimulator, going up to 10/10 when he turns it off.

He has pain in the left wrist, rated 9/10; with the stimulator, rated 5/10.

Mr. Doran has pain in the anal area constantly, rated 5-10/10.

He has pain in both knees when moving, rated 5-9/10.

Mr. Doran has headaches 2-3 times per week, lasting about one hour, rated 7-8/10.

He is impotent since shortly after the accident.

He has shaking/twitches in his left leg and hand. The left side of his mouth seems to be paralyzed.

He has pressure in the chest a few times a day almost every day, lasting about 10-15 minutes. Sometimes he has it when he takes a shower with rapid heartbeats.

His throat is very dry, and it makes him feel he is choking. He also has difficulty swallowing because of it.

He has abdominal pain daily with nausea. He has constant ringing in his ears. He feels physically weak. He is extremely constipated and has to take stool softeners.

CURRENT EMOTIONAL COMPLAINTS:

Mr. Doran feels sad all the time. He used to cry but now can't cry even though he wants to. He feels discouraged about the future and feels dissatisfied and bored with everything. Mr. Doran feels he is being punished. "Maybe my bad karma." He has thoughts about killing himself but won't do it.

Mr. Doran lost a big part of his self confidence. He feels disgusted with himself because he is unable to work and cannot even walk his dog. He blames himself for dropping things. He blames himself for getting injured. He should have had a helper.

He feels he looks ugly. "I cannot shave any longer, and I cannot afford a shave. I am bald, not like my father and brothers." Mr. Doran had problems making decisions. He does not trust his judgment. He lets his girlfriend make all decisions.

Mr. Doran has no energy and motivation. "I feel like a spent nickel. My entire body is sore." He gets tired from doing almost anything. He has to push himself very hard to do anything. He reads the newspapers. He listens to the Dodgers games on radio. "I cannot even tie a fishing hook to go fishing."

Mr. Doran has no appetite. He does not eat until supper. He has to force himself to eat. He lost all of his interest in sex. He is impotent.

Mr. Doran has lost most of his interest in other people. He talks with a couple of neighbors. Before the injury, he used to socialize about 6-10 hours per week with friends, going out to dinner or going fishing.

Mr. Doran goes to bed around 1:00 a.m. It takes 1-2 hours to fall asleep. He wakes up 1-2 times per night to go to the bathroom. It takes a while to fall asleep again. He wakes up around 7:30 a.m. In the last few weeks, he has nightmares, but he does not recall them.

He feels very fatigued, but he cannot fall asleep with the stimulator being on.

Mr. Doran feels worried about his physical condition. He worries about finances and about his girlfriend kicking him out.

He feels tense, restless, and nervous, and is unable to relax. He feels shaky, irritable, and impatient, but he keeps it all inside. He does not lose his temper.

He feels afraid of traffic and of crowds. He tries to avoid driving the freeways. He gets anxious in a store where there are a lot of people

Mr. Doran has problems with his short term memory. His concentration is not as good as it used to be. Sometimes when he reads, his mind wanders. He then needs to re-read the same thing over again.

PERSONAL HISTORY:

Mr. Doran was born in Pasadena on 6/4/1966. His father died in 1998 at age 77 from a stroke and complication of diabetes. He worked for an insurance group. He was strict and an alcoholic and was not available emotionally. He traveled a lot but was a good provider. His mother died in 2007 at age 81 from strokes and sepsis. She was a housewife and a "good mother."

Mr. Doran is the youngest of four siblings. He has one sister and two brothers. Since 2007 when his mother died, he has not spoken with his sister and brothers, as there were issues with the inheritance. His older brother is an alcoholic. Mr. Doran lived with the mother for a few years before her death and was her caregiver. But after the mother's death, they immediately sold the house. He received a lot less money from the inheritance than his other siblings.

He reported his childhood as normal and difficult, as he was not doing well in school like his siblings. There is no history of psychiatric problems in the family.

EDUCATIONAL HISTORY:

Mr. Doran attended St. Francis High School until the 11th grade. He did not graduate. He left home at age 17 and went to work. He took different classes related to plumbing.

MILITARY HISTORY:

None.

EMPLOYMENT HISTORY:

At age 17, Mr. Doran worked for a fire sprinkler company, first in manufacturing and then installing. He worked there until age 22. He then started working as a plumber at Benedict & Benedict until 1999. Then he moved to Nevada doing plumbing on new homes for three years. He came back to assist his mother after an accident.

He then moved to Alabama and worked as a plumber for Dean Plumbing for three years. He then worked for East Plumbing for a few years.

Then Mr. Doran moved to Indiana and worked there as a plumber for three companies, names unrecalled, until November, 1997, when he came back to California after his father had a stroke. He returned to Indiana, but work was very slow, and he returned to California to work. While he was there, his wife committed suicide on 12/3/2001. Then he worked as a self-employed plumber and took care of his mother, who had a stroke.

After his mother's death, Mr. Doran moved to live in Bishop, California. He worked for Dr. Drain. He was laid off and was on unemployment.

In 2009, he re-started working for Benedict & Benedict.

LEGAL HISTORY:

None.

MARITAL HISTORY:

Mr. Doran was married in 1993. His wife committed suicide in 2001. She was bipolar. They had no children.

He then remarried in 2002. She cheated on him, and they divorced in 2003.

In the last eight years, Mr. Doran has been in a relationship with Mary. She is 58 and is a widow. She has been on Social Security Disability for a bad knee and depression caused by her husband's death.

MEDICAL HISTORY:

Mr. Doran was diagnosed with diabetes 10 years ago. It has been controlled with oral medication.

High blood pressure was diagnosed in March, 2015, and he has been on low doses of medications.

Otherwise, he has been healthy.

Mr. Doran reported he has a "growth in his rectum." It started with a welt above the anus. It was diagnosed as a fistula. It started in December, 2015. He has been on antibiotics for a few months. The surgeon wants to do a colonoscopy first. They are waiting for Medi-Cal to OK it. It has been painful. He needs to sit on a semi-solid surface.

PREVIOUS INDUSTRIAL INJURIES:

None.

PREVIOUS PSYCHIATRIC HISTORY:

None.

CURRENT MEDICATIONS:

Neurontin, 800mg, four times per day; Elavil, 50mg; Metformin, 1000mg, twice per day; Lipizide, 5mg; medications for blood pressure, 5mg

HABITS:

Cigarettes: 1 pack per day for 35 years.
Alcohol: A little wine at dinner for the last eight years; before, he used to drink beer and whiskey.
Coffee: 1 cup per day.

Mr. Doran denied the use of street drugs. The last time he smoked marijuana was 20 years ago.

CLINICAL IMPRESSION:

In the mental status examination conducted on 6/21/16, Mr. Doran was seen as a well-developed, balding, bearded, well-nourished, 50-year-old Caucasian male who appeared to be his stated age. He was casually dressed.

He wore a brace on his right wrist. His left upper and lower extremities were shaking constantly. His left side of the mouth seemed paralyzed. He had to change positions and stand up at times.

Mr. Doran was somewhat tense and ill at ease throughout the interview but was pleasant, cooperative, and talkative. His affect was appropriate to the amount of tension, depression, and worry that he reported. His mood did reflect his depression and stated anxiousness and concern. He was serious throughout the interview. There was nothing to suggest malingering.

Mr. Doran was correctly oriented for time, place and person. There did not seem to be any defect noted in his remote memory ability. His immediate recall and short term memory were slightly impaired. His general fund of knowledge appeared to be in the average range, and was judged to be appropriate to his age, education and work experience. His concentration was impaired.

He made three mistakes on the serial 7's. He was unable to correctly repeat four digits backwards.

An essay of Mr. Doran's thought processes did not reveal any clinical evidence of loose associations, and there were no indications of delusions, hallucinations or ideas of reference.

His conceptualization ability appeared to be intact, and his capacity to do abstract thinking was felt to be within normal limits. The patient did not describe, and it was impossible to elicit, any evidence of abnormal features in his basic personality.

The patient's insight appeared to be fair. The patient's motivation to get his life stabilized from an emotional, physical, vocational viewpoint appeared to be quite good. His general judgment for events in his culture and lifestyle did not appear to be grossly impaired.

PSYCHOLOGICAL TESTING:

1. Mr. Doran scored 41 (severe depression) on the Beck Depression Inventory Self Rating Scale.
2. Mr. Doran scored 33 (moderate/severe anxiety) on the Hamilton Anxiety Rating Scale.
3. Mr. Doran scored 2 (not sleepy) on the Epworth Sleepiness Scale.
4. Mr. Doran scored 36/44/47 (not malingering) on the TOMM.

The Test of Memory Malingering (TOMM) provides a systematic method to assist neuropsychologists in discriminating between bona fide memory-impaired patients and malingerers. The TOMM is a 50-item recognition test for adults that includes two learning trials and a retention trial. During the two learning trials, the patient is shown 50 line-drawings (target pictures) of common objects for 3 seconds each, at 1-second intervals. The patient is then shown 50 recognition panels, one at a time. Each panel contains one of the previously presented target pictures and a new picture. The patient is required to select the correct picture (i.e., the picture shown during the learning trial). The same procedure is used on the optional retention trial except the target pictures are not re-administered.

The two learning trials alone are usually sufficient to assess malingering. However, use of the retention trial adds only a few minutes to the test and helps corroborate the results.

Several important characteristics make the TOMM particularly effective for detecting malingering:

1. The administration of a large number of visual stimuli gives the impression that the test is much more difficult than it really is. Malingerers believe the test would be difficult for people with genuine memory impairments and intentionally perform poorly, while non-malingering patients exert their full effort and do well.
2. The presentation of 50 pictures also provides the TOMM with good face validity as a test of learning and memory. This decreases its transparency as a test of

malingering and increases its effectiveness in detecting exaggerated or deliberately faked memory impairment.

3. Explicit feedback to patients on response correctness after each item widens the gap between the scores of memory-impaired patients and malingerers. Feedback provides a learning opportunity for highly motivated patients and should increase their response accuracy on subsequent trials, while it allows malingerers to more accurately track their performance and adjust it accordingly.

While the TOMM is sensitive to malingering, it is insensitive to neurological impairments. All individuals, including those with neurological impairments, have a remarkably high capacity for storing and retrieving pictures of common everyday objects, such as those used in the TOMM. The robustness of this effect permits the TOMM to offer a norm-based criterion to detect malingering. This supplements the more traditional procedure of using below-chance performance as the criterion for malingering.

Scoring the TOMM is an uncomplicated process. One point is given for each correct answer provided by the patient on the Recognition and Retention Trials. Thus, the minimum score on each of the Recognition and Retention Trials (no correct answers) is 0, while the maximum score (all answers correct) is 50.

Non-malingerers, even those with substantial impairment, score very well on the TOMM. Malingerers or suspected malingerers score very low on the TOMM. The research suggests that any score lower than 45 on Trial 2 or the Retention Trial should raise concern that the individual is not putting forth maximum effort and is likely malingering.

1. Scoring lower than chance on any trial indicates the possibility of malingering. This rule is based on the fact that a person can correctly identify 50% of the pictures by guessing. Thus, a score of 25 represents a chance level of responding on the TOMM. Moreover, application of the binomial distribution (Siegel, 1956) shows that the 95% confidence interval for chance performance ranged from 18 to 32. Consequently, scores below 18 are unlikely to occur by chance. These low scores imply that the person knew some of the pictures were correct, but intentionally picked the incorrect picture.
2. Any score lower than 45 on Trial 2 or the Retention Trial indicates the possibility of malingering. Since most malingerers do not obtain below-chance scores, most interpretations will rely on the second decision rule. This rule uses the score on the second trial as its point of reference. Performance on Trial 2 is very high for non-malingerers regardless of age, neurological dysfunction, or psychological symptom. More than 95% of adults obtained a score of 49 or 50 on the second trail. Most non-demented individuals obtained a perfect score on Trial 2. This occurred regardless of the individual's

performance on traditional tests of visual and verbal learning. Rarely did a non-demented patient obtain a score lower than 45.

In view of these results, any score lower than 45 on Trial 2 or on the Retention Trial should raise concern that the individual is not putting forth maximum effort and is likely malingering. Rather than using the score of 45 as a rigid cut-off, it should be viewed as a guideline, with the likelihood of malingering increasing as the score deviates further from the normative baseline for each specific diagnostic group.

MMPI-II Psychological testing was interpreted by A. B. Caldwell, PhD, on 6/22/16.

Attitude and Approach: He was very guarded, denying, and self-favorable in his approach to the inventory. The clinical scale elevations he obtained may be suppressed and incomplete and the pattern somewhat distorted. Considering just scales L, F, and K, the interpretive statements are probably accurate, but they may understate the severity of his problems and his level of disturbance.

Socio-cultural Influences vs. Conscious Distortion: Some of his clinical scales are apt to be significantly under-elevated, and the following report may significantly understate his level of disturbance. His elevation on the L scale, like his elevation on K, reflects considerable guardedness and denial, a conscious avoidance of admitting any faults or improper actions that might be held against him. The elevation on L should not be interpreted as reflecting more than a mild amount of ingrained properness or characterological self-control. These scores strongly suggest the possibility that he had to take the MMPI-2 "against his will" and that he was very cautiously self-protective as to how the test results might reflect badly on him or be used against him.

An additional contradiction must be noted. In contrast to his high needs to make a good impression, he showed a slightly above average willingness in some areas to emphasize his symptoms and complaints (scale Ds). This would not rule out some confusion in making his responses or uncertainty about how the results of the testing are to be used. This atypical approach to the items would add some doubt as to the validity of his profile, and the level of severity reflected in the following interpretation may need a careful area-by-area evaluation in interviews.

SYMPTOMS AND PERSONALITY CHARACTERISITCS

The profile indicates that he would readily become preoccupied with a wide variety of causes of physical pain and suffering. At least some aspects of localized pain, general malaise, weakness, and fatigue are apt to be seen as beyond medical

expectations for his current physical status. Such symptoms as G.I. pain or other G.I. complaints, hypertension, vasomotor instability, and headache are often associated with this profile. If there were a back injury, his complaints are likely to be seen as increased by psychological factors. Various issues involving his eating habits would also be typical. Many patients with similar profiles have shown intractable pain syndromes especially postoperatively. Spells such as fainting, crying, or dizziness are suggested along with other symptoms involving the head or disturbances or consciousness. At times he would show an unexpected acceptance of his physical symptoms and indifference about their consequences in his life. The secondary depression tests as moderate to severe, as limitedly denied and covered over, and as extensively expressed through the physical apprehensions. There may be 'smiling depression" elements and from time to time open breakthroughs of anguish. Crying and loss of appetite are likely expression of his depression. The current level of his day-to-day coping and immediate practical self-sufficiency tests as severely disorganized in many areas.

Similar patients often developed anxiety symptoms or acute panic attacks. They became phobic about physical illnesses, fearful of leaving home, and had other specific points of focus for their acute anxieties.

Similar patients have been described as being at a "throw in the sponge" phase of their lives at the time of testing. Multiple childhood rejections and deprivations were reported, including poor or alcoholic fathers, emotionally ill parents, fathers or mothers who had died during the patient's childhood, and families that lacked affection either because of strict and rigid attitudes or through an immoral and disorganized pattern. As children, these patients handled stresses by repressiveness and by learning passive and dependent roles. However, their emotional reactions became attached to strong psychophysiologic reaction patterns as well as being expressed through symbolic conversions of their anxiety. It has been speculated that these life-long conditioned autonomic reactions directly contributed to their high incidence of organic breakdowns and psychophysiologic disorders.

DIAGNOSTIC IMPRESSION

Diagnoses of conversion, pain, and hypochondriacal disorders and of psychophysiologic disorders are the most common with this pattern. Some of these patients were seen as having depressive disorders with a strong somatic emphasis. However, the clinical and diagnostic picture appears more mixed and severe than usual. It should be re-emphasized that his generally guarded and self-favorable responding together with his understatement of his problems and his idealized self-presentation make his profile more ambiguous than most.

REVIEW OF MEDICAL RECORDS:

1. Records from U. S. HealthWorks, also including:
   1. 9/28/12. Hand Rehabilitation notes. Pain 7-10/10. X-rays 100% healed. Naproxen, Prilosec, DM meds. Dynamometer readings and ROM Evaluation. Physical Therapy assessment.
   2. A. Elegado, MPT, 10/31/12. Ready for physical therapy. Cold packs; paraffin baths; joint mobilization.
   3. Same, 10/8/12. Pain in fracture area. Felt a pop; swelling in thumb.
   4. Same, 10/10/12. Supervised therapeutic exercises.
   5. Same, 10/15/12. Increased pain over weekend.
   6. Same, 10/17/12. Increased pain in medial elbow.
   7. Same, 10/22/12. Shooting pain in thumb for no apparent reason.
   8. Same, 10/26/12. Strength/ROM Report.
   9. Same, 11/1/12. Daily Therapy Treatment Note.
   10. Same, 11/2/12. Same treatment visit, 10/12.
   11. Same, 11/8/12. Still having a lot of pain.
   12. Same, 11/8/12. Slow progress, moderate to severe pain. Consider Dynasplint.
   13. Same, 11/12/12. Physical Therapy Evaluation, 12/12.
   14. Same, 11/12/12. Daily Therapy Treatment Note.

2. Records from Huntington Orthopedic Surgical Medical Group, including:
   1. George Tang, MD, 7/17/12. PTP Initial Ortho Evaluation. Right thumb first metacarpal fracture. Will need thumb spika cast. He takes Metformin and Januvia.
   2. Same. Work Status Report, 8/14/12. Temporarily Totally Disabled until 9/20/12.
   3. 9/20/12. Approved physical therapy 2 X 6. Naprosyn. Medrox cream.
   4. Work Status Report, 7/17/12. Temporarily Totally Disabled until 9/30/12.
   5. Same, 9/4/12. Temporarily Totally Disabled until 10/30/12.
   6. Same, 12/20/12. Temporarily Totally Disabled until 2/28/13.
   7. G. Tang, MD, 7/24/12, PR-2. Good alignment of fracture. Continue cast. Temporarily Totally Disabled until 9/30/12.
   8. Same, 8/14/12, PR-2. Naprosyn, Prilosec.
   9. Same, 9/4/12, PR-2. Should get a thumb spika orthosis for 2-3 weeks. Physical therapy 2 X 6.
   10. Same, 10/4/12, PR-2. Continue physical therapy. Temporarily Totally Disabled until 11/30/12. If not improving, will ask for an MRI.
   11. Same, 12/20/12, PR-2. Saw the neurologist who recommended EMG to right upper extremity. Some numbness on the thumb area. Finished physical therapy, which has been helpful to improving range of motion. Diagnosis: (1) first metacarpal fracture; (2) reflex sympathetic dystrophy.
   12. Same, 1/3/13. Request for EMG/NCS.

13. Same, 1/31/13, PR-2. EMG done 1/15/13. Showed mild carpal tunnel syndrome. Gabapentin to treat possible RSD.
14. Same. Work Status Report, 1/31/13. Temporarily Totally Disabled until 3/30/13.
15. Same, same, 10/4/12. Temporarily Totally Disabled until 11/30/12.
16. Same, 11/8/13, PR-2. Good callus formation of the fracture area; well-healed on X-rays. Refer to neurologist to rule out RSD.
17. Request authorization for neurological referral.

3. Records from Huntington Hospital, also including:
   1. James D. Luna, MD, 7/13/12. Left thumb injury two days ago. Past medical history: gout and diabetes. X-rays showed some gauging near the first MCP joint distally. No other fractures. Wound care: thumb spika splint. Referral for Workers' Compensation. Tetanus injection.
   2. Triage Assessment, 7/13/12.
   3. Warren W. Lam, MD, 7/13/12. Right thumb X-rays. No fracture. Soft tissue swelling.

4: Invoices by Meyer Distributing Company, 7/14/12 (X4), 4/19/12.

5. Moshen Ali, MD, 1/2/13. Neurological Evaluation. Diagnosis: (1) possible carpal tunnel syndrome; (2) possible Reflex Sympathetic Dystrophy. Will be scheduled for EMG.

6. Pouya Lavian, MD, 1/15/13. NCS/EMG. Impression: mild right carpal tunnel Syndrome.

7. Mallo Reddy, MD, 5/8/14. Internal Medicine Report. EKG – normal on 4/30/14. Diabetes Mellitus – Metformin, 1000mg twice per day. Benign Essential Hypertension, BP 138/81. Mr. Doran is medically cleared for surgery.

8. Justin Pham, MD, 4/11/13. Dual Echo and Sagital 3D sequence of right hand and wrist. Osteoarthritis at the 1st carpometacarpal and metacarpophalangeal joints.

9. Barath Kumar, MD, 6/12/13. Three phase bone scan with vascular flow. Immediate and delayed images. No evidence of increased vascilarity. Suggestion of diffusely increased activity in the right activity in the right wrist with a focal component in the right trapezium and right scaploid. This may suggest focal cortical injury. Opinion increased activity in the first right metacarpophalangeal joint.

10. Blood test results, 10/10/14, WBC – 13.6.

11. Monish Lexpati, MD, 5/1/14. Norma chest X-rays.

12. Blood and urine test results, 8/15/14. Glucose 111.

13. CID Management, 6/24/13. Certify Neurontin, 600mg; and Elavil, 100mg, between 5/31/13 to 8/19/13.
14. M. Randall, MD, 9/13/13 (CID Management). Certify: Stellate ganglion injection. Certify; Neurontin, 300mg; Norco; Docuprene, 100mg; Relafen, 100mg. Prilosec – not certified.

15. Ted Tanzer, MD, 12/12/13. Certify psychological clearance. Not certify – spinal cord stimulator trial.

16. CID Management, 3/20/14. Certify Neurontin, 900mg; and Norco, 10mg.

17. Brian Kutsunai, MD, 4/1/14. Certify spinal cord stimulator trial. Psychological clearance – non-certified.

18. Joy Hamilton, MD, 6/2/14. Elavil – certified.

19. CID Management, 11/4/14. Certify Neurontin and Norco.

20. Alexander Francini, MD, 2/5/15. Certify Norco, Neurontin, and Elavil.

21. Numerous Dalsy Bills – second reviews – electronic submissions.

22. Hamilton Chen, MD, 2/27/15. Modify Neurontin, Norco, and Elavil for five refills to one refill.

23. Same, 3/6/15. Same.

24. Numerous Providers' Requests for Second Bill Review.

25. Manoj Moholicar, MD, 4/29/15. Modify to one refill.

26. Heath Hinze, PsyD, 5/7/13. Initial psychological consultation. Scored 29 (moderate anxiety) on the Beck Anxiety Inventory. Scored 37 on the Beck Depression Inventory. Average on Somatization scale. Above average depression scale and below average anxiety scale on the P-3. Diagnosis: Depressive Disorder NOS (311); Anxiety Disorder NOS (300); Insomnia Due to Pain (780.52); Male Erectile Disorder (302.72). No Axis II diagnosis. GAF – 56. Not yet permanent and stationary. Initial trial of six psychotherapy visits over six weeks. If evidence of improvement, then 13-20 visits in 13-20 weeks.

27. Same, with Marsinah Ramirez Trujillo, MFT intern, 7/9/13, PR-2. Beck Anxiety Inventory, 38 (severe). Request authorization for four sessions of CBT.

28. Same, 8/6/13. Same. BDI, 41.

29. Same, 9/11/13. Notes – chose not to speak. Missed previous session.
30. Same, 9/10/13. BDI-II – 41.

31. Same, 9/10/13, PR-2. Depressed, hopeless, restricted effect.

32. Same, 10/8/13, PR-2. Angry, depressed, fearful, hopeless.

33. Same, Notes: 10/22/13. Explore maladaptive thoughts.

34. Same, Notes: 10/8/13. Hopelessness. Had a panic attack.

35. Same, 10/8/13. BDI-II-41, BAI-32.

36. Same, 11/12/13. Notes: Chose to be quiet.

37. Same, 11/12/13. BDI-44; BAI-36.

38. Same, 10/29/13. Notes: Rumination about former boss.

39. Same, 11/12/13, PR-2. Request four CBT sessions.

40. Same, 12/10/13. Notes: Needs to listen to others.

41. Same, 12/10/13. BDI-II-49, BAI-41.

42. Same, 10/3/13. Notes: Looks for way to manage emotions.

43. Same, 11/26/13. Notes: Discussed frustration with the system.

44. Same, 1/7/14, PR-2. BAI-43, BDI-52.

45. Heath Hinze, PsyD, 2/4/14. Psychological consultation and clearance of a spinal cord stimulation trial. BAI-41; BDI-51. The patient indicated he benefitted from the psychological treatment. He stays busy during the day; more optimistic. Mr. Doran is a qualified candidate to undergo the spinal cord stimulation trial.

46. H. Hinze, PsyD, Rina Varughese, MFT, 2/11/14, PR-2. Depressed. Flat affect. Request four sessions of CBT and Authorization Request.

47. Same, 4/1/14. Notes: Loss of escape activity.

48. Same, 4/22/14, PR-2. Agitated, depressed, normal affect.

49. Same, 4/22/14. Notes: Patient "gains solace" coming to the group.

50. Same, BDI-II-47; BAI-43.

51. Same, 4/20/14, PR-2. BDI-45; BAI-42.

52. Same, 6/17/14, PR-2. Hopeless, lost motivation.

53. Same, 6/24/14. Notes: No sharing with group.

54. Same, 7/8/14. Notes: No money for gas.

55. Same, 7/15/14. Notes: Looking forward to spinal stimulation trial.

56. Same, 7/22/14. Notes: Will have the procedure in August.

57. Same, 7/22/14. BDI-II-49; BAI-44.

58. Same, 7/22/14, PR-2. Unable to sleep due to pain. Depressed, anxious.

59. Same, 8/4/14. RFA.

60. Same, 8/5/14. Notes: Anger, frustration.

61. Same, 8/12/14. Notes: Frustration, financial problems.

62. Same, 8/19/14, PR-2. BAI – 45; BDI – 48.

63. Same, 8/26/14. RFA – four sessions of CBT.

64. Same, 9/4/14. Request Info Re: RFA.

65. Same, 9/4/14. Notes: Had surgery with no change.

66. Heath Hinze, PsyD. Rokhand Soltani, MFT Intern, 9/16/14, PR-2. Added diagnosis: Reflex Sympathetic Dystrophy of upper and lower limb. Falling out of relationship with partner.

67. Same, 9/23/14. Notes: Pain in back due to the procedure.

68. Same, 9/29/14. RFA. Four sessions of CBT.

69. Same, 9/30/14. Notes: He "hit rock bottom."

70. Same, 10/14/14, PR-2. "Appears apathetic, dysphonic euthymic."

71. Same, 10/21/14. Notes: After a specialist changed the setting of stimulator, he feel tingling on other areas of body but no help with the pain.

72. Same, 10/27/14. RFA. Four sessions of CBT.

73. Same, 11/18/14, PR-2. BAI – 50; BDI – 48.

74. Same, 11/24/14, PR-2. BAI – 46; BDI – 46.

75. Same, 11/24/14. RFA. Four sessions of CBT.

76. Same, 12/15/14. RFA. Same.

77. Same, 1/9/15. Request Info on Previous RFA.

78. Same, 12/16/14. Notes: Frustrated with lack of progress.

79. H. Hinze, PsyD, Nicole Herschler, IMF, 12/30/14, PR-2. BAI – 43; BDI – 44.

80. Same, 12/30/14. RFA. Four sessions of CBT.

81. Same, 1/13/14. Notes: Mr. Doran wants a settlement with future medical care.

82. Same, 1/20/14. Notes: His attorney cancelled doctors' appointment. Angry. Feels doctors work against him.

83. Same, 1/27/14, PR-2. Agitated, angry, irritable, hopeless, tense.

84. Same, 1/27/14. RFA. Four sessions of CBT.

85. Same, 10/28/14. Notes: Setting of stimulator fixed.

86. Same, 2/3/15. RFA. Four sessions of CBT.

87. Same, 2/24/15, PR-2. BAI – 37; BDI – 42.

88. Same, 3/9/15. RFA. Four sessions of CBT.

89. H. Hinze, PsyD, Jake Edward Goldman, MFT, 3/25/15, PR-2. BAI – 35; BDI – 59.

90. Same, 4/7/15. Notes: No meds for 11 days. Depression, 8/10; anxiety, 8/10; pain, 8/10. Cannot use his hand at all. Burning sensation from forearm.

91. Same, 4/14/15. Notes: Cannot sit still. Support group to help with isolation.

92. Same, 5/6/15, PR-2. Anxiety regarding pending court date.

93. Same, 5/20/15. Notes: Waiting for settlement to move.

94. Heath Hinze, PsyD, 6/2/15. Permanent and Stationary Psychological Evaluation. BAI – 35; BDI – 46. Diagnosis: Anxiety Disorder NOS; Depressive Disorder NOS. No Axis II Diagnosis. GAF 60 (15% WPI). Industrial causation, 100% apportioned to the injury on 7/11/12.

95. Soheil M. Aval, MD, 6/30/25, Ortho QME. Current medications: Metformin, Neurontin, Elavil, Norco. Mr. Doran is permanent and stationary with 25% WPI for the right wrist. 100% industrial causation with no apportionment. Diagnoses: (1) right hand trauma with reported non-displaced fracture of the right thumb with possible first metacarpal fracture per initial medical records; (2) subsequent right hand sympathetically mediated pain, most consistent with chronic regional pain syndrome; (3) mild right carpal tunnel syndrome, per electrodiagnostic evaluation of January 15, 2013; (4) mild left hand strain, secondary to overcompensation.

Mr. Doran is precluded from activities of repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with the right upper extremity. The left upper extremity does not require work restrictions. He is a Qualified Injured Worker.

Future Medical Care: Mr. Doran should be allowed future medical care which might include orthopedic consultations at times of flare-ups with a regimen of physical therapy and/or acupuncture. Updated diagnostic studies should be allowed. Mr. Doran should remain under the care of Dr. Kohan, his pain management specialist, for provision of various injections and monitoring, adjusting, and dispensation of medications. The spinal cord stimulator should be monitored.

Attached Review of Diagnostic Studies and Operative Reports and Medical Records (49 pages).

96. Edward G. Stokes, MD, 10/15/15. Initial Ortho Evaluation by PTP. Blood pressure 162/105. 0 score on the Epworth Sleepiness Scale. Diagnosis: (1) chronic regional pain syndrome, upper extremity; (2) left upper extremity intentional tremors, rule out neuro-degenerative disease; (3) crush injury of right hand; (4) Major Depression, Recurrent; (5) Anxiety, Unspecified; (6) s/p spinal cord stimulation placement with residuals. Requesting medical records. Referral for neurological consult. Referral to Gary Baker, MD, for pain management. On Gabapentin, 600mg, three times per day (anti-seizure?).

97. Same, 10/15/15. RFA.

98. Gary L. Baker, MD, 2/15/16. Initial Pain Management Evaluation. Pain 10/10 with no medications; 5/10 on medications. Current meds: Elavil; Glipizide, 10mg; Metformin, 2000mg; Neurontin. History of diabetes and hypertension controlled with medications.

99. Work related eye injury in 2010. Diagnosis: Type 2 Complex Regional Pain Syndrome, right upper extremity. Peripheral neuropathy. Diabetes Mellitus. Elavil, 50mg at bedtime; Neurontin, 600mg, four times per day.

100. Same, 2/22/16. RFA.

101. Same, 4/11/16. Insomnia Severity Index. Score – 23, severe. Clinical insomnia. BDI-II – 45 (severe).

102. Edwin Haronian, MD, 2/18/13. Doctor's First Report of Injury: Hand contusion, finger fracture. MRI of right wrist, consult pain management. Rule out RSD; four sessions of psychotherapy from depression and anxiety; psychological evaluation. Acupuncture, 2 X 3. Cream Baclofen, 60gm; Medrox Patch; Prilosec, 20mg, twice per day; Relafen, 750mg, twice per day; thumb spika; Ultram ER, 150mg, twice per day. Patient is temporarily totally disabled.

103. Same, 2/18/13. Left upper extremity 2% WPI. Right upper extremity 9% WPI, for combined 11% WPI.

104. Same, 2/18/13. Initial Comprehensive Orthopedic Evaluation. Diagnosis: right carpal tunnel syndrome; status post right thumb fracture, healed; right hand contusion. Request authorization to refer to Dr. Kohan for pain management. Neurodiagnostic studies for carpal tunnel. Mr. Doran will continue treatment with his physician for his diabetes.

105. Same, 3/18/13. Neurontin, 300mg, to be increased every day up to three times per day. Start Elavil, 25mg, at bedtime. Vitamin C, 500mg, twice per day.

106. Same, 4/1/13. Begin Lexapro instead of Elavil. Psychotherapy was authorized. Do a triple phase bone scan.

107. Same, 4/15/13. RFA.

108. Same, 4/29/13. MRI, normal. Refill meds.

109. Same, 4/23/13. RFA. Bone scan to rule RSD.

110. Same, 4/29/13. Disability status: temporarily totally disabled.

111. Same, 4/29/13. Bone scan requested.

112. Same, 5/31/13. Defer further handling of medications to Dr. Kohan. Better on Elavil and Neurontin, increase. Elavil to 100gm and Neurontin to 600mg three times per day or use Lyrica.

113. Same, 5/31/13. Temporarily totally disabled.

114. Edwin Haronian, MD, 7/12/13. Glucose 101.

115. Same, 7/22/13. Did not tolerate Elavil, 100mg. Elavil, 75mg. Start 5mg of Norco.

116. Same, 8/19/13. Consider spinal cord stimulator.

117. Same, 9/16/13. Pain, 6/10. Elavil, 50mg.

118. Same, 10/14/13. Will have stellate ganglion block by Dr. Kohan this Wednesday.

119. Same, 10/21/13. Temporarily totally disabled.

120. Same, 11/11/13. Temporarily totally disabled.

121. Same, 11/11/13. Minimal benefit from the ganglion block on 10/16/13. Requested psychological clearance for spinal cord stimulation.

122. Same, 12/4/13. RFA.

123. Same, 1/17/13. Request for Information on Previous Authorization Request (psychological clearance).

124. Same, 1/6/14. Dr. Kohan diagnosed reflex sympathetic dystrophy. Awaiting psychological clearance.

125. Same, 2/17/14. Cleared for spinal cord stimulation.

126. Same, 3/31/14. Request authorization for spinal cord stimulation.

127. Same, 5/12/14. Awaiting placement of stimulator this upcoming Wednesday.

128. Same, 6/23/14. Underwent spinal cord stimulation trial on 5/14/14 with fairly significant improvement in his pain and range of motion. Mr. Doran is an appropriate candidate for permanent placement. Request authorization.

129. Same, 6/23/14. Temporarily totally disabled.

130. Same, 5/12/14. Temporarily totally disabled.

131. Same, 8/4/14. Scheduled for a permanent placement of the stimulator on 8/28/14.

132. Same, 8/4/14. Temporarily totally disabled.

133. Same, 9/15/14. Temporarily totally disabled.

134. Same, 9/15/14. Surgery was performed 8/27/14. Less burning but is still symptomatic. Has difficulty with ADL's.

135. Same, 10/27/14. Significant RSD in right upper extremity. Temporarily totally disabled.

136. Same, 12/8/14. Was scheduled to see AME in November, but it was cancelled. Authorization request for Elavil and psychological treatment. Request 12 sessions of physical therapy to the cervical spine and both upper extremities.

137. Same, 12/29/14. RFA.

138. Same, 6/22/14. Same.

139. Jonathan F. Kohn, MD, 4/11/13. Pain Management Initial Report. Pain 8/10. Current medications: Metformin, 2000mg; Januvia, 100mg; Baclofen Cream; Medrox Patch; Prilosec, 20mg; Relafen, 750mg; Neurontin, 300mg; Lexapro, 10mg. Diagnosis: Possible mild CRPS. Recommend triple phase bone scan.

140. Same, 5/9/13. Awaiting authorization to be seen by a psychologist and for acupuncture. MRI on 4/11/13 showed osteoarthritis. Diagnosis: wrist bursitis. Rule out Complex Regional Pain Syndrome, Type 1. Will start Elavil, 50mg, at bedtime; stop Lexapro.

141. Same, 6/13/13. Complaints increase by any frequent use.

142. Same, 7/11/13. Neurontin, 600mg, three times per day. On Elavil sleeps better; decreased numbness and tingling.

143. Same, 7/25/13. Pain, 6/10. Elavil, 75mg. Decreased grip strength. Neurontin, 700mg X 3.

144. Same, 8/22/13. Norco, 5mg once per day. Request authorization for stellate ganglion block on the right side.

145. Same, 9/13/13. RFA for the above.

146. Same, 9/11/13. RFA. Same.

147. Same, 9/19/13. Pain, 8/10. Approved for the procedure. Start Lyrica, 50mg, twice per day. Increase Norco to 7.5mg twice per day.

148. Same, 10/1/13. Request information on previous RFA.

149. Same, 10/16/13. Operative Report. Stellate ganglion block on the right under fluoroscopy (with attached anesthesia record from Osteon Surgery Center).

150. Same, 10/17/13. Pain, 7/10. Tolerated the procedure well. On Lyrica, 50mg X 2, with no side effects.

151. Same, 10/23/13. RFA. Lyrica 100mg.

152. Same, 11/14/13. Pain, 9/10. He is a candidate for spinal stimulator trial.

153. Same, 12/5/13 and 1/21/14. RFA psychological evaluation for clearance for spinal stimulator trial.

154. Same, 11/14/13. On Lyrica, 100mg, twice per day. Control of neuropathic pain is sub-optimal. Stop Lyrica. Neurontin, 800mg, three times per day.

155. Same, 12/12/13. Pain, 6-7/10. Awaiting authorization for psychological clearance.

156. Same, 1/9/14. Pain, 9/10. Norco, 75mg, three times per day. Neurontin, 900mg, three times per day. Elavil, 40mg.

157. Same, 2/6/14. Pain, 8-9/10. Norco, 10mg, three times per day. Request authorization for spinal cord stimulator trial.

158. 3/6/14. Elavil, 40mg, Neurontin, 2700mg.

159. Same, 3/10/14. RFA.

160. Same, 3/19/14. RFA.

161. Same, 4/3/14. Medications not causing side effects.

162. Same, 4/10/14. RFA.

163. Same, 5/1/14, PR-2. Levaquin, 500mg, three times per day. After the trial, temporarily totally disabled.

164. Same, 5/7/14. RFA.

165. 5/2/14. Blood test results. Glucose, 110.

166. Same, 5/14/14. Operative Report: Myelogram. Percutaneous implantation of spinal cord stimulation leads times two, cervical spine under fluoroscopy. With attached anesthesia records from Kinetix Surgery Center.

167. Same, 5/19/14, PR-2. 70% improvement; improved functional capacity with ADL's. Self grooming and chores around the house.

168. Same, 5/19/14. RFA.

169. Same, 6/13/14. More than 70% improvement of symptoms.

170. Same, 5/21/14. RFA for medications.

171. Same, 6/13/14. RFA for final placement of the spinal cord stimulator.

172. Same, 6/19/14, PR-2. Significantly increased depression. Elavil, 50mg.

173. Same, 6/19/14, PR-2. Refill meds. Awaits authorization for permanent placement.

174. Same, 6/26/14. RFA – meds.

175. Same, 7/17/14, PR-2. Eager to proceed with permanent placement.

176. Same, 8/27/14. Operative Report. Implantation of leads times two, cervical spine. Implantation of pulse generator with attached anesthesia record from Kinetix Surgery Center.

177. Same, 9/4/14, PR-2. Significant improvement.

178. Same, 9/9/14, PR-2. The burning pain resolved. Continue same medications. No sign of infection at the incisions.

179. Same, 10/16/14, PR-2. 50% improvement. Some symptoms on the left upper extremity.

180. Same, 10/16/14, PR-2. Addressing emotional complaints.

181. Same, 10/16/14. RFA.

182. Same, 10/21/14. RFA medications: Neurontin, XXXXXXXX.

183. Twice per day. Neurontin, 300mg, three times per day. Elavil, 50mg.

184. Same, 11/14/14, PR-2. 40% improvement.

185. Same, 12/12/14, PR-2. Current financial situation is the primary stressor.

186. Same, 12/12/14, RFA – for meds. The patient was having difficulty obtaining his medications. In particular, Elavil was denied.

187. Same, 1/26/15. RFA.

188. Same, 12/17/14. RFA.

189. Same, 1/16/15, PR-2. X-rays of cervical spine do not show any movement of the leads.

190. Same, 1/21/15, PR-2. Feels like his is being shocked by the stimulator.

191. Same, 1/28/15. RFA for meds.

192. Same, 1/21/15. RFA. Increase Gabapentin to 600mg X 3.

193. Same, 1/22/15. RFA. Appeal Elavil.

194. Same, 1/26/15. Same.

195. Same, 1/28/15. RFA – meds.

196. Same, 3/18/15, PR-2. Residual pain addressed by Gabapentin.

197. Same, 4/15/15, PR-2. Addressing psychological symptoms. Anger and frustration with providers and insurance. Elavil, 50mg.
198. Same, 4/21/15, RFA – medications.

199. Same, 5/13/15, PR-2. Decreased Norco to 7.5mg once a day; Neurontin, 600mg, twice per day; Elavil, 50mg, at bedtime.

200. Same, 6/10/15, PR-2. Neurontin, 1800mg. Pain in left wrist is now constant. Left wrist tendonosis.

201. Same, 7/8/15, PR-2. 50% improvement with the stimulator. Awaiting request of QME ortho.

202. Same, 8/5/15, PR-2. Reviewed Dr. Aval's QME Report. Agreed Mr. Doran had CRP's of the left upper extremity.

203. Same, 9/2/15, PR-2. XXXXX requires any opoids. Will be provided with evaluation once in two month. T.T.D.

DIAGNOSIS:

Use of the DSM-IV-TR multiaxial classification ensures that attention is given to certain types of disorders, aspects of the environment, and areas of functioning that might be overlooked if the focus were on assessing a single presenting problem.

There are five axes in the DSM-IV-TR multiaxial classification. The first three axes constitute the official diagnostic assessment.

Axis I Clinical Syndromes:

1. 296.23 Major Depression, Single Episode, Severe.

2. 300.00 Anxiety Disorder NOS.

3. 316.00 Psychological Factors Affecting Medical Condition.

4. 780.52 Insomnia Due to Orthopedic Pain.

5. 307.42 Insomnia Due to Axis I Diagnoses.

6. Rule out: Pain Disorder with Both Psychological Factors and a Medical Condition.

Axis II Personality Disorders and Specific Developmental Disorders:

Immature, Histrionic, and Avoidant Personality Traits.

Axis III Physical Disorders and Conditions:

(Obtained from medical records and/or patient information).

1. RSD, right wrist and hand.
2. Musculoskeletal complaints.
3. Cardiovascular complaints.
4. Gastrointestinal complaints.
5. Headaches.
6. High blood pressure, by history, controlled with medications.
7. Diabetes, Type II – controlled with medications.
8. Neurological problems.

Axis IV: Psychosocial and Environmental Problems.

Occupational Problems.

Problems with Primary Support Group

Economic Problems

Axis V: Global Assessment of Functioning (GAF)

Current GAF: 55. This is equivalent to 23% WPI.

SUMMARY AND DISCUSSION:

Mr. Doran is a 50-year-old Caucasian male who was employed as a plumber by Benedict & Benedict Plumbing Company from 2009 until 7/11/12, when he was injured on the job. While he was cutting through a wall, a chunk of the wall fell on Mr. Doran's right hand. He sustained an open wound to his right thumb. He cleaned the wound and put tape on it. He was in a lot of pain.

A couple of days later, Mr. Doran reported he was examined at the ER at Memorial Hospital in Pasadena, and he was told he had a fracture in the right thumb. Records from Huntington Hospital from 7/13/12 showed X-rays with "some gauging near the first MCP joint distally, like a small torus or gauge in the bones. This is a result of the axial load blow to the tip of the finger."

Mr. Doran was seen by George Tang, MD, PTP orthopedic surgeon, on 7/17/12, who wrote that X-rays showed a non-displaced fracture with first metacarpal fracture. He put the thumb in a cast. Mr. Doran continued treatment with Dr. Tang, who prescribed Naprosyn and Prilosec and kept extending his medical leave.

Later on, the doctor also prescribed Medrox. On 11/8/12, Dr. Tang noted the possibility of Reflex Sympathetic Dystrophy (RSD) and referred Mr. Doran to a neurologist, as well as to physical therapy. He also referred him for EMG/NCS. Neurological evaluation was done by Moshen Ali, MD, on 1/2/13, who scheduled Mr. Doran for EMG.

On 1/31/13, Dr. Tang added Gabapentin for pain. This was the last appointment with Mr. Doran, as his attorney assigned Edwin Haronian, MD, as PTP ortho. In his report dated 2/18/13, Dr. Haronian requested authorization for acupuncture, MRI of the right wrist and hand, and a referral for Dr. Kohan at the same office for consultation to rule out RSD and for EMG. He also referred Mr. Doran for psychological evaluation and requested four sessions of psychotherapy.

Dr. Haronian provided thumb spika and prescribed Medrox patch. He found that Mr. Doran could work modified duties, but kept him as temporarily totally disabled if modified work was not available. He determined 9% WPI for the right upper extremity.

On 3/18/13, Dr. Haronian prescribed therapeutic cream, Neurontin, 300mg, Elavil, 25mg, and Vitamin C, 500mg.

On 4/1/13, Neurontin was stopped because it gave no benefits but made Mr. Doran "spacey." Mr. Doran did not like the Elavil, so was switched to Lexapro, and the doctor requested authorization for triple phase bone scan.

In his initial report dated 4/11/13, Dr. Kohan, a pain specialist, noted that EMG by Dr. Levin done on 1/15/13 showed mild right carpal tunnel on the right. The doctor diagnosed possible mild CRPS and recommended to restart Neurontin and Elavil. He wanted to review results of the triple phase bone scan before deciding a trial of stellate ganglion block.

On 4/29/13, Dr. Haronian reviewed MRI of the right wrist and noted it to be normal. On 5/31/13, Dr. Haronian noted that the depression and sleep improved on Elavil, 50mg, and Mr. Doran has less numbing and burning pain on Neurontin, 300mg three times per day.

On 6/12/13, Three Phase Bone Scan with Vascular Flow was done by B. Kumar, MD. It showed increased activity in the first right MCP joint, and the right trapezium and scaphoid. On 6/22/13, Dr. Haronian started tapering down Neurontin and started Norco.

On 7/11/13, Dr. Kohan requested authorization for stellate ganglion injection, even though the patient did not present with the required criteria for CRPS (Complex Regional Pain Syndrome). Mr. Doran did not tolerate the Elavil, 100mg, well. Dr. Kohan increased Neurontin and prescribed Lyrica.

On 10/16/13, Dr. Kohan did stellate ganglion injection on the right. It did not help. On 10/17/13, Dr. Kohan noted Mr. Doran was on Norco, 7.5mg, twice per day; Norco, 5mg, once per day; Elavil, 50mg, and Lyrica, 50mg. The doctor requested psychological clearance for a trial of spinal cord stimulator.

On 3/31/14, Dr. Haronian diagnosed RSD, Depressive Disorder NOS, Male Erectile Disorder, and Sleep Disorder Due to Pain.

On 5/14/14, Dr. Kohan had a trial of spinal cord stimulation, with 70% improvement.

On 8/27/14, Dr. Kohan installed the permanent electrodes of the spinal cord stimulator leads.

On 9/9/14, Dr. Kohan noted that Mr. Doran's burning pain has resolved with the use of the stimulator. He continues with Neurontin, 900mg, three times per day, in addition to Norco and Elavil. The doctor instructed Mr. Doran to reduce Neurontin gradually, one tablet every fourth day and to decrease Norco from three to two times a day.

On 10/16/14, Dr. Kohan noted that Mr. Doran uses the unit around the clock and reported 50% improvement in his symptoms and in particular the burning pain.

On 12/12/14, Dr. Kohan noted that Elavil was denied as psych is not an accepted body part. Dr. Kohan appealed it.

On 1/16/15, Dr. Kohan noted 40% improvement. Is undergoing physical therapy but reported buzzing in the left leg.

On 1/5/15, Norco, Elavil, and Neurontin were certified.

On 3/18/15, Dr. Kohan wrote that Mr. Doran's issues of depression and anxiety should be treated aggressively, yet no referral to a psychiatrist was given, nor did Dr. Kohan prescribe any additional psychotropic medications.

On June 20, 2015, Mr. Doran was evaluated by Soheil M. Aval, MD, QME ortho. His diagnoses were: (1) right hand trauma with reported non-displaced fracture of the right thumb with possible first metacarpal fracture per initial medical records; (2) subsequent right hand sympathetically mediated pain, most consistent with chronic regional pain syndrome; (3) mild right carpal tunnel syndrome, per electrodiagnostic evaluation of January 15, 2013; (4) mild left hand strain, secondary to overcompensation.

Dr. Aval found Mr. Doran's condition to be permanent and stationary with 25% WPI. Work restrictions precluded repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with the right upper extremity. Future care to include orthopedic consultation for flare-up, with physical therapy or acupuncture and diagnostic studies. Mr. Doran should remain under the care of Dr. Kohan for monitoring, adjusting, and dispensation of medications or injections.

Dr. Aval determined 100% industrial causation with no apportionment.

As Dr. Kohan and Dr. Haronian released Mr. Doran from under their care, he was referred to Edward G. Stokes, MD, PTP ortho. In his report dated 10/15/15, Dr. Stokes noted left upper extremity intermittent tremors. He noted to rule out degenerative disease and recommended neurological consultation on a private basis. He referred Mr. Doran for pain management consultation to Gary Baker, MD, and to transfer care as PTP.

In his initial report dated 2/15/16, Dr. Baker noted pain rated 5/10 with medications and 10/10 without medications. The patient reported continuous nausea and moderate constipation. Dr. Baker renewed prescriptions for Elavil, 50mg, and Gabapentin, 600mg, four times per day. On 4/11/16, Dr. Baker reported pain level

of 6-7/10 with medications. The patient completed fluoroscopic evaluation of the spinal cord stimulation on 3/15/16 and reprogramming of the SCS. Insomnia secondary to pain was worsening. Blood pressure was 158/97. Score on the Insomnia Severity Index was 23, indicating severe clinical insomnia. He scored 45 (severe depression) on the Beck Depression Inventory, and Dr. Baker considered a referral to a qualified psychiatrist.

I reviewed an initial psychological evaluation by Heath Hinze, PsyD, dated 5/7/13. At that time, Mr. Doran scored 37 (severe depression) on the Beck Depression Inventory and 29 (moderate anxiety) on the Beck Anxiety Inventory. Dr. Hinze diagnosed Depressive and Anxiety Disorders NOS, Insomnia Due to Pain, and Male Erectile Disorder. No Axis II Diagnosis, and a GAF of 56.
I reviewed numerous notes and PR-2's, all signed by Dr. Hinze, even though Mr. Doran told me he only saw Dr. Hinze for a total of 2-3 times over the duration of two years. Group therapy was conducted by different counselors.

On 2/4/14, Dr. Hinze conducted an evaluation for the purpose of giving psychological clearance for spinal cord stimulator. Beck Depression Inventory was 51; Beck Anxiety Inventory was 41, showing worsening of symptoms. Yet, the doctor stated that Mr. Doran benefitted from the psychological treatment and was more optimistic and clear for the SCS trial. On 6/2/15, Dr. Hinze wrote his Permanent and Stationary Report, with the same diagnoses, but a GAF of 60, equivalent to 15% WPI.

It is of note that the psychological treatment that was given to Mr. Doran was less than adequate. While he received very excessive group therapy sessions for years with documented severe depression and anxiety, he was never referred for psychiatric evaluation and treatment, and the only psychotropic medication that has been prescribed, other than a short time with Lexapro, is Elavil, 50mg. This dose is totally inadequate for depression. He was never provided with individual psychotherapy.

According to Mr. Doran, weekly sessions of group therapy were of minimal help. He stated he told it to Dr. Hinze and to the different group therapists. He also requested psychiatric referral for medications. Reportedly, he was told by Dr. Hinze that he did not need medications.

Mr. Doran admitted his anxiety and depression are to some extent the result of his financial worries. He denied ever getting Permanent Disability checks, which I find difficult to believe. He is awaiting a hearing at the Social Security office in September and expects retroactive pay to January, 2015.

Mr. Doran has a severe Parkinson-like tremor in his left upper and lower extremities and paralysis of the left side of his mouth. I agree with Dr. Stokes that

he needs to be evaluated by a neurologist to rule out Parkinson's disease or any other degenerative disease. However, Mr. Doran reported that he was told the tremor was a side effect of Neurontin. This is a possibility. Therefore, I believe the neurologic evaluation should be done on an industrial basis.

I agree with Dr. Baker that Mr. Doran would benefit from adequate psychiatric treatment, as this was never provided. However, we are almost four years after the injury and after an extensive course of two years of group therapy. Therefore, I chose to write this report as a Permanent and Stationary Report.

If, indeed, the parties would chose to send Mr. Doran for psychiatric treatment, then his psychiatric condition would be considered as temporarily partially disabled, until he would be released as permanent and stationary by the treating psychiatrist.

Currently, Mr. Doran's condition meets DSM-IV-TR criteria for Major Depression, Anxiety Disorder NOS, and Insomnia Due to Axis I Diagnoses and Orthopedic Pain. The diagnosis of Pain Disorder needs to be ruled out.

He also meets DSM-IV-TR criteria for Psychological Factors Affecting Medical Condition, as it is clear that at least part of his physical complaints are stress related.

Mr. Doran denied any previous psychiatric history. He admitted other recent sources of stress in his life, especially an anal fistula that causes pain and discomfort. He also admitted being worried by his financial situation and problems with his girlfriend that are caused by these but also by his impotence, depression, and inability to function.

Mr. Doran reported a difficult childhood caused by his father's "military style" of being strict and critical and being very disappointed in Mr. Doran's failure in school. Mr. Doran reported stress being cheated out of his inheritance by this siblings and not talking with them since his mother's death in 2007. For many years, he was his mother's caregiver after her strokes.

Mr. Doran reported his first wife, who suffered from Bipolar Disorder, committed suicide while he was away in 2001. His second wife, who was reportedly a "gold digger," cheated on him and then divorced him a year after they got married.

Mr. Doran has pre-existing diabetes. He also has left-sided neurological symptoms with Parkinson's-like movements of the left lower and upper extremities, as well as left sided paralysis of his mouth.

Mr. Doran also has pre-existent personality traits.

DISABILITY STATUS:

At no time ever was Mr. Doran temporarily totally disabled purely from a psychiatric point of view. At this time, his condition is regarded as permanent and stationary with moderate psychiatric disability.

CAUSATION:

Industrial causation is preponderant to all other causes combined in the psychiatric disability of Mr. Doran. Good faith personnel action was not a substantial factor. However, AOE/COE is a legal and not a medical decision, so I would leave it to the Trier of Fact.

APPORTIONMENT:

20% is apportioned to pre-existing and non-industrial factors as outlined above.

20% is a result of financial worries.

60% is apportioned to the industrial injury of 7/11/12.

RECOMMENDATION:

It is recommended to refer Mr. Doran to a proctologist for consultation to rule out industrial causation. It is probable that it resulted from his constipation, which is probably a side effect of the Neurontin.

Given the fact the Neurontin may also cause Parkinson's-like shaking on the left side, which is interfering significantly with his ability to function, a neurological consultation is also recommended.

Even though Mr. Doran scored only 2 on the Epworth Sleepiness Scale, this is not a good reflection of his sleep/arousal disability. This is because he cannot sleep during the day when the stimulator is on because it causes buzzing. Yet, since he turns off the stimulator at night, he cannot sleep well because of the pain and is, indeed, extremely fatigued during the day. The score of 23 (severe insomnia) on the Insomnia Severity Index submitted by Dr. Baker is much more accurate in this case. Therefore, I recommend polysomnogram in a good place to more accurately determine WPI for sleep and arousal issues.

OPINION AS TO DISABILITY RATING:

On the basis of this present psychiatric study, I believe that Mr. Doran has been vocationally disabled as a result of the above-described work-related accident. He reports himself suffering from a combination of physical and emotional disabilities.

The readers of this report are advised that the assessment, treatment, and rating of his physical disability are beyond the purview of the undersigned examiner, and rightfully belong under the jurisdiction of other medical specialists.

From a psychiatric viewpoint, I believe he has suffered emotional, mental, psychological, and personality distresses as a direct result of the industrial injury and continued inability to work at his usual/former occupation. The combination of physical and emotional disabilities have caused him to have difficulties in functioning in his everyday world. I believe that his present disabilities are due in part, at least, to psychological factors, and in my opinion, these psychological factors are the result of the claimed accident.

It is my opinion that for Workers' Compensation rating purposes, Mr. Doran's psychological status is permanent and stationary, and is of a moderate degree of impairment.

OBJECTIVE FACTORS OF DISABILITY:

Being socially withdrawn, impaired sleep, indecisiveness, not functioning in hobbies and in the household, impaired concentration and memory, avoiding driving the freeway.

SUBJECTIVE FACTORS OF DISABILITY:

Pain in upper extremities, pain in anal area, depression, anxiety, worries, tension, nervousness, irritability, anhedonia, headaches, weakness, fatigue, lack of energy, loss of self confidence, lack of motivation, guilt feelings, difficulty swallowing, choking feelings, nightmares, suicidal ideation, fear of being left alone/traffic/crowds.

WORK RESTRICTIONS:

Mr. Doran should avoid stresses at work.

VOCATIONAL REHABILITATION:

This is not indicated from a psychiatric point of view.

FUTURE PSYCHIATRIC CARE:

Mr. Doran would benefit from psychotropic medication and should be under psychiatric care once a month for at least two years.

No more psychotherapy is indicated at this time.

More intensive psychological or psychiatric care should be made available in case of deterioration in the future.

Work Function Impairment Form:

Work Function	Level of Impairment	Supporting Data (Cite Findings)
1. Ability to comprehend and follow instructions.	Slight	Impaired concentration and memory.
2. Ability to perform simple and repetitive tasks.	Very Slight	
3. Ability to maintain a work pace appropriate to a given workload.	Slight	As above.
4. Ability to perform complex or varied tasks.	Moderate	Impaired concentration and memory.
5. Ability to relate to other people beyond giving and receiving instructions.	Slight	Being socially withdrawn. Irritability. Losing his temper.
6. Ability to influence people.	Slight/Moderate	As above. Lack of energy and motivation. Lack of self confidence.
7. Ability to make generalizations, evaluations or decisions without immediate supervision.	Moderate	Indecisiveness. Lack of self confidence. Lack of energy and motivation. Impaired concentration and memory.
8. Ability to accept and carry out responsibility for direction, control and planning.	Moderate	As above.

AMA DISABILITY RATING:

1. Disability to perform activities of daily living: Slight/moderate impairment.

2. Social Function: Slight/Moderate impairment.

3. Concentration, persistence and pace: Slight impairment.

4. Deterioration or decompensation in complex or work like setting: Moderate impairment.

I personally interviewed the patient, conducted the psychiatric examination, administered and scored psychological testing, reviewed available medical records, and wrote the report. My secretary typed the report.

Thank you for referring this interesting patient to me. If I can be of further assistance regarding Mr. Doran, please do not hesitate to contact me.

Very truly yours,

Daphna Slonim, M.D.
Diplomate American Board of Psychiatry and Neurology
California License A 41160

DECLARATION

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I personally performed the evaluation of the patient on 6/21/16 in Los Angeles County and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.

I verify under penalty of perjury that the total time I spent on the following activities is true and correct.

a.	Face to face time with the patient	3 1/2 hours
b.	Review of records	13 ½ hours
c.	Report preparation and editing	10 1/2 hours

Date of Report: 7/18/16

Signed this 18th day of July, 2016 in Los Angeles County.

Daphna Slonim, M.D.
Diplomate, American Board of Psychiatry and Neurology
CA License A 41160

DS/mb

Dan Doran

PROOF OF SERVICE BY MAIL

State of California, County of Los Angeles

I am employed in the County of Los Angeles, State of California. I am over the age of eighteen years and not a party to the within action. My business address is: 822 S. Holt Ave. Los Angeles Ca 90035

On 7/18 16, I served the foregoing Med legal + Bill W. Green Esq 3419 Via Lido #607 Newport Beach Ca 92663

on interested parties in this action by placing a true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid in the United States mail at LA. California addressed as follows:

{claim #: ADJ 876 0713 }

Scif

P. O. Box 3171

Suisun City, Ca 94585-6171

Executed on 7/18/2016 al L.A. California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Declarant

SHLOMIT LAHAD

Name of Declarant (print)