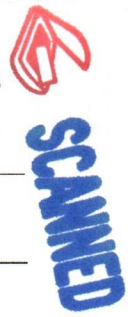
State of California

DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))



Case Name: SOOHOO, George *(employee name)* v SCIF, Attn: Robert Bull *(claims administrator name, or if none employer)*

Claim No.: 06380832; 06626694 **EAMS or WCAB Case No. (*if any*)**: _____

I, Donald Phan *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: 1524 Melody Ln. #1, Fullerton, CA 92831
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	11/9/21	SCIF, Attn: Robert Bull P.O. Box 65005, Fresno, CA 93650
A	11/9/21	Natalia Foley, Esq. 751 S. Weir Canyon Rd. #157-455, Anaheim, CA 92808
A	11/9/21	Philip Cohen, Esq. 1550 Hotel Cir N. #170, San Diego, CA 92108
A		

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 11/9/21

Donald Phan *(signature of declarant)*

Donald Phan *(print name)*

Qualified Medical Evaluator
Agreed Medical Evaluator
Clinical Psychology
Serving Southern California
310-596-6334 | www.lawrenceledesmaphd.com

Lawrence Ledesma, Ph.D.

PSYCHOLOGICAL PANEL QUALIFIED MEDICAL EVALUATION

October 11, 2021

RE:	SOOHOO, George
SS #:	562-78-4407
DOB:	November 28, 1953
CLAIM #:	06380832; 06626694
D/I:	08/01/2015 – 07/06/2018; 01/01/2015 – 06/10/2021
D/E:	October 11, 2021
EMPLOYER:	California Institution for Men

To Whom It May Concern:

Mr. George Soohoo was seen for a Panel Qualified Medical Evaluation in Psychology as scheduled on October 11, 2021, at my Irvine office located at 4199 Campus Drive, Suite 550, Irvine, CA 92612. The evaluation performed and the time spent performing such evaluation was in compliance with the guidelines established by the Industrial Medical Counsel or the Administrative Director pursuant to paragraph (3) of subdivision (J) of section 139.2.

The following report summarizes my findings and my opinion on diagnosis as well as the issues of disability, causation, and apportionment, if any, in relation to the alleged injury sustained by Mr. George Soohoo while employed by the California Institution for Men.

This psychiatric report is confidential and privileged. Some applicants and family members may tend to misunderstand and distort the information enclosed in this report. This may result in significant psychological distress to the applicant or may interfere with the treatment and eventual recovery from illness.

For individuals with self-destructive or assaultive tendencies, the consequences of ill- considered disclosure of this report may be serious. This report is meant for the use of qualified professionals only, and those with the need to know by operation of law. Persons breaching the confidential nature of this report assume the risk and liability of doing so.

At the onset of the examination, it was explained to the applicant that this report was not confidential and that the information obtained and findings, as well as diagnosis and report completed by the examining physician would be shared with insurance company and all other parties involved in this matter. Applicant expressed understanding and agreed.

BILLING STATEMENT:

ML-201 -95 -96
Comprehensive Medical-Legal Evaluation

This report falls under the billing guidelines for Medical-Legal reporting as revised by the Administrative Director for implementation effective April 1, 2021, as specified in Title 8. Industrial Relations Division 1. Department of Industrial Relations Chapter 4.5. Division of Workers' Compensation Subchapter 1. Administrative Director - Administrative Rules Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations Sections 9793-9795.

Section 9795 amends the medical-legal fee schedule for Workers' Compensation and designates fees for billing medical-legal evaluations under code ML-201. "Includes all comprehensive medical-legal evaluations that do not qualify as follow-up or supplemental medical-legal evaluations. The fee includes review of 200 pages of records. Review of records in excess of 200 pages shall be reimbursed at the rate of $3.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the

medical-legal evaluation and preparation of the report."

This evaluation was performed by a Psychiatrist or Psychologist and has a minimum 2.0 Multiplier. "-96 Evaluation performed by a Psychiatrist or Psychologist when a psychiatric or psychological evaluation is the primary focus of the medical-legal evaluation. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 2."

The following codes are being billed:

ML-201 -95 -96 Comprehensive Medical-Legal Evaluation (2.0 modifier of $2,015 base rate)	$4,030.00
ML-PRR - Record Review of **476** pages ($3.00 per page in excess of the 200 pages included in the ML-201 code)	$828.00
Total:	$4,858.00

I verify under penalty of perjury the total number of pages of records reviewed as part of the medical-legal evaluation and preparation of the report is **476** pages.

Psychological testing time, not included above, spent administering, scoring, interpreting and integrating test data. This time is billed using the appropriate CPT codes and is based on the county or counties in which the service or services were provided.

CPT 96136 and 96137 Psychological Test administration and scoring by the physician. (Testing was administered and scored in Orange County)	**3.00 hours**
CPT 96130 and 96131 Psychological testing evaluation services including integration of patient data, and interpretation of standardized test results and clinical data. (Psychological testing evaluation, integration and interpretation services were provided in Orange County)	**4.00 hours**

Psychological tests consisted of:

Millon Clinical Multiaxial Inventory-III (MCMI-III)
Beck Depression Inventory – II (BDI–II)
Beck Anxiety Inventory (BAI)
Brief Symptom Inventory (BSI)
PTSD Checklist - Civilian Version (PCL-C)
Fasttest Beck Inventory
Pain - Self Report of Severity
Katz Basic Activities of Daily Living (ADL) Scale
Lawton-Brody Instrumental Activities of Daily Living (L.A.D.L)
Activities of Daily Living
Review of Systems
Wahler Physical Symptoms Inventory (WPSI)
Epworth Sleepiness Scale (ESS)

INTRODUCTION:

On 10/11//2021, I conducted an extensive evaluation of the applicant, Mr. George Soohoo, to determine if he has work-related psychiatric injuries. In addition to my face-to-face examination with this applicant, I was able to review medical and nonmedical records provided. Other than these records, the applicant is the sole provider of the information from which this report including my assessment, recommendations, and conclusions were prepared.

REVIEW OF RECORDS:

The records were sorted, organized, and excerpted by Ms. April Ann Panis, a trained clerical word processor at eData Services.

7/18/18, Workers' Compensation Claim Form (DWC 1).
The applicant alleged injury to his cardiovascular system due to stress on [July 6, 2018].

7/20/18, signed by Keith Wresch, M.D., U.S. Medical Group, Doctor's First Report of Occupational Injury or Illness.
The applicant was employed for California Institution of Men when he alleged injury on July 6, 2018.

He was stressed from embarrassment, humility, and open degradation in front if dental staff. He felt fatigue, depressed, loss of energy, unable to sleep, and no desire to do anything.

Psych Complaints/Symptoms: He complained of stress at work. He experienced insomnia. It was moderately severe and constant.

Physical Exam: he was well developed and well nourished. He was alert and oriented to person, place, and time. His memory appeared intact. Mood was not abnormal. Affect was normal. There was no suicidal or homicidal ideation. Thought process was normal. He exhibited no abnormal thought content. Speech was within normal limits.

Diagnosis: Stress at work.

Plan: Psychiatry evaluation was requested.

Work Status: He may return to work and was to avoid current work environment and was to transfer to a different facility.

7/20/18, signed by Keith Wresch, M.D., U.S. HealthWorks Medical Group, Narrative Review -New Patient.
The applicant was stressed from embarrassment, humility, and open degradation in front if dental staff. He felt fatigue, depressed, loss of energy, unable to sleep, and no desire to do anything.

Psych Complaints/Symptoms: He complained of stress at work. He experienced insomnia. It was moderately severe and constant.

Occupational History: Length of employment was reported as 10 years or more. He worked 40 hours per week. Main job characteristics included sit down job, prolonged standing or walking, kneeling or squatting, bending, climbing, and operating hand tools/machinery.

Social History: He denied tobacco and alcohol used.

Allergy: He is allergic to Lisinopril and Aspirin.

Physical Exam: He was well developed and well nourished. He was alert and oriented to person, place, and time. His memory appeared intact. Mood was not abnormal. Affect was normal. There was no suicidal or homicidal ideation. Thought process was normal. He exhibited no abnormal thought content. Speech was within normal limits.

Diagnosis: Stress at work.

Plan: He was to return to clinic in 2 weeks.

Work Status: He may return to work and was to avoid current work environment and was to transfer to a different facility.

7/20/18, signed by Michael Fleming, P.A., U.S. HealthWorks Medical Group, Work Status Report.
The applicant may return to work and was to avoid current work environment and was to transfer to a different facility.

7/25/18, Laboratory Report.
Creatinine was 0.9, total bilirubin was 0.7, alkaline phosphatase was 41, AST was 37, ALT was 48, hemoglobin was 14.5, and TSH was 1.16.

7/26/18, signed by Kartik Shah, M.D., Primary Care Attending Note.
History of Present Illness: The applicant has a history of diabetes mellitus type 2, hypertension, hyperlipidemia, fatty liver disease, bilateral hearing loss, allergic rhinitis, dermatitis, chronic low back pain, obstructive sleep apnea, and depression.

He presented to get mainly his full records documented and service connected conditions documented. He worked as dentist at local prison. He was scheduled with outside psychiatrist for his depression.

Social History: He denied tobacco, alcohol, and drug used.

Family History: He has a family history of diabetes mellitus.

Allergy: He is allergic to Lisinopril and Aspirin.

Physical Exam: He was alert, oriented to person, place, and time, and in no acute distress.

Assessment: 1) Diabetes mellitus type 2. 2) Hypertension. 3) Hyperlipidemia. 4) Elevated LFTs/fatty liver disease. 5) Bilateral hearing loss. 6) Allergic rhinitis. 7) Dermatitis. 8) Chronic low back pain. 9) Obstructive sleep apnea. 10) Depression. 11) History of colon polyps.

Plan: Metformin, Fenofribrate, Lovastatin, Fish Oil, Amlodipine, Losartan, Loratadine, Clindamycin 1%, Triamcinolone, Hydrocortisone 2.5 mg, and Diclofenac were continued. He was to consult with audiologist.

7/27/18, signed by Keith Wresch, M.D., U.S. HealthWorks Medical Group, Primary Treating Physician's Progress Report.
The applicant's injury was the same. He was currently on modified duty.

Psych Complaints/Symptoms: His anxiety continued.

Occupational History: Length of employment was reported as 10 years or more. He worked 40 hours per week. Main job characteristics included sit down job, prolonged standing or walking, kneeling or squatting, bending, climbing, and operating hand tools/machinery.

Physical Exam: He was alert and oriented to person, place, and time. His memory appeared intact. Mood was not abnormal. Affect was normal. There was no suicidal or homicidal ideation. Thought process was normal. He exhibited no abnormal thought content. Speech was within normal limits.

Diagnosis: Work stress.

Plan: He was to return to clinic in 2 weeks.

Work Status: He may return to work and was to avoid current work environment and was to transfer to a different facility.

8/27/18, signed by Lynne Deboskey, Ph.D., Doctor's First Report of Occupational Injury or Illness.

The applicant was employed for California Department of Corrections and Rehab when he alleged injury on July 6, 2018.

Subjective Complaint: He complained of depression, anxiety, and anger.

Diagnosis: Adjustment disorder.

Work Status: He was precluded from working at CIM.

8/27/18, Psychological Health Center, Psychological Consulation and Treatment Recommendations.
History of Industrial Injury and Treatment: The applicant was a supervising dentist who alleged an industrial injury to the psyche on July 6, 2018 due to work stress from perceived unfair disciplinary action against him that resulted in a transfer to a different work site.

He was hired in August 2007 at the Chino Prison. He had been with the CA Department of Corrections since 1994. Prefacing remarks with him was off work in December 2017 for 6-8 weeks due to a back injury at work. He was unable to order supplies so he had a subordinate do it. He returned to work, in 2018 the CEO at CIM received EEO complaints against him, which he attributed to retaliation for previously writing up employees and due to a dental associate, who did not like him, because "I made him come on time." An acting supervisor wrote him up because the supply room was open with cardboard between the lock and keys. Another dental assistant filed an EEO against him for "yelling at her". He denies these allegations. He wrote her up several times, most recently for disobeying a directive about overtime. When a position opened up, he did not consider her qualified and so he did not recommend her for the position.

This dental assistant later claimed retaliation by him. However, describing the dental assistant as "showing up late and taking a long time to work and in collusion after me," the precipitating event occurred at a training conducted by him regarding new software to be learned at work. Including retaliation in her complaint, this dental assistant claimed he "yelled at her."

Waiting 9 plus months for the outcome from internal affairs, charges of verbal abuse and retaliation were met and substantiated by the investigation. The CEO, CO and he was informed of this by the CEO and he "was walked off and they took my keys and cell phone." Escorted off the property, he described his reaction as embarrassed and being disrespected." He was placed on administrative leave. His blood pressure was 180/96

and he went to his primary physician who increased the dosage of his medication. He was off work for a week. He was working at a different prison performing duties related to audits and training, and with no direct interaction with staff. Currently, he did not report significant problems with either his work function or with interpersonal relationships at a different prison on modified duty.

Subjective Complaints: He complained of depression, crying spells, anxiety, worry, ruminating, concentration problems, guilt, anger, and irritability, and withdrawal, hopeless and helpless, and reduced motivation. He received 3-4 hours of interrupted sleep.

Medical History: He had been diagnosed with diabetes, blood pressure problems, digestive, chronic pain (attributed to awkward postures required of him at work), respiratory, sleep apnea (2000 after automobile accident when fell asleep driving), or thyroid problems. He was in the process of obtaining a VA disability form loss of hearing due to being a reservist for 28 years.

Psychosocial History: He describes his childhood as "growing up in a bad neighborhood." Developmental milestones were disclosed as having occurred within normal limits and he denied physical, emotional abuse and/or a history of molestation or childhood psychopathology. He grew up in an intact family and parents were described in positive terms. His sister died of cancer at the age of 47. He had a 66 year old brother who was reportedly stable and not a source of stress. He was a hyperactive child but denied a history of learning disabilities or any behavior problems in school or growing up. He worked for the Department of Corrections since 1994. He served in the ASAR from 1986 to 2013 and had not experienced combat. He had been married 10 years to a 54-year-old medical assistant, and he described that relationship as "good." He was previously married from 1986 to 1996 they divorced due to growing apart.

Mental Status and Behavioral Observations: He was oriented in all spheres. He allowed an adequate rapport to be established and eye contact was normal. Speech production and psychomotor movements were unremarkable. Thought processes were logical and relevant. There was no indication of gross disruption of basic logical processes, concentration, or attention. Memory for immediate, recent, and remote events was intact. Intelligence appeared in the above average range as measured by his education and use of abstraction, conceptualization, and vocabulary. Maintaining a subdued demeanor, he described his mood as depressed and anxious. He exhibited adequate frustration tolerance throughout the examination. He did not exhibit any angry reactions or problems with impulse control. Judgment was unremarkable. Insight was poor.

Testing Rationale: [MMPI-2 validity scales were L-61, F-82, and K-45. The clinical scales were Hs-92, D-74, Hy-89, Pd-72, Pa-101, Pt-98, Sc-79, Ma-62, and Si-62].

On the Beck Depression Inventory, his score of 39 was indicative of a severely depressed mood.

On the Beck Anxiety Inventory, his score of 28 was indicative of a minimal to severely anxious mood.

Diagnoses: Axis I – 1) Adjustment Disorder with anxiety and depression. 2) Occupational problem. 3) Sleep disorder. 4) Stress related psychological factor/coping style affecting medical condition on Axis III. Axis II - No Personality Disorder indicated; exacerbation of personality traits negatively impacting Axis I. Axis III – Per the medical records. Axis IV - Psychosocial and Environmental Problems: 1) Problems with primary support group - mild. 2) Occupational problems - mild to moderate. 3) Economic problems - minimal. 4) Problems with access to health care services - minimal. 5) Problems related to interaction with the legal system/crime-minimal. Axis V – GAF was 65.

AOE Determinations: Causation and Threshold of Psychological Compensability Discussion.: His injury to the psyche on July 6, 2018. Within the realm of psychological probability, 85% of his psyche injury was predominantly from actual events of his employment causing the development of an adjustment disorder on July 6, 2018. Regarding a rationale, also previously discussed was a temporal relationship between his current period of psychological disability and actual acts of his employment on July 6, 2018. Furthermore, a new of pre-injury mental health, employment and psychosocial history supported findings of industrial psychological causation. Specifically, there was insufficient evidence of any work-related disability due to a psychological disorder, characterological pathology or life stressors impinging on him during the time at issue. However, also within the realm of psychological probability, results from this evaluation indicated that 15% of his current period of psychological disability stems from destabilizing contribution of aggravated maladaptive characterological traits combining with a pre-existing sleep disorder and non-industrial medical conditions to produce overtly impairing anxiety and depression that negative impacted an adequate adjustment in work place.

Disability Status: He was temporarily partially disabled psychologically with the work restriction of no patient care and he was precluded to work at CIM for 60 days.

Treatment Recommendations: Six individual cognitive behavioral therapy sessions were requested.

8/27/18, signed by Lynne Deboskey, Ph.D., Psychological Health Center, Work Status Report.
As of today and continuing through 60 days, the applicant was psychologically able to perform his usual and customary duties as a supervising dentist for CA Department of Corrections & Rehabilitation with the restrictions of no patient care, and not working at CIM facility.

9/7/18, signed by Lynne Deboskey, Ph.D., Request for Authorization.
Authorization was requested for six cognitive behavioral therapy and reevaluation.

9/13/18, San Diego Heart And Medical Clinic, Inc., Medical Report.
History of Present Illness: The applicant was a dentist and doctor who had been working for the State of California for 29 years. He also, was in the military for 29 years. He worked at Chino for 11 years and then was walked off with an EO claim and now he was doing some other job auditing. He was not happy with that. He claimed his blood pressure went sky high when that happened and to this day, he was upset about it, because he felt he was totally innocent.

Medical History: He had hypertension for a few years. He was a diabetic and had sleep apnea.

Social History: He was a nonsmoker and nondrinker.

Medications: He was on Metformin 500 mg, Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Losartan 50 mg, Amlodipine 5 mg, Vitamin C; fish oil; turmeric; and centrum.

Review of System: He was positive for depression, nervousness, agitation, and moodiness.

Physical Exam: He was well developed, well nourished, and in no acute distress.

Diagnosis: Hypertension with industrial aggravation.

Plan: Clopidogrel was started.

11/8/18, signed by Tara Nyasio, Psy.D., Mental Health Consult.
The applicant was alert and oriented to person, place, time, and situation. His mood was euthymic. Affect was normal and appropriate. Thought process were linear and goal directed.

He had been diagnosed with posttraumatic stress disorder while in the military. He experienced several instances in the military that lead to this diagnosis. He had nightmares, headaches, difficulty sleeping "(intrusive thoughts), and waking up screaming. He experienced a great deal of stress. He sometimes got afraid when he faced triggers that reminded him of the traumas that he experienced such as going out at night and firecrackers.

Goal: He was hoping to get documentation that he had a diagnosis of posttraumatic stress disorder. He was hoping to be able to work with psychologist for posttraumatic stress disorder and receive a letter documenting his diagnosis of posttraumatic stress disorder.

11/21/18, signed by Kathleen McDermott, Psychology Note.
Chief Complaint: The applicant stated, "I filed with the VA for disability. I have PTSD and I need to establish care here at the VA since my psychologist retired 15 years ago. They walked me off my job on July 6th, so I filed a stress claim. It's all in the notes I gave you."

History of Present Illness: He served in the Army both active duty (on orders) and in reserves for 30 years and achieved rank of Colonel 06 as Brigade Commander for Medical Brigade, overseeing >2,000 employees. He was a "dentist with two master's degrees" and retired from the Army in 2006 after attending War College and being eligible to be a General. His mother-became sick and he therefore, he turned down a job at the Pentagon to take care of his mother. He was recently working as a dentist in the state prison system, said he was "appointed by the governor."

Currently, he had nightmares twice per year around the times he heard fireworks (July 4th and Chinese New Year), which reminded him of the grenade that blew up in front of him. He was avoiding people who drink alcohol as this reminded him of the time he was, assaulted by three intoxicated men who beat him badly. He had "flashbacks" of "the ugliness of war." He felt scared often and his mood was "angry, depressed and irritable most days because of this". He was sleeping only 3 hours per night.

He spoke at length and with great detail about the issues he experienced at his job, including his CEO hitting him in the face while at lunch with coworkers, being walked off

his job on July 6, 2018, two EEO claims against him at his job, reporting his boss to Internal Affairs, and the difficulty he had finding treatment to address his denied claims from the state Compensation in Fund.

Psychiatric History: He saw psychologist approximately 20 years ago for 3 to 4 sessions. He had anti-anxiety medications for a short time, 15-20 years ago after he was assaulted. He had 3 to 4 sessions of psychotherapy 20 years ago.

Social History: He had one beer on holidays. He denied smoking and drug used.

Allergy: He is allergic to Aspirin and Lisinopril.

Medical History: He has a history of diabetes mellitus, hypertension, and hypercholesterolemia.

Mental Status: He was in no acute distress. Speech was difficult to interrupt and he was very talkative. Mood was angry, depressed and irritable most of the time/appeared euthymic. Affect was mood congruent, slightly bland, and greeted and smiles appropriately. There was no evidence of suicidal ideation, homicidal ideation, and delusions. Insight and judgment were fair.

Diagnoses: 1) Adjustment disorder. 2) Rule out posttraumatic stress disorder. 3) Rule out delusional disorder. 4) Rule out personality disorder.

Plan: He was referred to BHIP.

11/27/18, signed by Ronald Carlish, M.D., Echocardiogram Report.
Impression: Normal right ventricular function. Slight hypertrophy posterior left ventricular wall. Mild left ventricular and left atrial enlargement with normal left ventricular contractility 0.60. Diastolic dysfunction noted. No localized areas of impairment. Slight dilatation proximal aortic root with structurally normal aortic leaflets. No pericardial fluid identified.

11/27/18, signed by Ronald Carlish, M.D., Carotid Duplex Scan.
Conclusion: Normal study but for mild bilateral linear plaquing as described, not exceeding 25% diameter reduction. No significant focal flow obstruction was seen. All flow velocities, flow velocity ratios within normal limits.

12/3/18, Laboratory Report.

Hemoglobin was 15.7, creatinine was 1.06, total protein was 7.4, total bilirubin was 0.5, alkaline phosphatase was 47, AST was 39, ALT was 49, and hemoglobin A1C was 6.8.

12/14/18, signed by Stewart Lonky, M.D., Panel Qualified Medical Evaluation in the Specialty of Internal Medicine.
History of Present Illness: The applicant commenced employment with the California Department of Corrections & Rehabilitation as a dentist in January 1994.

In 2010, he began working at the California Mens Institute in Chino, California as a supervising dentist, performing dentistry about 60% of the time, with a marked increase within the last six months.

While assigned to Chino, there were substantial stressors, particularly within the last five years.

At a luncheon, the CEO struck him in the face and chuckled about it. The Chief Medical Officer spoke to the CEO who replied that he would not that again. He was very angry and frustrated by this physical assault and the CEO's response to having done it.

Then, another CEO was hired, Louie Escobal. After 60 days, he gave him two "N's," for "Not satisfactory." He tried to talk to the CEO who "blew up." He just could not talk to him.

On another occasion, the HPM3 was in his department to investigate whether a hygienist was changing a patient's treatment plan. The HPM3 lied to the CEO about whether another employee, George, had not made him aware of it. This caused him much angst. Apparently, that HPM3 was demoted after a two-year investigation and retired.

When interviewing for a new HPM3, he made a comment about her and the CEO informed the new HPM3 of his comments. In addition, the CEP hired someone without his input.

He felt demeaned, unfairly judged by him and physically abused by the CEO.

Finally, he described that two EEO complaints were filed against him, one by a hygienist who accused him of using abusive language and another by a dental assistant who filed in retaliation because he "tried to make her work" when he asked her to order supplies, and for training another employer for her position.

On July 6, 2018, he was escorted off the premises after the completion of the investigation and substantiation of the charges. He felt humiliated, demeaned and degraded by this action, in front of all of his employees, as he felt that it could have been bandied differently.

He was moved to the Regional Facility in Rancho Cucamonga. His blood pressure was 180/90. He had been diagnosed with hypertension previously, but it was controlled. He took Losartan, Hydrochlorothiazide and Amlodipine 5 mg.

Present Complaints: He was working currently at Rancho, performing audits.

After July 6, 2018, his dose of amlodipine was increased to 7.5 mg. He took time off, began working with a physical trainer, and changed his lifestyle.

Furthermore, after July 6, 2018, he had episodes of being short of breath. He requested a consultation with a physician. He was seen by Dr. Jack Kleid, a cardiologist who recommended a work-up that did not materialize.

Subsequently, he presented to Dr. Debosky, a psychologist for consultation. He was informed that he could not work at CIM for 60 days.

He selected another psychologist, Dr. Lawrence Woodward by whom he was to be evaluated on November 22, 2018.

When climbing stairs, he became short of breath, which was a relatively new occurrence.

Occasionally, he felt palpitations. He had a loss of appetite due to stress.

For the last two months, he had nightmares, trying to figure out what happened, what he might have done. He reiterated that accountability and integrity were important to him.

He was diagnosed with sleep apnea in 2007 by a Kaiser physician. In 2000, he underwent a sleep study at U.C. Irvine Medical Center. Currently, he used a BiPapmask.

He remained stressed and frustrated by the ongoing investigation and due to ruminating over why this was happening to him. He believes that all he did was did his job, met the audits and was a responsible employee; also, he made his staff accountable.

Occupational History: He commenced employment with the California Department of Corrections & Rehabilitation as a dentist in January 1994.

Initially, he was assigned to Ironwood Prison, opening the Dentistry Department. He worked there for eight years, after which time he worked at the headquarters in Sacramento for one year. He worked for eight years at the Department of Juvenile Justice, performing 50% administrative duties and 50% dentistry.

In 2010, he began working at the California Men's Institute in Chino, California as a supervising dentist, performing dentistry about 60% of the time, with a marked increase within the last six months.

Medical History: Ten years ago, he was diagnosed with diabetes mellitus and was prescribed Metformin. Usually his hemoglobin A1C was between 6.5 and 6.9; two months ago, it was 6.7.

Within the last five years, he had been diagnosed with mild kidney disease. Post traumatic stress disorder was diagnosed at an unspecified time. A grenade exploded during night training while he was in the military. In addition, he was attacked when stationed in Hawaii as a Brigade Commander. He saw many soldiers under his command lose limbs.

His Kaiser internist prescribed Clopidogrel because he is allergic to Aspirin. He has a history of sleep apnea, diagnosed in 2007. He has a history of elevated cholesterol.

He has a history of back pain secondary to repetitive and prolonged bending as a dentist.

Fifteen to 20 years ago, lipoma removed from his back.

Allergy: He is allergic to Lisinopril, Aspirin, and Lipitor.

Social History: He was a non-smoker. He drank very seldom. In 2013, he retired from the military after 30 years.

Medical records were reviewed.

Diagnoses: 1) Severe emotional stress associated with marked embarrassment and "dressing down" in front of subordinates. 2) Depression and anxiety with emotional stress. 3) History of back injury with ongoing back pain. 4) History of well-controlled hypertension with loss of control subsequent to emotional stress from events at work as

described in the history above. 5) Diabetes mellitus, pre-existing with reasonable control at this time. 6) Palpitations with no evidence of arrhythmia on Holter monitoring.

Impressions and Discussion: He had significant emotional involvement in the story that happened and it took a fair amount of time to extract a history that was objective from him without the interplay of emotions. However, it was opined that his history, if accurate, demonstrated what appeared to be some degree of significant difficulty both with subordinates and with supervisory personnel, the etiology of which was not entirely clear since Dr. Lonky did not have all of the personnel records involved with these events. Dr. Lonky was not a specialist in the field of psychiatry and Dr. Lonky was not a specialist in the field of orthopedic surgery.

From an internal medicine perspective, however, it was fairly clear to Dr. Lonky in taking his history and reviewing the records Dr. Lonky had including the psychological consultations that a significant feeling of despair, frustration, and even anger regarding the events that occurred at the California Men's Institute in Chino, being in a difficult relationship with his CEO who apparently struck him, and receiving non-satisfactory ratings for issues that were not completely described to him. These factors combined with EEO complaints that were filed against him, pushed him to a point where he had apparent acute break from an emotional standpoint. As Dr. Lonky already stated, Dr. Lonky was not a specialist in Psychiatry and would defer any further comments regarding these events, which occurred prior to his being escorted off the premises at the prison on July 6, 2018 and the subsequent emotional turmoil that ensued.

The unfortunate part about this case was Dr. Lonky had not yet been provided prior medical records. He was very forthcoming and telling Dr. Lonky that he had a prior history of high-elevated blood pressures and was on a very low dose of Amlodipine, a dose, which he believed to be 2.5 mg daily with reasonable control. Dr. Lonky had not been provided any medical records that antedate July 20, 2018 and Dr. Lonky would certainly appreciate being provided such medical records as soon as they become available.

In Dr. Lonky's meetings with him, Dr. Lonky was struck by the overall apologetic, embarrassed, and depressed mood, making Dr. Lonky consider that he was just the personality that might have a more exaggerated response to emotional stress. It was noteworthy that most if not all of his blood pressure subsequent to this event had been out of control from both systolic and diastolic standpoint.

Disability: Dr. Lonky would defer any comments regarding any psychiatric impairments and disabilities and any orthopedic impairments and disabilities to the appropriate specialist.

From an internal medicine perspective, at this juncture, there was an impairment rating according to table 4-2 in the AMA Guides, which would place him into a class 2 impairment level. However, without the results of a two dimensional echocardiogram, Dr. Lonky would delay any final rating of impairment in this case except to say that it was at least a Class 2 level according to table 4-2.

Causation and Apportionment: As discussed above, with reasonable medical probability, his emotional stress occurred during the course of his employment as described, and particularly with the events of July 20, 2018, that these events contributed to his development of a significant worsening of his hypertension such that his blood pressure elevations were sustained at this time.

While there would be a significant amount of apportionment to the event surrounding this employment and these events, he had a previous history of hypertension and it as imperative that Dr. Lonky had the opportunity to review medical records that antedated the event of July 20, 2018. Furthermore, Dr. Lonky needed to see his recent medical records from treating physicians who were taking care of him and it was Dr. Lonky's belief that he would do well in a structured environment to some degree at this time, particularly at work. Keeping him away from the previous place of employment was an extraordinarily important part of his overall management at this time. All efforts should be continued to diminish any time constraint or qualitative work overload at this juncture.

Recommendations: Dr. Lonky was looking forward to being forwarded the results of a two-dimensional echocardiogram.

12/24/18, signed by Shaun Chung, Psychology Note.
The applicant appeared ready to learn.

He has a history of adjustment disorder.

On April 27, 2017, he took his colleagues including boss' wife out to a work lunch at a MX food restaurant as boss' wife was retiring. It was a professional event. CEO showed up and a disagreement ensued, which ended by CEO striking him in face at MK restaurant. This was physically and emotionally painful and humiliating. Since this time, he had ongoing interpersonal harassment at work. He filed a report and claim against boss for

this act. Boss filed counterclaims against him. His employee had also been coercered into filing a retaliation claim against him. Due to all the interpersonal strike and claims, he "walked off the job" while EEO claims were pending. This was a large humiliation.

Since this time, he had decreased mood, energy, motivation, headaches, and blood pressure elevations while thinking of the event, nightmares 2 times a week, poor unrestful sleep, decreased frustration tolerance, anxiety when thinking about event. He remained future oriented.

Additionally, in the 1980s attacked in while active military in Hawaii 3 soldiers attacked him in a dark parking lot. Since this time, he had increased vigilance in dark places, avoided parking lots, avoided crowds, jumpy when he heard fireworks (July 4th and Chinese New Year). He also experienced some tension events in training with military. He had occasional flashbacks of event in parking lot.

Social History: He rarely drank on holidays. He denied smoking and drug used.

Mental Status Exam: Speech was normal, spontaneous speech, rate and volume. Mood was okay. Affect was euthymic and congruent. Thought process was linear. He denied suicidal and homicidal ideation. Cognition was grossly intact. Insight and judgment were good.

Assessment: 1) Adjustment disorder. 2) Rule out posttraumatic stress disorder attacked sustained in military 1989.

1/8/19, Application for Adjudication of Claim.
The applicant was employed as a supervisor of dental clinic at State of California Institutions of Corrections when he alleged injury to his head, ear, back, hips, nervous systems, and body systems from August 1, 2015 to July 6, 2018.

1/24/19, signed by Alexander Caliguiri, D.C., Requested Comprehensive Medical Legal Report.
History of Injury – AOE/COE: The applicant had been employed with the California Department of Corrections as a dentist for approximately 25 years. During this long tenure of employment with this employer, he worked at multiple locations and facilities. He worked at the California Institute for Men (CIM) Facility for approximately the last 10-11 years. His usual and customary work activities required him to perform dentistry a minimum of 45% of the time, but in actuality, he spent 60-70% of the time at work practicing dentistry. Along those lines, his practice of dentistry included prolonged

standing and prolonged stooping while performing dental procedures. He stood 5-6 hours per day while doing dental procedures. He was sit approximately 2 hours per day while performing dental procedures. He performed dental procedures 5 days per week through July 6, 2018. He last performed dentistry with this employer on July 6, 2018. He remained employed with the Department of Corrections but he was currently doing audits and peer reviews for 6-7 different Department of Corrections facilities. The development and progressive intensification of musculoskeletal complaints relative to his neck, spine and bilateral upper extremities as a result of his practice of dentistry with the California Department of Corrections through July 6, 2018.

He was also reporting additional complaints in relation to the claimed industrial injury, which arose out of and through the course of his employment with the California Department of Corrections. Many of these complaints were beyond Dr. Caliguiri's scope of expertise as a doctor of chiropractic. The additional complaints, which he was claiming in relation to this industrial injury included injuries to the psyche, cardiovascular system, and ears (hearing loss). Dr. Caliguiri would not be addressing these other complaints, which were beyond Dr. Caliguiri's scope of expertise other than to request specialty evaluation with appropriate medical specialists as related to these complaints.

He was also reporting a disruption of his normal sleep cycle because of chronic musculoskeletal pain. Dr. Caliguiri would be addressing causation of this complaint as his primary treating physician to the extent of Dr. Caliguiri's expertise, familiarity and experience with respect to derivative sleep disturbance conditions resulting from chronic musculoskeletal pain.

Chief Complaints: He complained of neck pain', headaches, pain and tingling throughout the bilateral upper extremities, tingling within both bands, low back pain, pain throughout the right lower extremity (sciatica), sleep disturbance resulting from chronic musculoskeletal pain.

Current illness included diabetes mellitus, kidney disease, hypertension, hypercholesterolemia, and sleep apnea.

Previous Injuries: He was a brigade commander and that he experienced prior episodes of transient low back pain between 2000 and 2013. These transient episodes of low back pain resulted from lifting soldiers, and from lifting/carrying large, heavy crates of dental equipment on a simulated battlefield weighing 75-100 pounds. These prior episodes of low back pain, which resulted from different military exercises, were transient. These transient episodes of low back pain subsided within days of the military exercises. He

never received treatment for any of these transient episodes of low back pain, nor did he file any claims for any of these transient episodes of low back pain.

He received injections performed to his left hand at Kaiser about 15 years ago, as well as received injections to his left hand performed at Grossmont approximately 15 years ago.

He lost his hearing in his left ear about 8 to 10 years ago. This was actually very common in dentists due to the high frequency pitch of the dental drills, which were utilized. He wore hearing aids within both ears. His left ear hearing loss was settled previously with an award of 10% permanent disability.

Surgeries: He had lipoma removed from his low back about 25 years ago. He had a benign cyst removed from his neck approximately 2 months ago.

Allergy: He is allergic to Lisinopril, Aspirin, and Lipitor.

Work History: He was employed as a dentist at State of California Department of Corrections at the time of the industrial injury, which had been designated to have occurred on July 6, 2018.

Diagnoses: 1) Cervical strain. 2) Cervical radiculitis. 3) Lumbar strain. 4) Sciatica-right lower extremity. 5) Probable bilateral carpal tunnel syndrome. 6) Headaches.

Sleep disturbance resulting from chronic musculoskeletal pain, superimposed upon preexisting sleep apnea, with a possible psychological/emotional contribution as well.

Discussion of Contested Issue Relative to Causation of Applicant's Musculoskeletal Complaints: Forensic analysis of this interesting claim results in a supported conclusion that his musculoskeletal complaints were causally related to his long tenure of practice of dentistry with the California Department of Corrections. He practiced dentistry with the California Department of Corrections for approximately 25 years at multiple locations and multiple facilities. For approximately the last 10-11 years, he practiced dentistry at the California Institute for Men (CIM) facility. The 60-70% of his time was spent practicing dentistry. As relates to this time spent practicing dentistry, he stood 5-6 hours per day and sat approximately 2 hours per day. He performed dentistry with this employer 5 days a week, through July 6, 2018.

Obvious, he could not have performed dentistry while standing with an erect posture. He would have had to bend forward at the waist in order to adopt a forward flexed, stooping

posture, which would be necessary to facilitate dentistry to a patient seated in a dental chair. This type of flexed forward posture would have subjected the viscoelastic structures of the neck and spine to prolonged static loading, resulting in fatigue and creep deformation, resulting in muscular straining and myofascial irritation.

Evident, the dental profession was a physically arduous profession, which subjected the body to a multitude of neuromusculoskeletal injuries relative to the neck, spine, shoulders and upper extremities. Considering the consistency between the biomechanics of his usual and customary work activities with his subjective complaints and objective findings, and also recognizing the association documented within the medical literature relative to these types of work activities inherent within the practice of dentistry in relation to his musculoskeletal symptoms and conditions, and being aware of the threshold and parameters relative to compensability/causation within the California Workers Compensation System, the undersigned examiner puts forth a supported conclusion to state with reasonable medical probability that his diagnosed conditions relative to his neck, low back and bilateral upper extremities were causally related to the subject industrial injury, which had been designated to occur on July 6, 2018. Once again, there was no evidence of a specific industrial injury occurring on or about July 6, 2018. He sustained a cumulative trauma industrial injury through his practice of dentistry, which he performed with the California Department of Corrections through July 6, 2018.

Discussion of Contested Issue Relative to the Applicant's Headache Complaints: By way of a Neck Disability Index: (NDI) of January 4, 2019, he indicated - "I have moderate headaches which come frequently." This reporting from him stood in sharp contrast to the December 14, 2018 reporting from panel QME physician Dr. Lonky, who at page 8 of his December 14, 2018 report, stated that he denied frequent headaches, dizziness, syncope or seizure.

His headache complaint was at a minimum, at least partially cervicogenic in its etiology. That being the case, his headache complaint represents a derivate injury in Dr. Caliguiri's opinion since the proximate causation relative to this headache complaint was his cervical spine disorder.

There may be additional contributing factors/caused, which also contributed towards his headache complaint. There was no rule, which stated that a headache could only result from one cause. There could he additional factors (e.g., hypertension, stress), which contribute to his headaches, but if these additional factors were present, that still did not serve to undermine a cervicogenic basis to at least account for some contribution of his headache complaint.

He had a painful condition of the neck. He demonstrated an asymmetric loss of cervical spine range of motion resulting from cervical subluxation (misalignment) and muscular imbalance. He additionally had objective findings, which included muscular guarding, hypertonicity and trigger points within the cervical spine. The cervical spinal nerve roots innervated the head. His headache complaint was cervicogenic in its etiology, at least in part.

Discussion of Contested Issue Relative to Causation of the Applicant's Sleep Disturbance Complaints: He has a long history of sleep apnea, dating back to 2000, for which he used a BiPAP sleep apnea machine while sleeping. Notwithstanding this preexisting, nonindustrial sleep apnea, his applicant reports, and the medical literature also supported, that his chronic musculoskeletal pain complaints within his neck, low back and wrists adversely impacted upon his normal sleep cycle.

The fact that he had a preexisting history of sleep apnea only serves to raise the specter of apportionment with respect to his current sleep disturbance complaint. In this particular case, the specter of apportionment relative to his sleep disturbance complaint was essentially moot.

Permanent and Stationary: He was not permanent and stationary at present. He required additional treatment to cure and relieve from the effects of the subject industrial injury of July 6, 2018.

Current Treatment Needed: He needed to be under the care of cardiologist. He required electrodiagnostic studies for the upper extremities. Updated evaluation with a sleep medicine specialist and orthopedic evaluation were recommended.

Apportionment: Apportionment related to causation of permanent disability. In as much he was not presently permanent and stationary, Dr. Caliguiri was currently unable to opine on the causation of his permanent disability. Apportionment would be comprehensively addressed upon him attaining a permanent and stationary status.

2/1/19, signed by Nicholas Brown, M.D., Psychology Consult.
The applicant endorsed thoughts about death or suicide on assessment measures. When therapist followed up about any recent or current suicidal ideation, he had at times wondered whether it was worth living due to his sense that he received unfair treatment following his assault by his employer. However, he denied any current or recent thoughts of suicide, planning for suicide, and/or intent to commit suicide. He denied owning a gun.

He denied a history of inpatient psychiatric hospitalizations, suicide attempts, or non-suicidal self-harm. He denied homicidal ideation. He had minimal drinking due to taking hypertension medication; no other substance use.

He had increased in posttraumatic stress disorder symptomatology, as most distressing to him. He was assaulted by his employer 2 years ago, and had since then been experiencing recurrent memories/associated distress, self-blame, low energy" and difficulties with trusting people. He was regularly triggered due to continuing to work. He had at times dealt with his distress by overeating. His goal was to reduce his posttraumatic stress disorder symptomatology and improved overall functioning.

Mental Status Exam: Speech was normal prosody rate and volume. Mood was anxious. Affect was matching. Thought process was linear and goal oriented. He denied suicidal and homicidal ideation. Insight and judgment were fair.

Assessment: 1) Adjustment disorder. 2) Rule out posttraumatic stress disorder attacked sustained in military 1989.

2/5/19, signed by Thomas Dosumu-Johnson, M.D., North Valley Diagnostic, Physical Medicine and Rehabilitation Consultation.
Conclusion: 1) Normal nerve conduction study of the lower extremities. 2) Normal electromyography of the lower extremities.

2/5/19, signed by Thomas Dosumu-Johnson, M.D., North Valley Diagnostic, Physical Medicine and Rehabilitation Consultation.
Conclusion: 1) Abnormal nerve conduction study. The result suggested possible bilateral carpal tunnel syndrome, left greater than right and possible cubital tunnel syndrome, left greater than right. 2) Abnormal electromyography. The results indicated a possible C5-C6 radiculopathy. Correlation was required.

2/26/19, signed by Nicholas Brown, M.D., Psychology Note.
The applicant was an active participant.

3/5/19, signed by Nicholas Brown, M.D., Psychology Note.
The applicant was an active participant.

There was no suicidal or homicidal ideation or other acute indicators expressed or observed. He was aware that in the event of a crisis they should use the MTC, Veterans Crisis Line, or 911.

4/2/19, signed by Nicholas Brown, M.D., Psychology Note.
The applicant's mood and anxiety symptoms decreased.

He was an active participant.

There was no suicidal or homicidal ideation or other acute indicators expressed or observed. He was aware that in the event of a crisis they should use the MTC, Veterans Crisis Line, or 911.

4/3/19, signed by Shaun Chung, M.D., Psychology Note.
The applicant has a history of adjustment disorder.

He was doing much better. The initial dysfunction of the assault and investigations at his work decreased and work was getting back to some normalcy. CEO was being civil with him and they were both trying to move on. He had been attending group therapy for anxiety and found it very helpful.

He had no depression. He was adjusting better. Sleep was good. He had occasional nightmares but more so related to passing of his mother several years ago. He had some avoidance related to assault in military but overall functioning well.

Social History: He rarely drank on holidays. He denied smoking and drug used.

Mental Status Exam: Speech was normal, spontaneous speech, rate, and volume. Mood was okay. Affect was euthymic, congruent, non-labile, and non-tearful. Thought process was linear. He denied suicidal and homicidal ideation. Cognition was grossly intact. Insight and judgment were good.

Assessment: 1) Adjustment disorder. 2) Rule out posttraumatic stress disorder attacked sustained in military 1989.

4/9/19, Laboratory Report.
Creatinine was 0.9, total bilirubin was 0.8, alkaline phosphatase was 49, AST 38, ALT was 46, hemoglobin was 14.7, and TSH was 1.45.

4/9/19, signed by Nicholas Brown, M.D., Psychology Consult.
The applicant's mood and anxiety symptoms were addressed.

He was an active participant.

There was no suicidal or homicidal ideation or other acute indicators expressed or observed. He was aware that in the event of a crisis they should use the MTC, Veterans Crisis Line, or 911.

4/10/19, signed by Shaun Chung, M.D., Psychology Consult.
The applicant was seen last week. At time, he felt stable at baseline. He felt like he was adjusting better to stressors at work. He was talking to psychologist and started to realize that he was under more stress at work that he was acknowledging and was still quite anxious regarding interactions with coworkers, boss, and CEO after assault. He had discussion with other vets, psychologists, and [Dr. Chung] about medications and he felt ready for trial to address mood, anxiety, and sleep. He denied suicidal and homicidal ideation. He admitted to more energy, motivation, and anxiety. He was open to start Lexapro and Hydroxine.

7/10/19, signed by Stewart Lonky, M.D., Panel Qualified Medical Evaluator's Supplemental Report in the Specialty of Internal Medicine.
Medical records were reviewed.

Impression and Discussion: Dr. Lonky had the opportunity to review the echocardiogram, which showed left ventricular hypertrophy. It should be stated at this time, therefore, that it was opined that there was an impairment regarding his hypertension, which was not a Class 2 impairment, as described previously in Dr. Lonky's initial report, but rather a Class 3 impairment, according to Table 4-2 in the AMA Guides. It was opined that there was a 30% whole-person impairment that was present with regard to the applicant's hypertension. It was opined that this was at maximum medical improvement at this time, according to the blood pressure readings that Dr. Lonky saw in the medical records, although his blood pressure was modestly elevated at the time of Dr. Lonky's evaluation. This was most likely secondary to "white-coat hypertension" and the fact that he was in Dr. Lonky's office to recount stressful episodes that occurred during the course of his employment as described.

The medical records demonstrated the fact that from at least 2007 until 2018, his medical therapy was consistent. It consisted of Amlodipine at 5 mg a day, as well as Losartan/Hydrochlorothiazide at a fixed dose. His blood pressure was reasonably well controlled, starting approximately in December 2008 and lasting through an evaluation, which took place when he was complaining of significant stress at work, in 2018.

Given the history that Dr. Lonky obtained, there was reason to believe that his blood pressure transiently elevated at that time, requiring his physicians to increase his Amlodipine from 5 mg to 7.5 mg. He was currently on this dose of medications, or at least was when Dr. Lonky evaluated him in November 2018.

Overall, therefore, it was opined that there were some important factors to discuss regarding his hypertensive impairment and the disability associated with it.

Given these medical records, it was opined that the hypertension in him pre-existed the stressful events that occurred during the course of his employment. There had been a mild aggravation of his hypertension as a result of the emotional stress that he experienced, as described in the history in Dr. Lonky's initial report. The aggravation of his hypertension, however, was a minor part of the overall contribution to his current disability. Therefore, given all of the information Dr. Lonky had and his experience as an internal medicine physician for over 35 years, that the contribution of the emotional stress during the course of his employment was a small part of his current disability.

Taking all these facts into consideration, it was opined that with regard to apportionment, 85% of his disability related to his hypertension should be attributed to pre-existing hypertension and considered not industrial. The remaining 15% of his disability secondary to his hypertension should be considered industrial, and secondary to the aggravation of his hypertension secondary to the intense emotional stress experienced as a result of the poor interpersonal relationships with his supervisor/CEO, as well as specific events that occurred on July 6, 2018.

It was opined, given the industrial contribution to his hypertension, however, that future treatment for his hypertension was provided for on an industrial basis. This would include continued treatment with his medications, and monitoring renal function, as well as monitoring for cerebrovascular complications of his hypertension.

7/13/19, signed by Alexander Caliguiri, D.C., Primary Treating Physician's Progress Report.

Dr. Lonky puts forth a discussion at pages 52 and 53 of his June 10, 2019 report. Dr. Lonky changed his prior opinion as related to the applicant's class II impairment relative to his cardiac problems. Dr. Lonky upon review of his records, to include an echocardiogram, now changes his prior opinion to a class III impairment pursuant to Table 4-2 within the AMA Guides, 5th Edition. Dr. Lonky was of the opinion that there was a 30% whole person impairment relative to his hypertension. Dr. Lonky was of the opinion that this condition was at maximum medical improvement at present.

Dr. Lonky stated that given the history that he obtained from the applicant, there was a reason to believe that his blood pressure transiently elevated between 2008 and 2018. Dr. Lonky stated "It is my opinion that hypertension in Dr. SooHoo preexisted this stress/ill event that occurred during the course of his employment. There has been a mild aggravation of his hypertension as a result of the emotional stress that he experienced, as described in the history in my initial report. The aggravation of his hypertension, however, is a minor part of the overall contribution to his current disability. Therefore, given all of the information I have and my experience as an internal medicine physician for over 35 years, that the contribution of the emotional stress during the course of his employment was a small part of his current disability."

Dr. Lonky went on to state his opinion as related to apportionment, that being that 85% of his disability related to his hypertension should be attributed to preexisting hypertension and considered nonindustrial, with the remaining 15% secondary to the aggravation of his hypertension, secondary to the intense emotional stress experience as a result of the poor interpersonal relationships with his supervisor/CEO, as well as specific events that occurred on July 6, 2018.

Dr. Lonky stated his opinion that since there was an industrial contribution to the applicant's hypertension; future treatment for his hypertension should be provided on an industrial basis.

Discussion: As a doctor of chiropractic, Dr. Caliguiri would obviously defer to Dr. Lonky's expert opinion as related to his cardiovascular condition. Having stated a, Dr. Caliguiri also stated that Dr. Lonky was correct in his opinion that additional treatment relative to his hypertension condition/cardiovascular complaints should be on an industrial basis since there was an aggravation of his hypertension as a result of the subject industrial injury.

Once again, with respect to internal medicine complaints such as hypertension/cardiovascular complaints, etc., Dr. Caliguiri would defer to Dr. Lonky since his scope of expertise, as a doctor of chiropractic did not extend to these types of internal medicine /cardiovascular conditions.

He required medical clearance by a cardiologist prior to initiating chiropractic care.

7/13/19, signed by Alexander Caliguiri, D.C., Request for Authorization.
Authorization was requested for evaluation with cardiologist.

7/26/19, California Consulting Group, Medical Note.
The applicant was release to return to work full time. To prevent anxiety, he should reported to someone other than Louie Escobell until further evaluation.

9/6/19, signed by Alexander Caliguiri, D.C., Primary Treating Physician's Progress Report.
The applicant was exonerated of all alleged charges against him, but his employer had not called him back for work in spite of this. He was currently being paid his full salary in spite of the fact that he was actually not presenting to the workplace.

He was evaluated by cardiologist Dr. Kleid on one occasion only and that Dr. Kleid recommended a cardiac stress test. This remained unauthorized by the industrial carrier.

He was still technically pending medical clearance from a cardiologist as related to initiating chiropractic care. However, in addition to his hypertension serving as an impediment towards treatment of his musculoskeletal injuries, he was recently diagnosed with adenocarcinoma (cancer) relative to his right kidney, and this also served as an impediment towards treatment of his musculoskeletal complaints. He continued to experience musculoskeletal complaints relative to his neck, low back and bilateral upper extremities.

10/7/19, signed by Danny Song, D.C., Primary Treating Physician's Initial Evaluation.
Chief Complaints: The applicant complained of constant piercing, shooting, achy, throbbing neck pain rated 7-9/10 radiating into both shoulders. He had intermittent numbness and tingling into both hands. He had constant, achy, throbbing bilateral hand pain rated 7-9/10. He had constant sharp, shooting, achy, throbbing lower back pain rated as 7-9/10 radiating into right hip area. He also had constant sharp, shooting, achy, throbbing right hip pain rated as 7-9/10.

He had difficulty with overhead activity, lifting, repetitive arm use, bending, twisting, and prolonged gripping.

He had hearing loss and increased in hypertension due to industrial causes. He complained of difficulty sleeping with nightmares and increased posttraumatic stress disorder.

History of Present Illness: While working as a dentist for the California Mens Institute, there were substantial physical and mental stressors. He worked as a dentist and supervised 15 dental assistants. One particular assistant did not want to do her work and constantly would be insubordinate. Mentally, he had stress from his CEO, which also included battery from the CEO hitting him in the face at one incident.

He was seen by internal medicine panel QME and was diagnosed with aggravated hypertension 15% related to his industrial stressors. He was last seen September 6, 2019 by Dr. Alexander Calguiri, requesting neurology consultation, ENT consultation, orthopedic consultation for right hip, sleep specialist, and orthopedic consultation for bilateral wrist. He also was seen by Dr. Debosky, psychologist one time and was recommended for cognitive behavioral therapy. Dr. Debosky was retired. He was referred to psychiatry at the Veterans Affair and prescribed medications due to this stress. He had been paying out of pocket to see psychologist Dr. Lawrence Woodburn.

The pain in his back started about 10 years ago. When asked why he did not claim a workers compensation claim, he replied he was administrative and did not feel it would be appropriate. He just went with his general insurance Kaiser. He was referred for MRI of lumbar spine at Kaiser and recommended for lumbar epidural injection. He did not want to pursue cortisone injections at this time. He complained of bilateral hand pain, which started about 10 years prior. His hand pain, numbness and tingling occurred do to repetitive hand piece use. Again, when asked why he did not claim a workers compensation claim, he replied he was administrative and did not feel it would be appropriate. Dr. Birdie gave him injections to his hands, which did not help. He received an EMG/NCV of the upper extremities with Dr. Caliguiti. His right hip started about 2·to 3 years ago. He just went with his general insurance Kaiser for treatment and was given an x-ray.

He complained of hearing loss, which occurred 15 years prior. The band pieces used for dentistry were high pitched. When asked why he did not claim a workers compensation claim, he replied he was administrative and did not feel it would be appropriate. He just went with his general insurance Kaiser for treatment and the Veterans Affair. He had a hearing test sometime a year ago.

He had hearing issues prior due to being in the military but over the last 15 years, his hearing became worse due to working in a high pitched hand piece machinery.

Medical History: He has a history of depression, hypercholesterolemia, diabetes, hypertension, rheumatoid arthritis, kidney disease, anxiety, sleep apnea, migraine, and adenocarcinoma. In 2019, he had right kidney removal due to cancer.

Occupational History: He had been employed as a dentist for the last 25 years.

On the job activities included standing, walking, bending, twisting, overhead work, and pushing, pulling, and lifting up to 25 pounds.

Social History: He did not use alcohol. He denied tobacco used. He denied the use of recreational drugs.

Diagnostic Impression: 1) Cervical strain. 2) Bilateral carpal tunnel syndrome. 3) Lumbar spondylosis. 4) Congenital lumbar stenosis. 5) Right hip strain. 6) Hypertension. 7) Hearing loss.

Disability Status: He was to be placed on modified duty with no lifting/pushing/pull over 10 pounds, no prolonged overhead work, no repetitive bending twisting, no prolong sitting/standing more than 30 minutes without breaks, and no forceful grasping. He was limited to excessive noise.

Prognosis: Guarded at this time.

Recommendations: Authorization was requested for orthopedic spine consultation, consultation with orthopedic hand specialist, MRI of the right hip, internal medicine consultation and follow-up, and ENT consultation.

10/8/19, signed by Danny Song, D.C., Request for Authorization.
Authorization was requested for orthopedic spine consultation, consultation with orthopedic hand specialist, MRI of the right hip, internal medicine consultation, and internal medicine follow-up.

10/9/19, signed by Shaun Chang, M.D., Correspondence.
Dr. Chang recommended that the applicant no longer report to his prior chain of command supervisor whom he currently had an active EC claim against. It was seemingly best practice that he be assigned to another supervisor given the reported history of assault against him and pending investigation.

11/4/19, signed by Danny Song, D.C., Primary Treating Physician's Progress Report.

Chief Complaints: The applicant complained of constant piercing, shooting, achy, throbbing neck pain rated 7-9/10 radiating into both shoulders. He had intermittent numbness and tingling into both hands. He had constant, achy, throbbing bilateral hand pain rated 7-9/10. He had constant sharp, shooting, achy, throbbing lower back pain rated as 7-9/10 radiating into right hip area. He also had constant sharp, shooting, achy, throbbing right hip pain rated as 7-9/10.

He had difficulty with overhead activity, lifting, repetitive arm use, bending, twisting, and prolonged gripping.

He had hearing loss and increased in hypertension due to industrial causes. He complained of difficulty sleeping with nightmares and increased posttraumatic stress disorder.

Medical History: He has a history of depression, hypercholesterolemia, diabetes, hypertension, rheumatoid arthritis, kidney disease, anxiety, sleep apnea, migraine, and adenocarcinoma. In 2019, he had right kidney removal due to cancer.

Occupational History: He had been employed as a dentist for the last 25 years.

On the job, activities included standing, walking, bending, twisting, overhead work, and pushing, pulling and lifting up to 25 pounds.

Social History: He did not use alcohol. He denied tobacco used. He denied the use of recreational drugs.

Diagnostic Impression: 1) Cervical strain. 2) Bilateral carpal tunnel syndrome. 3) Lumbar spondylosis. 4) Congenital lumbar stenosis. 5) Right hip strain. 6) Hypertension. 7) Hearing loss.

Disability Status: He was to be placed on modified duty with no lifting/pushing/pull over 10 pounds, no prolonged overhead work, no repetitive bending twisting, no prolong sitting/standing more than 30 minutes without breaks, and no forceful grasping. He was limited to excessive noise.

Prognosis: Guarded at this time.

Recommendations: Authorization was requested for internal medicine consultation, and ENT consultation.

6/11/21, Workers' Compensation Claim Form (DWC 1).
The applicant alleged stress, depression, anxiety, posttraumatic stress disorder, and panic attacks due to hostile work environment, discrimination based on age, nation of origin, and retaliation for complaints of violation of policies.

---END OF REVIEW OF RECORDS---

IDENTIFYING INFORMATION, SOCIAL, WORK HISTORY AS RELATED BY THE APPLICANT DURING FACE-TO-FACE EVALUATION:

Mr. George Soohoo is a 67 year-old married male who presents to my office today, October 11, 2021 for a Psychological Qualified Medical Evaluation. There was no interpreter required for this evaluation. The applicant's date of birth is November 28, 1953. There are two DOI's being alleged while employed at. The first DOI is from 08/01/2015 to 07/06/2018. The second DOI is from 01/01/2015 to 06/10/2021. He is claiming that the alleged assault and harassment suffered on those dates have resulted in psychiatric injuries. The date that the applicant last worked was on September 20, 2021.

The applicant was born on November 28, 1953 into a family with both parents married and living together. He never witnessed his parents verbally or physical fight.

The applicant's father was born and raised in China. He passed away in 1990. He was 75 at the time of his death due to a heart attack. His father finished high school in China and came to the United States in the 1940's. When he first arrived in the United States, he owned a dry-cleaning business. Later he owned a small grocery store in the San Diego area. He denies any negative issues with his father. He says that this was mostly due to the very limited time he spent with his father as his father was always working. His father was "very quiet" but doesn't remember any negative interactions. He states that he "treated me fine".

His mother is also deceased. She died in 2016 from complications that followed a stroke. She was also born in China. She worked with his father in the dry-cleaning business and then the grocery store. He denies any issues with her. He states that his relationship with his mother was always "Very Good". He says that both his parents always work very hard and worked many long hours during the weekdays and also on weekends.

He had one sister by the name of Mohing Soohoo. She passed away at the age of 47 in 1992 from colon cancer. He became tearful when talking about his sister. She was married and was a financial analyst. She lived in San Jose, California for most of her adult life. He said that he had a very good relationship with her. She had no mental health or substance abuse issues during her entire life.

He has brother by the name of Henry Soohoo. He states that his brother currently lives in San Diego California, he is married and works in the vocational industry. He says that his relationship with his brother is good.

As for his childhood experiences, he says that it was very difficult at times. However, they never had to worry about food, clothing, and shelter. He says that he had to work from an early age, as he started working around the age of 5 or 6. When he would come back from school he would work in the parent's business, first the dry-cleaning service and then the grocery store. He was disciplined as a child by his parents yelling and screaming at him at times. He was spanked by his mother up until an early age, he could not remember exactly when it ceased. He did not seem to believe that his parents were overly harsh or punitive. He just knew that he had to work, do his chores, and his schoolwork.

He was the only Asian student at an all Black and Hispanic school. He felt very much discriminated against by the other children and also by the teachers. He said that he was bullied by his peers. The bullying became a little better when he went to junior high school and then even a little better in high school. However, he says that it never ceased but just became less abusive. He reports that he was very good at math and that his teachers didn't believe how smart he was. He states that he remembers one teacher not even grading his paper even though he could see that he had all the answers correct. He helped someone in high school to get into Stanford University, but he didn't get in even though he knew he had better grades. This was around 1970 and he believes that he was discriminated against due to his Chinese heritage.

His sister and brother went to Chinese school after public school, so they were not as exposed to the bullying and discrimination as much as he was. He was the youngest

and so he says that by the time he was born his parents had no more money to send him to Chinese school. Instead, he had to work in the store and do his homework after the work was completed.

He denies any medical problems, physical traumas, head injuries, or surgeries as a child. He also denies any mental health problems during childhood, suicide attempts, psychiatric hospitalization, drug/alcohol problems and the applicant never saw a school counselor for academic, emotional, or behavioral problems while growing up.

The applicant states that he was in advanced math classes for most of his childhood. He says that the school experience was hard. He tried to fit in with the other children, but it was difficult. He lived in a very poor neighborhood, so a lot of his classmates he says were not good students. He said that he was able to make some friends along the way but mainly out of self-protection due to being bullied. He would often help the others with their homework and did some tutoring.

In the military he was also harassed beaten up by fellow soldiers who thought he was a Japanese tourist. They robbed him and beat him so badly that he was hospitalized.

He denies any childhood issues with learning, memory, or concentration.

He started dating in college. He went to UCLA undergraduate. His first marriage was at the age of 27. She was about 5 or six years younger than he and the marriage was arranged by the parents. She worked in her family's store. She had a degree from the University of Washington. He was married for 10 years before they divorced, and they had no children.

He was married for the second time when he was in his fifties. They are still married. She is 11 years younger than he. She is now 56 or 57. She had 3 grown children when he met and married her. She is of Filipino descent and works as a medical assistant. He says that she does not have any mental/medical issues or substance abuse issues. He says that they have a good relationship. One of her children lives in the Philippines and the other two live here. He says they see each other every two or three weeks.

The applicant currently lives with his wife in a house in Corona Del Mar.

OCCUPATIONAL HISTORY:

He first began to work at his parents store when he was a child. In college he worked in the student store.

He went for his doctorate in dental surgery. He has two masters and a doctorate.

After dental school he was recruited to teach at the Dental School in Tulsa Oklahoma. He has been an associate professor and has published numerous articles in the area of dentistry.

He owned his own business, G.M. Soohoo DDS & Associates from 1986 until 1994.

He denies ever being fired from employment.

He was in the Army from 1986 until 2013. He was a colonel as a dentist in the United States Army. He treated the soldiers in Fort Lewis Washington. He was in Iraq and flew into Afghanistan but denies ever being in any personal danger or witnessing firsthand any violence. He, however, believes he has some trauma related to seeing soldiers seriously injured in combat and would even be the one to have to tell the families if their son had died. He has some intrusive disturbing memories about the injuries he saw. He was in Germany after 9/11/01 and his base was shut down. He reports being very scared about what happened on 9/11 and what could possibly happen at his base.

HISTORY OF INJURY AS RELATED BY THE APPLICANT DURING FACE-TO-FACE EVALUATION:

He says that before the 2015 DOI he was working at the California Institute for Men. He started there in 2010. He was hired as Chief Dentist at first and was then changed to Supervising Dentist. The event that occurred that precipitated the first claim is when he alleges that he was hit by his supervisor in 2015. He was with others at the time at a Mexican restaurant having lunch for someone's last day at work. Mr. Escobar was his supervisor at the time, and he also joined them for lunch. The applicant states that during this lunch, suddenly, and for no apparent reason, Mr. Escobar backhanded him in the face. He has no clue as to why he was struck. Dr. Farooq, who was Chief Medical Officer, later came to him and say that he had spoken to Mr. Escobar and that Mr. Escobar said he would not do it again.

He says that even before he was hit, that it was a "hostile" environment at the worksite between Blacks and Hispanics. There were no other Asians in the Dental department and so he felt isolated in his department. He stated that he was twice accused of

something, the first time lying to someone about some records and another time he was accusing of yelling at his assistant. This second action was filed by other people, not the person he allegedly yelled at. He appealed that case and won.

He believes that the stress at CIM started when the new CEO, Mr. Escobar, started and after only six months wrote him up for needing improvement in "working with patients". This was without ever seeing him personally work with staff or patients.

He said that after that he didn't trust anyone anymore and it was difficult to talk to staff regarding things at the job. He was often asked when he was going to retire or when was he going to leave or was asked how many years he had been working. He believes that was a form of age discrimination or possible harassment by his co-workers. He began to have nightmares, was depressed, he would cry a lot, get headaches, felt isolated because he couldn't talk to anyone at work about his situation. These feelings all started to occur soon after Mr. Escobar started to work there and wrote him up.

He denies ever using foul language but admits that he may raise his voice due to his hearing loss due to his military experience and utilizing dental equipment that can be extremely loud, which must be held in his hand, and so is close to his ears.

Mr. Soohoo states that a Lawrence Woodburn, Ph.D. was treating him for these incidents at CIM. He would like to see someone for his symptoms but because his claim was denied he has not been able to see anyone. He last saw Dr. Woodburn about a year ago and would like to see someone if it could be approved.

When he was asked if there are any psychiatric symptoms that would interfere with his occupational functioning he stated that if he doesn't have the support of the staff and the CEO he feels very reluctant to go back to the same place. Especially if he is under the same person, Mr. Escobar. He reports that he continues to have headaches, crying bouts, gritting of his teeth, depression, nightmares, anxiety, intrusive thoughts related to CIM.

CURRENT SYMPTOMATOLOGY AS RELATED BY THE APPLICANT:

He says that he continues to be depressed, with nightmares, anxiety, bouts of crying, headaches, and intrusive thoughts regarding his time at CIM. He says that his appetite is "not good", his concentration is "poor", and his energy level low as he said he is "fatigued a lot". As far as his socializing, he said that he is "not as sociable especially at

work" because he lacks the trust of his co-workers. He is fine however, with his family. He "sticks with family" at this time. With family he can have fun. He enjoys meditation, walks on the beach, enjoys time with his wife's grandchildren, watching sports, going to musicals. The applicant states with respect to thoughts of suicide he "has thought it once" in the past "maybe" because he had been off work for 60 days. He denies any homicidal ideation. He also does not experience visual or auditory hallucinations, however due to his sleep apnea he says he has vivid nightmares. During the last three years he has had nightmares related to his boss, Mr. Escobar. Has also had nightmares in the past regarding being assaulted while in the military, his time seeing injured or dead soldiers in the military and now at CIM.

PSYCHIATRIC HISTORY:

In 1998 he saw a psychologist after he was attacked while off duty in the military. That incident was in Hawaii while he was on leave. He says that several other soldiers thought he was a tourist and attacked him and robbed him. While the assault was in Hawaii, his psychological treatment was in San Diego. He saw the psychologist for about a dozen times and says he had some improvement. This was in 1998 or 1999. He says that he was given a diagnosis of Posttraumatic Stress Disorder at the time of his treatment. The nightmares of the assault, however, continue to this day.

Since the DOI he has had various interactions with psychologists and psychiatrists. He saw a Lawrence Woodburn, Ph.D. from 2017 until 2019. His psychiatrist is Shawn Chung, MD.

PAST MEDICAL HISTORY:

Other than his current orthopedic issues as described above, the applicant has kidney cancer. He states that his kidney cancer has metastasized to his lungs. He will be starting therapy for these medical issues in the next few weeks. He has had right kidney surgery in which his right kidney was removed due to cancer. This was in 2019.

He has an 80% loss of hearing in left ear and 30% in his right due to his profession. He says that the equipment he uses is loud and over many years has left him with this hearing loss.

He denies any history of seizure disorder or concussions. He is currently being treated for diabetes, hypertension, sleep apnea and renal carcinoma.

SOCIAL SITUATIONS, HOBBIES, LEGAL HISTORY AS RELATED BY THE APPLICANT DURING FACE-TO-FACE EVALUATION:

The applicant currently lives with his wife. On a typical day the applicant wakes up at about 4:30 am when he is working and around 7:00 am when he is not. On the weekends he also wakes up early to start his day. He continues to enjoy meditation, walks on the beach with his wife, spending time with his wife's children, watching sports, and going to the theatre.

He reports no arrests. He has one bankruptcy 20 years ago. He filed for bankruptcy regarding a business and his private practice. He says that he did this mainly because he was deployed in the military and could not assist in the oversite of the business.
He has no lawsuits or civil suits. He denies any car accidents or injuries. He also denies any substance abuse or alcohol abuse. He denies ever smoking as an adult.

With respect to future plans, he says that he wishes to get his heath in as good condition as possible, both his mental health as well as his physical health.

As far as his returning to work, he stated that if he were placed under a different supervisor and had no contact with either Mr. Escobar or Mr. Escobar's subordinate, he would go back to his previous employment.

TESTING RESULTS:

According to the psychiatric questionnaire, the current psychiatric or emotional problems at this time include depression, anxiety, fatigue, and restlessness.

He does have difficulty with falling asleep and waking up early and being unable to fall back to sleep. He does not have nightmares once a week. He describes his appetite as fair.

The applicant describes his overall level of energy as poor. He describes his sex drive as fair. He is usually able to finish his routine chores and responsibilities. He describes his mood as "irritable, worried, concerned, upset."

For this claim, his duties included "administrative 80%, clinical care 45%, training 15%." He is unable to be at work. He writes, "Vertigo, immune / chemotherapy for lung cancer, depression."

The applicant indicates seeing a psychiatrist, Dr. Shawn Chung, M.D., in connection with this claim.

The applicant indicates he is also seeing other doctors for kidney cancer, lung cancer and Hematology at this time.

The applicant indicates he is taking Hydroxyzine 10 mg, Metformin 500 mg, Choidegral 75mg, Chlorhali done 25 mg, Lovastatin 20 mg, Escttalopram 20 mg, Lorazepam .5 mg, Ahycodipine 10 mg, Losartnvo 100 mg, Potassium chloride 20 mg.

The applicant indicates that he has never been injured on the job aside from this claim.

The applicant indicates he has not had any personal problems such as divorce, or financial difficulties, aside from the present one in the past 3 years. He writes, "Loss of mother – (2016); kidney cancer (2019) metathesis to lung (2020)."

Millon Clinical Multiaxial Inventory-III (MCMI-III):

The MCMI-III instrument provides a measure of 24 personality disorders and clinical syndromes for adults undergoing psychological or psychiatric assessment or treatment. Specifically designed to help assess both Axis I and Axis II disorders, this psychological test assists clinicians in psychiatric diagnosis, developing a treatment approach that takes into account the patient's personality style and coping behavior, and guiding treatment decisions based on the patient's personality pattern.

RESPONSE TENDENCIES

Unless this patient is a demonstrably well-functioning adult who is currently facing minor life stressors, his responses suggest (1) a well-established need for social approval and commendation, evident in tendencies to present himself in a favorable light, or (2) a general naivete about psychological matters, including a possible deficit in self-knowledge. The interpretation of this profile should be made with these characteristics in mind.

The BR scores reported for this individual have been modified to account for the psychic tension indicated by the elevation on Scale A (Anxiety) and the defensiveness suggested by the prominence of Personality Patterns Scale 5 (Narcissistic).

AXIS II: PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

There is reason to believe that at least a moderate level of pathology characterizes the overall personality organization of this man. Defective psychic structures suggest a failure to develop adequate internal cohesion and a less than satisfactory hierarchy of coping strategies. This man's foundation for effective intrapsychic regulation and socially acceptable interpersonal conduct appears deficient or incompetent. He is subjected to the flux of his own enigmatic attitudes and contradictory behavior, and his sense of psychic coherence is often precarious. He has probably had a checkered history of disappointments in his personal and family relationships. Deficits in his social attainments may also be notable as well as a tendency to precipitate self-defeating vicious circles. Earlier aspirations may have resulted in frustrating setbacks and efforts to achieve a consistent niche in life may have failed. Although he is usually able to function on a satisfactory basis, he may experience periods of marked emotional, cognitive, or behavioral dysfunction.

The MCMI-III profile of this man suggests that he cloaks a deep fear of autonomy with a veneer of sociability, maturity, and self-assurance. His public front of social propriety and conformity probably hides a deep, conflictful submission to others and intense but suppressed antagonism. He struggles to maintain a disciplined self-restraint and social affability. A long-standing pattern of being deferential and ingratiating with superiors is notable. His recent failures to evoke the approval of those in authority may have led to a significant period of depression and anxiety.

Recently moody and straining to express attitudes that are contrary to his feelings of anger and dejection, he may have become overly sensitive to the demands and expectations of others. Alert to signs of potential hostility and rejection, he avoids disapproval by adapting his behavior to the desires of others. By identifying with the views of authorities and by adhering to their rules, he acquires transient feelings of importance and significance.

Despite denials to the contrary, his habitual preoccupation with external approval has resulted in feelings of impotence, anger, and dependency. He represses these feelings

because they signify the disparity between his public front of propriety and self-assurance and the sterility he feels within. Deep resentment may be harbored toward those to whom he feels he must conform and submit. These antagonistic feelings periodically erupt in irrational angry outbursts that are quickly diluted with expressions of guilt and contrition. Such public displays of inconsistency and impulsiveness disturb him because they markedly contradict the public image he desires to portray.

This man increasingly complains about unfair treatment, anticipates disapproval from others, and feels that others no longer appreciate his efforts to be diligent and responsible. Unable to maintain his controls and equanimity, he may experience a growing number of physical symptoms and discomfort.

GROSSMAN PERSONALITY FACET SCALES

The Grossman facet scales are designed to aid in the interpretation of elevations on the Clinical Personality Patterns and Severe Personality Pathology scales by helping to pinpoint the specific personality processes (e.g., self-image, interpersonal relations) that underlie overall scale elevations. A careful analysis of this patient's facet scale scores suggests that the following characteristics are among his most prominent personality features.

Most notable is his preoccupation with minor fantasies of success, beauty, or love, a somewhat undisciplined imagination that takes liberties with objective reality to assert and reinforce his boastful self-image. He places few limits on his fantasies or rationalizations, and his imagination is left to run free of the constraints of reality or the views of others. He is cognitively inclined to exaggerate his power, to freely transform failures into successes, and to construct lengthy and intricate rationalizations that inflate his self-worth or justify what he feels is his due, quickly deprecating those who refuse to accept or enhance his superior self-image.

Also salient is his vigilantly guarded attitude. He maintains a wary hyperalertness in order to ward off anticipated deception and malice from others, leading him to resist all sources of external influence. Whether faced with danger or not, he maintains a fixed level of preparedness, an alert vigilance against the possibility of attack and derogation. He exhibits edgy tension, abrasive irritability, and an ever-present defensive stance from which he can spring into action at the slightest offense. His state of rigid control never seems to abate, and he rarely relaxes or lets down his guard.

Also worthy of attention are his suspiciousness regarding the motives of others and his tendency to misconstrue innocuous events as signifying proof of duplicity or conspiratorial intent. His learned feelings and attitudes have produced deep mistrust and pervasive suspiciousness of others. He is notoriously oversensitive and disposed to detect signs of trickery and deception everywhere. He is preoccupied with these thoughts, actively picking up minute cues, then magnifying and distorting them so as to confirm to his worst expectations. To further complicate matters, events that fail to confirm his suspicions are evidence in his mind of just how deceitful and clever others can be.

Early treatment efforts are likely to produce optimal results if they are oriented toward modifying the personality features just described.

AXIS I: CLINICAL SYNDROMES

The features and dynamics of the following Axis I clinical syndromes appear worthy of description and analysis. They may arise in response to external precipitants but are likely to reflect and accentuate several of the more enduring and pervasive aspects of this man's basic personality makeup.

Episodes suggestive of a major depressive disorder appear to have overtaken this man. Although he is not psychologically disposed to permit himself to succumb to strong emotions or to expose his perceived weaknesses to others, he displays a variety of chronic symptoms (e.g., fatigue, inefficiency, inability to concentrate) that are perhaps due to the press of persistent troublesome events or to the impact of biological dysfunction. These symptoms are likely to be associated with feelings of worthlessness and guilt as a result of his need to maintain appearances and adhere to proprieties. Not inclined to exhibit either the colorless or withdrawn qualities seen in other depressives, this man is prone to turn his strong emotions inward, claiming that he deserves the punishment he now suffers. He believes that such self-condemnatory comments will help deter the reproach he anticipates for his failures, transforming criticism and rebukes into expressions of support and understanding.

A number of delusional facets to this man's thinking (e.g., transient ideas of reference, mixed jealousy, and persecutory beliefs) interweave with other features to constitute a mini-paranoid episode. He believes that he has been betrayed or forsaken by persons whose support he had hoped to gain. His previously repressed resentments have slipped through once-adequate controls, breaking through as irrational--but brief--expressions of anger and suspicion. Tensions are likely to accumulate, compelling him to be quite touchy and irritable.

This man is unaccustomed to experiences that characterize a generalized anxiety disorder, yet his MCMI-III responses indicate that he is undergoing this syndrome presently. In addition to physical indices such as a diffuse apprehensiveness, he may be subject to persistent bodily tension and muscular pains as well as undue perspiration or chest palpitations. Behavioral indices such as a sense of foreboding, feeling jumpy and on edge, and short periods of unexplained fatigue, if not exhaustion, are also possible. Most likely prompted by recent, unexpected failures and a sense perhaps of being a fraud underneath it all, his current state stems from an inability to have things go his way, a reversal of his usual success in manipulating events to his liking.

This man appears to have experienced an event or events that may have involved physical threat or serious injury to which he responded with intense fear or horror. Although he is not characteristically fearful or anxious, the memory of this upsetting experience appears to come back in intensive and distressing recollections. He avoids exposure to cues that resemble or symbolize aspects of the traumatic event. Where they cannot be avoided, as in recurring nightmares and flashbacks, he may feel terrified, exhibiting a variety of signs of intense anxiety. Anticipation of their recurrence may result in persistent anxious symptoms, such as difficulty in sleeping, exaggerated startle response, or a protective numbing and detachment.

NOTEWORTHY RESPONSES

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation

1. Lately, my strength seems to be draining out of me, even in the morning. (True)
4. I feel weak and tired much of the time. (True)
37. I very often lose my ability to feel any sensations in parts of my body. (True)
55. In recent weeks I feel worn out for no special reason. (True)
74. I can't seem to sleep, and wake up just as tired as when I went to bed. (True)
149. I feel shaky and have difficulty falling asleep because painful memories of a past event keep running through my mind. (True)

Interpersonal Alienation

10. What few feelings I seem to have I rarely show to the outside world. (True)
63. Many people have been spying into my private life for years. (True)
167. I take great care to keep my life a private matter so no one can take advantage

of me. (True)

Emotional Dyscontrol

34. Lately, I have gone all to pieces. (True)
83. My moods seem to change a great deal from one day to the next. (True)
87. I often get angry with people who do things slowly. (True)
134. I sometimes feel crazy-like or unreal when things start to go badly in my life. (True)

Self-Destructive Potential

44. I feel terribly depressed and sad much of the time now. (True)
150. Looking ahead as each day begins makes me feel terribly depressed. (True)

Childhood Abuse

No items endorsed.

Eating Disorder

No items endorsed.

POSSIBLE DSM-IV MULTIAXIAL DIAGNOSES

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the DSM-IV, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-III.

Axis I: Clinical Syndrome

The major complaints and behaviors of the patient parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

296.64 Bipolar Disorder (mixed, with psychotic features)
300.02 Generalized Anxiety Disorder
309.81 Posttraumatic Stress Disorder

Axis II: Personality Disorders

Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the most probable DSM-IV diagnoses (Disorders, Traits, Features) that characterize this patient.

Personality configuration composed of the following:

301.81 Narcissistic Personality Disorder
with Obsessive Compulsive Personality Traits
Paranoid Personality Features
and Histrionic Personality Features

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment. The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Axis IV: Psychosocial and Environmental Problems
In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating her present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

Illness or Fatigue; Job or School Problems

TREATMENT GUIDE

If additional clinical data are supportive of the MCMI-III's hypotheses, it is likely that this patient's difficulties can be managed with either brief or extended therapeutic methods. The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses.

As a first step, it would appear advisable to implement methods to ameliorate this patient's current state of clinical anxiety, depressive hopelessness, or pathological personality functioning by the rapid implementation of supportive psychotherapeutic measures. With appropriate consultation, targeted psychopharmacologic medications may also be useful at this initial stage.

Once this patient's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

Supportive and short-term therapy are the major initial vehicles for treating this patient. Several psychopharmacologic agents may be considered, with appropriate consultation, for alleviating tense feelings. Also useful may be various interpersonal techniques (e.g., Benjamin, Klerman) designed to counteract the patient's tendency to feel and act superior to problematic situations. Cognitive reorientation methods geared to reframing assumptions about himself and the expectations of others may be used gradually and with discretion. Care should be taken to accomplish the purposes of altering these dysfunctional beliefs, especially because this patient may grasp the point of these methods but only at an abstract or intellectual level. To rework the foundations of his lifestyle need not require long-term procedures. Rather, circumscribed, and focused approaches can offer significant personality reconstruction in a condensed and fruitful way. Although interpersonal methods that focus on the patient alone would probably be successful, he may not be especially amenable to group or family therapy. That is, he may refuse to participate wholeheartedly as a patient, or he may display extreme resistance if forced to relinquish his defenses and expose his feelings in front of others.

In general, he is likely to regard therapy, either brief or extended, as a threat to his defensive armor. While it may be possible to readily relieve his symptoms, he may try to avoid self-exploration and self-awareness. His defensiveness is deeply protective and must be honored by the therapist; probing should proceed no faster than the patient can tolerate. Only after building trust and confidence in the therapeutic relationship can the therapist begin to bring cognitive and interpersonal methods into the open. For every piece of defensive armor removed, however, the therapist must attempt to bolster the patient's sense that the treatment process will be constructive and self-enhancing. To remove more defenses than the patient can handle should be avoided to prevent relapse. He may be sufficiently well-guarded and self-assured, however, to ignore or intellectualize distressing confrontations, but nonetheless, caution is the byword.

As noted, this patient may not only be suspicious of therapy and psychology but may tend to denigrate sentimentality, intimate feelings, and tenderness. His narcissistic streak leads him to lack sympathy for the weak and oppressed. The therapist cannot allow the entire therapeutic enterprise to be hostage to his indifference. A directive cognitive approach may lead him to recognize that dealing with the softer emotions need not undermine the foundations of his interpersonal style or reactivate feelings that he has

buried for years. His assumption that sympathy and tender feelings only distract and divert people from being correct and successful can be confronted cognitively. His exploitive inclinations, propriety, and conventional regulations may be examined and counteracted by combining cognitive and interpersonal therapies.

Beck Depression Inventory – II (BDI–II):

The BDI-II is used to assess the existence and severity of symptoms of depression in accordance with the criteria described in the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (DSM–IV). This new edition of the Beck Depression Inventory is the most widely used instrument for detecting depression.

The BDI-II contains 21 questions. Each answer is scored on a scale value of 0 to 3. The scores correlate with the following categories of depression: 0-13 - minimal depression, 14-19 - mild depression, 20-28 - moderate depression, and 29-63 - severe depression.

The applicant's score is 22, which is in the **"moderate"** category of depression.

Responses

I feel sad much of the time.
I feel more discouraged about my future than I used to be.
I do not feel like a failure.
I don't enjoy things as much as I used to.
I don't feel particularly guilty.
I don't feel I am being punished.
I have lost confidence in myself.
I don't criticize or blame myself more than usual.
I have thoughts of killing myself, but I would not carry them out.
I cry more than I used to.
I feel more restless or wound up than usual.
I am less interested in other people or things than before.
I find it more difficulty to make decisions than usual.
I do not feel I am worthless.
I don't have enough energy to do very much.
I wake up 1-2 hours early and can't get back to sleep.
I am more irritable than usual.
I have no appetite at all.
It's hard to keep my mind on anything for very long.

I am too tired or fatigued to do a lot of the things I used to do.
I have not noticed any recent change in my interest in sex.

Beck Anxiety Inventory (BAI):

The BAI is a 21-question multiple choice self-report inventory that is used for measuring the severity of an individual's anxiety. The questions ask about how the subject has been feeling in the last week, expressed as common symptoms of anxiety. It is designed for an age range of 17-80 years old.

Each question has the same set of four possible answer choices: Not at all, Mildly, Moderately, or Severely. Each answer is given a score of 0 to 3 points. The BAI has a maximum score of 63.

0 – 7	Minimal Anxiety
8 – 15	Mild Anxiety
16 – 35	Moderate Anxiety
36+	Severe Anxiety

The applicant's score is 26, which is in the **"moderate"** category of anxiety.

Responses

Not at all – feeling of choking, fear of losing control, difficulty in breathing.

Mildly – feeling hot, wobbliness in legs, unsteady, terrified or afraid, hands trembling, shaky / unsteady, indigestion, faint / lightheaded, face flushed, hot / cold sweats.

Moderately – numbness or tingling, unable to relax, fear of worst happening, dizzy or lightheaded, heart pounding / racing, nervous, fear of dying, scared.

Severely – none.

Brief Symptom Inventory (BSI):

The BSI is a 53-item self-report symptom inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients as well as community non-patient respondents. It is essentially the brief form of the SCL-90-R.

Each item of the BSI is rated on a five-point scale of distress (0-4), ranging from "not at all" (0) at one pole to "extremely" (4) at the other. Maximum score is 212.

The BSI is a widely used self-report inventory designed to reflect current psychological symptom status.

The applicant's score is 53 out of a total score of 212, which indicates a mild to moderate level of distress.

Responses

Not at all – faint or dizziness, the idea that someone else can control your thoughts, feeling others are to blame for most of your troubles, pain in heart or chest, feeling afraid in open spaces or on the streets, thoughts of ending your life, temper outburst that you could not control, feeling inferior to others, feeling afraid to travel on buses, subways, or trains, trouble getting your breath, hot or cold spells, the idea that you should be punished for your sins, having urges to beat, injure, or harm someone, having urges to break or smash things, feeling self-conscious with others, feeling uneasy in crowds, such as shopping at a movie, never feeling close to another person, getting into frequent arguments, feelings of worthlessness, feelings of guilt, the idea that something is wrong with your mind.

A little bit – trouble remembering things, feeling easily annoyed or irritated, feelings that most people cannot be trusted, suddenly scared for no reason, feeling lonely even when you are with people, feeling blocked in getting things done, feeling lonely, nausea or upset stomach, feeling that you are watched or talked about by others, your mind going blank, spells of terror or panic, others not giving you proper credit for your achievements, feeling so restless you couldn't sit still, feeling that people will take advantage of you if you let them.

Moderately – nervousness or shakiness inside, poor appetite, feeling blue, feeling not interested in things, feeling fearful, your feelings being easily hurt, feeling that people are unfriendly or dislike you, trouble falling asleep, having to check and double check what you do, difficulty making decisions, having to avoid certain things, places or activities because they frighten you, feeling hopeless about the future, trouble concentrating, feeling weak in parts of your body, feeling tense or keyed up, thoughts of death and dying, feeling nervous when you are left alone.

Quite a bit – numbness or tingling in parts of your body.

Extremely – none.

Pain - Self Report of Severity:

a. Rate how severe your pain is right now at this moment. **7**

On a scale of 0 to 10, with 0 being no pain, and 10 being the most severe pain you can imagine.

b. Rate how severe your pain is at its worst. **8**

On a scale of 0 to 10, with 0 being no pain, and 10 being excruciating.

c. Rate how severe your pain is on average. **7**

On a scale of 0 to 10, with 0 being no pain, and 10 being excruciating.

d. Rate how much your pain is aggravated by activity. **6**

On a scale of 0 to 10, with 0 being activity does not aggravate pain, and 10 being excruciating following any activity.

e. Rate how frequently you experience pain. **8**

On a scale of 0 to 10, with 0 being rarely, and 10 being all of the time.

Katz Basic Activities of Daily Living (ADL) Scale:

The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of an individual's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring, continence, and feeding. Individuals are scored yes/no for independence in each of the six functions. Yes = 1 and No = 0. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

In the thirty-five years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults.

The applicant's score is 6 out of a total score of 6, which indicates no impairment in function with regards to basic activities of daily living.

Applicant's Performance on Katz Basic Activities of Daily Living:

The applicant indicates that he is independent with bathing, dressing, toileting, transferring, continence, and feeding.

The applicant indicates that he is dependent with none of the categories listed.

Lawton-Brody Instrumental Activities of Daily Living (L.A.D.L):

The assessment of functional status is critical when caring for older adults. Normal aging changes, acute illness, worsening chronic illness, and hospitalization can contribute to a decline in the ability to perform tasks necessary to live independently in the community. The information from a functional assessment can provide objective data to assist with targeting individualized rehabilitation needs or to plan for specific in home services such as meal preparation, nursing and personal care, home-maker services, financial and medication management, and/or continuous supervision. A functional assessment can also guide the clinician to focus on the person's baseline capabilities, facilitating early recognition of changes that may signify a need either for additional resources or for a medical work-up.

The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills. These skills are considered more complex

than the basic activities of daily living as measured by the Katz Index of ADLs. The instrument is most useful for identifying how a person is functioning at the present time and for identifying improvement or deterioration over time. There are eight domains of function measured with the Lawton IADL scale. Historically, women were scored on all eight areas of function; men were not scored in the domains of food preparation, housekeeping, laundering. However, current recommendations are to assess all domains for both genders. Persons are scored according to their highest level of functioning in that category. A summary score ranges from 8 (high function, independent) to 30 (low function, dependent).

This instrument is intended to be used among older adults, and may be used in community, clinic, or hospital settings. The instrument is not useful for institutionalized older adults. It may be used as a baseline assessment tool and to compare baseline function to periodic assessments.

The applicant's score is 8, which indicates high function with regards to instrumental activities of daily living.

Applicant's Performance on Lawton-Brody Instrumental Activities of Daily Living:

Ability to use telephone – Operates telephone on own initiate, looks up and dials numbers, etc.

Shopping – Takes care of all shopping needs independently.

Food preparation – Plans, prepares and serves adequate meals independently.

Housekeeping – Maintains house alone or with occasional assistance.

Laundry – Does personal laundry completely.

Mode of transportation – Travels independently on public transportation or drives own car.

Responsibility for own medications – Is responsible for taking medication in correct dosages at correct time.

Ability to handle finances – Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income.

Activities of Daily Living:

Self-Care, Personal Hygiene:

Without Difficulty – take a shower, take a bath, wash & dry body, wash & dry face, turn on/off faucets, brush teeth, get on/off toilet, comb/brush hair, dress self, put on/off shoes/socks, open carton of milk, open a jar, lift glass/cup to mouth, make a meal, lift fork/spoon to mouth.

Physical activity:

With Much Difficulty – lift 20 lbs., lift 30 lbs.

With Some Difficulty – sit, recline, rise from chair, get in/out of bed, climb flight of 10 stairs, work outdoors, carry groceries, lift 5 lbs., lift 10 lbs., walk.

Without Difficulty – stand, light housework, shop/do errands, care for children/parents, engage in hobbies.

Communication:

With Much Difficulty – hear clearly.
Without Difficulty – write a note, type a message on a computer/typewriter, see a television screen, use a telephone, speak clearly.

Sensory Function:

Without Difficulty – feel what you touch, taste what you eat, smell what you eat.

Travel:

With Some Difficulty – get in/out of car, ride a bicycle.
Without Difficulty – drive a car, ride in a car, fly a plane.

Sexual Function:

Without Difficulty – Engage in sexual activity.

Sleep:

With Some Difficulty – go to sleep, sleep through the night, have a restful sleep, feel refreshed after sleep.

Review of Systems:

General:

Fevers, chills or sweat
Recent loss of appetite
Fatigue
Trouble sleeping

Eyes:

Blurred or double vision
Eye discharge

If you are a man:

Increased frequency of urination

PTSD Checklist - Civilian Version (PCL-C):

The PCL is a 17-item self-report checklist of PTSD symptoms based closely on the DSM-IV criteria.

Respondents rate each item from 1 ("not at all") to 5 ("extremely") to indicate the degree to which they have been bothered by that particular symptom over the past month. Maximum score is 85.

Three versions of the PCL are available, although the differences are slight. The PCL-M is a military version and questions refer to *"a stressful military experience"*. The PCL-C is a general civilian version that is not linked to a specific event; the questions refer to *"a stressful experience from the past"*.

The PCL-S can be referenced to any specific traumatic event; participants are asked to nominate the event and questions refer to *"the stressful experience."* Scoring is the same for all three versions.

The applicant's score is 62 out of a total score of 85, which indicates a severe level of PTSD symptoms.

Responses

Not at all – feeling emotionally numb or being unable to have loving feelings for those close to you.

A little bit – none.

Moderately – trouble remembering important parts of a stressful experience from the past, feeling irritable or having angry outburst, having difficulty concentrating.

Quite a bit – repeated, disturbing memories, thoughts or images of a stressful experience from the past, repeated, disturbing dreams of a stressful experience from the past, suddenly acting or feeling as if a stressful experience were happening again, feeling very upset when something reminded you of a stressful experience from the past, having physical reactions when something reminded you of a stressful experience from the past, avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it, avoid activities or situations because they remind you of a stressful experience from the past, loss of interest in things that you used to enjoy, feeling distant or cut off from other people, feeling as if your future will somehow be cut short, trouble falling or staying asleep, being super alert or watchful on guard, feeling jumpy or easily startled.

Extremely – none.

Fasttest Beck Inventory:

1. I feel blue or sad.
2. I feel I have nothing to look forward to.
3. I do not feel like a failure.
4. I do not enjoy things the way I used to.
5. I do not feel particularly guilty.

6. I have a feeling that something bad may happen to me.
7. I do not feel disappointed in myself.
8. I do not feel I am worse than anybody else.
9. I do not have any thoughts of harming myself.
10. I cry now more than I used to.
11. I get annoyed or irritated more easily than I used to.
12. I have not lost interest in other people.
13. I am less sure of myself now and try to put off making decisions.
14. I don't feel I look any worse than I used to.
15. It takes extra effort to get started at doing something.
16. I wake up more tired in the morning than I used to.
17. I get tired more easily than I used to.
18. My appetite is not good as it used to be.
19. I have lost more than 10 pounds.
20. I am no more concerned about my health than usual.
21. I have not noticed any recent changes in my interest in sex.

Wahler Physical Symptoms Inventory (WPSI):

The WPSI is an instrument designed to measure the degree of physical or somatic complaints endorsed by an individual. H.J. Wahler designed the inventory to specifically include those complaints considered to be exclusively somatic in composition, eliminating items of a psychological nature.

Each item on the WPSI is rated on a six-point scale of distress (0-5), ranging from "almost never" (0) at one pole to "nearly every day" (5) at the other. Maximum score is 210.

The applicant's score is 114 out of a total score of 210, which indicates a moderate level of somatic complaints.

<u>Responses</u>

Almost never – swelling of arms, stuttering or stammering, heart trouble, paralysis, burning, any trouble with the senses of taste or smell, difficulty swallowing, seizures, gaining weight, chest pains.

About once a year – trouble with teeth, difficulty breathing.

About once a month – intestinal or stomach trouble, fainting spells, excessive perspiration, bowel trouble, vomiting, hay fever or other allergies.

About once a week – feeling hot or cold regardless of the weather, losing weight, numbness or lack of feeling in any part of the body, dizzy spells, muscular tension, twitching muscles.

About twice a week – nausea, headaches, neck aches or pains, arm or leg aches or pains, shakiness, difficulty sleeping, difficulty with urination, trouble with eyes or vision.

Nearly every day – trouble with ears or hearing, backaches, aches or pains in hands or feet, abnormal blood pressure, skin trouble, feeling tired, muscular weakness, poor health in general, excessive gas, difficulty with appetite.

Epworth Sleepiness Scale (ESS):

The ESS is a self-administered questionnaire with 8 questions. It provides a measure of a general level of daytime sleepiness, or their average sleep propensity in daily life. It has become the world standard method for making this assessment.

The ESS asks people to rate, on a 4-point scale (0 – 3), their usual chances of dozing off or falling asleep in 8 different situations or activities that most people engage in as part of their daily lives, although not necessarily every day. It does not ask people how often they doze off in each situation. That would depend very much on how often they happened to be in those situations.

Rather it asks what the chances are that they would doze off whenever they were in each situation. This requires a mental judgment which, it seems, most people are able to make in a meaningful way. The total ESS score is the sum of 8 item-scores and can range between 0 and 24.The higher the score, the higher the person's level of daytime sleepiness. Most people can answer the ESS, without assistance, in 2 or 3 minutes.

Applicant's Performance on ESS:

The applicant's score is 12. A total score of 10 or more suggests that he may need further evaluation by a physician to determine the cause of his excessive daytime sleepiness and whether he has an underlying sleep disorder.

DSM-5 DIAGNOSTIC IMPRESSION:

Major Depressive disorder, moderate
Post-traumatic Stress Disorder

GAF: 58 GAF Range: 51 - 60

GAF Ratings:

91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81 – 90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
71 – 80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or general functioning (e.g. temporarily falling behind in school work).
61 – 70	Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functions (e.g. occasional truancy, or theft within the household) but generally functioning pretty well, has some meaningful interpersonal relationships.
51 – 60	**Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or coworkers).**
41 – 50	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).
31 – 40	Some impairments in reality testing or communications (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relationship, judgment, thinking, or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant in home and is failing at school).
21 – 30	Behavior is *considerably* influenced by delusions or hallucinations OR serious impairments in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR

	inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends).
11 – 20	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent; manic excitement) OR occasionally fails to main minimal personal hygiene (e.g. smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).
1 – 10	Persistent dangerous of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

DISCUSSION:

Mr. George Soohoo is a 67 year-old married male who presents to my office today, October 11, 2021 for a Psychological Qualified Medical Evaluation. There was no interpreter required for this evaluation. The applicant's date of birth is November 28, 1953. There are two DOI's being alleged while employed at California Institute for Men. The first DOI is from 08/01/2015 to 07/06/2018. The second DOI was from 01/01/2015 to 06/10/2021. He is claiming that the alleged assault and subsequent and ongoing harassment that he suffered during those times have resulted in his psychiatric injuries. The applicant was unable to clarify the differences between the two DOI's.

The diagnoses for this claimant are thus Posttraumatic Stress Disorder and Major Depressive disorder, single episode, severe, without psychotic features. Each of the diagnoses will be addressed.

According to the Diagnostic and Statistical Manual of Mental Disorders – 5th edition – the criteria for Posttraumatic Stress Disorder (PTSD) are:

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma

Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g. first responders, medics)

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use, or other illness.

Two specifications:

- Dissociative Specification: In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
    - Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
    - Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").
- **Delayed Specification.** Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

With respect to the criteria of Posttraumatic stress disorder, the applicant directly experienced, allegedly, a physical assault by Mr. Escobar. This satisfies Criteria A. It appears that with respect to Criterion B (one required) the traumatic events are persistently re-experienced, in the following way(s): Unwanted upsetting memories, Nightmares, Flashbacks, Emotional distress after exposure to traumatic reminders and Physical reactivity after exposure to traumatic reminders. As for Criterion C (one required) he avoids trauma-related stimuli both with thoughts and feelings and avoids trauma related reminders. Criterion D requires negative thoughts or feelings beginning or worsened after the trauma. Mr. Soohoo experiences following way(s): Overly negative thoughts and assumptions about oneself or the world, decreased interest in activities, Feeling isolated, and some Difficulty experiencing positive affect. With respect to Criterion E (two required) he has irritability, hypervigilance, difficulty concentrating and difficulty sleeping issues that began or worsened after the trauma. His symptoms have lasted longer than one month, satisfying Criterion F. His symptoms have created distress and functional impairment in both his occupational and his social life satisfying Criterion G. As for Criterion H his symptoms are not due to medication, substance use, or other illness.

The results of the following psychological assessments will be discussed below as they also support the diagnosis of Posttraumatic Stress Disorder.

Mr. Soohoo had a BR score of 79 on the Posttraumatic Stress Disorder scale of the MCM-III. The MCMI-III Interpretive report stipulated the following:

This man appears to have experienced an event or events that may have involved physical threat or serious injury to which he responded with intense fear or horror. Although he is not characteristically fearful or anxious, the memory of this upsetting

experience appears to come back in intensive and distressing recollections. He avoids exposure to cues that resemble or symbolize aspects of the traumatic event. Where they cannot be avoided, as in recurring nightmares and flashbacks, he may feel terrified, exhibiting a variety of signs of intense anxiety. Anticipation of their recurrence may result in persistent anxious symptoms, such as difficulty in sleeping, exaggerated startle response, or a protective numbing and detachment.

This man is unaccustomed to experiences that characterize a generalized anxiety disorder, yet his MCMI-III responses indicate that he is undergoing this syndrome presently. In addition to physical indices such as a diffuse apprehensiveness, he may be subject to persistent bodily tension and muscular pains as well as undue perspiration or chest palpitations. Behavioral indices such as a sense of foreboding, feeling jumpy and on edge, and short periods of unexplained fatigue, if not exhaustion, are also possible. Most likely prompted by recent, unexpected failures and a sense perhaps of being a fraud underneath it all, his current state stems from an inability to have things go his way, a reversal of his usual success in manipulating events to his liking.

Also salient is his vigilantly guarded attitude. He maintains a wary hyperalertness in order to ward off anticipated deception and malice from others, leading him to resist all sources of external influence. Whether faced with danger or not, he maintains a fixed level of preparedness, an alert vigilance against the possibility of attack and derogation. He exhibits edgy tension, abrasive irritability, and an ever-present defensive stance from which he can spring into action at the slightest offense. His state of rigid control never seems to abate, and he rarely relaxes or lets down his guard.

His results on the PTSD Checklist - Civilian Version (PCL-C) supports the MCMI-III findings. The PCL is a 17-item self-report checklist of PTSD symptoms based closely on the DSM-IV criteria. Respondents rate each item from 1 ("not at all") to 5 ("extremely") to indicate the degree to which they have been bothered by that particular symptom over the past month. The applicant's score is 62 out of a total score of 85, which indicates a severe level of PTSD symptoms.

His responses on the PTSD Checklist are listed here:

Not at all – feeling emotionally numb or being unable to have loving feelings for those close to you.

A little bit – none.

Moderately – trouble remembering important parts of a stressful experience from the past, feeling irritable or having angry outburst, having difficulty concentrating.

Quite a bit – repeated, disturbing memories, thoughts or images of a stressful experience from the past, repeated, disturbing dreams of a stressful experience from the past, suddenly acting or feeling as if a stressful experience were happening again, feeling very upset when something reminded you of a stressful experience from the past, having physical reactions when something reminded you of a stressful experience from the past, avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it, avoid activities or situations because they remind you of a stressful experience from the past, loss of interest in things that you used to enjoy, feeling distant or cut off from other people, feeling as if your future will somehow be cut short, trouble falling or staying asleep, being super alert or watchful on guard, feeling jumpy or easily startled.

Extremely – none.

Assessments that address symptoms that are indicative of PTSD are those on the Beck Anxiety Inventory and the Brief Symptom Inventory. Both also show an elevation of anxiety symptoms being experienced by Mr. Soohoo.

The Beck Anxiety Inventory (BAI) is a 21-question multiple choice self-report inventory that is used for measuring the severity of an individual's anxiety. The questions ask about how the subject has been feeling in the last week, expressed as common symptoms of anxiety. It is designed for an age range of 17-80 years old. The BAI has a maximum score of 63. The applicant's score is 26, which is in the **"moderate"** category of anxiety.

The Brief Symptom Inventory (BSI) is a 53-item self-report symptom inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients as well as community non-patient respondents. It is essentially the brief form of the SCL-90-R. Each item of the BSI is rated on a five-point scale of distress (0-4), ranging from "not at all" (0) at one pole to "extremely" (4) at the other. Maximum score is 212. The applicant's score is 53 out of a total score of 212, which indicates a mild to moderate level of distress.

According to DSM-V the diagnostic criteria for a Major Depressive Episode stipulates:

The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

To receive a diagnosis of depression, these symptoms must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition.

Mr. Soohoo has experienced depressed mood every day for many months. He reports experiencing a depressed mood most of the day, nearly every day, markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, a significant decrease in appetite nearly every day, lethargy and reduced mental energy, and feelings of worthlessness about his inability to work and take care of the family nearly every day. These experiences have only existed since the DOI's.

The results of the following psychological assessments support the diagnosis of Major Depressive Disorder and will be reviewed below.

Mr. Soohoo had a BR score of 87 on the Major Depression scale of the MCM-III. The MCMI-III Interpretive report stipulated the following:

Episodes suggestive of a major depressive disorder appear to have overtaken this man. Although he is not psychologically disposed to permit himself to succumb to strong emotions or to expose his perceived weaknesses to others, he displays a variety of chronic symptoms (e.g., fatigue, inefficiency, inability to concentrate) that are perhaps due to the press of persistent troublesome events or to the impact of biological dysfunction. These symptoms are likely to be associated with feelings of worthlessness and guilt as a result of his need to maintain appearances and adhere to proprieties. Not inclined to exhibit either the colorless or withdrawn qualities seen in other depressives,

this man is prone to turn his strong emotions inward, claiming that he deserves the punishment he now suffers. He believes that such self-condemnatory comments will help deter the reproach he anticipates for his failures, transforming criticism and rebukes into expressions of support and understanding.

The results on his Beck Depression Inventory – II (BDI–II) also supports a diagnosis of Major Depressive Disorder. The BDI-II is used to assess the existence and severity of symptoms of depression in accordance with the criteria described in the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (DSM–IV). This new edition of the Beck Depression Inventory is the most widely used instrument for detecting depression. The applicant's score is 22, which is in the **"moderate"** category of depression. His responses to the questions are listed below:

Responses

I feel sad much of the time.
I feel more discouraged about my future than I used to be.
I do not feel like a failure.
I don't enjoy things as much as I used to.
I don't feel particularly guilty.
I don't feel I am being punished.
I have lost confidence in myself.
I don't criticize or blame myself more than usual.
I have thoughts of killing myself, but I would not carry them out.
I cry more than I used to.
I feel more restless or wound up than usual.
I am less interested in other people or things than before.
I find it more difficulty to make decisions than usual.
I do not feel I am worthless.
I don't have enough energy to do very much.
I wake up 1-2 hours early and can't get back to sleep.
I am more irritable than usual.
I have no appetite at all.
It's hard to keep my mind on anything for very long.
I am too tired or fatigued to do a lot of the things I used to do.
I have not noticed any recent change in my interest in sex.

The conclusion from all the information presented to this examiner is that the assault by Mr. Soohoo's superior, Mr. Escobar, at the restaurant, and the other incidents at his

employment which he perceives as being ongoing harassment by Mr. Escobar and his fellow employees at CIM were the predominant cause (51% or more) from all other sources combined contributing to the development of Mr. Soohoo's psychiatric condition's of Posttraumatic Stress Disorder and Major Depressive Disorder, moderate (pursuant to Labor Code Section 3208.3).

I believe that it is necessary to discuss this case in further detail, even though the conclusion is well substantiated. If it were not for the physical assault by Mr. Escobar on Mr. Soohoo the conclusion of this QME evaluation may have been different given the applicants pre-existing and non-industrial factors listed below. Several people, including other patrons at the restaurant, witnessed the assault according to Mr. Soohoo. Indeed, if his superior did indeed come to Mr. Soohoo, as the applicant stated he did in this evaluation, and said that he, Mr. Farooq, would assure that it (an assault) would never happen again, then an egregious act of negligence was committed by the supervisor. This act should never have been dismissed. It most likely led to the applicant believing that he was working in an unsafe environment with little to no support from his superiors or his colleagues.

On the other hand, Mr. Soohoo reported a long history of feeling discriminated against beginning in elementary school. He reports on-going bullying by his peers for many years, who were mostly Black and Hispanic. He also stated that he believes that he was discriminated against in his application to Stanford University. Furthermore, Mr. Soohoo was assaulted while in the military by fellow soldiers who believed that he was an Asian tourist. The assault was of a serious nature as he was hospitalized, and he later sought psychological treatment for Postraumatic Stress Disorder. The applicant admitted during this evaluation that the assault, and other events, such as the hand grenade going off close to him, that he witnessed while in the service, were traumatic and continue to cause symptoms of anxiety.

This evaluator believes that the Clinical Personality Patterns and Severe Personality Pathology scales of the MCMI-III needs to be addressed. The Grossman facet scales are designed to aid in the interpretation of elevations on the Clinical Personality Patterns and Severe Personality Pathology scales by helping to pinpoint the specific personality processes (e.g., self-image, interpersonal relations) that underlie overall scale elevations. The results presented in a previous section will be addressed. The applicant's scores suggest the following personality characteristics:

Most notable is his preoccupation with minor fantasies of success, beauty, or love, a somewhat undisciplined imagination that takes liberties with objective reality to assert and

reinforce his boastful self-image. He places few limits on his fantasies or rationalizations, and his imagination is left to run free of the constraints of reality or the views of others. He is cognitively inclined to exaggerate his power, to freely transform failures into successes, and to construct lengthy and intricate rationalizations that inflate his self-worth or justify what he feels is his due, quickly deprecating those who refuse to accept or enhance his superior self-image.

Also salient is his vigilantly guarded attitude. He maintains a wary hyperalertness in order to ward off anticipated deception and malice from others, leading him to resist all sources of external influence. Whether faced with danger or not, he maintains a fixed level of preparedness, an alert vigilance against the possibility of attack and derogation. He exhibits edgy tension, abrasive irritability, and an ever-present defensive stance from which he can spring into action at the slightest offense. His state of rigid control never seems to abate, and he rarely relaxes or lets down his guard.

Also worthy of attention are his suspiciousness regarding the motives of others and his tendency to misconstrue innocuous events as signifying proof of duplicity or conspiratorial intent. His learned feelings and attitudes have produced deep mistrust and pervasive suspiciousness of others. He is notoriously oversensitive and disposed to detect signs of trickery and deception everywhere. He is preoccupied with these thoughts, actively picking up minute cues, then magnifying and distorting them so as to confirm his worst expectations. To further complicate matters, events that fail to confirm his suspicions are evidence in his mind of just how deceitful and clever others can be.

The MCMI-III therefore is stating that the applicant has a characteristic interpersonal style of guardedness, suspiciousness etc. that is most likely a longstanding personality style. This "style" in conjunction with his developmental history, previous assault, and hearing loss are all factors, albeit less than a 49% cause, that have contributed to his current psychiatric conditions. This evaluator believes that the symptoms of the Posttraumatic Disorder are an aggravation of the severity of his pre-existing condition of PTSD. With respect to his Major Depressive Disorder diagnosis, this appears to be a new disorder that arose during, and was due to, the physical assault, harassment, write-up by Mr. Escobar, and accusations of verbal abuse and retaliation by others at CIM during the timeframe of the DOI's. He did not report ever experiencing or seeking treatment for depressive symptoms prior to the DOI's. The overwhelmingly deciding factors that supports this applicant's claim, in this applicant's opinion, is the physical assault and non-action by his superior that laid the groundwork for him to feel disrespected, minimized, and unsupported at CIM. Without that incident, and/or with the support of his superior

Mr. Farooq, he may have been able to emotionally manage the other incidents that he alleges occurred at his employment.

RELEVANT RESEARCH:

According to *The Link Between Depression and Physical Symptoms* (Primary Care Companion to the Journal of Clinical Psychiatry, February 2004), in general, the worse the painful physical symptoms, the more severe the depression. Physical symptoms have been found to increase the duration of depressed mood. In a study of chronic pain as a predictor of depressive morbidity in the general population, Ohayon and Schatzberg found that of the study participants who reported at least 1 key symptom of depression, those with a chronic painful physical condition reported a longer duration of depressed mood (19.0 months) than those without chronic pain (13.3 months).

According to *Incidence and Cost of Depression after Occupational Injury* (Journal of Occupational and Environmental Medicine, September 2012), occupational injury is a significant source of injury morbidity in the United States. It influences workers' psychological and physical well-being, which includes increasing their risk of suffering from depression-related illnesses. In this study, they examined whether injured workers were more likely to be treated for outpatient depression than their uninjured coworkers during the study period (3 months after occupational injury). The results clearly showed that injured workers were more likely than non-injured workers to suffer from depression during the study period.

This study adds to the literature suggesting that occupational injury may be followed by depressive episodes. Although more analysis should be done in this area to confirm this finding, including analyses conducted over longer follow-up periods; the occupational health community, employers, and others may reasonably anticipate that injured workers may need mental health services.

According to *Course, Diagnosis, and Treatment of Depressive Symptomatology in Workers Following a Workplace Injury: A Prospective Cohort Study* from (The Canadian Journal of Psychiatry August 2009), undetected depression is a well-known phenomenon in primary care. They found a similar pattern of under-diagnosis in their sample of injured workers. Low diagnosis rates may be attributed to several reasons. At the individual worker level, possible reasons include delayed help-seeking owing to poor self-awareness of depressive symptoms, unwillingness to disclose problems, concern over stigma, and possible fear of losing compensation benefits through symptom disclosure. Workers are also presumably more likely to consult their physicians for injury-related physical issues than for depressive symptoms. As such, they may discuss their physical and pain-related symptoms more openly than depressive symptoms. Non-detection of

depression may also be due to health care provider behavior, as a result of lack of knowledge and skills regarding assessment of mental health issues, preoccupation with the worker's physical health problems, and time demands of the provider's practice.

According to *Depression as a Psychosocial Consequence of Occupational Injury in the US Working Population: Findings from the Medical Expenditure Panel Survey* (BioMed Central Public Health, April 2013), after excluding subjects with previous depression and concurrent depression at baseline, and controlling for relevant covariates including comorbidity, disability, and sociodemographic factors, subjects injured at work showed higher odds of subsequent depression compared with those who had a non-occupational injury. One year after the injury, a worker who had experienced a workplace injury at baseline was 2.18 times more likely to be depressed than one who had no injury.

Furthermore, the differential effect increased as the time since injury increased; that is, the longer the time since the injury, the higher the risk of depression, if the injury was occupational. The increased risk of depression among workers with occupational injuries remained substantive after accounting for injury severity and number of treatment episodes. This finding implies that those injured at work may have an increased risk of subsequent depression compared with workers with non-occupational injuries. It may also reflect that the psychosocial aftermath of occupational injury is more complex than non-occupational injury and is probably related to the longer duration of treatment, lost earnings, and distress involved in litigation for workplace injury.

According to *Incidence of Depression, Anxiety and Stress Following Traumatic Injury: a Longitudinal Study* (Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine, March 2015), traumatic injury is responsible for 11% of global mortality and contributes to a significant amount of physical and psychological morbidity for all age groups. Patients with traumatic injury report a substantial reduction in health-related quality of life compared to other patients, including long-term psychological and physical disability. The psychological impact of injury includes the development of acute and long-term mental health problems such as post-traumatic stress, depression and anxiety.

Depression has been identified in up to 42% of injury survivors, from as early as 6 weeks to as long as 20 years post injury. Characteristic symptoms of depression include feelings of prolonged unhappiness, lethargy and a general lack of interest in the environment and self.

In this study, depression, anxiety and/or stress occurred following injury in a high proportion of patients during hospitalization (58.7%), and at 3 (40.2%) and 6 months following injury (23.9%). The severity of these symptoms ranged from mild to extremely severe.

The factor found to be primarily associated with the incidence of depression, anxiety and stress symptoms at three-month post injury in this study was an Intensive Care Unit admission. The factors associated with depression, anxiety and stress symptoms six months post injury were again, an Intensive Care Unit admission, and secondly, the reporting of depression, anxiety and/or stress symptoms in the moderate/severe/extremely severe categories at 3 months post injury.

Although ICU admission was a predictor of persistent depression, anxiety and stress symptoms, all patients admitted to hospital following injury should be screened as the majority of participants reporting moderate and above depression, anxiety and stress symptoms were not severely injured and may not have had an ICU admission. These findings are consistent with other literature describing the mental health outcomes in both the injured and non-injured population. The finding that a large proportion of participants had high depression, anxiety and stress scores at 3 months suggests routine longitudinal follow-up is needed and supports findings by Richmond et al., who showed that injured participants experience an increase in psychological distress at 3 months after discharge from hospital when compared to baseline findings.

According to *The Contribution of Supervisor Behavior to Employee Psychological Well-Being* (Work and Stress, July 2004), supervisor behavior made a statistically significant contribution to the prediction of psychiatric disturbance beyond a step-one variate comprised of age, health practices, support from other people at work, support from home, stressful life events, and stressful work events. This study provides additional evidence that supervisor behavior can affect employee well-being and suggests that those seeking to create healthier workplaces should not neglect supervision.

According to *Health and Well-being at Work: The Key Role of Supervisor Support* (SSM - Population Health, December 2017), being unable to count on the support of a direct supervisor in case of problems at work and even at home was shown to involve a substantially increased risk of poor health and work-related outcomes. Multiple sources of social support, and particularly supervisor support, seem to be important resources of health and well-being at work and need to be considered as key factors in workplace health promotion.

CAUSATION:

Based upon information gathered from the face-to-face interview of Mr. Soohoo, review of available records, and my analysis of the case, it is my opinion with a reasonable degree of medical certainty that the actual events of employment were the predominant cause (51% or more) from all other sources combined contributing to the aggravation of Mr. Soohoo's psychiatric condition of Posttraumatic Stress Disorder and development of

his Major Depressive Disorder, moderate (pursuant to Labor Code Section 3208.3). The personnel actions as described in the medical record dated 08/27/2018 as well as his description of those incidents at this evaluation were a substantial cause (35% to 40%) of the applicant's psychiatric injury. The applicant's psychiatric condition was predominantly AOE and COE. Other factors (pre-existing and non-industrial) also contributed but to a lesser extent.

DISABILITY:

The claimant, Mr. George Soohoo, is currently experiencing symptoms of moderate depression and posttraumatic stress disorder according to the psychological assessment results (MCMI-III, Beck Depression Inventory, Beck Anxiety Inventory, Brief Symptom Inventory) as well as by the assessment of his presentation during the clinical interview.

With respect to disability, it is my opinion the applicant became Temporarily Partially Disabled beginning sometime in August of 2015. He continued to work full time, however. The applicant states today that the date he last worked was on September 20, 2021. It appears then that he became Temporarily Totally Disabled on September 20, 2021 and has continued to be Temporarily Totally Disabled.

Permanent Disability

The applicant's psychiatric condition has not reached permanent and stationary status. He has not reached maximum medical improvement.

The applicant can be assessed for permanent disability after his condition reaches permanent and stationary status.

APPORTIONMENT:

The applicant's psychiatric condition is currently not permanent and stationary. He has not reached maximum medical improvement at this time. Formal apportionment analysis can be completed after his condition reaches permanent and stationary status, which is expected following the recommended treatment.

TREATMENT / FUTURE MEDICAL CARE:

The MCMI -III specifically addresses treatment for this individual. It states that as a first step, it would appear advisable to implement methods to ameliorate this patient's current

state of clinical anxiety, depressive hopelessness, or pathological personality functioning by the rapid implementation of supportive psychotherapeutic measures. With appropriate consultation, targeted psychopharmacologic medications may also be useful at this initial stage. Once this patient's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

It goes on to state that supportive and short-term therapy are the major initial vehicles for treating this patient. Several psychopharmacologic agents may be considered, with appropriate consultation, for alleviating tense feelings. Cognitive reorientation methods geared to reframing assumptions about himself and the expectations of others may be used gradually and with discretion. Care should be taken to accomplish the purposes of altering these dysfunctional beliefs, especially because this patient may grasp the point of these methods but only at an abstract or intellectual level. To rework the foundations of his lifestyle need not require long-term procedures. Rather, circumscribed, and focused approaches can offer significant personality reconstruction in a condensed and fruitful way.

In general, he is likely to regard therapy, either brief or extended, as a threat to his defensive armor. While it may be possible to readily relieve his symptoms, he may try to avoid self-exploration and self-awareness. His defensiveness is deeply protective and must be honored by the therapist; probing should proceed no faster than the patient can tolerate. Only after building trust and confidence in the therapeutic relationship can the therapist begin to bring cognitive and interpersonal methods into the open. For every piece of defensive armor removed, however, the therapist must attempt to bolster the patient's sense that the treatment process will be constructive and self-enhancing. To remove more defenses than the patient can handle should be avoided to prevent relapse. He may be sufficiently well-guarded and self-assured, however, to ignore or intellectualize distressing confrontations, but nonetheless, caution is the byword.

And finally, it states that this patient may not only be suspicious of therapy and psychology but may tend to denigrate sentimentality, intimate feelings, and tenderness. His narcissistic streak leads him to lack sympathy for the weak and oppressed. The therapist cannot allow the entire therapeutic enterprise to be hostage to his indifference. A directive cognitive approach may lead him to recognize that dealing with the softer emotions need not undermine the foundations of his interpersonal style or reactivate feelings that he has buried for years. His assumption that sympathy and tender feelings only distract and divert people from being correct and successful can be confronted cognitively.

Given the above recommendations this examiner recommends the applicant be referred to both a psychiatrist and a psychologist for ongoing psychiatric treatment. In order to pharmacotherapeutically manage his severe symptoms of anxiety and depression, treatment with a psychiatrist should be for no less than six months on an industrial basis. After this six-month period his psychiatrist should decide if further pharmacotherapy is required. With regards to the need for a psychologist, as stated above the applicant would like to see someone on an individual basis. He has utilized individual psychotherapy in the past for his service-related posttraumatic stress disorder and with respect to his symptoms related to this workers compensation claim. A trial of Eye Movement Desensitization Reprocessing (EMDR) should also be considered as it has been shown to be more affective with adult experienced traumas. EMDR can also be employed in conjunction with his individual psychotherapy. Considering the severity of his posttraumatic stress disorder symptoms, individual psychotherapy should be considered for at least one year. However, EMDR has been shown to be a successful treatment for trauma and so if it is employed as soon as possible in his treatment, maybe his symptoms can become more manageable, and he will not require long term individual psychotherapy.

PRE-EXISTING DISABILITY AND NON-INDUSTRIAL FACTORS

The following is a list of the pre-existing and non-industrial factors:

- Assault while in the military resulting in psychological treatment and a diagnosis of PTSD – 1989
- Exposure to soldier's traumatic injuries during his time in the service – 1986 - 2013
- Loss of sister from cancer - 1992
- Loss of mother – 2016
- kidney cancer diagnosis and surgery - 2019
- cancer metathesizing to lung - 2020

PROGNOSIS:

The prognosis for his psychiatric injuries is guarded even with appropriate aggressive treatment given the following: the chronicity of his current PTSD symptoms, his previous history of being diagnosed with PTSD, his serious medical condition which is adding to his psychiatric distress, and his lack of psychological insight. Considering his tendency to minimize his symptoms, he would need to be strongly encouraged to follow through with

his psychiatric treatment regimen. It is hoped that he realizes that he is at such a serious state that he will follow through on the referrals given to him.

The applicant would have serious difficulty, on a psychiatric basis, competing in the open labor market at this time. The applicant's physical injuries also seriously limit the range of job duties that he can perform at this time even if he were more psychologically stable.

VOCATIONAL REHABILITATION:

The applicant does not qualify for vocational rehabilitation.

REGARDING THE 8 CATEGORIES OF IMPAIRMENT, THE ASSESSMENT OF THE APPLICANT'S LEVEL OF IMPAIRMENT IS AS FOLLOWS:

1. Ability to comprehend and follow instructions: **moderate impairment** in the ability to maintain attention and concentration for necessary periods, and the ability to do work requiring setting limits and tolerances of standards.

2. Ability to perform simple and repetitive tasks: **mild to moderate impairment** in the ability to ask simple questions or request assistance, and the ability to perform activities of a routine nature.

3. Ability to maintain a work pace appropriate to a given workload: **moderate impairment** in the ability to perform activities within a schedule, maintain regular attendance, and be punctual, and the ability to complete a normal workday and/or workweek and perform at a consistent pace.

4. Ability to perform complex and variable tasks: **moderate impairment** in the ability to synthesize, coordinate, and analyze data, the ability to perform jobs requiring precise attainment of limits, and tolerances of standards, and the ability to perform a variety of duties often changing from one task to another of a different nature without loss of efficiency or composure.

5. Ability to relate to other people beyond giving and receiving instructions: **moderate impairment** in the ability to get along with co-workers or peers, the ability to perform work activities requiring negotiating with, explaining or persuading, and the ability to respond appropriately to evaluation or criticism.

6. Ability to influence people: **mild impairment** in the ability to convince or direct others, the ability to understand the meaning of words, and to use them appropriately and effectively, and in the ability to interact appropriately with people.

7. Ability to make generalizations, evaluations, or decisions without immediate supervision: **mild impairment** in the ability to make independent decisions or judgments, based on appropriate information, and the ability to set realistic goals or make plans independent of others.

8. Ability to accept and carryout responsibility for direction, control, and planning: **moderate impairment** in the ability to set realistic goals or make plans independent of others, the ability to negotiate with, instruct, or supervise people, and the ability to respond appropriately to changes in the work conditions.

This report is being made on the basis of the information provided and described above. If additional information becomes available which affects either the veracity or the accuracy of the data provided, all of the conclusions contained herein may be subject to revision. This concludes the Panel Qualified Medical Evaluation in Psychology of Mr. George Soohoo. Please contact me if you have any questions regarding this report.

DISCLOSURE:

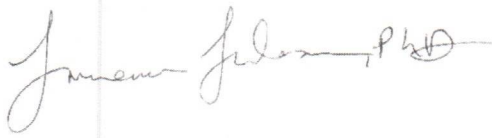
EData, Medical Historian, sorted, organized and excerpted the medical records. I, Dr. Lawrence Ledesma personally reviewed and annotated the available medical records. Report was prepared and edited by me, Dr. Ledesma. I, Dr. Ledesma, am an independent contractor of a medical group, Veritas Med-Legal. Veritas Med-Legal incurs expenses associated with QME office locations as well as other expenses on my behalf. As a result, part of reimbursement is being shared with Veritas Med-Legal. No amount has been charged in excess of the professional services and the reasonable cost of diagnostic testing, if any. I, Dr. Ledesma, do not have any financial interest in any diagnostic facility, laboratory, health facility or other physician to which this applicant has been or might be referred. The opinions herein stated are my own. I have attempted to address all the issues which normally arise in the course of Medical-Legal examination pursuant to the California Labor Code, and consistent with the time allowed in this report classification.

I declare under penalty of perjury that I have not violated Labor Code Section 139.3,

and that the information contained in this report and its attachments, including billing, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have 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 have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Date of Report: October 11, 2021

Dated the 6th day of November, 2021 in Orange County, California.



Signature of Physician
Lawrence Ledesma, Ph.D. PSY12355
Qualified Medical Evaluator
Clinical Psychology