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May 25, 2021

Subsequent Injures Benefit Trust Fund
Department of Industrial Relations
Division of Workers' Compensation
1750 Howe Avenue, Suite 370
Sacramento, California 95825-3367

Workers Defenders Law Group
8018 E. Santa Ana Canyon, Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

In Reference:	**Williams, Kevin**
Social Security #:	XXX-XX-5680
Date of Birth:	February 17, 1964
Dates of Injury:	CT: September 9, 2018- March 20, 2019
	CT: October 1, 2018- March 15, 2019
	SI: January 22, 2019
Employer:	Walmart Associates, Inc.
Occupation:	Receiving Clerk
WCAB	ADJ12524618, ADJ12524635; ADJ12743430
SIF Case No:	SIF12524618
Date of Examination:	May 5, 2021

Please do not release this report directly to the examinee. This psychological report is CONFIDENTIAL. Showing or allowing the claimant to read this report could be detrimental and psychologically harmful to this individual. Misunderstandings, misinterpretations, and severe emotional reactions are often encountered when this happens without the presence of a qualified and competent psychological expert Therefore, in the best interest of the claimant, with rare exceptions, it is advisable to discuss only pertinent findings with the applicant. Any emotional distress or violent reaction and other risk will be the responsibility of the person who allows the applicant to read or copy this report.

SUBSEQUENT INJURY BENEFITS TRUST FUND
PSYCHOLOGICAL ELIGIBILITY EVALUATION REPORT

To Whom It May Concern:

I conducted a psychological evaluation of Mr. Williams at the request of Workers Defenders Law Group to help determine whether or not Mr. Williams qualifies for benefits from the Subsequent Injuries Benefits Trust Fund. Specifically, Workers Defenders Law Group requested that I evaluate any pre-existing psychological disability and any psychological disability following his subsequent injuries.

Before the examination, Mr. Williams was admonished that confidentiality and privilege normally extended to the psychologist-examinee relationship were waived for the purposes of this evaluation. Mr. Williams was also informed that a copy of my findings would be sent to the Subsequent Injuries Benefits Trust Fund, his legal counsel and to the referring physician. Mr. Williams indicated understanding and agreed to proceed. It is my opinion that he appeared competent to consent to this evaluation.

As per the Opinion and Decisions of *Susan Meyers vs. Council on Aging* (Case No. ADJ3374876/SJO0268303) " ... the parties may either agree to use a specified examiner like an AME, or they may each obtain an evaluation and reporting from a qualified physician like a QME. ***Any qualified physician who reasonably reports on the SIBTF claim is entitled to receive a reasonable fee to be paid by the SIBTF pursuant to section 4753.5 and in accordance with the official medical-legal fee schedule.***" (***Emphasis added***). This examination is being billed as an ML-201-96, Comprehensive Medical-legal Evaluation:

- ✓ Two hours or more of face to face
- ✓ A psychiatric or psychological evaluation, which is the primary focus of the medical-legal evaluation.

The psychological evaluation involved lengthy and detailed history, clinical examination, mental status, review of psychometric findings, and report preparation. All aspects of the evaluation except clerical and transcription duties were performed by myself. Psychological testing was administered and scored in the office and interpreted by myself. All opinions expressed herein are those of the undersigned. Verification under penalty of perjury of the total time spent in each of these activities:

Face to face time	2 hours	30 minutes
Psychometric testing*	1 hour	00 minutes

MLPRR - In addition, I declare under penalty of perjury that have received and personally reviewed 636 pages of medical records which included a declaration however the attestation indicated 606 pages.

*Total Time spent for psychological testing, billed as CPT code 96101, includes face-to-face administration time, scoring, and interpretation.

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PRE-EXISTING DISABILITY HISTORY

In order to adhere to the required format of an SIBTF medical-legal report I have demarcated the specific issues unique to this case. I have separated from the subsequent injuries all the prior industrial injuries and pre-existing conditions and disorders that were present before the subsequent injuries of CT: September 9, 2018- March 20, 2019, CT: October 1, 2018- March 15, 2019, and SI: January 22, 2019.
The following sections of this report will address the pre-existing disabilities, pre-existing labor disablement, and pre-existing work restrictions. Below is a narrative of Mr. Williams's disability history prior to the date of his subsequent work injury.

Identifying Information:

Mr. Williams is a 57-year-old married African-American male who is currently "disabled" and has been receiving disability benefits since June 2019, which is his current source of income. Interpreting service was not provided, as Mr. Williams was English speaking. Mr. Williams's employment duties as a Receiving Clerk included receiving and scanning products into the system to sending to the appropriate department. He was on a committee for liens, making products more accessible, such as making items more visible.

History of Childhood Events:

Mr. Williams was born and raised in Hollywood, California at Kaiser Sunset Medical Center. He was raised by both parents until the age of 16 when his parents divorced and then he lived with his mother. His father worked in the parts division of General Motors and his mother worked at Northrop Aircraft. He has four brothers and one sister. Mr. Williams was the youngest, 6th child.

He described his childhood as "sad." He reported there was too much arguing and fighting in his family and that violence took place. His father drank "too much" and was abusive to his mother. His father was not abusive to him or his siblings. He was in excellent health as a child. He denied ever having any physical or sexual abuse during his childhood. He was verbally abused by his father from ages of 12-16.

His childhood experiences still affect him and he "stays to himself." He did not trust people and would anger easily. His childhood experiences affected his ability to work including interacting with his coworkers. He "snapped" at coworkers. In 1998, he was fired from Vons for fighting with an associate. He was sensitive to managers' criticizing him, but he was able to follow directions from managers. He just had problems with his subordinates. He was suspended from Walmart twice, but he was exonerated both times due to false allegations.

Mr. Williams first experienced emotional difficulties in his life when he was 16 years old. He was sad and embarrassed, because the police would come to the house frequently due to his dad "beating and choking" his mom. The police also came to the house, because his dad pulled a gun on his brother. His dad was a "functional alcoholic." He worked, but then he drank on the weekends.

Academic History:

Educationally, Mr. Williams reported doing adequately in school completing up to 12th grade. He graduated from high school in 1981. He denied ever having any history of learning disabilities and was never involved in special educational classes. Behaviorally, he was expelled from school in the 10th grade for fighting and missing classes. He was suspended from school in the 11th and 12th grade for fighting. He attended Chaffey College and received a certificate in Information and Technology. He attended Wilmington University online and is in the process of getting a degree in Applied Technology.

Military Service:

The examinee never served in the armed forces.

Relationship History (before and after subsequent injuries):

Mr. Williams had three serious relationships in his lifetime. He had been married for four years. Before the subsequent injuries, he was happy in his relationship with his wife. After the subsequent injuries, he is still happy in his relationship with his wife. He has one child, a daughter age 25.

Mr. Williams resides in Chino Hills, California. During today's evaluation, I inquired the examinee if there were any coexisting family stressors that could be contributing to his presenting psychological complaints and he denied this to be the case.

Work History:

Prior to the subsequent injuries, Mr. Williams worked for the following employers:

Employer	Date Started	Date Left	Position Held	Reason for Leaving
Federal Express	07/2014	08/2015	Parcel Sorter	Advancement
Coastal Pacific	04/2007	09/2008	Outbound Picker	Terminated
Whole Foods	05/2004	06/2008	Driver	Advancement
Dedicated Management	04/2003	05/2004	Assistant Manager	Went out of business
Vons Grocery	05/1985	09/1998	Order Selector	Terminated

The examinee represented he had a fairly stable work history. He has worked for approximately six different companies in his career. He was terminated for cause from Coastal Pacific and Vons Grocery for fighting with coworkers/associates. He collected unemployment benefits (E.D.D.) after he was fired from Coastal Pacific and Vons Grocery. Prior to this workers' compensation claim, he has never received disability benefits.

Medical History (before and after subsequent injuries):

Mr. Williams denied ever having any medical conditions before the subsequent injuries, except for having to wear eyeglasses since age 50 and being diagnosed with high cholesterol three years ago. There is no history of an involvement in a serious automobile accident requiring emergency treatment. To the best of his knowledge, he has never sustained a head injury. Before to the subsequent injuries, he had no hospitalizations or surgeries. Before the subsequent injuries, he has never been medically disabled and had no prior non-work related injuries.

Prior to the current industrial injuries, the examinee indicated he was in reasonably good health. He did not use sick leave excessively during his employment.
After the subsequent injuries, he had not developed any medical problems.

According to the medical record of Patient Message by Dr. Jeffrey C. Petrilla, M.D. dated 04/24/08, Mr. Williams was unable to work on 04/14/08 and 04/15/08 due to illness.

According to the medical record of Progress Note by Dr. Ernesto U. Campos, D.O. at Kaiser dated 04/28/08, the examinee had subacute left (L) sided low back pain (LBP) for two weeks associated with some slight numbness on the L side. He hurt his back with twisting motion while working on his car. He was unable to take higher doses of medication due to having one kidney. He was born with three kidneys and two were surgically removed.

According to the medical record of Progress Note by Dr. Diana J. Lee, O.D. at Kaiser dated 08/14/17, Mr. Williams had decreased vision distance. He was employed as a Warehouseman for

two yrs. Diagnoses (Dx): 1) Bilateral (B/L) incipient cataract. 2) Presbyopia. 3) B/L myopia. 4) B/L astigmatism.

According to the medical record of Progress Note by Dr. Christopher B. Yan, M.D dated 01/11/18, the examinee had occasional urinary frequency and erectile dysfunction.

According to the medical record of ED Report by Dr. Teri L. Vieth, M.D. at Kaiser dated 09/14/18, the examinee was diagnosed with: 1) Small bowel obstruction. 2) Upper abdominal pain. 3) Vomiting. 4) Abdominal distention.

According to the medical record of CT of Abdomen & Pelvis by Dr. Jerome Tsai, M.D. at Kaiser dated 09/15/18, Mr. Williams was suggested to have mild fatty liver.

According to the medical record of Progress Note by Dr. Ameerah A. Shaban, M.D. at Kaiser dated 08/22/19, he presented with constant B/L ankle swelling. Dx: 1) Swelling of B/L legs. 2) Unhealthy drinking behavior. 3)Abnormal increased body weight. 4) History of nephrectomy. 5) Hyperlipidemia.

According to the medical record of Patient Message by Dr. Christopher B. Yan, M.D. dated 03/04/21, Mr. Williams was having personal and financial problems, therefore, he had to cancel his appointment. He was not working, because of cutbacks. He reported his urine stream slowed down or sometimes even stopped.

According to the medical record of TAV by Dr. Kent K. Miyamoto, M.D. at Kaiser dated 03/25/21, Mr. Williams underwent nephrectomy at age 5, possibly related to infection or nonfunction.

Current Medications:	Dosage	Frequency	Date Began
Cholesterol medication	One pill	1 x a day	3 years ago

Mr. Williams denied having any side effects from his medications.

Medical/Psychological Conditions and Incidences (before subsequent injuries)

Childhood years:	Arguments, fighting, and domestic violence in the family
Ages 12-16:	Verbally abused by his alcoholic father
10th grade:	Expelled for fighting
11th and 12th grades:	Suspended for fighting
Age 16:	Parents divorced
1998:	Snapped at colleagues and fired from Vons for fighting with coworker
2000:	Arrested on a bench warrant and spent three months in jail
2001:	Attended a 6-month drug treatment program at Salvation Army for methamphetamine use
2001:	Methamphetamine use affected his ability to care for his daughter
08/08/2008:	His niece whom he was very close to was murdered

2008:	He was terminated from Coastal Pacific in September 2008 for fighting
2014:	Began wearing prescription glasses at age 50
2018	High cholesterol
2018:	Suspended from Walmart twice due to false allegations
2018:	Diagnosed with high cholesterol
January 2018:	Urinary frequency and erectile dysfunction

Medical/Psychological Conditions and Incidences (during and after subsequent injuries)

09/14/2018:	Diagnosed with small bowel obstruction, upper abdominal pain, vomiting, and abdominal distention
09/15/2018:	Mild fatty liver
08/22/2019:	Constant bilateral ankle swelling and abnormal increased body weight
2020:	Death of mother
December 2020:	Death of sister-in-law related to COVID-19
03/04/2021:	He was having personal and financial problems. Urine stream slowed down and stopped sometimes.

Surgery (before subsequent injuries)

Age 5:	Underwent nephrectomy

Surgery (after subsequent injuries)
None

Mental Health History (before and after subsequent injuries):

Mr. Williams had never been psychiatrically hospitalized. Before the subsequent injuries, he never experienced psychological problems, received psychological counseling, or received medication designed to relieve emotional symptoms. He denied a history of suicidal gestures or suicide attempts before or after the subsequent injuries. He had not received psychological/psychiatric treatment for the subsequent injuries. He denied ever having any instances of auditory or visual hallucinations. There was no reported family history of mental illness.
According to the medical record of Psychological Testing Report by Dr. Nelson J. Flores, Ph.D. at Psychological Assessment Services dated 11/12/19, the examinee reported variety of symptoms indicating depression, anxiety, sleep difficulties, sexual difficulties, memory problems, attention span deficits, gastrointestinal disturbances, and physical complaints. His mood was anxious and sad during testing. He reported minimal clinical levels of anxiety and severe levels of depression. Test data suggested his intellectual functioning appeared to be impacted by his set of symptoms.

Current Psychological Symptoms:

Mr. Williams feels sad or depressed at this time, because he is not working and is mad at Walmart. He had a depressed mood most of each day for the past two weeks, because he kept thinking, "Why they lied on me and Walmart never showed me the video of choking that lady?"

He was angry and wrote a statement about his anger as follows:

"Angrily fighting for custody of my daughter, it took me nearly two years to finally obtain custody. Having trouble finding a job, my niece was murdered after only six months of marriage and was just admitted to medical school. (https://criminaldiscoursepodcast.com/jan-pietrzak/). She was my sister only child, lost my mom just recently. At Walmart was given a task that I normally do not do, is how I hurt my back then months later, they terminated me for choking a White female employee, which I did not do. Never called the police nor did they send her to the clinic. Said they had it on video, but I was never allowed to view the video. Been unemployed since, not able to find another job. Unemployment has been a nightmare, for three months did not receive any benefits. Just recently started getting my benefits. Lost my sister-in-law to COVID 19. Just last week, my EDD visa card was hacked for $920.00, very angry, and have no patience. Along with back pain, shoulder, pain behind my legs, and my fingers hurt."

He had not had a decreased interest in most activities most of each day for the past two weeks. He noted he used to play golf, but cannot due to back pain and COVID-19. He had feelings of worthlessness or low self-esteem for most of each day for the past two weeks due to being dependent on unemployment, stating, "I got hacked for $920.00." Over the past three months his level of depression had stayed the same. He had a significant weight change or change in appetite and had gained 40 pounds since the subsequent injuries. He ate more, because he was not working.

He feels anxious and worried at this time. He experienced excessive worry or anxiety more days than not for the last six months. He worries about his bills and unemployment. He has experienced feeling restless more days than not for the last six months. He stated, "Hard to sleep or get comfortable." He has experienced anxiety causing irritability more days than not for the last six months.

Substance Abuse History (before and after subsequent injuries):

Before the subsequent injuries, Mr. Williams drank three beers a day. After the subsequent injuries, he currently drinks three beers a day. Before and after the subsequent injuries, he did not smoke cigarettes. Before and after the subsequent injuries, he did not use marijuana. He denied misusing prescriptive medications in the recent or remote past. Before the subsequent injuries 20 years ago, he used methamphetamine for two years. He attended a 6-month program at the Salvation Army for his methamphetamine use and he had been sober for 20 years.

He reported his methamphetamine use 20 years ago did not affect his work. However, it affected his ability to care for his daughter when she was 5 years old. After he got sober, he fought for custody and finally won custody after two years of fighting for custody.

Legal History:

In early 2000, he was arrested on a bench warrant for unpaid citations and spent three months in a county jail. From a civil perspective, the examinee denied ever being involved in a lawsuit—whether it be as a plaintiff or as a defendant. Prior to this current workers' compensation claim, he stated he has never received disability benefits.

History of Crisis or Abuse:

Between the ages of 12 and 16, the examinee was subjected to verbal abuse by his alcoholic father. As an adult, the examinee denied ever experiencing anything shocking or traumatic. As an adult, he denied ever being exposed to domestic violence or suffering from serious emotional abuse or neglect. As an adult, the examinee denied ever being the victim of an assault (i.e. whether it be physical or sexual). There is no record of the examinee ever being exposed to a natural disaster (e.g., fire, hurricane, etc.) that could have resulted in the development of a posttraumatic stress condition.

The examinee had experienced the deaths of close family members. His niece was murdered when Mr. Williams was 40 years old. His niece, his sister's only child, was murdered on August 8, 2008. His niece got married six months prior to her death and she had been accepted to medical school. His niece and her husband were duct-taped, and his niece was sexually assaulted. Both his niece and her husband were shot execution style in the head and killed by Black marines. He was very angry/mad about his niece's death. He was very close with his niece and she helped him raise his daughter. He just lost his mom recently and his sister-in-law died from COVID-19 in December 2020.

BEFORE the LAST Work Injury (also known as Subsequent Injury), Mr. Williams did not have difficulty in any areas of functioning; such as self-care, communication, physical activity, sensory function, household activity, travel, sexual function, and sleep function.

Self-care and Personal Hygiene BEFORE the Subsequent Injury		✓	**No Difficulties**
	Urinating		Trimming toe nails
	Defecating		Dressing
	Wiping after defecating		Putting on socks, shoes, and pants
	Brushing teeth with spine bent forward		Putting on shirt/blouse
	Bathing		Combing hair
	Washing hair		Eating
	Washing back		Drinking
	Washing feet/toes		Shopping
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Communication BEFORE the Subsequent Injury		✓	**No Difficulties**
	Speaking/talking		Writing
	Hearing		Texting
	Seeing		Keyboarding
	Reading (including learning problems, vision, or attention deficits)		Using a mouse

	Using a phone		Typing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Physical Activity BEFORE the Subsequent Injury		✓	**No Difficulties**
	Walking		Sitting
	Standing		Kneeling
	Pulling		Climbing stairs or ladders
	Squatting		Shoulder level or overhead work
	Bending or twisting at the waist		Lifting and carrying
	Bending or twisting at the neck		Using the right or left hand
	Balancing		Using the right or left foot
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Sensory Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Smelling		Feeling
	Hearing		Tasting
	Seeing		Swallowing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Household Activity BEFORE the Subsequent Injury		✓	**No Difficulties**
	Chopping or cutting food		Mopping or sweeping
	Opening jars		Vacuuming
	Cooking		Yard work
	Washing and putting dishes away		Dusting
	Opening doors		Making beds
	Scrubbing		Doing the laundry
	Repetitive use of the right hand		Repetitive use of the left hand
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Travel BEFORE the Subsequent Injury		✓	**No Difficulties**
	Riding as a passenger	If you have trouble sitting, approximately how long can you remain seated at a time?	
	Driving	If you have trouble driving,	

		approximately how long can you drive before needing to rest?	
	Handling/lifting luggage	Approximately how many times per year do you travel BEFORE the Subsequent Injury?	
	Keeping arms elevated (right)		Holding or squeezing the steering wheel
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Sexual Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Erection		Painful sex (in the genital area)
	Orgasm		Back pain with intimate relations
	Lubrication		Neck pain with intimate relations
	Lack of desire		Joint pain with intimate relations
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Sleep Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Falling asleep		Sleeping on the right side
	Staying asleep		Sleeping on the left side
	Interrupted/restless sleep		Sleeping on the back
	Sleeping too much		Sleeping on the stomach
	Daytime fatigue or sleepiness	Did you ever taken any medications to help you sleep BEFORE the Subsequent Injury?	
How many hours could you typically sleep at a time without waking up during the night?		How many hours total were you able to sleep at night?	
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Description of Pre-Existing Injury(ies):

Childhood years: Arguments, fighting, and domestic violence in the family
Ages 12-16: Verbally abused by his alcoholic father
10th grade: Expelled for fighting
11th and 12th grades: Suspended for fighting

Age 16: Parents divorced
1998: Snapped at colleagues and fired from Vons for fighting with coworker

2000:	Arrested on a bench warrant and spent three months in jail
2001:	Attended a 6-month drug treatment program at Salvation Army for methamphetamine use
2001:	Methamphetamine use affected his ability to care for his daughter
08/08/2008:	His niece whom he was very close to was murdered
2008:	He was terminated from Coastal Pacific in September 2008 for fighting
2014:	Began wearing prescription glasses at age 50
2018	High cholesterol
2018:	Suspended from Walmart twice due to false allegations
2018:	Diagnosed with high cholesterol
January 2018:	Urinary frequency and erectile dysfunction

Periods of TTD from Pre-Existing:
None

Pre-existing Psych Symptoms:
Child verbal abuse
Academic problem
Occupational problem
Grief
Methamphetamine use

PRE-EXISTING PSYCHIATRIC DIAGNOSES

AXIS I: **EPISODE OF MENTAL/CLINICAL DISORDER**
Parent-Child Relational Problem (V61.20)
Academic Problem (V62.3)
Occupational Problem (V62.2)
Bereavement (V62.82)
Amphetamine Dependence (304.40)

AXIS II: **PERSONALITY DISORDER**
No Diagnosis (V71.09)

AXIS III: **PHYSICAL DISORDERS AND CONDITIONS**
Status per the review of the medical records above.

AXIS IV: **SEVERITY OF PSYCHOSOCIAL STRESSORS**
Severe

(1) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

(2) Non-Industrial and concurrent stressful issues were identified and these include: Verbal abuse by father, school suspensions and expulsion, death of his niece, methamphetamine use, and incarceration for three months.

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - 50

Please Note: Use of the DSM IV-TR is provided in the above instance as the DSM-5 no longer provides a GAF score, which is necessary in an evaluation of this nature.

DISCUSSION OF PRE-EXISTING DISABILITY RATING

Mr. Williams experienced grief, anger, drug use, and impairment of his functional abilities. I conclude Mr. Williams experienced severe work limiting impairments on a psychological basis prior to the subsequent industrial injuries. The following issues contributed to his pre-existing psychological disability:

Mr. Williams has been experiencing problems with academia, getting along with colleagues, drug use, incarceration, and grief. He was suspended and expelled in high school for fighting. He has gotten into several fights with previous colleagues in which he was terminated from his employers. His methamphetamine use caused him to lose custody of his then 5-year-old daughter in which he had to attend a drug rehab program for six months. He was incarcerated for three months due to a bench warrant. He grieved over his niece's death, which made him very angry and act out his anger at work.

Based on this clinical picture and the impact on his functioning, it is my opinion that Mr. Williams met criteria for Parent-Child Relational Problem, Academic Problem, Occupational Problem, Bereavement, and Amphetamine Dependence. Additionally, his GAF score was 50 - which is equivalent to a WPI of 30%. This GAF falls into the 41-50 decile, which is described by the 2004 Permanent Disability Rating Schedule as follows:

This GAF falls into the 41 – 50 decile, which is described by the 2004 Permanent Disability Rating Schedule as follows:

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, cannot work).

It is also my opinion that these disorders significantly impacted Mr. Williams's occupational functioning causing pre-existing labor disablement, evidenced by his multiple work terminations relating to physical fights with his colleagues, inability to get along with his colleagues due to his anger issue, inability to work due to a three-month incarceration, inability to take care of his daughter regarding drug use, and grief over his niece resulting in him to anger easily at work. Mr. Williams's symptoms had reached a plateau and he was

able to work for other companies for a brief period before he became industrially injured in spite of his psychological impairment. Thus, these psychological diagnoses were permanent and stationary prior to his subsequent industrial injuries of CT: September 9, 2018- March 20, 2019, CT: October 1, 2018- March 15, 2019, and SI: January 22, 2019. Consequently, the following actual psychological work restrictions existed prior to the subsequent injuries:

- **Due to his symptoms of grief, anger, and legal troubles, Mr. Williams required a flexible work schedule to accommodate his need for weekly psychotherapy sessions and monthly psychiatric consultations.**
- **An understanding supervisory to provide feedback to Mr. Williams in a sensitive manner due to his fragile self-esteem and anger.**
- **Promoting as much predictability as possible in the employee's daily tasks.**
- **Providing clear guidelines and instructions, possibly in writing.**
- **Allowing for flexibility with regard to pace of work and timing of breaks.**
- **Working as part of a team to decrease the employee's anger and inability to get along with colleagues.**
- **Avoiding excessive work hours, overtime, and insisting on Mr. Williams taking normal breaks and a lunch.**
- **No assignment of excessive job pressures such as multiple, frequent deadlines, or frequently working with difficult people.**

These actual pre-existing restrictions provide evidence of Mr. Williams's actual labor disablement that was present prior to his subsequent industrial injury.

SUBSEQUENT INDUSTRIAL INJURY

History of Subsequent Injury:

What follows is a narrative of Mr. Williams's subsequent injuries, the resulting psychiatric disability, and existing work restrictions. Mr. Williams worked at Walmart beginning in August 2015 and last worked on April 11, 2019. He injured himself on CT: September 9, 2018- March 20, 2019, CT: October 1, 2018 - March 15, 2019, and SI: January 22, 2019 while employed as a Receiving Clerk. He injured his back, neck, and shoulders. He reported the following:

CT: September 9, 2018- March 20, 2019

According to the medical record of Application for Adjudication dated 09/09/19 with date of injury (DOI): CT 09/09/18 - 03/20/19, Mr. Williams sustained stress and strain due to repetitive movement over a period of time and due to lifting heavy boxes. He injured his lower back, neck, shoulders, upper extremities, and lower extremities. At the time he was employed at Wal-Mart Associates, Inc. as a Record Processor.

CT: October 1, 2018 - March 15, 2019

He reported, "A lot of people made accusations due to jealousy, because I was promoted. I was accused two times. There were rumors that I was going to attack a manager and they suspended me. They moved me to receiving. I was best friends with the manager. The other accusation was me making comments about some girl's butt. I did not do any of these."

According to the medical record of Application for Adjudication dated 09/09/19 with DOI: CT 10/01/18-03/15/19, the examinee sustained stress due to a hostile work environment, and racial and sexual harassment. He was employed for Wal-Mart Associates, Inc. as a Record Processor at the time.

SI: November 2018: He stated his subsequent injuries happened as a result of performing a repetitive movement over the "matter of a week."

"I was told to do a job that I do not normally perform. I was asked to perform palletizing, which was not my normal job, where I had to take product from the belt, lift it off, then place onto a wood pallet, then wrap the pallet. After a few days I told the manager my back was hurting. He said that I was faking, because I did not want to do the job. He then made me work there daily. After a few more days of working in palletizing, I was bending over to wrap a pallet and got sharp pain in my back. Then I asked to go to a clinic and was on light duty until February 2019. A month later I was terminated after I was accused of choking a White female employee, which I did not do. They never called the police nor did they send her to the clinic. They said they had it on video, but I was never allowed to view the video."

[Author's comment: *It appears the November 2018 specific incident was a one-time injury that was not a subsequent injury, but a prior injury*].

SI: January 22, 2019

[Author's comment: *Mr. Williams could not recall the exact date the incident he was accused of, but he believes it was on January 22, 2019 that he was accused of choking a White female colleague, in which he denied ever laying his hands on. This examiner could not find this industrial incident in the medical records*].

His work duties and responsibilities changed after the subsequent injuries. The work was modified to light duty. Mr. Williams did not receive positive feedback at Walmart before the subsequent injuries occurred. After the subsequent injuries, he received "nothing but negative feedback."

Before the subsequent injuries, he worked 10 hours per day, 4 days per week, and made $800.00 per week. He no longer works for the company and is no longer employed with the company. He is not currently working for any employer. He received EDD benefits from Unemployment Insurance for these industrial injuries.

Mr. Williams has frequent pain in his neck, shoulders, hands, and back. The pain in his neck, shoulders, hands, and back are all at a pain level of 8 (on a scale of 0-10, 10 being the most severe pain). The pain in his back travels to the back of his thighs.

Treatment for his subsequent injuries consisted of physical therapy and a back brace, which had been helpful to a point. He had not received surgery for these injuries.

Mr. Williams reported the onset of depressive symptoms from these injuries which began in 2019. He reported he felt depressed:

"Because my mom just passed away, as I didn't ever get my name to clear about choking the girl, not able to work, niece's death, etc."

ACTIVITIES OF DAILY LIVING CHECKLIST

SELF-CARE/PERSONAL HYGIENE

Mr. Williams often has problems sleeping at night, because he cannot stop thinking or worrying. He sometimes does not feel rested in the morning and often feels sleepy during the daytime. He sometimes lacks the desire to have sexual relations. He sometimes is physically unable to have sexual relations.

HOUSEHOLD ACTIVITIES

He denies having a problem in this area.

SOCIAL FUNCTIONING

He denies having a problem in this area.

FAMILY AND SOCIAL ACTIVITIES

He sometimes spends many days in his room and has no interest in talking to others. He often does not get along well with others. He sometimes does not want to initiate social contact with friends and family. He sometimes does not accept criticism appropriate from others.

RECREATIONAL ACTIVITIES

He sometimes has no interest in attending social gatherings, meetings, or church events. He sometimes cannot muster the energy or concentration to play board games, cards, or video games.

MEDICAL ACTIVITIES

He sometimes forgets to take his medications. He sometimes has no energy to do home-based physical therapy exercises. He sometimes loses important papers given to him by doctors or the insurance company.

MANAGING FINANCES AND PERSONAL ITEMS

He sometimes loses his wallet, keys or cell phone, or forget where he parked his car. He sometimes misplaces important financial papers or documents.

ADAPTIVE FUNCTIONING

He denies having a problem in this area.

COMMUNICATION ACTIVITIES

He often starts to fall asleep if he reads something for more than a few minutes. He often loses interest when watching television and stops watching the show. He sometimes loses interest in communicating with others by email, text, or phone. He sometimes loses interest in reading the newspaper or watching the news on TV. He sometimes does not attend normal events and communicating activities (e.g. church, social clubs, volunteer events, visiting relatives, etc.).

EMOTIONAL AND OCCUPATIONAL FUNCTIONS

He agrees he would not be able to interact with coworkers or supervisors appropriately because of his emotions. He agrees he does not have the psychological energy to multi-task. He strongly agrees he is hypersensitive to environmental factors (e.g., noise, delays, disappointments, setbacks, etc.) and responds in anger when these occur. He strongly agrees he has difficulty controlling his emotions and this causes problems when he interacted with people.

STRESS TOLERANCE

He denies having a problem in this area.

MENTAL STATUS EVALUATION

General Appearance
Mr. Williams is a 57-year-old married African-American male who is 6'2" tall and weighs 220 or 240 pounds. He appeared to look his stated age and presented with acceptable personal hygiene. He was dressed casual in a white T-shirt, green sweatpants, and was wearing a face mask.

Manner of Relating
Mr. Williams related in reasonably open, self-disclosing fashion and generally waited for me to ask questions rather than talk about his issues freely. He demonstrated no difficulty maintaining

eye contact. I did not sense any sign of defensiveness or evasiveness. He was amiable and amenable to answering all of my questions. He cried when talking about his niece. Otherwise, he was calm and cooperative with the evaluation process and completed the psychosocial questionnaires with relevant detail.

Psychomotor Activities
His movements were noted to be **fluid,** as he seemed to have **no difficulty in walking** from the waiting room to my office. I did not observe him to have any difficulty sitting down into a chair at the beginning of the interview or rising from the chair at the end of our session.

Speech and Language
Mr. Williams spoke at a middle range volume; his speech rate was normal, with normal articulation. The examinee was lucid and linguistically coherent. His ability to communicate was normal and his use of vocabulary and pronunciation was adequate given his level of experience and education. Slang or profanity was not used in conversation.

Orientation and Cognition
Mr. Williams appeared to be functioning at an average intellectual level, with a fund of knowledge appropriate for his age, educational level, and life experiences. He showed appropriate judgment and average abstract reasoning. Orientation in all spheres was intact. Ability to concentrate was impaired. Long-term memory was intact. His short-term memory was impaired.

Thought Content and Processes
Mr. Williams denied ever having auditory or visual hallucinations, bizarre sensory experiences, heightened tactile sensitivities, or other gross perceptual disturbances. His thought processes did not show any signs of psychotic functioning. He did not express any paranoia, ideas of references, or admits to any delusionary beliefs. In general, he seemed rational and coherent, with no perceptual oddities observed.

Emotional Process
His emotional expression was most noteworthy for his tearful affect indicative of his underlying depressed state.

Impulse Control
Mr. Williams **denied** the presence of any **suicidal ideations**-whether they are passive or active in nature. He also showed no propensity towards aggressive behavior. He comes to have **adequate self-control.**

PSYCHOLOGICAL TESTS ADMINISTERED AND RESULTS

- Beck Depression Inventory-II (BDI-II)
- Beck Anxiety Inventory (BAI)
- Epworth Sleepiness Scale (ESS)

- Hamilton Rating Scale for Depression (HAM-D)
- Hamilton Anxiety Rating Scale (HAM-A)
- Montreal Cognitive Assessment (MOCA)
- Fear Avoidance Beliefs Questionnaire (FABQ)
- Modified Somatic Perceptions Questionnaire (MSPQ)
- Pain Catastrophizing Scale (PCS)
- Pain Drawing (PD)
- AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 18 (18-4, Page 576)
- Minnesota Multiphasic PersonalityInventory-2 (MMPI-2)

BECK DEPRESSION INVENTORY-II (BDI-II)

The BDI-II is one of the most widely used screening tests for depression. It is an easily scored test consisting of 21 items that are rated on a 4-point Likert scale ranging from 0 to 3. The maximum total score is 63. The test requires the examinee to rate himself across a wide range of common depressive symptoms including sadness, loss of pleasure, guilt, indecisiveness, changes in sleep patterns, fatigue, etc. The BDI-II items are consonant with the DSM-IV criteria for depressive based diagnoses. The cut off scoring criteria for the BDI-II is as follows:

TOTAL SCORE	RANGE
0-13	No or minimal depression
14-19	Mild depression
20-28	Moderate depression
29-63	Severe depression
Below 4	Possible denial of depression, faking good; lower than usual scores even for normal

On the Beck Depression Inventory, Mr. Williams obtained a score of 33, thereby placing him in the severe range of clinical depression. In examining his overall pattern of symptoms, the examinee's responses appear to emphasize both affective and cognitive symptoms of depression. In terms of suicide potential, the BDI-II manual recommends that the examinee pay careful attention to the examinee's responses to item #2 (pessimism) and item #9 (suicidal ideas). The combination of hopelessness with recurrent suicidal thoughts with intent are considered better indicators of self-destructive behavior than the emotional intensity of depression. On items #2 and #9, the examinee obtained a combined score of **2** indicating that there is likely to be no concern with suicidal potential.

BECK ANXIETY INVENTORY (BAI)

The Beck Anxiety Inventory (BAI) is a 21-item test that measures the severity of self-reported anxiety. The BAI requires the examinee to rate a set of symptoms across a 4-point Likert scale from 0-3. The maximum BAI score is 63. The cutoff scoring criteria for the BAI is as follows:

TOTAL SCORE	RANGE
0-7	Minimal anxiety
8-15	Mild anxiety
16-25	Moderate anxiety
26-63	Severe anxiety

The examinee obtained a total score of 13, which is suggestive of a mildly anxious state.

EPWORTH SLEEPINESS SCALE (ESS)

The Epworth Sleepiness Scale (ESS) is a short test, recently developed at the Epworth Hospital in Australia that measures excessive daytime sleepiness. The ESS is an acceptable and well-regarded alternative for a time-consuming and expensive laboratory testing procedure. The ESS is a subjective, self-report instrument that describes eight different situations and four possible answers for each situation. Various authors have assigned differing cutoff scores to determine excessive daytime sleepiness. At the present time, there are no national norms available for the ESS. However, this instrument is likely the most widely used test for sleepiness.

The AME Guides define four sages of sleep-related impairment (pages 31 7-318). The ESS is an instrument that the clinician can utilize to assess sleep impairment vis-à-vis the effect of sleepiness upon alertness. However; it should be realized that the score obtained on the ESS is not norm-based and must be only used as general guide to assessing sleepiness or decreased alertness. An average score is probably 7-8. A score of more than 10 indicates the probable need for professional assistance. Sleep Apnea examinees score from 11.7 (CPAP) to 16 (no CPAP), Narcolepsy examinees score about 7.5. The maximum possible score on the ESS is 24.

John, MW. (1991) A new method for measuring daytime sleepiness: The Epworth sleepiness scale. Sleep, 14, 540-545. 1991

Scale
0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situations	**Score**
Sitting & Reading	3
Looking at TV	2
Sitting inactive in a public place	2
When a passenger in a car for 1 hour with no breaks	3
Lying down to rest in the afternoon	3
Sitting & talking to someone	0
Sitting quietly after lunch with no alcohol	2
In a car while stopped for a few minutes in traffic	0

Total Score = 15

The examinee received a score of 15, reflecting that he may be excessively sleepy depending on the situation.

Prior to the subsequent injuries, it took him 30 minutes to fall asleep and he slept for 8 hours at night and did not wake up at night due to pain, anxiety, or depression. After the subsequent injuries beginning November 2018, it takes him 1 hour to fall asleep and he sleeps for 5-6 hours each night. He wakes up two times at night due to pain and excessive thoughts about his current predicament.

HAMILTON DEPRESSION RATING SCALE (HAM-D)

The test was developed by Dr. Hamilton and is not a "self-rating" test. Rather, applicants discuss their responses with the physician who rates their degree of depression and/or anxiety. Both are considered the most objective measure of an applicant's degree of depression and/or anxiety. Scores to determine the degree of depression and anxiety vary by clinician. The Hamilton Rating Scale for Depression is the most commonly used psychiatric test in psychiatric pharmacologic management and in research studies because of its objectivity. This test emphasizes vegetative depressive symptoms – such as sleep, appetite, and sexual disturbance – in contrast to the Beck Depression Inventory which emphasizes affective, cognitive and vegetative symptoms.

The Hamilton Rating Scale for Depression is used extensively to measure clinical improvement in levels of depression, and an antidepressant is considered efficacious if it results in 50% reduction in the applicant's scores on this test.

TOTAL SCORE	RANGE
0 – 7	None/Minimal Depression
8 – 13	Mild
14 – 18	Moderate
19 - 22	Severe
23+	Very Severe

On the HAM-D, Mr. Williams obtained a score of 14, thereby placing him in the moderate range of clinical depression.

It is important to note that the HAM-D results are consistent with his interview demeanor. He reported having depression in which he has suicidal thoughts.

HAMILTON ANXIETY RATING SCALE (HAM-A)

The **Hamilton Anxiety Rating Scale** (HAM-A) is a psychological questionnaire used by clinicians to rate the severity of a patient's anxiety. The scale consists of 14 items designed to assess the severity of a patient's anxiety. Each of the 14 items contains a number of symptoms, and each group of symptoms is rated on a scale of zero to four, with four being the most severe.

All of these scores are used to compute an overarching score that indicates a person's anxiety severity. The scale is intended for adults, adolescents, and children.

Each item is scored independently based on a five-point, ratio scale. A rating of 0 indicates that the feeling is not present in the patient. A rating of 1 indicates mild prevalence of the feeling in the patient. A rating of 2 indicates moderate prevalence of the feeling in the patient. A rating of 3 indicates severe prevalence of the feeling in the patient. A rating of 4 indicates a very severe prevalence of the feeling in the patient. To implement the Hamilton Anxiety Rating Scale, the clinician proceeds through the fourteen items, evaluating each criterion independently in form of the five-point scale described above.

Upon the completion of the evaluation, the clinician compiles a total, composite score based upon the summation of each of the 14 individually rated items. This calculation will yield a comprehensive score in the range of 0 to 56.

TOTAL SCORE	RANGE
0 – 7	None/Minimal Anxiety
8 – 17	Mild
18 – 24	Moderate
25+	Severe

The examinee obtained a total score of 12, which is suggestive of a mildly anxious state.

MONTREAL COGNITIVE ASSESSMENT (MoCA)

The Montreal Cognitive Assessment, MoCA, was created in 1996 (Copyright Z. Nasreddine MD). It was validated by: Ziad S. Nasreddine, Natalie A. Phillips, Valerie Bedirian, Simon Charbonneau, Victor Whitehead, Isabelle Collin, Jeffrey L. Cummings and Howard Chertkow, The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool for Mild Cognitive Impairment. J Am Geriatr Soc, 2005, 53:695-9. The MoCA test is a one-page 30-point test administered in 10 minutes. The test and administration instructions are freely accessible for clinicians at **www.mocatest.org**. The test is available in 34 languages or dialects. There are 3 alternate forms in English, designed for use in longitudinal settings.

The MoCA assesses several cognitive domains. The short-term memory recall task (5 points) involves two learning trials of five nouns and delayed recall after approximately 5 minutes. Visuospatial abilities are assessed using a clock-drawing task (3 points) and a three-dimensional cube copy (1 point). Multiple aspects of executive functions are assessed using an alternation task adapted from the trail-making B task (1 point), a phonemic fluency task (1 point), and a two-item verbal abstraction task (2 points). Attention, concentration and working memory are evaluated using a sustained attention task (target detection using tapping; 1 point), a serial subtraction task. (3 points), and digits forward and backward (1 point each). Language is assessed using a three-item confrontation naming task with low-familiarity animals (lion, camel, rhinoceros; 3 points), repetition of two syntactically complex sentences (2 points), and the aforementioned fluency task.

MOCA SCORES			
	Normal Controls (NC)	**Mild Cognitive Impairment (MCI)**	**Alzheimer's Disease (AD)**
Number of Subjects	90	94	93
MoCA Average Score	27.4	22.1	16.2
MoCA Standard Deviation	2.2	3.1	4.8
MoCA score range	25.2 - 29.6	19.0 – 25.2	21.0 – 11.4
Suggested cut-off score	≥26	<26	<26ψ
Although the average MoCA score for the AD group is much lower that the MCI group, there is overlap between them. The suggested MoCA cut-off score is thus the same for both. The distinction between AD and MCI is mostly dependent on the presence of associated functional impairment and not on a specific score on the MoCA test.			

(MOCA Score is below 27;
Slight Behavioral Processing Difficulties Observed)

The MOCA has a maximum score of 30. A score of 26 or greater is considered normal. The examinee's cognitive performance on the MOCA was below the cut off score of 27. He received a total score of 22. This finding suggests that there may very well be some cognitive deficits that are interfering with his ability to sustain concentration, attend to task, and retain information. In examining his MOCA performance, the following cognitive processing areas showed the greatest deficits.

1. **Attention** was noted to be strained as he struggled in the Serial 7 subtraction task. He received a score of 1 out of 3.

2. **Language** skills revealed deficit in repetition of two syntactically complex sentences. He received a score of 1 out of 2.

3. **Abstraction** abilities were assessed to be poor as he had difficulty in comprehending how discrete items could be alike. This finding could infer a difficulty in complex problem-solving abilities. He received a score of 1 out of 2.

4. **Delayed Recall (Short-term memory recall)** was weak as evidenced by the fact that he could only recall 1 item out of 5 items (e.g. face, velvet, etc.) after a five-minute time delay.

FEAR AVOIDANCE BELIEFS QUESTIONNAIRE (FABQ)

The role of fear avoidance beliefs in the development of long-term disability has been gaining importance in recent years. It is important that this psychological factor is assessed so that treatment can address unhelpful beliefs that may contribute to the development or maintenance of disability. The FABQ is a reliable and valid measurement that was developed by Waddell to

investigate fear- avoidance beliefs and predict those who have a high pain avoidance behavior. Clinically, these people may need to be supervised more than those that confront their pain.

The FABQ consists of 2 subscales, which are reflected in the division of the outcome form into 2 separate sections. The first subscale (items 1-5) is the Physical Activity subscale (FABQPA), and the second subscale (items 6-16) is the Work subscale (FABQW). Each subscale is graded separately by summing the responses respective scale items (0-6 for each item); for scoring purposes, only 4 of the physical activity scale items are scored (24 possible points) and only 7 of the work items (42 possible points). A low FABQPA score (less than 19) and FABQW (less than 15) were one of 5 variables in a clinical prediction rule that increased the probability of positive outcomes for individuals with low back pain.

Scoring the Physical Activity subscale (FABQPA)
Sum items 2,3,4, and 5= 24 Total

Scoring the Work subscale (FABQW)
Sum items 6,7,9,10,11,12, and 15= 42 Total

Mr. Williams obtained an **FABQPA** score of **24** and an **FABQW** score of **41**. Based on Mr. Williams's scores, he is demonstrating significant fear beliefs about work and physical activity pain and has decreased probability of positive outcomes.

MODIFIED SOMATIC PERCEPTIONS QUESTIONNAIRE

The MSPQ is a 13 item self-report scale for patients with chronic pain or disabilities. It can help identify somatic complaints that may be associated with psychological responses such as anxiety or depression. The higher the score, the more marked the general somatic symptoms. The number of perceptions at each intensity level can help gauge the number of limiting symptoms. A person with significant somatic complaints would be a candidate for psychological interventions to aid coping.

Each item is scored on a scale from zero (0) to three (3). Patients who produce a score of 12 or greater (maximum score is 39) are at risk for a prolonged recovery. The questionnaire contains a total of 22 items, but only 13 are used to calculate the score. The remaining items are included to reduce the possibility of a response bias. The higher the score, the more hypersensitive the examinee is to bodily sensations, processes, and discomfort.

Mr. Williams received a raw score of 6, which does not reflect risk for a prolonged recovery or a pattern of somatic hypersensitivity.

PAIN CATASTROPHIZING SCALE (PCS)

Pain catastrophizing is characterized by the tendency to magnify the threat value of a pain stimulus and to feel helpless in the presence of pain, as well as by a relative inability to prevent or inhibit pain-related thoughts in anticipation of, during, or following a painful event (Quartana, Campbell, & Edwards, 2009). Pain catastrophizing affects how individuals experience pain. Sullivan et al.

(1995) state that people who catastrophize tend to do three things, all of which are measured by the PCS questionnaire; They ruminate about their pain (e.g. "I can't stop thinking about how much it hurts"), they magnify their pain (e.g. "I'm afraid that something serious might happen"), and they feel helpless to manage their pain (e.g. "There is nothing I can do to reduce the intensity of my pain").

Further, it is becoming increasingly clear that catastrophic thinking in relation to pain is a risk factor for chronicity and disability. In other words, catastrophizing not only contributes to heightened levels of pain and emotional distress, but also increases the probability that the pain condition will persist over an extended period of time. As such, this measure is helpful for examining the current thinking and coping process as it relates to the current physical state, and quantifying an individual's pain experience, as well as providing information related to future adjustment and recovery. The available research shows that a PCS raw score of 30 (which falls at the 75th percentile in clinical samples at chronic pain treatment centers) when coupled with a Beck Depression score greater than 16, predicts that more than 70% of these patients will be totally disabled from working a year following the date of injury. Thus, a raw score of 30 will be considered clinically significant in this analysis.

Mr. Williams received a raw score of <u>26</u> that does not reflect a nearly constant state of catastrophizing related to his pain condition.

PAIN DRAWING (PD)

The Pain Drawing (PD) is a pictorial representation of the human body on which examinees can indicate graphically where and how pain is affecting them. The PD is comprised of two images representing the front and back of the body respectively. A total pain score is calculated based on the extent of pain indicated on the diagrams. This score is useful both as a positive measure and as a guide for future treatment.

Scoring System for Pain Drawings

Unreal drawings. If one or more of the following pain localizations are drawn in, two points are assigned.

A. Total leg pain
B. Frontal aspect of one or both legs
C. Unilateral or bilateral anterior tibial pain
D. Back of leg (isolated, knee included)
E. Circumferential thigh pain

Drawings showing "expansion" or "magnification' of pain (one or two points per area, depending upon extent)

A. Pain drawn outside the outline as an indication of magnification.

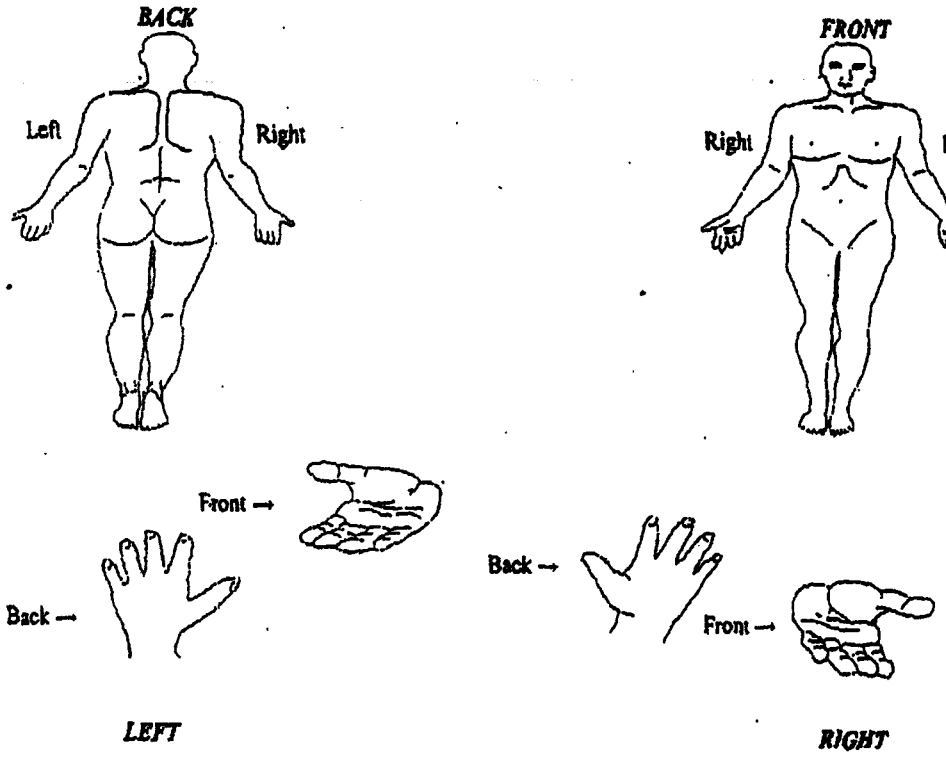
"I particularly hurt here" indicators (each category scores one point).

1. *Additional explanatory notes*
2. *Circle painful areas*
3. *Draw lines to demarcate painful areas.*

D. Use arrows to describe anatomically not explainable pain. Use additional symbols.

With this rating system, a score of three or more is generally thought to represent a pain perception that may be influenced by psychological factors. Some of the readily apparent expressions of psychological distress include pain distributions that are non-anatomic or bizarre, drawings showing "magnification" or 'expansion" of symptoms, and drawings that demonstrate "look how bad I am indicators."

In reviewing the examinee's pain drawing, none of these domains were found.



On the front portion of this form, Mr. Williams complains of numbness/tingling in the front of his thighs. On the back portion of this form, he complains of numbness/tingling in the back of his thighs. On the hand portion of this form, he has no complaints. In the last two months, his condition had gotten better.

It should be noted that the examinee's pain drawing was consistent with his report of somatic health concerns. This consistency provides additional validation for my assessment that I find him to be a credible historian.

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TABLE 18-4, PAGE 576

I. Pain (Self-Report of Severity)

A. Rate how severe your pain is **right now, at this moment**

0	1	2	3	4	5	6	7	8	9	10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst**

0	1	2	3	4	5	6	7	8	9	10

None — Excruciating

C. Rate how severe your pain is **on the average**

0	1	2	3	4	5	6	7	8	9	10

None — Excruciating

D. Rate how much your pain is **aggravated by activity**

0	1	2	3	4	5	6	7	8	9	10

Activity does not aggravate pain — Excruciating following any activity

E. Rate how **frequently** you experience pain

0	1	2	3	4	5	6	7	8	9	10

Rarely — All of the time

II. Activity Limitation of Interference

A. How much does your pain interfere with your ability to **walk 1 block**?

0	1	2	3	4	5	6	7	8	9	10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of grocery)?

0	1	2	3	4	5	6	7	8	9	10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10

Does not restrict ability to sit for ½ hour — Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to **stand for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**?

0	1	2	3	4	5	6	7	8	9	10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with my daily activities — Completely interferes with with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse**?

0	1	2	3	4	5	6	7	8	9	10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely unable to do any jobs around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — My pain makes it impossible

to at all shower or bathe without help

M. How much does your pain interfere with your ability to **write or type**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to engage in sex

P. How much does your pain interfere with your ability to **concentrate**?

0	1	2	3	4	5	6	7	8	9	10

Never — All the time

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week

0	1	2	3	4	5	6	7	8	9	10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

C. During the past week, how **depressed** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

D. During the past week, how **irritable** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

E. In general, how anxious/worried are you about performing activities because they **might make your pain symptoms worse**?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2 (MMPI-2)

The MMPI-2 is the most frequently used clinical personality and psychopathology test for evaluating injured workers, forensic, medical and chronic pain examinees. The test is comprehensive. The MMPI-2 is an objectively scored and interpreted, reliable and valid instrument. It has three (3) primary validity and ten (10) clinical scales. High scores provide "objective" information regarding an examinee's receptivity toward psychological and medical treatment, along with providing diagnostic clarification of major psychiatric disorders. In general, the validity scales are designed to identify test-taking attitude. Examinees who are forthright on the validity scale items have made a number of "statements" of importance in personal injury or litigation cases. They did not try to "fake good' or "fake bad;" they neither exaggerated nor minimized their symptoms. These examinees answered honestly, and their answers on the balance of the test and other instruments are also likely to be honest. Therefore, one can believe, with a reasonable degree of certainty, what the test says about the examinee's degree of depression, anxiety, and worry about physical problems. The converse is also true. The examinees whose validity scale scores suggest exaggeration, cover-up, or other attempts to obfuscate has provided a strong suggestion that the other claims may also be false or at least not entirely true.

Profile Validity

Mr. Williams responded to the MMPI-2 items in an unusual manner. He claimed an unrealistic amount of virtue while also endorsing a great number of psychological difficulties. This reflects some unconventional and possibly bizarre beliefs. In addition, his approach to the MMPI-2 items was somewhat inconsistent. He tended to endorse items False regardless of their content. This pattern suggests some carelessness or inattention to content.

"VRIN" (Variable Response Inconsistency Scale)

The VRIN comprises pairs of selected questions that would be expected to be answered in a consistent manner if the individual is approaching the testing in a valid manner. Each pair of items is either similar or opposite in content. It would be expected that similar items would be answered in the same direction. If the individual answers in the opposite direction, then it indicates an inconsistent response, therefore, scoring as one raw score on the VRIN scale. Pairs of items with opposite contents would be expected to be answered in opposite directions. If instead, these pairs are answered in the same direction, this would represent inconsistent responding, which would also be scored as one raw score point on the VRIN scale. A high VRIN is a T score of 80 or above. A high number of inconsistent responses suggests indiscriminate responding. Thus, the profile would be considered invalid. If VRIN is high along with a high *F*, this further suggests the individual has answered in a random manner. In contrast, a low or moderate VRIN accompanied by high *F* suggests the individual was either severely disturbed or was intentionally attempting to exaggerate symptoms.

Mr. Williams achieved a T-score of 69 on the VRIN Scale. This indicates he responded to test items in an inconsistent manner.

"TRIN" (True Response Inconsistency Scale)

TRIN scales are like the VRIN scale in comprising pairs of items. However, only pairs with opposite contents are included. This means there would be two ways for an individual to obtain a response that would be scored on the VRIN scale. A "True" response to both items would indicate inconsistency and would be scored as plus one raw score point. A "False" response to both pairs would also indicate inconsistency, but would be scored as minus one point. A high TRIN is a T score of 80 or above. Scores in this range indicate the person is indiscriminately answering "True" to the items (acquiescence or yea-saying). A high *F* accompanied by a high TRIN suggests indiscriminate responding, whereas a high *F* and a low to moderate TRIN suggest either excessive pathology or an exaggeration of symptoms.

The examinee achieved a T-score of 71 on the VRIN Scale. This indicates he responded to test items in an inconsistent manner, indiscriminately answering "True" to test items.

"L SCALE" (LIE SCALE)

This is a 15-item "perfection" scale designed to determine how much an individual is obviously trying to make himself look positive. Research reveals a T-score of 50 through 60 indicates an individual who sees himself as virtuous, conforming, and self-controlled. A T-score of 60 and above indicates that the individual is likely to repress or deny unfavorable traits.

The examinee achieved a T-score of 70 on the L Scale. This indicates Mr. Williams is likely to repress or deny unfavorable traits.

"F SCALE" (FREQUENCY or CONFUSION SCALE)

This scale was developed to measure symptom exaggeration or confusion, as evidenced by reporting an excessive number of psychological problems. Research reveals that T-scores in the range of 45 or below are generally considered free from stress, honest, and conventional. Moderate (T-scores of 56-64) can indicate social protest or commitment to religious or political movements. Moderately high elevations (T-scores of 60-70) indicate that the individual has problems, but is not overwhelmed by them or too worried about them. Marked elevations (T-scores of 70-80) are found in individuals with an unusual and unconventional thinking style. They may be overly anxious, displaying a "cry for help," or may or actually have reading difficulty. Individuals being evaluated in personal injury cases may have conscious or unconscious motivation to appear symptomatic or ill. If so, either because of real problems or because of this motivation, the person will have a relatively high F Scale. T-scores in the range of 90-100 usually indicate a random marking of the test items. Research indicates this may be the result of a person who is illiterate and does not want to admit it, someone who is confused, or someone who has brain damage. Generally, T-scores equal to 100 or above are an indication of error somewhere, such as scoring, deliberately marking the items in an all-time, all-false, or random format, or a reading error. If these possibilities are ruled out, however, the score can reflect the severity of the psychopathology in the person or the degree to which the individual feels the need to look pathological.

Mr. Williams achieved a T-score of 95 on the F scale, indicating random marking of the test items.

"K SCALE" (CORRECTION SCALE)

This is a 30-item scale designed to measure the individual's defensiveness or guardedness. This scale was developed as a correction for the tendency to deny problems. The K scale is a much more subtle scale than the L scale, as a result, can detect defensiveness in even sophisticated individuals. T-scores of 35 or below indicate individuals who are too willing to admit their own problems, and may tend to exaggerate them. Average scores (T-scores of 45-60) are found in people who are generally demonstrating "a balance between self-disclosure and self-protection." T-scores of 65 or above indicate individuals who are consistently trying to maintain a façade of adequacy and control, and are admitting to no problems or weakness. Such persons have a serious lack of insight into and understanding of their own behavior.

The examinee obtained a T-score 70 on the K scale, indicating he is consistently trying to maintain a façade of adequacy and control, and are admitting to no problems or weakness.

WHEN THE THREE PRIMARY VALIDITY SCALES ARE PSYCHOMETRICALLY AND STATISTICALLY ANALYZED, THERE IS NO EVIDENCE OF DEFENSIVENESS, INTENTIONAL MALINGERING OR SYMPTOM MAGNIFICATION.

In examining the ten clinical scales, particular emphasis was placed on the Four (4)-cluster empirically derived MMPI typology for chronic pain sufferers has been demonstrated by combining the results of 10 investigative teams. **These MMPI 'types' have been labeled P-A-I-N** and appear to have important clinical and demographic correlates. They are as follows:

Type P is the most 'psychopathological' looking as nearly all scales are usually elevated. Type P patients are extreme in their claims of physical illness, psychological distress, and social maladaptation. Demographic correlates include poor education, high rates of unemployment, and limited household income.

Type A is defined by a 'conversion V' on the 'neurotic' triad scales. It has no unique correlates.

Type I has elevations on all of the neurotic triad scales and on no others. Type I patients appear to be the most physically infirm with multiple surgeries and hospitalizations. They may not improve physical status with treatment, but appear to benefit psychologically.

Type N profiles are 'normal' in that no scale, except perhaps scale K, is often elevated. Type N patients are moderate in their claims of ill health, often are better educated and employed, and appear to respond well to treatment.

In examining Mr. Williams's clinical scales, **his profile most closely matches the Type P classification. Upon further examination of Mr. Williams's profile, his clinical configural codetype appears to resemble the 1-2/2-1 codetype, which is described below:**

1-2/2-1

MMPI-2 INTERPRETATION

Scale 1-Hs

Scale l-Hs should basically be interpreted as the extent and intensity of attention that is focused on the person's physical symptoms and the security of one's health status. Those with scores that are relatively elevated, e.g., over T-70 to T-80, and high in the code, typically are strongly preoccupied with their bodily problems and anything that is perceived to identify a threat or risk of increasing decline and greater vulnerability of the person's intact survival. It is correct, of course, that the scale was based on contrasting the responses of patients without any identifiable medical causes for their health distresses versus normal subjects. But an elevation does not demonstrate that a person's physical complaints are without medical cause: one person can be seriously ill and markedly illness preoccupied, while another person can he equally seriously ill and only intermittently or even insufficiently attentive to their illness. High to very high scores do mark a serious potential for developing symptomatic concerns primarily on a fear-generated basis, but a high score on 1-Hs is still not a proof that any given symptom does not have a partly or even primarily physiologic origin.

The diagnoses of somatization (lower K) and hypochondriasis (similar MMPI-2 patterns but higher K) are clinical judgments as to whether the extent of concern is or is not disproportionate to the person's medical status. If substantially elevated, then the interpretation of the scale is of a heightened level of fear of (1) physical disablement and (2) progressive decline, perhaps resulting from prior experiences of imminently disabling or especially death-frightening moments. The resulting adaptive self-protections can range from a mild cautiousness or inhibition of physical activities with scattered repetitive health concerns when under emotional stress (e.g., T-score 55 to 65) to an immobilization of most activities and unending illness concerns (e.g., T-score over 85 and first or second in the code). Thus, this extent of preoccupation is what scale l-Hs is assessing; whether particular symptoms are more strongly due to medical vs. psychologic contributions is a secondary implication depending in part on the person's actual health status.

Data from the Mayo clinic (Swenson, Pearson, & Osborne, 1973) indicated a close to 10-point T-score increase in medical patients in general; that is broadly an average one standard deviation increase in health concerns as a function of being sick and in a hospital. Obviously, some disorders are more threatening than others, so this baseline is naturally variable among patients of diverse diagnoses. A 20 or 30 point or larger upward T-score shift (from T 50) on 1-Hs tells us that the person's mental attention and psychic energy have become strongly focused on health and illness issues.

Scale 2-D

The common theme among those with scale 2-D depression patterns is some element of loss. Loss is broadly defined; it is not limited to someone's death or a singular tragedy. There can be a decline in one's health, aging beyond the capacity to ever have a much-wanted child, a major decline of social supports, the ending of a career (even if expected, more personally tragic if not), a loss of one's life expectations from a happy marriage, giving up one's hopes of future travel, and so forth. A chronic deprivation of positively rewarding experiences in childhood seems to have a

substantially overlapping and predisposing impact, perhaps understandable in part by the inhibition of the will as an adaptation to a marked reduction or generalized absence of positive inputs and rewards (e.g., a self-preoccupied or depressed mother).

Clients with 1-2/2-1 code types present themselves as concerned about their physical functioning. General physical symptoms are seen with manifestations of a somatization or psychophysiologic reaction. Even when or if they have real physical symptoms, clients exaggerate their severity. These clients often complain of nausea, vomiting, weakness, insomnia, and fatigue rather than classical depressive features. Dizziness, chest and back pains, and tachycardia may be reported.

They lack insight into their somatic symptoms and behavior, often refusing to acknowledge that their symptoms are related to emotional conflict and are used as a means of avoiding their psychological problems. The somatic symptoms are focused around the alimentary system, particularly on abdominal pain and backaches. Their symptoms are vague, nonspecific, and difficult to isolate medically. These clients return to their physicians repeatedly with limited change in their physical condition.

They think in a very concrete manner and tend to focus extensively on their physical symptoms. They see their judgment as being poor, particularly when compared to how they used to function. Sustained attention and concentration are difficult for them.

Individuals with the 1-2/2-1 profile may have a history of drug or alcohol abuse. These clients are typically introverted, shy, self-conscious, and passive dependent. They may harbor resentment against people for not providing them with attention and emotional support. They are likely to be extremely sensitive and manipulate other using their symptoms.

Mr. Williams's profile suggests he is experiencing many psychological problems. He is probably an extremely depressed and ineffective individual who is exhibiting personality deterioration at this time. He may be quite confused and disoriented. He may appear tense, anxious, agitated, or hostile at times. Individuals with this profile are typically experiencing extreme physical symptoms, depressed mood, and cognitive disorganization.

He appears to feel very insecure. His life adjustment is chronically poor and he may drift from job to job or place to place. Social withdrawal is characteristic of his behavior. He has many vague physical concerns and may have somatic delusions.

He reports a preoccupation with feeling guilty and unworthy. He feels that he deserves to be punished for wrongs he has committed. He feels regretful and unhappy about life, and he seems plagued by anxiety and worry about the future. He feels hopeless at times and feels that he is a condemned person. He has difficulty managing routine affairs, and the items he endorsed suggest a poor memory, concentration problems, and an inability to make decisions. He appears to be immobilized and withdrawn and has no energy for life. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes.

There is a strong possibility that he has seriously contemplated suicide. He is rather high-strung and believes that he feels things more, or more intensely, than others do. He feels quite lonely and misunderstood at times.

[**Author's comment:** *Contrary to the MMPI-2 results of Mr. Williams contemplating suicide as a possibility, he has denied past and present suicidal ideations or attempts during our interview*].

Mr. Williams has not developed effective ways of dealing with others and feels very inadequate and socially alienated. He is somewhat shy, with some social concerns and inhibitions. He is a bit hypersensitive about what others think of him and may have concerns about his relationships with others. He may have some difficulty expressing his feelings toward others. He harbors many negative work attitudes that could limit his adaptability in the workplace. His low morale and lack of interest in work could impair future adjustment to employment.

RELIABILITY AND CREDIBILITY

After a careful review of the above information, it is the undersigned's professional opinion that Mr. Williams is a candid and generally credible historian who is not exaggerating his symptoms for secondary gain. I have factored in his self-reporting style of both over and under reporting of symptoms into my conceptualization of his diagnoses and level of impairment.

Mr. Williams's account of his injury corroborated with the narrative of the injury outlined in the medical records.

Mr. Williams's account of how his psyche and functions of daily living were impacted by his orthopedic injuries were reasonable. He was able to coherently address how the combination of depression and anxiety negatively affected his mood, cognition, and behavior.

During today's evaluation, I paid close attention to Mr. Williams's self-report of emotional pain and his non-verbal behavior. Generally speaking, if an individual complains of significant depression and anxiety, one would expect to see this manifested, to some degree in his body language during the examination. This observation practice represents one way of assessing an examinee's reliability, as emotional pain cannot be objectively measured. During today's interview, I observed the following relevant information pertaining to Mr. Williams's pain behavior:

- ✓ He began to cry spontaneously when talking about his chronic pain state and his deceased niece who was brutally murdered.

And finally, I turn to an analysis of the psychometric findings to gauge Mr. Williams's reliability and validity.

The psychological test results showed a generally consistent elevation across multiple tests measuring depression and anxiety. His anxiety tests yielded mild scores, but his depression tests ranged from moderate to severe symptoms.

After a careful review of the above information, it is the undersigned's professional opinion that Mr. Williams is a candid historian who is not exaggerating his symptoms for secondary gain. There is no psychological test data to support the phenomenon of pain amplification. There is no scientific basis to suggest that the examinee is consciously feigning malingering symptoms. He self- disclosed appropriately during the evaluation process and I did not sense that he was minimizing personal problems existing before or after the discussed industrial injury.

SUBSEQUENT INJURY PSYCHIATRIC DIAGNOSES

AXIS I: **EPISODE OF MENTAL/CLINICAL DISORDER**
Major Depression, Single Episode, Moderate with Anxious Distress (296.22)
Pain Disorder Associated with Both Psychological Factors and a General Medical Condition (307.89)
Insomnia Related to Anxious Disorder (327.02)
Male Hypoactive Sexual Desire Disorder (625.8)

AXIS II: **PERSONALITY DISORDER**
No Diagnosis (V71.09)

AXIS III: **PHYSICAL DISORDERS AND CONDITIONS**
Status per the review of the medical records above.

AXIS IV: **SEVERITY OF PSYCHOSOCIAL STRESSORS**
Severe

(1) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

(2) Non-Industrial and concurrent stressful issues were identified and these include:

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - 48

Please Note: Use of the DSM IV-TR is provided in the above instance as the DSM-5 no longer provides a GAF score, which is necessary in an evaluation of this nature.

DISCUSSION OF SUBSEQUENT INJURY PSYCHIATRIC DIAGNOSES

Major Depressive Disorder with Anxious Distress

Taking into consideration the available information, Mr. Williams's cluster of symptoms would best be categorized as a mood disorder. According to the DSM 5, the essential features of Major Depressive Disorder (MDD) with Anxious Distress is defined as the presence of at least two of the following symptoms during the majority of days of a major depressive episode or persistent

depressive disorder (dysthymia): 1. Feeling keyed up or tense 2. Feeling unusually restless 3. Difficulty concentrating because of worry 4. Fear that something awful may happen and 5. Feeling that the individual might lose control of himself or herself. Following his injury, Mr. Williams reported the following symptoms:

- "I feel sad or depressed at this time, because I am not working and am mad at Walmart. I feel a depressed mood most of each day for the past two weeks, because I keep thinking, "Why they lied on me and Walmart never showed me the video of choking that lady?"

- "I used to play golf, but cannot due to back pain and COVID-19. I feel worthless or have low self-esteem due to being dependent on unemployment. I got hacked for $920.00. I gained 40 pounds, eating more, because I'm not working."

- "I feel anxious and worried at this time. I experience excessive worry or anxiety. I worry about my bills and unemployment. I feel restless more days than not. It's hard to sleep or get comfortable. I have experienced anxiety causing irritability."

Pain Disorder Associated with Both Psychological Factors and a General Medical Condition
Taking into consideration the available information, Mr. Williams's cluster of symptoms would best be categorized as a somatic symptom and related disorder. According to the DSM 5, the diagnostic criteria for Pain Disorder Associated with Both Psychological Factors and a General Medical Condition include pain symptoms that cause clinically significant distress or impairment. The psychological or behavioral factors are judged to have an important role in onset, severity, exacerbation, or maintenance of pain symptoms. Following his injuries, Mr. Williams reported the following symptoms:

- "I have not had surgery for these subsequent injuries, but I feel a lot of pain every day. I had physical therapy, but I'm still in pain."

Insomnia Related to Anxious Disorder
Taking into consideration the available information, Mr. Williams's cluster of symptoms would best be categorized as a sleep-wake disorder. According to the DSM 5, the essential features of Insomnia Related to Anxious Disorder include sleeplessness (individual receiving less than 5 ½ hours of sleep per night on average without medications), fatigue, difficulty falling asleep, and frequently interrupted sleep. These sleep disturbances have been persisting for more than one month. Following his injury, Mr. Williams reported the following symptoms:

- "Prior to the subsequent injuries, it took me 30 minutes to fall asleep and I slept for 8 hours at night and did not wake up at night due to pain, anxiety, or depression. After the subsequent injuries beginning November 2018, it takes me 1 hour to fall asleep and I sleep for 5-6 hours each night. I wake up two times at night due to pain and excessive thoughts about my current predicament."

Sexual Dysfunction Due to a General Medical Condition
Taking into consideration the available information, Mr. Williams's cluster of symptoms would best be categorized as a sexual dysfunction disorder. According to the DSM 5, the diagnostic

criteria for Sexual Dysfunction Due to a General Medical Condition include pain associated with intercourse, hypoactive sexual desire, male erectile dysfunction, or other forms of sexual dysfunction (e.g., Orgasmic Disorders) and must cause marked distress or interpersonal difficulty. Following his injuries, Mr. Williams reported the following symptoms:

- "I have less sexual desire. I have pain in my back during sexual intimacy. I still have sex four times per week."

SUBSEQUENT INJURY IMPAIRMENT RATING

ANALYSIS AND EXPLANATION OF MR. WILLIAMS'S PSYCHOLOGICAL IMPAIRMENT RATING

On page 365 of the AMA guides, Table 14-1 provides a guide for rating mental impairment in each of the four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment. The following are recommended as anchors for the categories of the scale.

Area of Aspect of Functioning	Class 1 No Impairment	Class 2 Mild Impairment	Class 3 Moderate Impairment	Class 4 Marked Impairment	Class 5 Extreme Impairment
Activities of Daily Living		✓			
Social Functioning		✓			
Concentration		✓			
Adaptation			✓		

ACTIVITIES OF DAILY LIVING

SELF CARE/PERSONAL HYGIENE ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I neglect to bathe or shower.	Often	Sometimes	[redacted]	Not Applicable
2. I neglect to brush my teeth.	Often	Sometimes	[redacted]	Not Applicable
3. I have no interest in my appearance.	Often	Sometimes	[redacted]	Not Applicable
4. I have no interest in shaving or putting on make-up.	Often	Sometimes	[redacted]	Not Applicable
5. I have no interest in getting dressed on most days.	Often	Sometimes	[redacted]	Not Applicable
6. I have problems sleeping at night because I can't stop thinking or worrying.	[redacted]	Sometimes	Never	Not Applicable
7. I do not feel rested in the morning when it is time to get up.	Often	[redacted]	Never	Not Applicable
8. I feel sleepy during the daytime.	[redacted]	Sometimes	Never	Not Applicable

9. I lack the desire to have sexual relations.	Often	[redacted]	Never	Not Applicable
10. I am physically unable to have sexual relations.	Often	[redacted]	Never	Not Applicable
11. I no longer have a desire to travel (e.g., road trips or by airplane).	Often	Sometimes	[redacted]	Not Applicable

HOUSEHOLD ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I can't prepare a meal by myself.	Often	Sometimes	[redacted]	Not Applicable
2. I forget to turn off the stove or close the refrigerator.	Often	Sometimes	[redacted]	Not Applicable
3. I can't seem to organize the house. Everything is messed up.	Often	Sometimes	[redacted]	Not Applicable
4. I have no energy to clean my house.	Often	Sometimes	[redacted]	Not Applicable
5. I can't focus and repair things that are broken in the home.	Often	Sometimes	[redacted]	Not Applicable

SOCIAL FUNCTIONING

FAMILY AND SOCIAL ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I lack the energy to take care of children or pets.	Often	Sometimes	[redacted]	Not Applicable
2. I can't take care of the people at home that I used to do before my injury.	Often	Sometimes	[redacted]	Not Applicable
3. I spend many days in my room and have no interest in talking to others.	Often	[redacted]	Never	Not Applicable
4. I can't seem to listen to others and understand what they are saying to me.	Often	Sometimes	[redacted]	Not Applicable
5. I lack the cognitive stamina to be involved with friends or family.	Often	Sometimes	[redacted]	Not Applicable
6. I don't get along well with others.	[redacted]	Sometimes	Never	Not Applicable
7. I don't want to initiate contact with friends and family.	Often	[redacted]	Never	Not Applicable
8. I don't think I can accept criticism appropriately from others.	Often	[redacted]	Never	Not Applicable

RECREATIONAL ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I have no ability to concentrate and do my normal hobbies (e.g., gardening, fishing, etc.).	Often	Sometimes	[redacted]	Not Applicable
2. I have no interest in attending social gatherings, meetings, or church events.	Often	[redacted]	Never	Not Applicable
3. I do not trust my driving abilities.	Often	Sometimes	[redacted]	Not Applicable
4. I cannot concentrate on completing art projects, doing music activities, or building projects.	Often	Sometimes	[redacted]	Not Applicable

5. I could not muster the energy and concentration to play board games, cards, or video games.	Often	[redacted]	Never	Not Applicable

CONCENTRATION

MEDICAL ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I forget to take my medications.	Often	[redacted]	Never	Not Applicable
2. I forget my doctor's appointments.	Often	Sometimes	[redacted]	Not Applicable
3. I can't seem to remember what my doctors instruct me to do.	Often	Sometimes	[redacted]	Not Applicable
4. I have no energy to do home-based physical therapy exercises.	Often	[redacted]	Never	Not Applicable
5. I lost important papers that doctor gives me or the insurance company sends me.	Often	[redacted]	Never	Not Applicable
6. I am unable to complete a project near others without being distracted.	Often	Sometimes	[redacted]	Not Applicable
7. My day is interrupted by my psychological symptoms.	Often	Sometimes	[redacted]	Not Applicable

MANAGING FINANCES AND PERSONAL ITEMS	LEVEL OF IMPAIRMENT			
1. I cannot manage a checkbook.	Often	Sometimes	[redacted]	Not Applicable
2. I get confused when paying for items at a store.	Often	Sometimes	[redacted]	Not Applicable
3. I lose my wallet or purse or cell phone.	Often	[redacted]	Never	Not Applicable
4. I lose my keys or forget where I parked my car.	Often	[redacted]	Never	Not Applicable
5. I misplace important financial papers or documents.	Often	[redacted]	Never	Not Applicable

ADAPTATION

COMMUNICATION ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I start to fall asleep if I read something for more than a few minutes.	[redacted]	Sometimes	Never	Not Applicable
2. I lose interest when watching television and stop watching the show.	[redacted]	Sometimes	Never	Not Applicable
3. I have lost interest in communicating with others by email or by phone.	Often	[redacted]	Never	Not Applicable
4. I have lost interest in reading the newspaper or watching the news on TV	Often	[redacted]	Never	Not Applicable
5. I have stopped attending normal events and communicating activities (e.g., church, social clubs, volunteer events, visiting	Often	[redacted]	Never	Not Applicable

relatives, etc.).		[redacted]		

EMOTIONAL AND OCCUPATIONAL FUNCTIONS	LEVEL OF IMPAIRMENT			
1. I feel that I would be able to perform any job I am qualified for without problems at this time.	Strongly Agree	Agree	[redacted]	Strongly Disagree
2. I feel I would be able to interact with coworkers respectfully and without any problems on my part.	Strongly Agree	[redacted]	Disagree	Strongly Disagree
3. I don't have the psychological energy to multi-task.	Strongly Agree	[redacted]	Disagree	Strongly Disagree
4. I become emotionally overwhelmed when demands are placed upon me.	Strongly Agree	Agree	[redacted]	Strongly Disagree
5. I am hypersensitive to environmental factors (e.g., noise, delays, disappointments, setbacks, etc.) and respond in anger when these occur.	[redacted]	Agree	Disagree	Strongly Disagree
6. I have difficulty controlling my emotions and this causes problems when I interact with people.	[redacted]	Agree	Disagree	Strongly Disagree
7. I am not able to maintain a productive schedule where I complete the goals I set for my household, family, and work (if employed).	Strongly Agree	Agree	[redacted]	Strongly Disagree

Comparison of Daily Life BEFORE and AFTER SUBSEQUENT INJURY

Normal life shortly BEFORE the final (SUBSEQUENT) industrial injury

Please describe what a typical **weekday** was like for you shortly **before** the injury.

1. What time did you wake up? **"6am"**
2. How often would you take a shower or bath? **"Daily"**
3. How many hours a day did you work on average? **"10 hours"**
4. Did you participate in any exercise or sports team? **"Yes, golf"**
5. What types of activities did you do after you finished work? **"Golf"**
6. What would you normally do for fun during the week? **"Golf and family"**
7. What time did you typically go to bed during the week? **"10pm"**

Please describe what a typical **weekend** was like for you shortly **before** the injury:

1. What time would you typically wake up on the weekend? **"7am"**
2. What was a typical weekend day for you like? **"Family, clan and golf"**
3. What type of social activities was normal for you to do on the weekends? **"Family"**
4. If you were sexually active shortly before the injury, how often was it normal for you to engage in sexual activity? **"4 times a week"**

Normal Life at this time (Currently)

Please describe what a typical **weekday** is like for you **at this time after** your injury:

1. What time do you typically wake up? **"9am"**
2. How often do you take a shower or bath? **"Daily"**
3. How do you spend most of your weekdays? **"Nothing"**
4. Do you participate in any exercise or sports at this time? **"No"** If yes, please describe
5. What time do you typically go to bed? **"1am"**
6. What do you normally do for fun/socializing during the week? **"Nothing"**

Please describe what a typical **weekend** is like for you **at this time after** your injury:

1. What time do you typically wake up? **"Late"**
2. How do you spend a typical weekend day? **"Wake up, eat, watch TV, just lay around"**
3. What type of social activities are you doing on the weekend at this time? **"None"**
4. Are you sexually active at this time? **"Yes"** If so, how many times on average is it normal for you to engage in sexual activity? **"4 times a week"**
5. If you are not active, or less active, when did you notice this change? N/A
6. What do you think caused this change? N/A

AFTER or BECAUSE of the SUBSEQUENT INJURY, Mr. Williams indicated difficulties or limitations in areas below.

Self-care and Personal Hygiene CURRENTLY			**No Difficulties**
	Urinating		Trimming toe nails
	Defecating		Dressing
	Wiping after defecating	✓	Putting on socks, shoes, and pants
	Brushing teeth with spine bent forward		Putting on shirt/blouse
	Bathing		Combing hair
	Washing hair		Eating
	Washing back		Drinking
	Washing feet/toes	✓	Shopping
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"My back hurts when I bend over to put on shoes or walk too long."**			

Communication CURRENTLY			**No Difficulties**
	Speaking/talking		Writing
	Hearing		Texting
	Seeing	✓	Keyboarding
	Reading (including learning problems, vision, or attention deficits)		Using a mouse
	Using a phone		Typing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Using the keyboard, fingers hurt."**			

Physical Activity CURRENTLY			**No Difficulties**
✓	Walking		Sitting
✓	Standing		Kneeling
	Pulling		Climbing stairs or ladders
	Squatting	✓	Shoulder level or overhead work
✓	Bending or twisting at the waist	✓	Lifting and carrying
✓	Bending or twisting at the neck	✓	Using the right or left hand
	Balancing		Using the right or left foot
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Walking for a long time, standing in one place, bending over, try not to lift or carry."**			
Sensory Function CURRENTLY		✓	**No Difficulties**
	Smelling		Feeling
	Hearing		Tasting
	Seeing		Swallowing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			
Household Activity CURRENTLY			**No Difficulties**
	Chopping or cutting food		Mopping or sweeping
✓	Opening jars		Vacuuming
	Cooking	✓	Yard work
	Washing and putting dishes away		Dusting
	Opening doors		Making beds
	Scrubbing		Doing the laundry
	Repetitive use of the right hand		Repetitive use of the left hand
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Doing yard work."**			

Travel CURRENTLY			**No Difficulties**
✓	Riding as a passenger	If you have trouble sitting, approximately how long can you remain seated at a time?	**45 mins**
✓	Driving **"Reposition myself many times, my back hurts."**	If you have trouble driving, approximately how long can you drive before needing to rest?	**45 mins**
✓	Handling/lifting luggage **"Do not lift."**	Approximately how many times per year do you travel AFTER the	

		Subsequent Injury?		
	Keeping arms elevated	✓	Holding or squeezing the steering wheel	
Other difficulties:				
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Arms get tired/change position holding steering wheel."**				
Sexual Function CURRENTLY			**No Difficulties**	
	Erection		Painful sex (in the genital area)	
	Orgasm	✓	Back pain with intimate relations	
	Lubrication		Neck pain with intimate relations	
	Lack of desire		Joint pain with intimate relations	
Other difficulties:				
If you indicated difficulties in this area, please describe how these difficulties make you feel:				
Sleep Function CURRENTLY			**No Difficulties**	
✓	Falling asleep		Sleeping on the right side	
	Staying asleep		Sleeping on the left side	
	Interrupted/restless sleep		Sleeping on the back	
	Sleeping too much	✓	Sleeping on the stomach	
✓	Daytime fatigue or sleepiness	Have you ever taken any medications to help you sleep AFTER the Subsequent Injury?		
How many hours can you typically sleep at a time without waking up during the night?	**2 hours**	How many hours total are you able to sleep at night?		**5-6 hours**
If you indicated difficulties in this area, please describe how these difficulties make you feel: **"Cannot get comfortable, and my mind keeps me up."**				

Collectively, the above outlined impairments suggest that Mr. Williams is moderately impaired. The Schedule of Rating Disabilities (January 2005) provided the following guidelines for rating patients' GAF.

Starting at the top level of the GAF scale, evaluate each range by asking, "Is either the individual's symptom severity OR level of functioning worse than what is indicated in the range description?"

[**Author's Comment:** *Mr. Williams is not gravely disabled, does not have auditory/visual hallucinations, and does not have suicidal ideations. These descriptions are for individuals who fall in the serious symptom category. However, due to his inability to control his anger, keep a job, and be in good standing with his employers, he falls in the serious symptoms GAF range. Therefore, I have placed him in the serious range of the symptoms scale*].

Using these guidelines, Mr. Williams's psychiatric disability falls into the 41-50 decile. This is the range of functioning described as:

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).

All of his psychological testing combined indicates he is in the mild to severe range of both symptom severity and functional impairment (i.e., BDI, BAI, and etc.). Mr. Williams describes limited social interactions and physical activity as a consequence of both his physical limitations and psychological status following the industrial injuries. Whereas Mr. Williams previously enjoyed a rather active social life of playing golf, following the industrial injuries this has been reduced and more limited to immediate family members and staying at home.

Thus, after careful consideration of all of the information contained in this report, Mr. Williams's score is placed at the level of 48, which translates to a Whole Person Impairment (WPI) of 34%.

Arousal and Sleep Disorder Impairment:
The AMA Guides on Page 317, Table 13-4, provides a guide for rating arousal and sleep disorder impairment on a four-category scale that ranges from no impairment to extreme impairment. In reviewing the medical records and incorporating the findings of the psychological testing, namely the clinically significant Epworth Sleepiness Scale, Mr. Williams appears to have developed a Class 1 Impairment related to his chronic sleep disorder.

Table 13-4	Class 1	Class 2	Class 3	Class 4
	Impairment	Impairment	Impairment	Impairment
	1-9%	10-29%	30-49%	70-90%
Sleep & Arousal Disorders	Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living	Reduced daytime alertness, interferes with ability to perform some activities of daily living	Reduced daytime alertness, ability to perform activities of daily living significantly limited	Severe reduction of daytime alertness, individual unable to care for self in any situation or manner
WPI %				

Sleep disorders are ratable in Chapter 13 of the AMA Guides under Sleep and Arousal Dysfunctions. Table 13-4 of the AMA Guidelines states that a Class 1 Sleep and Arousal Disorder is one in which an individual experiences "Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living." A score of 15/24 is equal to excessive sleepiness, or class 1 impairment. **Based upon his chronic sleep dysfunction, and his Epworth Sleepiness Scale score of 15, the level of his current sleep impairment is equal to a 7%**

disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injuries.

He reported, "I have a change in my sleep since my subsequent injuries. I am not able to sleep well. Sleep is really bad. Prior to the subsequent injuries, it took me 10 minutes to fall asleep and I slept for 8 hours at night and did not wake up at night due to pain, anxiety, or depression. After the subsequent injuries beginning November 2018, it takes me 1 hour to fall asleep and I sleep for 5-6 hours each night. I wake up twice a night at night due to pain and worrying."

Sexual Dysfunction Disorder Impairment:
The AMA Guides on Page 156, Table 7-5, provides a guide for rating permanent impairment due to penile disease on a three-category scale that ranges from no impairment to extreme impairment. This particular table covers abnormalities involving male reproductive organs. Per AMA Fifth Edition Guides, Table 7-5, page 156, and other tables under Section 7.7 and other do not cover the issues adequately. In reviewing the medical records and incorporating the findings of the psychological testing, namely the clinically significant difficulties or limitations chart, Mr. Williams appears to have developed a Class 1 Impairment related to his sexual dysfunction disorder.

Table 7-5 Criteria for Rating Permanent Impairment Due to Penile Disease		
Class 1 0%- 10% Impairment of the Whole Person	Class 2 11%- 19% Impairment of the Whole Person	Class 3 20% Impairment of the Whole Person
Sexual function possible but with varying degrees of difficulty of erection, ejaculation, or sensation	Sexual function possible with sufficient erection but with impaired ejaculation and sensation	No sexual function possible

Sexual Dysfunction Disorders are ratable in Chapter 7 of the AMA Guides under Male Reproductive Organs Table 7-5 of the AMA Guidelines states that a Class 1 Male Reproductive Organs Impairment is one in which an individual experiences "Sexual function possible but with varying degrees of difficulty of erection, ejaculation, or sensation." Mr. Williams reportedly sometimes has no sexual desire. He has pain in his back during sexual intimacy. He still has sex four times per week.

Based upon his mild sexual dysfunction of Class 1 impairment, the level of his current sexual impairment is equal to a 1% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injuries.

CAUSATION OF SUBSEQUENT DISABILITIES AND LABOR IMPAIRMENT

Mr. Williams injured himself at Walmart on CT: September 9, 2018- March 20, 2019, CT: October 1, 2018 - March 15, 2019, and SI: January 22, 2019 while employed as a Receiving Clerk. He injured his back, neck, and shoulders. He sustained injury from repetitive movement, stress from working in a hostile work environment, and from a specific incident. As a result of this subsequent

injuries, Mr. Williams developed psychiatric symptoms. My evaluation on May 5, 2021 consisted of a clinical interview, mental status exam, review of medical records, and psychological testing. The results of my evaluation found that Mr. Williams currently suffers from Major Depression, Single Episode, Moderate with Anxious Distress; Pain Disorder Associated with Both Psychological Factors and a General Medical Condition; Insomnia Related to Anxious Disorder; and Male Hypoactive Sexual Desire Disorder.

These disorders and his functional limitations qualified him for a GAF of 48 - which is equivalent to a WPI of 34%.

Mr. Williams has been diagnosed with Insomnia Related to Anxious Disorder caused by the subsequent injuries. Sleep disorders are ratable in Chapter 13 of the AMA Guides under Sleep and Arousal Dysfunctions. Table 13-4 of the AMA Guidelines states that a Class 1 Sleep and Arousal Disorder is one in which an individual experiences "Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living." A score of 15/24 is equal to excessive sleepiness, or class 1 impairment. **Based upon his chronic sleep dysfunction that arose out of his subsequent injuries, the level of his sleep impairment is equal to a 7% disability rating.**

Mr. Williams has been diagnosed with Sexual Dysfunction Disorder, specifically Male Hypoactive Sexual Desire Disorder caused by the subsequent injuries. Sexual Dysfunction Disorders are ratable in Chapter 7 of the AMA Guides under Male Reproductive Organs Table 7-5 of the AMA Guidelines states that a Class 1 Male Reproductive Organs Impairment is one in which an individual experiences "Sexual function possible but with varying degrees of difficulty of erection, ejaculation, or sensation." His problem with less sexual desire and pain in his back during sexual intimacy is equal to mild impairment, or class 1 impairment. **Based upon his sexual dysfunction that arose out of his subsequent injuries, the level of his sexual impairment is equal to a 1% disability rating. Based on his history, his condition is attributable to compensable consequences of orthopedic issues.**

It is my opinion that Mr. Williams's subsequent psychiatric injury was not predominantly caused by the actual events of employment, because he had pre-existing psychiatric conditions that interfered with his employment prior to the subsequent injuries, such as being fired for fighting with colleagues regarding anger issues.

This issue is clearly seen via an examination of his GAF and WPI scores prior to and subsequent to his injuries. Mr. Williams's prior GAF score of 50 equates to a WPI of 30%. Following his subsequent injuries, his psychiatric condition deteriorated significantly. The increase in depressive and anxiety symptoms resulted in a decrease of his GAF to 48 - which means his disability increased by 4% to 34%. The subsequent injuries disability do not represent the predominant cause of his overall disability rating.
GIVEN THE LENGTH OF TIME THAT HAS EXPIRED AND THE CONSISTENCY OF PSYCHIATRIC SYMPTOMS SINCE THEIR INCEPTION, IT IS MY OPINION THAT MR. WILLIAMS'S PSYCHIATRIC DISABILITY IS NOW PERMANENT AND STATIONARY.

Mr. Williams's psychiatric injury is labor disabling and requires the following work restrictions:

- **Part-time schedule with frequent breaks due to his fragile and emotional states (from his depression, anxiety, and anger).**
- **Flexible schedule to accommodate Mr. Williams's need for weekly psychotherapy.**
- **Flexible schedule to accommodate Mr. Williams's sleep disorder.**
- **No assignment of excessive job pressures such as multiple, frequent deadlines, or frequently working with difficult people.**

Due to his cognitive difficulties from his depression and anxiety, Mr. Williams requires the following:

- **Accommodation of increased time due to slower pace and persistence.**
- **Understanding supervisor to break larger tasks into a series of smaller ones.**
- **Frequent feedback on performance with sensitivity to Mr. Williams's struggles with criticism and feedback.**
- **Time to reconnect with co-workers given Mr. Williams's deteriorated social skills (resulting from his depressive symptoms of social withdrawal).**
- **Frequent feedback on performance by an understanding supervisor to accommodate Mr. Williams's low self-esteem (due to his depression, incontinence, and inability to function sexually).**

APPORTIONMENT BETWEEN DISABILITY STEMMING FROM SUBSEQUENT INJURY AND PRE - EXISTING DISABILITIES

As stated above, Mr. Williams had a pre-existing psychiatric disability that was permanent and stationary, ratable, and work limiting. His rating was as follows:

Preexisting Psychiatric Impairment:	30% WPI from GAF of 50

I believe that Mr. Williams's psychiatric condition was aggravated by the subsequent injuries and he subsequently experienced psychiatric deterioration. I believe the increase of his psychiatric impairment is not due solely to the subsequent injuries. Mr. Williams's current psychiatric disability rating is as follows:

Current Psychiatric Impairment:	34% WPI from GAF of 48
The subtraction method is applied	34% WPI minus 30 % WPI = 4% 4% WPI apportioned to the Subsequent Injury

PRE-EXISTING DISABILITY	SUBSEQUENT DISABILITY
Psychiatric disability - 30%	Psychiatric disability increased by 4% to 34%

Please note: The preponderance of psyche impairment only goes to causation of the psyche injury, not causation of the psyche disability.

The aforementioned ratings are unmodified and uncombined. Mr. Williams's disability from the subsequent and pre-existing is greater than that which resulted from the subsequent alone.

DISCLOSURE NOTICE

The history contained within this report was provided by Mr. Williams, and I personally took the necessary notes. I reviewed the complete history, testing, and notes, remarked on any additional information and made the necessary evaluations and interpretation.

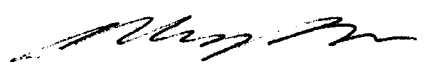
The final draft was submitted to me for my review and signature. I reserve the right to change my opinion based on additional medical evidence.

The medical records were typed by a transcription service. However, I reviewed the medical records directly and this time is reflected in the Complexity Factors section.

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

Disclosures, Disclaimers and Affidavit of Compliance: I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except to information I have indicated I received from others. As to that information, I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and I have not offered, delivered, received or accepted any rate, fund, commission, preference, patronage, dividend, discount, or any consideration, whether in the form of money of otherwise, as compensation, or inducement for any referred examination or evaluation, Moreover, Labor Code Section 4628J, requires the undersigned to indicated the county in which the document was signed. This document was signed in Huntington Park, Los Angeles County.
Signed this 25th day of May, 2021.

Respectfully,



Nhung Phan, Psy.D.

Clinical Psychologist
Ca. License No. PSY28271

Attached: Review of medical records

REVIEW OF MEDICAL RECORDS:
WILLIAMS, Kevin
DOB: 02/17/64

Pages Uploaded for Review: 630
Total Pages Reviewed: 630

Declaration and Attestation of Records: Total page count 606.

Application for Adjudication dated 09/09/19 w/DOI: CT 09/09/18 - 03/20/19. Stress and strain due to repetitive movement over period of time and due to lifting heavy boxes, injured lower back, neck, shoulders, upper extremities and lower extremities. Reported to supervisor and sent to industrial clinic. Employed for Wal-Mart Associates, Inc. as a Record Processor.

Application for Adjudication dated 09/09/19 w/DOI: CT 10/01/18 - 03/15/19. Pt reports stress due to hostile work environment, racial and sexual harassment. Employed for Wal-Mart Associates, Inc. as a Record Processor.

WC Claim Form dated 09/03/19 w/DOI: 01/2019; CT 11/2018 - 03/19/19. Stress and strain due to repetitive movement over period of time. Injured lower back/neck/shoulder.

WC Claim Form dated 09/03/19 w/DOI: CT 10/2018 - 03/15/19. Stress due to hostile work environment.

Compromise & Release dated 11/13/19 w/DOI: 01/22/19; CT: 10/01/18 - 03/15/19, CT 09/09/18 - 03/20/19. Settlement Amount: $15,000.00.

04/15/08 - Telephone Encounter by Jeffrey C. Petrilla, MD at Kaiser. Pt c/o LBP rated 7/10 since yesterday. Working on his car. Took Tylenol with partial relief. Recommended symptomatic care, OTC NSAIDs, heat, and stretches. Requesting for OWO for 04/14/08 & 04/15/08. Assigned to Chino Clinic as requested.

04/24/08 - Telephone Encounter by Jeffrey C. Petrilla, MD. Pt called and stated OWO should be for 2 days, but was only given 1 day. Doctor states pt didn't contact until 04/15/08 and cannot backdate OWO.

04/24/08 - Patient Message by Jeffrey C. Petrilla, MD. Received doctor's note stating pt states unable to attend work on 04/14/08 and has been ill and unable to attend work on 04/14/08. Filled FMLA papers but they need doctor's note to state pt was ill on both days 04/14/08 and 04/15/08.

04/25/08 - Telephone Encounter by Jeffrey C. Petrilla, MD. Informed pt that doctor cannot grant any OWO for the time before he contacted office. His OWO cannot be modified from how it was written in any format. Generally, FMLA is for serious medical conditions, not just couple of days of OWO for back pain. Pt is still having back pain and requesting appointment.

04/28/08 - Progress Note by Ernesto U. Campos, DO at Kaiser. Pt c/o subacute L sided LBP for 2 wks associated with some slight numbness on L side. Hurt back with twisting motion while working on car. Pain increased by walking and prolonged sitting. Pt tried NSAIDs. Unable to take higher doses due to having one kidney. Born with 3 kidneys and 2 were surgically removed. PE: Alert and oriented x3, no acute distress. Dx: Strain of back, L sided. Rx: Prednisone 20 mg and Nabumetone 500 mg. Plan: Ordered x-ray of lumbosacral spine. Ordered labs. Takes meds as directed. Advised stretching, exercises, massage, and ice or heat.

04/28/08 - Lab Rpt from Kaiser. MCV (H) 94.1. TSH (L) 0.33.

05/04/08 - X-ray of Lumbosacral Spine by Monica L. Leung, MD at Kaiser.
Impression: Mild degenerative changes. No definite acute fx identified.

05/08/08 - Patient Message by Ernesto U. Campos, DO. Pt was put on light duty and employer does not have light duty. Informed to call medical records to have disability forms filled out. Have FMLA/disability office that takes care of paperwork.

05/15/08 - Progress Note by Ernesto U. Campos, DO. Pt would like to go back to work. Pain almost completely resolved and much improved. Nabumetone helps. PE: Alert and oriented x3, no acute distress. Dx: Strain of back, almost resolved. Plan: Take meds as directed. Full duty.

04/02/16 - Lab Rpt from Kaiser. Globin fecal is within normal limits.

04/05/16 - Patient Message from Kaiser. Requested colorectal cancer screening.

04/15/16 - Progress Note by Christopher B. Yan, MD at Kaiser. Pt presents for annual physical exam. PE: Oriented to person, place and time. Does not appear dehydrated. Has non-toxic appearance. No distress. Psych: Mood, memory, affect and judgment normal. Dx: Routine adult health check up exam. Plan: Ordered labs.

10/20/16 - Progress Note by Grace A. Wan, MD at Kaiser. Pt c/o dizziness and light HA this morning at work. Needs note from doctor stating he is ok to return to work tomorrow. He is working more overtime as warehouseman. Admits to not eating usual breakfast and hydrating this morning before going into work. Work environment is climate-controlled. But notes break room was very hot, AC not working. SH: Drinks 14 cans of beer/wk. PE: Oriented to person, place, and time and well-developed, well-nourished and in no distress. Dx: Dizziness. Plan: Measure orthostatic vital signs. Ordered glucose, POCT.

10/20/16 - Lab Rpt from Kaiser. Performed glucose POCT and found to be within normal limits.

08/14/17 - Progress Note by Diana J. Lee, OD at Kaiser. Pt c/o decreased vision distance. Employed as a Warehouseman for 2 yrs. PE: Oriented in time, place, and person. Mood is normal. Dx: 1) B/L incipient cataract. 2) Presbyopia. 3) B/L myopia. 4) B/L astigmatism. Plan: Requested refraction assessment.

01/11/18 - Progress Note by Christopher B. Yan, MD. Pt c/o occasional urinary frequency and erectile dysfunction. SH: Drinks 14 cans of beer/wk. Dx: 1) Routine adult health check up exam. 2) Urinary frequency. 3) Erectile dysfunction. Rx: Sildenafil 20 mg. Plan: Ordered labs.

01/11/18 - Lab Rpt from Kaiser. RBC auto (L) 4.61. LDL (H) 120. HDL (L) 36.

03/27/18 - Patient Message by Christopher B. Yan, MD. Reviewed lab test and requested to start low dose cholesterol med, Atorvastatin 20 mg.

08/27/18 - Patient Message by Christopher B. Yan, MD. Pt stopped drinking beer and changed his diet. Requesting refill of generic Viagra, which is working now.

09/14/18 - ED Rpt by Teri L. Vieth, MD at Kaiser. Pt presents to ED with sharp, severe and continuous abdominal pain associated with bloating. Current Meds: Revatio 20 mg, Viagra 100 mg and Lipitor 20 mg. SH: Drinks 14 cans of beer/wk. PE: Well-developed, well-nourished, and mild distress. Psych: Normal affect. Alert and oriented to person, place, and time. ED Course: Ordered and reviewed labs and CT of abdomen and pelvis. Treated with meds. Dx: 1) Small bowel obstruction. 2) Upper abdominal pain. 3) Vomiting. 4) Abdominal distention. Plan: Consulted general surgery.

09/14/18 - H&P by Jason P. Laird, PA/Lori J. Chow, MD at Kaiser. Pt presents with c/o progressing abdominal pain beginning today, which became severe. States he fell to the ground and called 911 this afternoon. Had lunch today at work w/o issue, with pain beginning after. Admits to associated nausea with pain, with first episode of vomiting occurring here in ER after attempting to ingest contrast. States his belly was bloated. Last had BM today. Admits drinking beer daily. PMH: Hyperlipidemia. SH: Drinks 14 cans of beer/wk. Current Meds: Revatio 20 mg, Viagra 100 mg and Lipitor 20 mg. PE: AA&O x3. Dx: Small bowel obstruction on imaging. Plan: Admit to surgical service. NPO, IV fluids and NG tube.

09/14/18 - Lab Rpt from Kaiser. WBC auto (H) 15.6. MCV (H) 95.3. Glucose, random (H) 142. Bilirubin total (H) 1.3. Specific gravity, UA (H) 1.049. Protein, UA (A) 30 (1+). Leukocyte esterase, UA (A) positive. Urobilinogen, UA, QL (A) 2.0 (1+). Neutrophils absolute automated count (H) 12.70. Monocytes automated count (H) 1.1.3.

09/14/18 - Rhythm Strip from Kaiser.

09/15/18 - CT of Abdomen & Pelvis by Jerome Tsai, MD at Kaiser.
Impression: 1) Findings are suspicious for small bowel obstruction. There is small volume ascites. 2) L and sigmoid colons appear collapsed with apparent mild wall thickening which may be related to under distention. Mild nonspecific colitis would be difficult to exclude. Correlate clinically. 3) Moderate bibasilar subsegmental atelectasis and/or scarring, L > R with infiltrate not excluded. Correlate clinically. There are couple small pulmonary nodular opacities. Please refer to regional guidelines for management of small pulmonary nodules. 4) Suggestion of mild fatty liver. There

is small mildly ill-defined indeterminate focus of apparent enhancement at posterior R liver. 5) L kidney is not identified.

09/15/18 - Progress Note by Lori J. Chow, MD. Pt is feeling the same, will allow attempt at NGT, wants water for dry mouth. PE: Alert, in no acute distress, and oriented. Assessment: Admitted overnight for SBO, not able to tolerate NGT placement last night. Plan: RN to try again this AM. Pt to have SBFT later today if abnormal will take to OR tomorrow.

09/15/18 - X-ray of SM Bowel by Jerome Tsai, MD at Kaiser.
Findings/Impression: Initial scout images demonstrate multiple dilated loops of small bowel throughout abdomen and pelvis in keeping with small bowel obstruction as seen on recent CT exam. No large volume free air is identified. Following instillation of contrast, contrast appears to remain within stomach during majority of exam. At the 2 hour mark, contrast remains within stomach. At 4 hour mark, small amount of contrast appears to be extending into duodenum. However, it was reported that at this time nurse applied suction, thus removing an indeterminant amount of contrast from exam. This was discussed with ordering physician, Dr. Bowman, who agreed to terminate exam at this time. F/u abdominal radiographs will be obtained. Given difficulty in passage of contrast and persistent dilated loops of small bowel, small bowel obstruction remains considered with degree of gastric outlet obstruction not excluded.

09/15/18 - Lab Rpt from Kaiser. WBC auto (H) 15.5. MCV (H) 96.

09/15/18 - Care Planning Progress Note from Kaiser.

09/15/18 - Multidisciplinary Progress Note from Kaiser.

09/16/18 - X-ray of Abd by Furhawn A. Shah, MD at Kaiser.
Findings/Impression: An enteric tube is visualized as far as proximal stomach with tip obscured by overlying contrast. Unchanged contrast opacifies stomach. No significant contrast is visualized within small or large bowel. Stable multiple dilated loops of small bowel measuring up to 4.7 cm. The colon is largely collapsed. These findings remain concerning for small bowel obstruction with possible degree of gastric outlet obstruction not excluded. No evidence of pneumoperitoneum on this limited supine view.

09/16/18 - Progress Note by Lori J. Chow, MD. Pt has diarrhea x 2 overnight, not sure if passing gas, feels better overall though mouth is dry. PE: Alert and in no acute distress. Dx: Small bowel obstruction. Plan: Ordered x-ray of KUB. Continue plan.

09/16/18 - X-ray of KUB by Furhawn A. Shah, MD at Kaiser.
Findings/Impression: Stable enteric tube tip projects over proximal stomach. L upper abdominal surgical clips. Interval worsening small bowel dilatation measuring up to 5.9 cm. The contrast as progressed opacify colon. Interval worsening progression of contrast to opacify colon. The differential includes partial small bowel obstruction or ileus. Recommend clinical correlation and

continued attention on imaging to resolution of small bowel dilatation. No evidence of pneumoperitoneum on this limited supine view.

09/16/18 - Lab Rpt from Kaiser. RBC auto (L) 4.60. MCV (H) 97.1.

09/17/18 - Anesthesia Encounter by Mona Limm, MD at Kaiser.

09/17/18 - Progress Note by Lori J. Chow, MD. Feeling more normal/better, not sure if passing gas, did have loose stool this AM. PE: Alert, in no acute distress and oriented. Dx: Small bowel obstruction. Plan: Requested diagnostic laparoscopy, possible exploratory laparotomy.

09/17/18 - Operative Rpt by Lori J. Chow, MD. Pre/Postop Dx: Partial small bowel obstruction. Procedure Performed: Laparoscopy diagnostic and lysis of adhesions.

09/17/18 - X-ray of KUB by Sangku Kang, MD at Kaiser.
Findings/Impression: 1 view. Portable. Contrast in colon. Dilated small bowel loops. Partial obstruction and/or ileus. No significant interval change since yesterday's KUB.

09/17/18 - Lab Rpt from Kaiser. Sodium (L) 133. Chloride (L) 100. MCV (H) 95.3.

09/18/18 - Progress Note by Lori J. Chow, MD. Pt is s/p day 1 after procedure. Feels good, ready for home, eating full liquids and enjoying it. PE: Alert, in no acute distress, and oriented. Dx: Small bowel obstruction. Plan: D/c home.

09/18/18 - Lab Rpt from Kaiser. Performed BUN and creatinine and found to be within normal limits.

09/18/18 - Discharge Summary by Lori J. Chow, MD. Pt admitted for SBO, clinically improved somewhat and contrast into colon but persistent dilated small bowel in central abdomen so taken to OR for laparoscopy at which time likely congenital mesenteric fold causing obstruction was identified and lysed. Post-operatively, pt has done well and feels much better and felt ready for DC home. Discharge Dx: Small bowel obstruction. Discharge Meds: Hydrocodone-Acetaminophen 5-325 mg, Docusate Sodium 100 mg, Revatio 20 mg, Viagra 100 mg and Lipitor 20 mg. Plan: Encouraged regular walking and exercise. Disposition: Discharged to home in stable condition. Return to work on 09/24/18.

09/18/18 - Anesthesia Postop Note by David Khatibi, MD at Kaiser.

02/17/19 - Patient Message by Christopher B. Yan, MD. Informed pt that he has an active prescription for Sildenafil 20 mg.

03/28/19 - Progress Note by Diana J. Lee, OD. Pt presents for lost glasses. PMH: Hyperlipidemia and small bowel obstruction. Current Meds: Sildenafil 20 mg and Atorvastatin 20 mg. PE: Appears

to be oriented in time, place and person. Mood is normal. Dx: 1) Presbyopia. 2) B/L astigmatism. 3) B/L myopia. 4) B/L incipient cataract. 5) B/L pinguecula. Plan: Prescription given.

08/01/19 - Patient Message by Christopher B. Yan, MD. Pt reports B/L calf swelling x1 wk. Requesting appointment sooner, scheduled.

08/22/19 - Progress Note by Ameerah A. Shaban, MD at Kaiser. Pt presents with constant B/L ankle swelling x2 wks. Has 1 kidney, born with 3 kidneys and 2 removed at age 5 as they were not functioning. Does not exercise. Mother passed away in May and has been lazy and has been working from home and not moving around much. Drinks 2 beers a day. Has been wearing thermal socks/compression socks to bed. PE: Well-developed, well-nourished, and in no distress. Psych: Affect normal. Dx: 1) Swelling of B/L legs. 2) Unhealthy drinking behavior. 3) Abnl increased body weight. 4) H/o nephrectomy. 5) Hyperlipidemia. Plan: Recommended compression stocking during day, leg elevation at home and exercise. Ordered labs. Recommended diet and exercise.

08/22/19 - Lab Rpt from Kaiser. HDL (L) 30. LDL (H) 118. Triglyceride nonfasting (H) 183. MCV (H) 95.1.

08/23/19 - Patient Message by Ameerah A. Shaban, MD. All labs completed yesterday were normal except elevated triglycerides and bad cholesterol. Recommended low fat diet and exercise. Kidney function was normal but slightly worse than last time it was checked. Recommended to drink more fluids.

11/12/19 - Psychological Testing Rpt by Nelson J. Flores, Ph.D. at Psychological Assessment Services. This complex psychological testing was administered for diagnostic purposes, as well as to thoroughly explore issues of personality, cognition, malingering and/or exaggeration. On Medical and Psychiatric Symptom Checklist, pt reported variety of symptoms indicating depression, anxiety, sleep difficulties, sexual difficulties, memory problems, attention span deficits, GI disturbances and physical complaints. On BAI, pt obtained score of 6, is indicative of minimal clinical levels of anxiety. On BDI, obtained score of 34, is indicative of severe levels of depression. T-score on MMPI-2, L 65, F 67, K 60, HS 81, D 83, HY 84, PD 67, MF 50, PA 72, PT 70, SC 63, MA 43, and SI 55. On Raven's Standard Progressive Matrices, pt score of 23 places him within 29th percentile relative to people of his age. Pt was alert and there is no indication that pt may be experiencing neuropsychological disturbances. On Epworth Sleepiness Scale pt obtained a score of 14, which is indicative of moderate excessive daytime sleepiness. On Insomnia Severity Index obtained a score of 17, which is indicative of moderate clinical insomnia. Discussion: Pt was administered comprehensive battery of psychological tests to help in dx of possible emotional and psychological disturbances. Completed the battery of psychological tests in cooperative manner. During the pretest and the testing sessions, his mood was anxious and sad. Showed no impairment in production of speech or his thought process. Denied any perceptual disorder. Results of psychological tests suggest pt is reporting minimal clinical levels of anxiety and severe levels of depression. Test data suggests that pt's intellectual functioning appears to be impacted by his current set of symptoms.

03/04/21 - Patient Message by Christopher B. Yan, MD. Pt is having personal and financial problem, so had to cancel appointment. Not working right now because of cutbacks. Reports urine stream slows down or sometimes even stops. States he wants to only have an appointment with Dr. Yan.

03/11/21 - VAV by Christopher B. Yan, MD. Pt c/o urinary urgency and frequency. It is sometimes hard to push urine out. PE: Well appearing, no apparent distress. Dx: 1) Urinary frequency. 2) Urinary urgency. Rx: Ciprofloxacin 500 mg. Plan: Ordered labs. Referral to urology.

03/25/21 - TAV by Kent K. Miyamoto, MD at Kaiser. Pt referred for urinary frequency, hesitancy and intermittent urinary stream for past 1 month. Prior to this time, he voided w/o difficulty. H/o R nephrectomy at age 5, possibly related to infection or nonfunction. Consumes sodas and beer daily. Advised to avoid dietary bladder irritants. Dx: 1) Urinary frequency. 2) Urinary urgency. 3) H/o nephrectomy. Plan: Continue ongoing med reconciliation.

NP/rpc/ft

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: **Williams, Kevin** *(employee name)* v **Walmart Associates, Inc.** *(claims administrator name, or if none employer)*

Claim No.: **SIF12524618**

EAMS or WCAB Case No. *(if any)*: **ADJ12524618**

I, **RAYLENE TENORIO** *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: **1680 PLUM LANE, REDLANDS CA 92374**
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	06/07/21	Subsequent Injures Benefit Trust Fund- SENT ELECTRONICALLY
A	06/07/21	Workers Defenders Law Group 8010 E. Santa Ana Canyon, Ste. 100-215 Anaheim Hills, CA 92808 Attn: Natalie Foley, Esq.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 06/07/2021

Raylene Tenorio
(signature of declarant)

RAYLENE TENORIO
(print name)