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August 6, 2012

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OCT 2 7 2012
Received

RE: **Timothy Smith**

Employer:	U.S. Foodservice, Inc.
EAMS Number:	ADJ 7562162
Claim Number:	004063-060555-WC-01
Date of Injury:	CT 11/3/09 – 11/3/10
Date of Exam:	August 6, 2012

AGREED MEDICAL EXAMINATION IN PSYCHOLOGY

On August 6, 2012, Timothy Smith underwent an initial Agreed Medical Examination in Psychology at Comprehensive Psychological Service, Inc.'s Encino office. At your request, this evaluation addressed all relevant medical-legal issues including diagnosis, temporary disability, permanent disability, causation, apportionment, and future treatment. The condition was evaluated and the time spent was beyond what is contemplated for a complex medical-legal evaluation and therefore is extraordinary in circumstances.

WARNING: Psychological reports are highly confidential; the contents should not be revealed to anyone except those professionals who are directly involved in the processing of the claim. It is particularly important that the contents of a psychological report not be shown or given to the subject of the examination. Major distortions and misinterpretations of the report may occur and unnecessary emotional upset of the applicant would result. This report should not be read to the applicant, even in part, for the above reasons. Any person ignoring or violating this admonition must assume full responsibility for the applicant's subsequent reactions.

Method of Evaluation:

The evaluation of Timothy Smith was conducted as follows. Factors of complexity included the need to address causation and apportionment, as well as a highly individualized interplay of stressors that required assessment of both industrial and non-industrial elements. The interview required far more than the minimum of 2.00 hours face-to-face time.

On August 6, 2012, David Freeman, Ph.D., Qualified Medical Evaluator and Licensed Clinical Psychologist, conducted a comprehensive medical-legal examination. Dr. Freeman, with the assistance of Patricia Hesterly, Ph.D., Qualified Medical Evaluator and Licensed Clinical Psychologist, conducted a face-to-face interview, a mental status examination and gathered a detailed clinical history of the alleged work place injuries, as well as the applicant's past history and current condition. Total face-to-face time with the physicians was 5.50 hours.

Drs. Freeman and Hesterly reviewed all relevant records (4.25 hours).

Psychological testing was administered and scored in our offices and interpreted by Drs. Freeman and Hesterly, along with computer-generated profiles and reports provided by NCS Assessments.

Following the clinical interview, Dr. Freeman and Dr. Hesterly conferred together on all aspects of the case. Based on their conclusions, Dr. Hesterly prepared an initial draft of the historical and clinical sections of the report and Dr. Freeman prepared the medical-legal opinions and edited the entire report. All opinions expressed herein are those of Dr. Freeman. Total report preparation time was 13.75 hours.

Sources of fact/Admonition:

Sources of fact for this report include a comprehensive psychological examination of Timothy Smith conducted on August 6, 2012, psychological testing administered in our office and completed the same day and the review of the medical file and collateral data. All this information was carefully reviewed and incorporated into the ultimate findings and opinions reflected in this report.

The applicant was explained the medical-legal purpose of this evaluation, that we did not have a confidential doctor-patient relationship, and that a report would be filed. The examinee appeared to understand this admonishment.

BILLING STATEMENT UNDER ML104 – revised July 1, 2006

This report falls under the new billing guidelines for Medical-Legal reporting as revised by the Administrative Director for implementation as of July 1, 2006 and specified in *Title 8, California Code of Regulations, Chapter 4.5, Division of Workers' Compensation.*

Section 9795 amends the medical-legal fee schedule for Workers' Compensation and designates fees for billing medical-legal evaluations under code **ML 104**. "The physician shall be reimbursed at the rate of **RV 5**, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician" *($12.50 x 5 = $62.50 per quarter hour, or AME's at $15.625 x 5 = $78.13 per quarter hour).*

This medical-legal psychological evaluation involved extraordinary circumstances. This was a complex case, which required a lengthy face-to-face psychological examination of two hours or more, the careful review and analysis of a medical file and collateral data, the analysis of psychological testing results, and may have necessitated medical and legal research on the Workers' Compensation issues involved and/or the issue of denial or modification of treatment, as well as addressing the questions of medical causation, apportionment, multiple employers and/or body parts.

This *Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances* meets the ML104 criteria by addressing four or more of the following complexity factors:

- ✓ 1. two or more hours of face-to-face interview.
- ✓ 2. two or more hours of record review.
- ☐ 3. two or more hours of medical research.
- ☐ 4. four or more hours spent on complexity factors 1-3 (two complexity factors).
- ☐ 5. six or more hours spent on complexity factors 1-3 (three complexity factors).
- ✓ 6. addressing the issue of medical causation.
- ✓ 7. addressing the issue of apportionment.
- ☐ 8. addressing the issue of medical monitoring following toxic exposure.
- ✓ 9. a psychiatric or psychological evaluation.
- ☐ 10. addressing the issue of denial or modification of treatment.

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

a.	Face-to-face time with the applicant	5.50 hours
b.	Medical research, review of records and prior reports and significant commentary on medical records	4.25 hours
c.	Conceptualization, dictation of rough draft, corrections and preparation of final draft	13.75 hours
	TOTAL:	23.50 hours

I. INTRODUCTION/IDENTIFYING INFORMATION

Timothy Smith is a 48-year-old, left-handed, currently separated, Caucasian male who lives in Whittier, California.

Mr. Smith was employed as a Logistics Supervisor for U.S. Foodservice, Inc. from June 11, 2007 until November 3, 2010. He last worked on November 3, 2010, at which time he was placed on a medical leave of absence due to stress-related complaints associated with his allegations of an excessive workload with unrealistic expectations while in the course of performing his usual and customary job duties. Additionally, he reported the development of chronic pain between his neck and middle back and across both shoulders associated with the repetitive nature of his job duties working at a computer as long as 60 hours a week and internal medical conditions, hypertension, chronic headaches and gastrointestinal disturbances, which he believes are solely stress-related conditions. He further alleges the development of multiple psychological symptoms and long-term functional impairment from a psychological perspective. These symptoms have contributed to a disruption in the quality of his life with a chronic fatigue due to poor sleep, diminished libido and severe symptoms of depression and anxiety. He has not resumed gainful employment nor has he worked in any other capacity.

II. DESCRIPTION OF APPLICANT/MENTAL STATUS EXAMINATION

Mr. Smith was driven to this morning's examination by his mother, and he arrived promptly for the appointment. He reported being able to drive short distances on city streets, but being unwilling to drive the freeways because he is so anxious he doubts his ability to safely operate a vehicle at freeway speed. He reported his height to be 5 feet, 11 inches and his weight to be 225 pounds. This reflects a gain of 25 to 35 pounds over what Mr. Smith believes his normal weight to be. In his opinion, the weight gain is a consequence of all the medications he has been taking for his mood disturbance symptoms as well as the lack of any physical activity since he last worked. He was adequately groomed and neatly dressed, wearing black slacks, a dress shirt open at the collar, dress shoes and glasses. His hair was short, and he had a neatly-trimmed, greying goatee. He appeared to be his stated age of 48 years and obese.

There was no pain behavior apparent throughout the course of the evaluation. Mr. Smith walked with a normal gait; he did not shift in his chair or demonstrate any other pain behavior. He sat in a fairly slouched position within the chair and repeatedly stated how tired he felt. When asked, he reported that he actually had a good night's sleep the night prior to this evaluation; he indicated that the fatigue he feels on a constant basis is a consequence of all the medications he takes. He feels groggy when he awakens each

morning. There was no psychomotor slowing, restlessness or agitation. There were no unusual mannerisms or excessive gesturing.

Mr. Smith presented as pleasant and cooperative, demonstrating good eye contact with the evaluators. He also presented in an open and friendly manner; rapport was easily established and well maintained during the evaluation. The purpose of this evaluation was discussed; the applicant demonstrated good motivation and effort on a formal symptom validity measure, which was administered at the onset of the evaluation. Although Mr. Smith exhibited a tendency to be digressive at the onset of the evaluation, when prompted, he kept his answers to the topic at hand. His answers were thoughtful and provided sufficient details with respect to his clinical history.

The applicant spoke in a normal tone of voice and at a normal rate, appearing fully capable of adequately expressing his thoughts and feelings. There were no word-finding delays and his comments remained relevant to the topic at hand throughout the lengthy interview.

Mr. Smith's mood was noticeably depressed and anxious. This was consistent with his self-report. He displayed a very limited range of emotional expression, never smiling or appearing at ease. He became tearful at a number of points during the evaluation, most particularly when discussing the impact of the stressors at work upon his current functioning. At least twice during the evaluation he needed approximately 20 or 30 seconds to regain his composure when he cried. He denied current suicidal ideation and/or homicidal ideation.

The applicant demonstrated no psychotic processes as would be the case with delusions, hallucinations, tangential responses, or flight of ideas. His thought processes were logical and adequately organized. Based upon his overall presentation, occupational history and educational achievement, his intellectual functioning is estimated to be within the high average range. Overall, his judgment appeared intact; however, his insight into the psychological aspects of his condition was fair, though sufficient for the purposes of the evaluation.

III. CURRENT CONDITION

Physical Complaints

Mr. Smith reported that his primary physical concern at this time is an area of his back between his shoulder blades, traveling up his spine to his neck. He characterized the pain as an aching pain if he is inactive; this pain can become more severe with any activities. He used to be an avid golfer; in the 18 months since he stopped working, he has gradually

decreased his involvement in golf because this particular pain intensifies dramatically after golfing. At its worst. the pain rates an intensity level of 9/10 (with zero representing no pain at all and 10 representing excruciating pain). He has discovered a means by which he can relieve this pain. He leans up against a pole in his house, putting pressure on this area of his spine by leaning into the pole until he hears a popping sound. Once he hears this popping sound. the pain in this area of his back rates an intensity level of 3/10, and it remains at that reduced level for about 24 hours. He engages in this activity twice weekly. Additionally, he utilizes a TENS unit, although he does not experience any particular benefit from this. As well, when first beginning treatment with the orthopedic surgeon, Dr. Capen, the applicant was provided with what he called a "neck stabilizer," described as a device that wrapped around his neck and was intended to take the pressure off his cervical spine. This pain emerged in the spring of 2008.

The second area of physical concern described by Mr. Smith is the bilateral shoulders. This is actually pain that radiates from the neck across both shoulders and feels tense and aching. As long as he is experiencing pain between the thoracic region and his neck, the applicant has the bilateral shoulder pain. At its worst. this pain rates an intensity level of 8/10. It subsides completely for one or two days after he "pops" his spine. as described above. Then the pain gradually increases to the higher intensity level.

Mr. Smith currently does not have access to prescription pain medication. He utilizes over-the-counter-strength Tylenol approximately three times a week. This only takes the edge off the more severe levels of pain.

As to the activities in which the applicant must engage, he reported that he can perform all household tasks necessary such as cooking, cleaning or doing his laundry. However, he does these tasks at a much slower pace. He rests frequently throughout the period of time he is engaged in such tasks. He purchases only prepared foods, like frozen dinners, to avoid prolonged cooking activities. This is particularly noteworthy because Mr. Smith has received some informal training as a chef, and he derives a great deal of pleasure from cooking. As to recreational activities, the applicant can no longer play golf because of the upper back-to-neck pain. When this became more of a problem, he tried to play a less strenuous version of golf, called "pitch and putt;" currently, he is even unable to engage in this activity without causing the back pain to intensify.

Review of Systems

Mr. Smith reported having headaches usually every other day. On the days that he has a headache, he wakes up with the headache; he located the headache pain in the temporal region of his forehead. The headache pain rates an intensity level of 7/10; Mr. Smith is prescribed Neurontin, which he takes prophylactically each night. He believes the headache responds to Neurontin overnight on the occasions that he wakes up headache-

free; on the other hand, the other mornings when he wakes up with a headache; he simply finds that stress has been too overwhelming for the Neurontin to be effective. The headaches began in the fall of 2007.

With respect to gastrointestinal complaints, Mr. Smith experiences nausea with vomiting at least twice a month. He has associated more intense times of stress with these bouts of nausea and vomiting. Additionally, he experiences alternating constipation and diarrhea, switching between the two conditions approximately every two or three days. He is prescribed medication for each issue through Dr. Leoni. A review of Dr. Leoni's records reveals he has diagnosed the applicant with irritable bowel syndrome.

As to dizziness. Mr. Smith reported frequent episodes of dizziness. more recently of such severity as to cause him to be unsteady on his feet. Two months ago. during such an episode. he fell backwards and struck his head on the kitchen counter. He was unconscious for a brief period of time. and he sustained a cut on his head. Upon regaining consciousness. he was fully aware of where he was and what had happened to him. although he felt dazed and he had a headache. The dizziness had dissipated. He did not seek medical attention on this occasion.

Mr. Smith reported that he was diagnosed with hypertension in February 2012; however. information within the medical records suggests that he was initially diagnosed with this condition on November 14, 2007 by Dr. Lejano at Kaiser Permanente. Mr. Smith acknowledged that he was, in fact, diagnosed with hypertension at that time and he was placed on antihypertensive medication quite briefly. Within two or three months, Dr. Lejano determined that his blood pressure had stabilized and he told the applicant he no longer required this medication. On the other hand, his primary treating physician. the psychiatrist, Dr. Nehorayan, referred the applicant for an evaluation leading to the February 2012 diagnosis. Currently, the applicant takes Lisinopril for this condition. On this same occasion, that is, in about February 2012, Mr. Smith was also diagnosed with borderline diabetes. Currently, he does not require medications to control his blood sugar level; however, he is fully aware that he must lose weight in order to avoid such medications. He has tried to be more attentive to an appropriate diabetic diet.

Mr. Smith spoke at some length on the effect the weight gain has had on his well-being. In addition to having the potential to seriously affect his medical conditions, he feels unattractive because of his weight gain. He is aware that his orthopedic pain could be improved if he were able to lose weight; he is also aware that he might be able to engage in some physical activity without increasing his pain if he lost some weight.

Mr. Smith has an extensive history of sinus problems, which ultimately led to a surgical intervention. This will be discussed thoroughly in the Past History section of this report

to follow. Mr. Smith was diagnosed with asthma as a child. He has required medication to stabilize this condition throughout his life.

The applicant feared he was having a heart attack on an occasion in about 2006; he underwent a full cardiac workup and no abnormalities were discovered. The physician informed him that he had a pinched nerve underneath his ribcage and this had been the source of his pain.

The applicant denied any other chronic medical conditions or any history of consultations for cardiovascular, cerebrovascular or neurological concerns, anoxia, hypoxia, cancer, motor problems or exposure to toxins or heavy metal exposure. Finally, he denied any history of seizures or vertigo.

Medical Treatment

Currently, Mr. Smith does not see any Workers' Compensation physicians. He has been released by both Drs. Capen and Leoni. He receives all of his medical treatment through Kaiser Permanente, and he consults there regularly for medications for the hypertension and for the monitoring of his diabetic condition.

Neurovegetative Functioning

With respect to his sleep, Mr. Smith stated, "I'm not sleeping." He has no difficulty initiating sleep because of a number of psychotropic medications he takes at bedtime. However, after about five hours, between 2 a.m. and 3 a.m., he awakens. He has no idea what causes him to wake, and he stated he cannot return to sleep. Initially, he could not offer any explanation as to why he is unable to fall asleep, stating, "I'm just wide awake." However, with some questioning, he acknowledged that ruminations interfere with his ability to return to sleep for about 30 or 60 minutes in the middle of the night. The applicant became quite tearful at this point in the evaluation, acknowledging that he ruminates on how much money he has borrowed, the fact that he and his wife have now separated and the uncertainty of his recovery. While he sleeps between seven and eight hours each night, it is broken sleep. He never feels rested and, as noted, he feels groggy every morning.

As to his appetite, Mr. Smith finds that food continues to taste good to him; although he acknowledged that he eats emotionally. Because he has been trying to control his food consumption in order to lose some weight, he began drinking a great deal of water to distract himself from eating. In the last several months, he has been successful by losing five pounds.

Initially, Mr. Smith denied that there has been any loss of interest in sexual intimacy; on the other hand, he has been unable to achieve an erection since he was first prescribed psychotropic medications in December 2010 by Dr. Nehorayan. He believes that it is only the psychotropic medications that are responsible for his inability to achieve an erection and, thus, have some normalcy in his sex life. However, when we asked the applicant the nature of his sexual intimacy with his wife prior to the work-related stress issues, he indicated that they had sex only about once a month because his wife was disinterested. He and his wife have not engaged in any sexual intimacy in the more-than 18 months since he began taking psychotropic medications. While he acknowledged that this loss is significant, from his perspective, it is not nearly as significant as the financial strain of all the money he has borrowed or his current separation from his wife.

Neurocognitive Complaints

The applicant reported that he is forgetful, often misplaces things within his home and he forgets the names of people he should know. He feels confused much of the time and, as a consequence, he is easily distracted from tasks or in the midst of a conversation. He does not retain information he has read and he struggles to make decisions. As noted earlier, it was observed during the course of this evaluation that the applicant was, indeed, easily confused and distracted. From his perspective, Mr. Smith became aware of these changes in his cognitive functioning in late 2009 or early 2010, reactive to experiences of stress at work.

Emotional Complaints

Mr. Smith described depression as his primary emotional complaint, noting that he feels sad, discouraged and hopeless. He further reported that he cries every day, sobbing for as long as 20 minutes at a time. This is provoked by the sense of hopelessness that he experiences. Each night, as he takes the various psychotropic medications, he feels "bummed out," reminded of the extent to which his mental health has deteriorated. The sense of loss the applicant experiences is compounded by his lack of financial resources. He has cashed in his entire 401K monies, exhausted his savings and borrowed against an inheritance. He acknowledged that he has considered suicide as an option, but only as a last resort. He denied currently having any specific plans or any intent to harm himself; he cited his mother as a deterrent.

Mr. Smith reported a profound lack of confidence and loss of self-esteem as he has watched the quality of his life slowly deteriorate. He and his wife are currently separated, and this is yet another reminder of all that he has lost. He ruminates throughout the day on the extent of his losses, and as he does so, anxiety gradually intensifies. He tries to avoid this, but at least once a week he is unable to do so. When he gets significantly

anxious, he gets a panicked feeling, and he experiences physiological correlates such as trembling and shaking. This almost always happens when he is faced with paying bills. The applicant utilizes the anti-anxiety agent Ativan every day, trying to keep these symptoms minimized.

Overall, Mr. Smith rated the intensity of his emotional distress at a level of 7/10 (with zero representing no emotional distress at all and 10 representing emotional distress of such intensity as to warrant psychiatric hospitalization), noting that it is a constant, daily experience. He had a great deal of difficulty stating when precisely these symptoms began; he was much more aware of physiological correlates of stress such as headaches. Indeed, he did not think that he actually began to recognize that he was depressed until he stopped working despite the fact that he was receiving mental health care at Kaiser Permanente for more than a year before his last day of work. He acknowledged during the course of this evaluation that he simply did not understand the nature of depression or anxiety, and he simply saw all of his experiences at work leading up to his last day with his employer as stress.

Mental Health Treatment

In approximately December 2010, the applicant first consulted with Dr. Nehorayan, a psychiatrist, who became his primary treating physician. Through Dr. Nehorayan, he was referred to a Ms. Jill Adler, a therapist. He participated in every-other-week mental health counseling sessions for about one year throughout 2011; he did not think this was particularly beneficial treatment. For about one year during parts of 2009 and 2010, he was receiving mental health treatment at Kaiser Permanente. There was a psychiatrist there who provided medications such as Ativan and Xanax; as well, he found benefit in treatment he received from a Licensed Clinical Social Worker there, Ms. Toshkov.

Currently, Dr. Nehorayan prescribes the antidepressant medication, Effexor, the anti-anxiety agents, Klonopin and lorazepam, as well as antipsychotic medications, Seroquel and Risperidone, to Mr. Smith.

We spoke with Mr. Smith about the potential for additional psychotherapy treatment. He indicated that because of the positive experience he had with Ms. Toshkov, he would be interested in further mental health treatment.

Typical Day

Mr. Smith usually gets up each morning between 7:30 a.m. and 8 a.m. He utilizes the bathroom and then makes breakfast for himself. He does not read or watch television while he eats; indeed he reported that he does not bother to read now because he cannot retain anything he has read. After breakfast, he picks up around his home and he does at least one housecleaning chore such as vacuuming. Additionally, in the morning, Mr.

Smith spends between five and 10 minutes on the computer, just answering his e-mail. He also spends a little extra time checking the news headlines. He does not read about the news, again, because of his retention problem. On the other hand, he listens to approximately six hours of programming on the radio. He likes talk-radio programs, reporting that he is able to follow the discussions. He likes to hear discussions on local and international news.

Mr. Smith smokes during the day, and he likes to go outside each time he smokes because it promotes leaving his home rather than remaining isolated. However, he does not engage in any discussions with anyone he might meet while he is outside smoking.

In the afternoon, Mr. Smith typically goes out to a local store to purchase cigarettes and small items for dinner that night. He dislikes going into public settings during the work week because he believes everyone who sees him knows that he is not working and views him as somehow flawed. He used to help an elderly neighbor with shopping once a week; this man was recently hospitalized; as a consequence, Mr. Smith seldom engages with any other adults.

Also, during the afternoon, the applicant allows himself to watch some television. He intentionally avoids turning on the television earlier in the day because he does not want to spend all of his time watching television. He records all the programs that interest him, and he picks and chooses what he watches according to his interest at any given time. All together, he watches about four hours of television a day.

In the later afternoon, the applicant heats up whatever he has purchased for dinner, eats while he watches television and he then cleans up the kitchen. He takes his medications at approximately 8 p.m., retires and is asleep by 9:30 p.m.

Saturday is the only day Mr. Smith feels comfortable leaving his home without being overwhelmed with a sense of being viewed as an impaired or flawed person. Thus, he does more extensive errands on Saturdays, such as going to Wal-Mart or the post office. This is the only variation during the weekend from the applicant's just-described weekday activities.

Significant Relationships/Social Involvement

Marjorie, 49 years old, is the applicant's wife. She works as a cosmetologist. In May 2012, she went to live with her father briefly because he needed some help after the insertion of a pacemaker. However, after three months, when the applicant's father-in-law was no longer in need of this assistance, his wife did not return home. He has pressed her as to why she has not come back to live with him, and he has found her to be unwilling to discuss her reasons. Each time he asks her, she just dismisses him. He has

asked her specifically if there is something he could say or do that would lead to her returning to live with him, and she simply does not answer him. He texts her every other day, and he calls two or three times a week. She typically responds to his texts, but she does not always answer the phone when he calls. He has seen her only once in the last three months.

Prior to Marjorie leaving to stay with her father, the relationship was already strained. Mr. Smith described his wife as fairly compulsive, acting out her compulsivity primarily in housecleaning. For example, she used a toothbrush to scrub her floors. She never allowed her husband to do any of the housecleaning tasks, and Mr. Smith simply assumed she was happier doing this herself because she was so particular about how it was to be done. Prior to Mr. Smith becoming injured, one of the highlights of their relationship was a Sunday meal that he took great pains to prepare: the couple enjoyed this meal together each Sunday evening. After he became injured, his wife did not voice any concerns or frustration over the change in the quality of their life. For example, she did not complain about the decline in their income or changes in his mood. However, once she moved in with her father, she began to voice these complaints.

Mr. Smith acknowledged that his current uncertainty over his marriage is a significant source of distress for him. He believes that had he not become injured, his marriage would have remained relatively stable, at least in comparison with how he had known it throughout the 10 years the couple had been married.

Mr. Smith's mother, 72 years old and semi-retired, is the only other adult with whom he has regular contact. She enjoys good health and works on a part-time, seasonal basis for H & R Block, doing taxes. He speaks with his mother several times a week, noting, "If she hasn't heard from me, she calls to check on me."

Mr. Smith does not really have a relationship with his father, describing him as a "difficult person."

Overall, Mr. Smith has a very restricted social world. He used to enjoy going out with friends, playing golf and cooking. He has distanced himself from his former friends; he simply does not want to be around other people.

Information on Children

Mr. Smith is the father of two, adult daughters. His 25-year-old daughter is currently in graduate school, studying to become a pharmacist. She lives in Riverside, California. His 23-year-old daughter currently does not work and is going to school. She lives in San Jacinto, California with her mother.. This daughter is married and has three children and her entire family lives with her mother.

Mr. Smith does not see his daughters or grandchildren very often because of the distance. He rarely sees his grandchildren because this is also a factor of a somewhat poorly-developed relationship with his younger daughter. This will be discussed more thoroughly in the Past History section of this report to follow. There are no health issues for Mr. Smith's daughters or grandchildren.

Furthermore, Mr. Smith has two, adult stepsons. These are his wife's sons from her prior relationship. Both were in college when Mr. Smith married his wife; thus, they did not establish an integrated family unit with their marriage. The applicant did begin playing golf with the older of his stepsons with his wife's encouragement. His older stepson is a pediatric dentist living in Dallas, Texas and his younger stepson lives in Placentia, California.

Financial Situation

Currently, the applicant does not collect any benefits. He never received Workers' Compensation benefits, and he collected the one-year maximum of State Disability Insurance benefits. He has recently filed for Social Security Disability benefits. He has a pending August 30. 2012 appointment and a September 6. 2012 hearing on his application for these benefits. As noted earlier. Mr. Smith has depleted his retirement savings and personal savings as well as borrowing against his inheritance as he has struggled without any financial resources other than one year of State Disability Insurance benefits since he last worked.

Health Related Habits

Mr. Smith had smoked cigarettes for many years; in about 2005, he was successful in quitting this habit. However, in the spring of 2010, reactive to the significant stressors at work, he began to smoke again. He now smokes approximately one-half pack of cigarettes per day. Additionally, he tries to avoid caffeine, but he does drink one cup of coffee a day and he also drinks tea. Furthermore, he drinks one glass of wine on a very occasional basis, perhaps once or twice a month. The applicant denied any current or historical use of recreational or illicit drugs.

Current Legal History

This claim represents the applicant's only current Workers' Compensation claim or lawsuit.

Religious History

Mr. Smith does not attend church, and he has not been involved in any church community as an adult. On the other hand, he likes to pray every day, noting that he carries with him a little book of positive affirmations and reads them frequently.

IV. HISTORY OF PRESENT ILLNESS

Mr. Smith began working as a Logistics Supervisor on June 11, 2007 with U.S. Foodservice, Inc. This company warehoused food products and then shipped these products out by customers' orders. Mr. Smith was responsible for managing all inbound shipping traffic, which included third-party shippers or the company's own truckers. He was specifically responsible for the revenue generated by shipping services. He was expected to maintain a particular level of revenue. His job duties primarily required computer work; he worked 11 to 12 hours a day, five days a week, always at a computer station. He was paid $65,000 a year, and he was not reimbursed for the additional hours he worked each week. He reported that he had a very good working relationship with his co-workers. He described everyone in the facility as professional and cooperative. The applicant was awarded a Top Performance recognition in 2008, and in early 2009, he received a small raise in his salary. Mr. Smith denied having any issues of a disciplinary nature; he was never counseled or written up. He denied any issues with tardiness or attendance.

As to his personal life at the time he began this employment, Mr. Smith was married to Marjorie, his second wife, and his daughters were living with their mother. His stepsons were living elsewhere as well. He maintained a good relationship with both of his daughters.

The applicant reported that emotional difficulties began soon after his date of hire with U.S. Foodservice, Inc. By virtue of performing his expected job duties, he learned that the freight rates charged to his employer's customers in the computer were inflated. These were the rates charged to customers and were a source of revenue to his employer. Because he believed it was his responsibility to accurately reflect freight revenue and costs, he became frustrated when he did not have access to make such corrections. He spoke with Mr. Alan Trantham, the Supply Chain Manager who told him, "I can't do anything about it." Mr. Smith then went to the Director of Purchasing, Mr. Bob Nash (Mr. Trantham's supervisor), and he explained his concern. He specifically detailed for Mr. Nash that he did not want to be responsible for these errors because he feared there were legal implications if he did not make the corrections. He specifically recalled Mr. Nash stating, "Create your own future." Mr. Smith took this to mean that his job would be in jeopardy if he pursued this matter. Mr. Smith felt he had no option but to simply do as he was told. At that particular point in time, the fall of 2007, he saw the job market as being difficult if he were to consider finding a new job. His previous employment had

ended because of an economic downturn. As well, he considered that the semi-annual corporate audit might produce a resolution to this problem.

Nevertheless, by the fall of 2007, Mr. Smith began to experience severe headaches. He felt threatened both in terms of his job security and the potential unethical or legally-questionable duties he was asked to perform. The medical records provide information about the extent to which the applicant was likely experiencing some emotional distress through somatic avenues. For example, at Kaiser Permanente, Dr. Guiomar Constanza Iriarte noted on September 8, 2007 that the applicant "felt miserable." Just barely three weeks later, on September 26, 2007, Dr. Iriarte noted that the applicant was in tears in the office and he was advised going off work. Mr. Smith felt he could not miss any time from work because of the pressure from his employer to maintain his workload. Another physician, Dr. Daniel Ree, also noted (on November 6, 2007) that the applicant should be off work, but he declined. On November 14, 2007, Dr. Elena Lejano diagnosed the applicant with hypertension.

Mr. Smith explained that at Kaiser Permanente, the doctors struggled to understand the nature of his headaches. He was evaluated by Ear, Nose and Throat specialists because of his history with chronic sinusitis; as well, he was evaluated by neurologists. Ultimately, he was referred to psychiatrists. In November 2007, Dr. Lidia Tiplea recommended that the applicant attend stress management classes offered by Kaiser Permanente. Mr. Smith declined these classes because it would have been impossible for him to meet the class schedule with his 60-hour-per-week work schedule.

In early 2008, Mr. Smith was acknowledged by his employer as a top performer. He took enormous pride in this achievement, believing that it reflected his employer's value of his work. It served to reinforce the necessity of his continued work effort. However, in this same timeframe, he began to experience the orthopedic pain in his upper back between his shoulder blades and up to his neck and across both shoulders. He believed it was simply a consequence of the extensive hours he spent working at a computer work station, "just grinding it out." The medical records continue to corroborate the extent to which the applicant was reporting work stress to his treating physicians at Kaiser Permanente. A February 19, 2008 document from Dr. Tiplea reveals the doctor's report of a great deal of pressure at work and feeling he had no skills with which to cope with the pressure. On this occasion, Dr. Tiplea referred the applicant for psychiatric treatment.

In the summer of 2008, approximately in June, Mr. Smith noted that corporate officials found the problems of which he had been aware for some time having to do with inflated shipping costs. He explained that the corporate officials directed each individual buyer, approximately 30 buyers at his facility alone, to fix this problem. However, upper management was not directed to be responsible for the problem. Additionally, Mr. Smith was not issued any directive to repair this particular problem in the charging of inbound

shipping costs to customers. Mr. Smith continued to believe that the reason upper management did not want this problem fixed was that it would impact their yearly bonuses. In this same timeframe, the applicant treated at Kaiser Permanente for erectile dysfunction. A document dated June 21, 2008 by Dr. Krishnamoorthy reveals the applicant's complaint of erectile dysfunction and the provision of a prescription for Viagra. Concurrently, the applicant had already been prescribed Ativan, which he acknowledged he took during the day at work.

In the summer of 2008, the applicant experienced physiological correlates of anxiety such as trembling and feeling physical weakness along with fear each time he went into a meeting at work. The purpose of these meetings was to assess the extent of revenue being generated within each department responsible for generating revenue as compared to costs. Mr. Smith rated the intensity of his emotional distress in the summer of 2008 at a level of 5/10. He denied there were any changes in his neurovegetative functioning, noting that he was only aware of the severe headaches and the panic feelings before each of the above-described meetings.

In the latter portion of 2008, a medical problem associated with a pre-existing injury to his right great toe and foot became more problematic for the applicant such that he sought treatment at Kaiser Permanente. The nature of this injury was such that he developed a chronic cyst in the area of the joint of his right great toe. He had developed a habit of wearing band-aids and two pairs of socks on his right foot each day to combat the chronic draining of this cyst. He denied any emotional distress associated with this orthopedic condition. However, by February 2009, a physician, Dr. Tran, at Kaiser Permanente insisted that he consider the need for surgery to end the chronicity of his symptoms.

Also in early 2009, the President of the facility where Mr. Smith worked as well as the Director of Finance were fired. The applicant understood that there was a "mishandling of money somewhere" responsible for the terminations of these two, upper management officials. There was a new President and a new Director of Finance who came into the facility. This new President is the individual who actually gave the applicant the only raise he received from his employer. Mr. Smith experienced some brief hopefulness that these two, new individuals would address the problems that had plagued him having to do with the inflated shipping costs passed on to customers. Nevertheless, as this did not immediately take place, he continued to cope with the chronic headaches and orthopedic pain.

In the summer of 2009, the tracking system that was used independently amongst the various facilities of the applicant's employer across Southern California were merged into one system, and this resulted in the disparities in the shipping costs charged to customers being revealed. Once again, Mr. Smith had some hopefulness that this would be the end of the extreme amount of pressure he felt from his immediate supervisors for maintaining

the revenue, which supported their yearly bonuses. Indeed, there was a change in how an individual's performance was evaluated. Prior to this point in time, pure revenue dollars was the basis upon which the applicant's performance was evaluated. Following the merging of these tracking systems amongst the various facilities, "managed cases" became the system of evaluation of the applicant's performance. He described "managed cases" as a measure of how shipping costs were dispersed among actual container shipments.

Mr. Smith recognized that if he got creative with how he bundled shipments, he could keep revenue at a level expected by his supervisors while reducing costs. Thus, he tried to make certain that shipments were grouped such that every container that came in was full. He also tried to reduce costs by having outbound truck drivers collect an inbound shipment on their return to the facility, thereby further reducing costs while maintaining the same revenue. However, the upshot of this approach was that other departments within the applicant's facility were not happy with his bundling of shipments or having a return driver pick up an inbound freight shipment. By the applicant's account, "everything became a challenge" at this point in time. The union was not happy with the grouping or bundling of inbound shipments and the Transportation Department was not happy that the applicant had outbound truck drivers pick up incoming shipments, as a consequence, there were actions taken by the Transportation Department such as simply not picking up a load he wanted on an inbound basis, claiming that they "missed the load," and buyers became unhappy that an inbound shipment was bundled, and they sometimes had goods on hand that were not immediately required for an outbound shipment. This created a scenario where Mr. Smith was trapped between management wanting revenue maintained for bonus purposes and the Transportation Department and buyers being unhappy with the means by which the applicant achieved an appropriate reduction in shipping costs to maintain revenue.

During the summer of 2009, Mr. Smith was receiving psychiatric and psychological treatment through Kaiser Permanente. The records reveal on August 5, 2009 that Ativan was discontinued and Xanax was issued in its place. He was treating with the psychiatrist, Dr. Ken Reiter and the Licensed Clinical Social Worker, Ms. Toshkov. The records further reveal that the applicant remained in treatment with Ms. Toshkov for just over a year, from October 2009 until November 2010. During her initial evaluation of October 3, 2009, Ms Toshkov diagnosed the applicant with a Generalized Anxiety Disorder.

On October 27, 2009, Mr. Smith underwent the surgery on his right foot as described to him earlier by Dr. Tran. He was off work for only about one-and-a-half days, indicating that he was very concerned about missing any more work than was necessary because of the potential impact on his workload.

Throughout the balance of 2009 and into 2010, Mr. Smith continued to function with the pressures from management, the Transportation Department and the buyers. The Transportation Department continued to drop loads that he had wanted picked up by a company truck and the Operations Department began to refuse inbound loads based upon complaints from the buyers. By July 2010, Mr. Smith resumed smoking, a habit he had been able to abstain from for five years. He did so to try to calm his nerves, but also to provide a reason to get up from his desk and go outside at least a few times a day. During the summer of 2010, Mr. Smith felt that he might actually have a nervous breakdown because he was so overwhelmed with anxiety. Ms. Toshkov kept encouraging him to consider a medical leave of absence for that very reason.

Finally, in early November 2010, Mr. Smith felt he had no option but to take a medical leave of absence. He stated, "I was going to die at my desk." He rated the intensity of his emotional distress on November 3, 2010, his last day of work, at a level of 10/10. He executed the documents for a Family Medical Leave Act in order to protect his job.

On December 6, 2010, the applicant was first evaluated by the psychiatrist, Dr. Marc Nehorayan. Dr. Nehorayan became the applicant's primary treating physician and noted his complaints of insomnia, fatigue, feelings of panic, restlessness, distressing dreams and daily anxiety. On Mental Status Examination, Dr. Nehorayan observed the applicant to sit in a rigid and tense fashion, suggestive of anxiety. His facial expression revealed apprehension, depression and anger. As well, Mr. Smith appeared restless and fidgety to Dr. Nehorayan. Dr. Nehorayan placed the applicant on psychotropic medications and referred him for psychotherapy. The claimant began twice-monthly sessions with Dr. Nehorayan's associate, Ms. Jill Adler. With therapy he came to understand the connection between the emotional problems he was having and the headaches and stress he experienced at work. Overall, he did not find the treatment with Ms. Adler to be particularly beneficial while he believed that the psychotropic medications were slightly helpful in reducing the severity of his mood disturbance symptoms. However, there was a slight decrease in the intensity at the end of 2010 primarily because he was not at work exposed to the stressors in his position; he rated the intensity of his mood disturbance at 7/10.

The applicant was referred to the orthopedic surgeon, Dr. Daniel Capen; Dr. Capen initially evaluated Mr. Smith on December 10, 2010. Dr. Capen noted the applicant attributed his headaches to pressure to meet certain goals at work and his neck, shoulder and upper back pain to the nature and physical demands of his job duties. This is consistent with information provided to us by Mr. Smith.

In mid January 2011, Mr. Smith received a certified letter from his employer indicating that his job had been eliminated. While he was technically still employed, by his account, he, nevertheless, realized this ended his career with U.S. Foodservice, Inc. He felt

betrayed because he had done everything asked of him, to the point of seriously jeopardizing his mental and physical health. In early 2011, following the effective termination action, Mr. Smith rated the intensity of his mood disturbance at a level of 8/10, reflecting a slight increase reactive to the termination

Throughout the spring of 2011, Mr. Smith continued to treat with Ms. Adler and Dr. Nehorayan. Dr. Nehorayan extended his Disability and noted on April 5, 2011 that the applicant reported passive suicidal ideation without an intent to harm himself. Also in April 2011, the applicant was referred to the internist, Dr. Sean Leoni; on April 26, 2011, he was diagnosed with irritable bowel syndrome by Dr. Leoni.

Despite the fact that he was collecting State Disability Insurance benefits, Mr. Smith experienced significant financial strain without having his normal income. Most of his anxiety now that he was off work was driven by his fears about his financial stability. By the summer of 2011, he reported to Dr. Nehorayan that his marriage was strained. On the other hand, Mr. Smith reported to us that the strain he experienced in his marriage was from his own perspective because he did not believe his wife was expressing frustration or anger with the dramatic change in their lifestyle due to the loss of income or his increased moodiness.

In the fall of 2011, Mr. Smith took steps to address his concerns about his financial stability by applying for Social Security Disability benefits. A September 28, 2011 document from Dr. Nehorayan reveals the applicant's report that he was "kicked out" of an evaluation for these benefits because he was upset and he threw a water bottle when speaking with a physician, Dr. Reznick. Mr. Smith acknowledged that he was very anxious about this evaluation and frustrated that Dr. Reznick would not look at a list of medications he had brought to provide information to the evaluating physician. He expressed frustration and regrets that one of the changes in his mood and behavior has been in an area of expressing his frustration and irritability.

Also in the fall of 2011, Dr. Nehorayan, Dr. Leoni and Dr. Capen issued Maximal Medical Improvement Evaluation Reports. Mr. Smith agreed that by that point in time, all of his symptoms had become chronic. He awaited the outcome of his application for Social Security Disability benefits while continuing to rely on his retirement and personal savings to subsist.

In May 2012, Mr. Smith's wife explained to him she was going to live with her parents because her father recently had a pacemaker inserted. However, after her father had recovered and he was able to resume many of his usual activities, she did not return home to live with the applicant. As discussed in the Current Condition section of this report, Mr. Smith's wife has not shared with him very much about her feelings leading to this decision. Mr. Smith acknowledged when questioned that he believes his marriage very

well may be over as a consequence of his wife's decision to not return to their home. He believes there is little he can do or say to influence her.

Recently, Mr. Smith learned from his wife that she had a daughter years earlier and she had placed this daughter for adoption at the time of her birth. One day in the spring of 2012, the applicant's wife brought this daughter and her toddler-aged daughter to Mr. Smith's home. Mr. Smith's wife explained that her daughter had nowhere to live and was going to live with "us." However, because his wife was still living with her father, the "us" actually meant this daughter and her child would be living with Mr. Smith. Because he still hoped to do something that would positively influence his wife's view of him and, thus, their marriage, Mr. Smith agreed to this arrangement. However, in the three months this young woman and her daughter have been living with him. Mr. Smith has become increasingly frustrated with her lack of consideration in terms of tidiness about the house. As well, she does not contribute any money to rent or household expenses while, nevertheless, purchasing personal items for her and her daughter.

As to his future, Mr. Smith stated that he cannot see anything beyond his current circumstances. From his perspective, his greatest challenge is how he will meet his rent obligation each month. He currently borrows money from his mother simply to remain in his home. He acknowledged that he is profoundly discouraged to the point that he likely would not be a viable, potential employee even in an interview process.

V. PAST HISTORY

Developmental History

Mr. Smith was born on October 20, 1963 in Los Angeles, and he grew up primarily in suburbs, Downey and Anaheim. Although he has no memory of the early months of his life, he has learned from family members that because both of his parents contracted hepatitis when he was an infant, he spent the first several months of his life with his grandparents.

The applicant reported that, to the best of his knowledge, he reached all of his developmental milestones at the appropriate ages. He denied that he sustained any serious or traumatic injuries or suffered from any serious illnesses as a child.

While Mr. Smith denied that he was ever exposed to any physical or emotional abuse, he acknowledged an incident of sexual molestation in 1975 when he was approximately 12 years old. He was on a Little League team, and he was also taking Kung Fu lessons at that time. The Kung Fu teacher enticed several members of this Little League team to his garage under the ruse of being the official photographer for the team. This teacher told

several boys, one at a time, that they had to spend the night with him as part of the process of having their picture taken. During the course of the night Mr. Smith spent with this man, he was forced to perform oral sex on this individual. Mr. Smith recalled feeling frightened despite the fact that this man did not threaten to harm him or the members of his family if he were to tell what happened. Mr. Smith told his mother what had happened and she did not believe him. As a consequence, because this man lived on the same street where the applicant lived with his mother, he told his mother he wanted to go and live with his father and he did so. The applicant's parents had been divorced for a number of years at that time. According to the claimant, he simply determined to push this event out of his mind, stating, "I tried to forget about it." He believes that he was successful in doing so and he resolved any feelings associated with the molestation.

Family History

Mr. Smith's father was an engineer and a professor at Cerritos Community College; he is now retired. His mother worked as an office clerk for trucking companies. His parents divorced when Mr. Smith was approximately 6 years old. He recalled there was a great deal of verbal arguing and fighting between his parents and his father was physically abusive to his mother. Indeed, he stated, "My father was not a nice man." Mr. Smith, the youngest of three sons, recalled that he cried when his parents divorced, asked them why they had to fight and why they could not stay together. He lived with his mother until he was about 12 years old, as noted above, and he then lived with his father. Mr. Smith reported that he enjoyed a good relationship with both of his brothers. He believes one of his brothers was also a victim of molestation by the same perpetrator for his own molestation; however, his brother has not acknowledged this.

Medical History

Mr. Smith was diagnosed with asthma as a child. He has required medication to stabilize this condition throughout his life.

In approximately 1989, the applicant sustained a work-related injury to the great toe of his right foot. He was using a highly-pressurized water gun to strip paint off a building at a Toyota dealership. Despite the fact that he was wearing steel-toed boots, when he lost his footing while still handling this device, the stream of water at 600 pounds p.s.i. struck the end of his right boot and severely damaged his great, right toe. As described in the History of Present Illness section of this report, many years later, Mr. Smith had reconstructive surgery for this injury.

In 2000, the applicant was helping someone move, lifting and carrying furniture up a stairway. He experienced pain in his lower back and he sought treatment with an orthopedist. The orthopedist advised him that there was little that could be done for the

back strain, which had occurred. Mr. Smith reported low-grade, lumbar spine pain that has persisted since that time. He denied that it interfered with his ability to work while also acknowledging that it was not possible for him to enjoy playing golf without experiencing more intense lower back pain after this injury.
Mr. Smith developed chronic sinusitis in early 2003; the medical records contain a number of documents from his treating physicians at Kaiser Permanente detailing the extent of diagnostic studies and treatment for this condition leading up to an April 3, 2003 surgical procedure. Mr. Smith reported that following this surgery, he no longer had any problems with sinusitis or the sinus headaches, which he found to be very uncomfortable.

The applicant's medical history is unremarkable for any other significant medical conditions. His history is also negative for any significant physical injuries.

Mental Health History

The applicant has no history of any difficulty with alcohol or illicit substances.

Educational and Social History

Mr. Smith reported that he was an average student in elementary school; he preferred sports over academics. As well, he described himself as a shy child. He liked to play on his Little League team, and he enjoyed Kung Fu until the incident of molestation.

When he was a senior in high school, living with his father, the applicant's father moved to Colorado, to a suburb outside Denver. The applicant had been active on the water polo team at his high school in California, and he was able to continue in this activity at his new high school. However, he acknowledged that moving as a senior in high school was very difficult and he was not very successful in transitioning socially. Mr. Smith graduated from high school in 1981, indicating that he never intended to go on to college.

Marital/Relationship History

Mr. Smith married his first wife in 1982, and the couple divorced in about 1989 following many episodes of infidelity on the part of Mr. Smith's wife. He stated, "We had five good days in total out of every month of our marriage; we just did not get along." On the other hand, Mr. Smith acknowledged that his first wife had several abortions and miscarriages while they were married, and he later came to believe that some of these pregnancies were a consequence of her extra-marital affairs. Mr. Smith had a vasectomy after his first daughter was born; eleven months later, his second daughter was born. He was not certain that she was his daughter because of the vasectomy. Indeed, his wife told him that he was not the father of this second daughter. Thus, when the couple divorced and this daughter was an infant, Mr. Smith did not make any effort to establish a

relationship with her. He involved himself extensively in visitation and support of his older daughter, believing that she was, actually, his only biological child. His wife made this very difficult for the first year following the divorce, even hiding his daughter from him.

Mr. Smith believes that he was actually more angry than depressed when his first marriage ended. He specifically denied any changes in his neurovegetative functioning or in his ability to perform his customary duties at work. After one year, he was successful in getting visitation rights with his older daughter and he continued to have nothing to do with the younger daughter. When his second daughter was 14 years old, she took steps to have testing to determine paternity. It was only then that the applicant learned he actually is her biological father. In those intervening years, Mr. Smith and his former wife evolved into a more amicable relationship. Thus, when his younger daughter was 14 years old, Mr. Smith began establishing a relationship with her. However, to this day, he has a more meaningful and mutually-satisfying relationship with his older daughter.

Mr. Smith married his second wife, Marjorie, in 2002. When he met her, she told him of her two sons from a prior marriage, but she did not tell him of the daughter she placed for adoption prior to her first marriage. At the time the applicant married Marjorie, her sons were grown, and they did not live with the couple. His adolescent daughters lived with their mother, but they visited Mr. Smith and his new wife. His second marriage was comfortable and satisfying, and Mr. Smith believed it was a far more stable marriage than his first.

Legal History

Mr. Smith did not file a Workers' Compensation claim for the injury to his great, right toe. Furthermore, there is no history of bankruptcies or evictions. There is also no history of any arrests, including charges for driving under the influence. The applicant has never been a victim of a crime, nor has he ever been involved in any episodes of domestic violence.

Occupational History

After the applicant graduated from high school in 1981, he worked as a dye maker because he had taken several machine-shop classes in high school. His father got him this job because of his business connections. Mr. Smith indicated that he did not really enjoy this work. Thus, he began working at a restaurant as a bus boy. He was very interested in cooking, and he tried to learn from the chefs in the restaurant. Eventually, he learned enough, and he was coached enough by various chefs that he was allowed to do prep work in restaurants with well-known chefs. Despite not having any formal culinary training, eventually, Mr. Smith was able to work as a chef in small restaurants. He

worked as a chef for about four years after spending four or five years reaching this position.

Mr. Smith felt he could make more money in other business ventures. Thus, he became a warehouse manager for a plumbing, heating and air-conditioning supplier. He worked there for about five years, until 1995. Between August 1995 and November 1998, Mr. Smith worked as a dispatcher for Crescent Truck Lines. After leaving this company in November 1998 and until December 1999, he worked as a Safety Assistant for Gilbert West, a trucking company.

Between December 1999 and March 2007, Mr. Smith worked for Pro-Line Freight System as the Director of Transportation and Safety. This company closed their doors for business, and the applicant was then hired by U.S. Foodservice, Inc.

VI. PSYCHOLOGICAL TESTING

The services of an interpreter were not required for administration of the psychological testing.

The applicant was administered the following psychological tests:

- Symptom Validity Testing
  - Test of Memory Malingering (TOMM)
- WTAR (Wechsler Test of Adult Reading)
- Cognitive testing
  - WAIS-III Processing Speed Index
- NIS Self-Report Form
- Pain Patient Profile (P-3)
- Minnesota Multiphasic Personality Inventory-2-RF (MMPI-2-RF)
- Millon Clinical Multiaxial Inventory-III (MCMI-III)
- Wahler Physical Symptoms Inventory (WPSI)
- Beck Depression Inventory (BDI)
- Beck Anxiety Inventory (BAI)

Tests of Memory Malingering (TOMM)

The applicant was administered this formal symptom validity test, The Test of Memory Malingering (i.e., TOMM), to assess level of effort and motivation during the Mental Status Examination. The applicant received a score of 48/50 on the TOMM test. This performance was above the cut-off score and suggestive of good effort. Results suggest

that the applicant did not attempt to exaggerate or over-report psychological or physical symptomatology.

Wechsler Test of Adult Reading (WTAR)

The applicant was administered the Wechsler Adult Reading Test (WTAR). The WTAR is an oral reading test that can provide an estimate of an individual's premorbid intellectual functioning. Oral reading skills are generally spared in most neurologic and psychiatric conditions. The WTAR was developed using the normative data from the Wechsler Adult Intelligence Test – Third Edition (WAIS-III). Thus obtaining a WTAR premorbid estimate score provides one method for comparing an individuals current cognitive functioning to their estimated premorbid intellectual level.

The results from the WTAR suggest that the applicant's estimated premorbid intellectual level fell in the high-average range (WTAR: 77th percentile).

WAIS-III

The applicant was administered several subtests from the Wechsler Adult Intelligence Test, 3rd Edition (WAIS-III). The results from the WAIS-III testing indicate that the applicant's Processing Speed skills fell in the impaired range (PSI: 2nd percentile).

NIS Self-Report Form

The NIS Self-Report Form was administered to the applicant and used to aid in an understanding of self-reported cognitive difficulties.

Pain Patient Profile-3 (P-3)

Pain resulting from physical injury, illness or disease is a multi-dimensional phenomenon with components including physiological, psychological and other influencing variables. Factors such as depression, anxiety and excessive somatic preoccupation are specifically identified in the medical literature as actively contributing to the etiology, maintenance and intensity of pain.

The Pain Patient Profile-3 (P-3) is designed to identify pain patients who are experiencing emotional distress that may be affecting their symptoms and their response to treatment. The profile interpretations and recommendations in this report are all based on pain patients as the primary reference group. It is important to keep in mind that the average pain patient is significantly more depressed, anxious and preoccupied with somatic thoughts than the average population.

This applicant's score on the Validity Index suggests that he was able to read the items and appropriately attend to item content. It appears that he approached the test in an open and honest manner and his scores suggest that his test results can be interpreted with confidence.

Mr. Smith's T-score on the Depression Scale (70T) suggests that he is significantly more depressed than the average pain patient. He endorsed items including disrupted sleeping, chronic fatigue, a sense of hopelessness and suicidal ideation reflective of this level of depression. The applicant's Anxiety Scale (58T) suggests that he is more anxious than the average pain patient. He endorsed items reflecting persistent nervousness and tension, ruminative thinking and physiological correlates such as sweating and trembling. As to somatization, the results (60T) suggest he has more concerns and problems with health-related issues than the pain patient population. He endorsed the most severe responses reflecting a somatization process; he described himself as weak and tired, experiencing frequent headaches and generalized body aches and pains.

Minnesota Multiphasic Personality Inventory-2-RF (MMPI-2-RF)

The Minnesota Multiphasic Personality Inventory-2-RF (MMPI-2-RF) is a revised version of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), an objective psychological inventory. The applicant answered all of the 338 items in this lengthy psychological test, taking an average amount of time for its completion.

The computer-generated profile was scored with software provided by NCS Assessments and a computer-generated interpretation of the MMPI-2-RF was created with software from Psychological Assessment Resources.

The following represents our analysis and conclusions drawn from the results of the applicant's psychological testing, which includes our review of the computer-generated interpretation as well as the profile produced by the tests results.

Validity: (T Scores)

VRIN-r	TRIN-r	L-r	F-r	K-r	Fs	Fp-r	FBS-r	RBS
53	57	52	74	48	66	42	86	76

Restructured Clinical Scales: (T Scores)

RCd	RC1	RC2	RC3	RC4	RC6	RC7	RC8	RC9
66	81	73	46	52	56	57	52	45

Attention/Comprehension/Validity

Mr. Smith read the test items accurately and endorsed them in a consistent manner (VRIN-r = 53T; TRIN-r = 57T). The results also suggest that the applicant did not over-report psychological (F-r = 74T; Fp-r = 42T) complaints on the inventory. Nevertheless, there was an indication of embellishment of somatic complaints (FBS-r = 86T) and cognitive (RBS = 76T) complaints on the inventory. However, in our opinion, the claimant likely embellished his test responses in order to communicate his degree of ongoing affective distress. We feel that the claimant is suffering from a bonafide depression and exaggerated his level of cognitive and somatic concerns in order to clearly convey his emotional distress. The MMPI-2-RF is considered valid for interpretation.

Symptoms/Personality Traits

It should be noted that elevations on the basic clinical scales can occur for several reasons, one of which is when an individual is experiencing significant demoralization. However, this applicant did not evidence marked elevation on the demoralization scale (RCd = 66T). Moreover, after demoralization was removed from the clinical scales, he still evidenced moderate depression and low positive emotion (RC2 = 73T) and somatic concerns (RC1 = 81T). This pattern of scores tends to corroborate the presence of a bona fide clinical depression.

The results of the MMPI-2-RF are organized in broad dimensions: Emotional/Internalizing Dysfunction (EID); Thought Dysfunction (THD); and Behavioral/ Externalizing Dysfunction (BXD). The EID results indicate an overall gauge of the applicant's emotional functioning, between a below-average of emotional difficulties or an above-average level of emotional difficulties. For Mr. Smith, the EID Scale (72T) suggests significant emotional distress. For the THD Scale, an individual's overall estimate of reported thought dysfunction is indicated. For Mr. Smith, the THD Scale (57T) suggests no problems with thought dysfunction. The BXD Scale reflects an overall estimate of the applicant's behavioral acting-out tendencies. For Mr. Smith, the BXD Scale (46T) suggests it is unlikely that he engages in acting-out behavior.

Elevations on the somatic scales suggest a significant somatization process. That is, independent of whether he actually has objective medical symptoms (see Record Review), the results suggest that Mr. Smith's experience of pain and physical illness is significantly impacted by psychological factors. The MLS Scale reflects a generalized sense of well-being. For Mr. Smith, the results indicate a generalized sense of malaise manifested in poor health, fatigue and weakness to the point of being incapacitated (MLS = 87T). Specific complaints include difficulty sleeping, low energy and sexual dysfunction. Within the area of physical functioning, Mr. Smith is specifically endorsing

gastrointestinal complaints (GIC = 88T), head pain (HPC = 85T), neurological complaints (NUC = 75T) and cognitive difficulties (COG = 75T).

The MMPI-2-RF evaluates specific issues of demoralization and dysfunctional negative emotions (reflected in the Restructured Scales RCd and RC7) on a number of scales. The Suicide/Death Ideation Scale (SUI = 2 raw) indicates the applicant endorsed two of the five items having to do with suicidal ideation. Again, throughout the course of this evaluation, Mr. Smith denied having any current plan or intent to harm himself. As well, he endorsed test items indicating that he feels helpless in the face of making any changes to his current circumstances (HLP = 69T). The applicant is endorsing self-doubt (SFD = 65T) as reflected in a sense of inferiority, insecurity and little self-confidence. Mr. Smith further views himself as passive and lacking in self-reliance (NFC = 64T), believing he is not capable of coping with his current problems. He views himself as indecisive and ineffective, even with small and inconsequential matters. He is preoccupied with what he considers to be disappointments and set-backs, often having to do with financial stress (STW = 73T). Anxiety is clearly indicated (AXY = 80T) with intrusive ideation and disrupted sleep.

There is an indication of issues with personality pathology suggested in the results of the MMPI-2-RF, with significant issues with anxiety, insecurity and excessive worries with a tendency to expect the worst happening (NEGE-r = 69T) to the point of being inhibited behaviorally and/or feeling excessively guilty. As well, the results reveal the applicant lacks positive emotional experiences and avoidance of social situations and interactions (INTR-r = 67T) to the point of persistent pessimism and complaints of depression.

In summary, the MMPI-2-RF findings suggest a man who is experiencing substantial psychological distress and emotional weakness at this time.

Millon Clinical Multiaxial Inventory-III (MCMI-III)

The Millon Clinical Multiaxial Inventory-III was administered and completed by the applicant in a standard amount of time.

The computer-generated profile was scored with software provided by NCS Assessments.

The following is a summarization of both the computer-generated data, as well as my interpretation of the test results.

The applicant obtained the following BR scores:

Modifying Indices	**BR**	**Severe Personality Pathology**	**BR**
Disclosure	55	Schizotypal	62

Desirability	55
Debasement	61

Personality Patterns	**BR**
Schizoid	72
Avoidant	77
Depressive	67
Dependent	87
Histrionic	40
Narcissistic	35
Antisocial	12
Sadistic	24
Compulsive	75
Negativistic	30
Masochistic	57

Borderline	69
Paranoid	66

Clinical Syndromes	**BR**
Anxiety Disorder	87
Somatoform Disorder	73
Bipolar Manic Disorder	36
Dysthymia	80
Alcohol Dependence	0
Drug Dependence	20
Post-Traumatic Stress Disorder	75

Severe Clinical Syndromes	**BR**
Thought Disorder	62
Major Depression	93
Delusional Disorder	60

The results of this objective psychological inventory reveal the applicant did not endorse the test items in either a negative or a positive pattern. This is suggestive that the results of the clinical scales reflect an accurate accounting of the applicant's current emotional experiences.

The clinical scales reveal significant elevations indicative of current mood disturbance symptomatology (Major Depression = 93BR; Anxiety = 87BR; Dysthymia = 80BR; Post-Traumatic Stress = 75BR). Additionally, the Somatoform Scale (73BR) reveals the extent to which the applicant engages in a somatic process for experiencing some of his emotional distress.

Finally, there are several Clinical Personality Pattern Scales elevated to a clinically significant level (Dependent = 87BR; Avoidant = 77BR; Compulsive = 75BR). These elevations imply issues the applicant may have with his interpersonal relationships, which may not necessarily be reflective of the pervasive pattern of maladaptive behavior associated with these syndromes. On the other hand, taken together with the clinical history, these elevated scales suggest the possibility that there has been some interplay between the applicant's tendency towards personality traits and his emotionally-reactive response to his orthopedic injury.

Wahler Physical Symptoms Inventory

The applicant was administered the Wahler Physical Symptoms Inventory and received a score that corresponded to the 9th decile, which suggests that he is reporting a marked degree of physical symptoms relative to a male psychiatric population.

Beck Depression Inventory

On the BDI, the applicant scored 38, placing him in the severe range of subjective depression.

Beck Anxiety Inventory

On the BAI, the applicant scored 35, placing him in the severe range of subjective anxiety.

VII. REVIEW OF RECORDS

Gregory Meyer, M.D. – Presbyterian Intercommunity Hospital

A February 16, 2003 Emergency Department Visit indicated that the Claimant presented with complaint of headache. The Claimant reported that he had headache for the last six days prior to date. He consulted with his family doctor in "Wednesday," who administered a shot of Imitrex but he was not better. He consulted with his doctor again in Friday and was prescribed Zithromax and Vicodin, but he was not better. Therefore, he presented to the emergency room.
On this examination date, the Claimant stated that he had a lot of pressure on his head and a lot of nasal congestion. He reported that he had been taking Benadryl at night. He reported having a lot of runny nose and "greenish stuff" coming from his nose, and that he coughed occasionally. He described his headache as all frontal and he had mild photophobia. He had some nausea and "bad" cold symptoms.

The Claimant was currently working as a Manager for Safety for a trucking company. He smoked about a half a pack a day. Past medical history was remarkable for asthma, for which he had been hospitalized. He reported having sinusitis in the past and that the pain was similar to "this." Family history was significant for his mother who had history of migraine. Emergency Room Diagnosis was Acute Sinusitis. The Claimant was taken off work for one or two days.

Jagdish Patel, M.D. – Presbyterian Intercommunity ospital (Diagnostic Studies)

A February 17, 2003 CT of the Head without Contrast revealed a normal study.

A CT of the Paranasal Sinuses revealed chronic pansinusitis, more prominent on the left.

An August 21, 2009 Chest X-ray revealed minimal atelectatic changes at the left lung base.

Roger Woodard, M.D. – Presbyterian Intercommunity Hospital

A pair of Emergency Department Visits indicated that on February 28, 2003, the Claimant presented with chief complaint of headache that was worsening since the day prior to date. He had nasal stuffiness and green discharges. He reported that light bothered him. He also reported that he took a sample of Ultracet earlier on this examination date and developed a little swelling of his hands, as well as a little tingling in his face that had since resolved. Discharge Impressions were Cephalgia; and Sinusitis.

On August 21, 2009, the Claimant complained "burning" pain to the mid arm and forearm on the left, which stopped at about the mid forearm and "goes up" to the axilla. He also had pain to his chest, mild nausea, and mild shortness of breath. Final Diagnosis was Acute Chest and Arm Pain Secondary to T1-T2 Nerve Root Compression.

Brian Machida, M.D. – Presbyterian Intercommunity Hospital

An April 03, 2003 Preoperative History and Physical indicated that the Claimant presented for surgical correction of his problems due to persistence of severe headache and sinus pain unresponsive to antibiotic treatment. [Please note that page 2 of this two-page report which may possibly contain the rest of the Physical examination, Diagnosis and Treatment plan was not received in the stock of records for review.]

An April 03, 2003 Operative Report indicated the Pre-Operative and Post-Operative Diagnosis of Sinusitis, Deviated Septum, Hypertrophic Turbinates. Sinusotomies with turbinate modification was performed.

Edward Jarema, M.D. – Presbyterian Intercommunity Hospital

An March 10, 2007 Emergency Department Visit indicated that the Claimant presented with complaint of right flank pain, right upper quadrant abdominal pain that had been bothering him since six days prior to date, "crampy" in nature and unrelenting. He used to be a smoker but had "quit fifteen" years prior to date. Discharge Impressions were Acute Right Upper Quadrant Pain, Etiology Unsure; and Asthma.

Marsha Guerrein, M.D.
Presbyterian Intercommunity Hospital (Diagnostic Studies)

A March 10, 2007 CT of the Abdomen and Pelvis revealed the following Opinions: (1) No evidence of hydronephrosis or renal calculi; (2) No evidence of gallstones; and (3) No

obvious appendicitis. Appendix is difficult to see, "but Dr. Guerrein believe normal." If the patient has persistent symptoms then reevaluation is recommended of the patient with rectal contrast.

An Ultrasound of the Right Upper Abdominal Quadrant demonstrated no evidence of cholecystitis, or hydronephrosis.

Guiomar Constanza Iriarte, M.D. – Kaiser Permanente

A group of three Progress Notes indicated that on September 08, 2007, the Claimant presented with complaints of persistent headache and generalized pain. He reportedly felt miserable. Impression was Sinus Headache. Darvocet was prescribed.

On September 26, 2007, the Claimant reported having severe headache and congestion for one week. It was noted that the Claimant was in tears. He was taken off work.

On October 05, 2007, the Claimant presented with no new complaints.

Jeanette Manato Barrera, P.A. – Kaiser Permanente

A September 23, 2007 Progress Note indicated that the Claimant presented with facial pain with persistent postnasal drip and dry cough for three days. Assessment was Sinusitis. Toradol was prescribed.

Niraj Bhupatray Rawal, M.D. – Kaiser Permanente (Diagnostic Studies)

September 26, 2007: X-rays of the Sinuses indicated that maxillary sinuses are somewhat hypoplastic with mucosal thickening seen but with no air-fluid levels to suggest acute sinusitis. Frontal sinuses appear clear.
An October 31, 2007 MRI of the Brain without Contrast demonstrated the following Impressions: (1) No intracranial abnormality; and (2) Thickening of the middle and inferior turbinates on the left, with a hypoplastic left maxillary sinus suggesting previous sinus disease.

Ramana Babu Muthyala, M.D. – Kaiser Permanente (Diagnostic Studies)

A September 30, 2007 CT of the Head with and without Contrast revealed a negative examination.

An October 03, 2007 CT of the Sinus with Contrast indicated a minimal bilateral maxillary sinus disease.

Chai-Yung Johnny Tsai, M.D. – Kaiser Permanente

An October 08, 2007 Progress Note indicated that the Claimant presented with a history of sharp, piercing bilateral headaches behind eyes/throat associated with nausea. He noted that he had similar symptoms four years prior to date which lasted for four months. Diagnosis was Headache.

Elena Lejano, M.D. – Kaiser Permanente

A pair of Progress Notes indicated that on October 08, 2007, the Claimant complained of headache located between ears and shooting pains to the eye [laterality unspecified] and that he felt like someone was squeezing his brain. He noted that his headache began after attending football game one month prior to date, wherein he had "lots of yelling." Assessment was Headache.

On November 14, 2007, the Claimant reported that he was on a roller coaster and he could not "get off." He then had headache and felt like he had been through a ringer. He had ongoing headaches for two months which made him feel worn out. He reportedly took Norco, as well as Topamax that made him feel very "out of sorts" and felt like he did not realize what he was doing and seemed to be repeating himself "a lot over and over." He also noted that his face was swelling and was hot. Additional Assessments were as follows: (1) "Not Current Smoker;" (2) Pain in or Around Eye: and (3) Hypertension.

A December 12, 2007 Call Documentation indicated that the Claimant reportedly had been making effort to get off from pain medications. He stated that his headaches had improved. He noted weak heartbeat the day prior to date.

Lidia Tiplea, M.D. – Neurology – Kaiser Permanente

A October 18, 2007 Neurology Consultation indicated that the Claimant presented with a new onset of headache since September 20, 2007. He described his pain as severe to the mid frontal in between eyes, and sharp and piercing pain below eyes. Assessment was Headache, Sinus.

A pair of Neurology Follow-Up Visits indicated that on November 23, 2007, the Claimant continued to complain of headache. Additional Assessments were Headache, Mixed; and Analgesic Overuse Headache. Indocin was prescribed. Dr. Tiplea advised the Claimant to wean off from Tylenol #3. Stress management class was considered

On January 04, 2008, the Claimant reported that he was off the Prednisone and decreased caffeine intake by 50%. He also decreased his intake of Vicodin and Tylenol #3. He reportedly slept better.

A January 11, 2008 Progress Note indicated that Dr. Tiplea had reviewed the report of Dr. Lejano dated January 10, 2008. Following the review, Dr. Tiplea stated that she was in agreement with the report.

A February 19, 2008 Neurology Follow-Up Visit indicated that the Claimant reported having significant stress at work all this time that exacerbated his headaches. He added that he was in a lot of pressure at work and that he did not know how to cope with the stress. Additional Assessment was Stress Reaction Causing Mixed Disturbance. Referral to Psychiatrist was recommended.

Daniel Ree, M.D. – Kaiser Permanente

A November 01, 2007 MRI of the Brain revealed thickening of the middle and inferior turbinates on the left, with a hypoplastic left maxillary sinus suggesting previous sinus disease.

A November 06, 2007 Progress Note indicated that the Claimant reported that Maxalt and Imitrex as well as Midrin and Morphine had caused "sick" to his stomach. Impression was Chronically Daily Headache with Analgesic Rebound. Dr. Ree advised the Claimant to take time off for one week but the Claimant was not willing to take days off.

Margarita Santamaria, M.D. – Kaiser Permanente

A November 11, 2007 Progress Note indicated that the Claimant complained of headache for two weeks, described as squeezing sensation to the top of his head. Diagnosis was Headache.

Thai Dang, D.O – Kaiser Permanente

A November 17, 2007 Progress Note indicated that the Claimant complained of constant squeezing generalized headache for nine weeks, and occasional eye pain. Diagnosis was Headache.

Hsuyuan Wu, M.D. – Kaiser Permanente

An April 29, 2008 Progress Note indicated that the Claimant complained of "benign prostatic hypertrophy symptoms" which started a few months prior to date. Diagnoses were "Not Current Smoker;" and Benign Prostatic Hypertrophy.

A May 13, 2008 Call Documentation indicated that the Claimant was unable to tolerate Hytrin and that it had not helped his benign prostatic hypertrophy symptoms.

A November 09, 2010 Progress note indicated that the Claimant complained of a small firm bump on his inner lower gum area. He reported taking Viagra at this time with not much improvement. Additional Diagnoses were as follows: (1) "Smoker;" (2) "Counseling on Smoking Cessation;" (3) Oral Dermoid Cyst; (4) Asthma; and (5) Erectile Dysfunction, Organic.

Sabitha Krishnamoorthy, M.D. – Kaiser Permanente

A June 21, 2008 Progress Note indicated that the Claimant reportedly desired Viagra to treat his erectile dysfunction. Current medication included Lorazepam. Diagnosis was Erectile Dysfunction. Viagra was prescribed.

Anjum Sameena, M.D. – Kaiser Permanente

A July 09, 2008 Progress Note indicated that the Claimant presented with complaint of acne. Diagnosis was Acne.

Thomas Wing Lim, O.D. – Kaiser Permanente

An October 11, 2008 Progress Note indicated that the Claimant complained of blurred vision "at near." Diagnoses were as follows: (1) Myopia; (2) Astigmatism; and (3) Presbyopia.

Renuka Singh, M.D. – Kaiser Permanente

A November 02, 2008 Progress Note indicated that the Claimant complained of acne rash with redness on his nose, forehead, and checks "on and off" for many years. He requested Doxycycline, or otherwise, this would usually progress to "big bumps" on his face. Assessment was Rosacea.

David Kamyong Kahng, M.D. – Kaiser Permanente

A February 19, 2009 Progress Note indicated that the Claimant reported undergoing right foot/big toe surgery twenty years prior to date after injuring it with a high pressure water gun. He indicated that for the past two days, he noticed some swelling and drainage of clear fluid [body part/s unspecified]. Assessment was Possible Open Joint [unspecified].

Estrella Yabes, R.N. – Kaiser Permanente

A February 20, 2009 Wound Care Inpatient Initial Consult indicated that the Claimant reported having drainage and pain to the dorsum of his foot, plantar and graft site, two to three days prior to date. He had wound to his right median hallux.

Kanagal Satyanarayana, M.D. – Kaiser Permanente (Diagnostic Study)

February 20, 2009: X-rays of the Right Foot demonstrated mild degree of hallux valgus deformity involving the big toe. There was no evidence of osteomyelitis seen. No other significant abnormalities are seen.

Jennifer Tran, D.P.M. – Kaiser Permanente

A group of five Progress Notes indicated that on March 01, 2009, the Claimant presented for follow-up examination of his right foot pain which, at this time, had localized to the bottom of his foot when walking. Diagnoses were Sesamoiditis: and History of Lower Extremity Skin Ulcer. The Claimant expressed that he did not want to undergo surgery at this time to revise the scar.

On March 28, 2009, the Claimant reported that the pain on the bottom of his foot was less at this time after receiving cortisone injection on his last examination. However, he continued to have swelling to his great toe joint with pain while wearing shoes. Additional Diagnosis was Cyst of Bursa. The Claimant expressed that he was not willing to take off work.

On May 07, 2009 and May 29, 2009, no new complaints were noted.
On September 28, 2009, the Claimant was scheduled for minor surgery, removal of ganglion cyst right first toe.

An October 27, 2009 Operative Note indicated the Pre-Operative and Post-Operative Diagnosis of Right Foot Painful Scar and Ganglion Cyst. Right foot, excision/biopsy of skin lesion and excision of cyst was performed.

A pair of Work Status Reports indicated that on October 27, 2009, a Diagnosis of Hypersensitivity Pain, Scar was noted. The Claimant was post surgery and was taken off work from this date through October 28, 2009.
On October 30, 2009, a Diagnosis of "Aftercare, Postop Wound Evaluation" was noted. The Claimant was deemed able to return to work at full capacity.

A group of four Progress Notes indicated that on November 02, 2009, the Claimant continued to complain of right foot pain. Final Pathologic Diagnosis was Skin, Right Foot. Excision: Showing Features Suggestive of Focally Ruptured Cyst with Chronic Inflammation and Dermal Cicatrix.

On November 17, 2009, November 27, 2009, and January 09, 2010, the Claimant continued to have pain to the foot on bottom of great toe joint.

Monica Miller, R.N. – Kaiser Permanente

A March 02, 2009 Call Documentation indicated that the Claimant complained of "burning" sensation at the bottom of right foot when stepping down, which started after receiving cortisone injection per Dr. Tran. Ms. Miller then informed the Claimant that the sensation was in response to the effect of medication and would eventually get better following few more days.

Alan Ira Gelman, M.D. – Kaiser Permanente

An April 06, 2009 Progress Note indicated that the Claimant reported that, eight days prior to date, he developed rhinorrhea, congestion, with ear pressure, and that the symptoms returned several days prior to date. At this time, he had right throat pain. He reported taking antihistamine the night prior to this examination date. Assessments were Pharyngitis; and Allergic Rhinitis.

Shaun Ryan Reid, M.D. – Kaiser Permanente

A May 11, 2009 Progress Note indicated that the Claimant presented for follow-up examination of his rosacea. He reported that he was doing well. Assessment was Rosacea.

Nelson Barritt Arnstein, M.D. – Kaiser Permanente (Diagnostic Study)

A May 15, 2009 Three-Phase Bone Scan of the Feet demonstrated mild arthritic changes of the metatarsophalangeal (MP) and tarsometatarsal (TM) joints of the right first toe. There does not appear to be any abnormal sesamoid bone activity.

Ferdinand Almonte Merioles, P.T. – Kaiser Permanente

A July 10, 2009 eight-page compilation of Physical Therapy Reports indicated that the Claimant received four physical therapy sessions with modality on various dates from July 10, 2009 through September 30, 2009 to the right foot.

Titus Adepoju, P.A. – Kaiser Permanente

An October 11, 2009 Progress Note indicated that the Claimant presented with complaint of flare up of facial acne. Assessment was Acne.

Donald Pierre, P.A. – Kaiser Permanente

A November 01, 2009 Progress Note indicated that the Claimant presented for refill of medication. The Claimant had not complained of any discomfort. Review of Systems was significant for nervousness and anxiousness. Current mediations included Alprazolam. Diagnosis was "Medication Refill."

Kymberly Franklin, M.D. – Kaiser Permanente

A December 13, 2009 Progress Note indicated that the Claimant presented with pain with opening of his jaw, chest congestion, productive cough, and wheezing. Diagnoses were as follows: (1) Otitis Media; (2) Upper Respiratory Infection; and (3) Temporomandibular Joint Disorder.

Edwin Joshua Solorzano, M.D. – Kaiser Permanente

A February 14, 2010 Progress Note indicated that the Claimant complained of wheezing. He stated that he was having shortness of breath the morning of this date, but that he was feeling better at this time. He also had cough. Assessment was Bronchitis.

Kathleen Shaw Newman, P.A. – Kaiser Permanente

An April 19, 2010 Progress Note indicated that the Claimant complained of cough described as paroxysmal and wheezy. He also complained of chest tightness, headache, and bilateral ear pain. Assessments were Cough; and Asthma, with Acute Exacerbation.

Jonathan Wonseok Lee, M.D. – Internal Medicine – Kaiser Permanente

A pair of Progress Notes indicated that on June 15, 2010, the Claimant presented with complaint of cough for four days with intermittent episodes of wheezing and chest tightness. Assessments were as follows: (1) Asthma, with Acute Exacerbation; (2) "Asthma;" and (3) "Not Current Smoker."

On August 20, 2009, the Claimant presented with complaints of pain to the left upper arm and upper forearm. He reported having similar symptoms two to three days prior to this date. Additional Assessment was Arm Pain. Advil was prescribed.

Michael George Seroka, M.D. – Kaiser Permanente

An August 29, 2010 Progress Note indicated that the Claimant presented for "Doxy" refill as he was having flare up of rosacea for the past few days. Assessment was Rosacea with Flare.

Alan Shi-Kong Young, M.D. – Kaiser Permanente

A September 10, 2010 Progress Note indicated that the Claimant reported walking upstairs on this date and had a sudden right knee pain described as sharp and stabbing. Assessment was Knee Pain.

Workers' Compensation Appeals Board – State of California

An November 10, 2010 Application for Adjudication of Claim filed for the CT injury from November 03, 2009 through November 03, 2010 due to continuous and repeated psychological trauma causing disability to the neck, shoulder [laterality unspecified], back, "psych, and digestive" while working for U.S. Food Service as a "District Supervisor/Manager/Date."

An Employee's Claim for Workers' Compensation Benefits filed for the CT injury sustained from November 03, 2009 through November 03, 2010 due to continuous and repeated psychological trauma causing disability involving the neck, shoulders, spine, "psyche, headache, sleeping difficulties, internal, and other parts of his body" while employed with U.S. Food Service.

Eugene Alwen Chu, M.D. – Kaiser Permanente

A pair of Progress Notes indicated that on November 11, 2010, the Claimant complained of lower gum area small firm bump for the past few months that had been progressively enlarging and felt hard. Current medications included Mirtazapine and Clonazepam. Impression was Right Mandibular Gingival Bony Lesion.

On December 09, 2010, no new complaints were noted.

John Sanghun Lee, M.D. – Kaiser Permanente (Diagnostic Study)

A November 16, 2010 CT of the Facial Bones without Contrast demonstrated the following Impressions: (1) No focal bony or soft tissue mass of the right mandible or face; and (2) Chronic sinusitis.

Marc Nehorayan, M.D. – Psychiatry – Psychiatric Medical Group

A December 06, 2010 Treating Physician's Initial Evaluation and Report with Psychological Test Results and with a Request for Authorization for Psychiatric Treatment indicated that the Claimant was examined for the CT injury from November 03, 2009 through November 03, 2010 while employed with U.S. Food Services as a Logistics Supervisor.

The Claimant reported that he had been employed with the aforementioned employed since June 11, 2007. His job duties included managing cases and managing freight revenues. He was expected to produce growth in both categories. He reported that his position suited him because he had previous employment history in this type of work. His Supervisor at the time of the incident was Mr. Mike Martin who was the Director of Purchasing. The Claimant had never been promoted, nor had he ever been demoted.

The job mostly required him to sit and work at a computer for longer hours, approximately eleven hours per day five days per week. He made a yearly salary of $65, 500. His job required him to work overtime but he was paid for his overtime. He was expected to work as a salaried employee long extended day to get the job done. He reported that he had a good relationship with co-workers. He indicated that everyone in his facility was professional and everybody got along well with each other.

The Claimant denied having problems with attendance or tardiness, receiving negative write-ups, being sent for counseling, having disciplinary action taken against him, being suspended, being terminated, or filing union grievances. He was awarded as a top performer in the year 2008 and was given good work performance evaluations throughout his employment. The Claimant was not currently working. Since November 04, 2010, he had not worked for U.S. Food Service in any capacity, nor had he worked for any other employer.

The Claimant reported that his emotional difficulties began son after he started working for U.S. Food Services. He began experiencing work-related anxiety soon after he was hired and put in charge of checking and correcting freight revenues. He soon realized that although the rates in the computer were incorrect and he was hired to correct them, he was not able to access the computer to make the needed corrections. He spoke with his Supervisors including the Supply Chain Manager, Mr. Alan Trantham and the Director of Purchasing, Bob Naah, but that he was, for the most part, ignored. He reported an extreme sense of anxiety knowing that he was barred from doing the very job

that he was hired to do. He began experiencing severe headaches. Although his job was extremely stressful, he felt pressured to increase productivity. He continued to feel threatened that some of the things he was asked to do were not ethical and were perhaps legally questionable. When he voiced out his concerns, he was informed to "create his own future in the company."

The Claimant's headache became very more severe and frequent. Along with the frequent headaches, he began experiencing nausea and diarrhea along with worsening insomnia. He started consulting with physicians including a Neurologist, ENTs and other medical specialists. He tried different medications including oral steroids as well as several different pain medications including Hydrocodone. He was eventually referred to the Psychiatry Department and began having therapy at Kaiser Permanente. He was informed by his physician that his symptoms were due to the stress and anxiety that he was experiencing at work. He continued to consult with Dr. "Toshkev" for weekly therapy and counseling and reported that he experienced some relief of symptoms due to his weekly therapy.

At this time, the Claimant was taking Gabapentin, Lorazepam, and Mirtazapine. The Claimant related that as a result of his work related stress and anxiety, he was currently experiencing severe insomnia, fatigue, loss of energy, panic attacks, poor memory, poor concentration, inappropriate guilt, restlessness, "mind going blank," nightmares and distressing dreams, and decreased ability to think along with daily anxiety. He reported that his symptoms had been present for approximately three years and was gradually worsening in the last year to the point that he was placed off work by his physician, Dr. Tran. The Claimant reported that he was placed off work due to severe work related stress, depression, and anxiety.

As to psychiatric history, the Claimant noted that prior to this incident he had never been treated by a psychiatrist, psychologist, or other mental health professional. He never attempted suicide or tried to harm or kill anyone. He had never been hospitalized for a psychiatric condition. No one in his family had ever suffered from psychiatric r psychological problems, nor was there a family history of psychiatric or psychological problems.

The Claimant disclosed that there was one incident of sexual abuse when he was twelve years old, at which time, he chose not to talk about the incident and did not discuss it with anyone. Since then, he had resolved any feelings regarding this matter. He reported that he had an "excellent" with his wife and he had been able to deal with any issues related to this matter on his own without any kind of treatment or therapy.

The Claimant was born in Los Angeles, California. His mother is 67 years old, a retired Office Manager who enjoyed good health. His father is 68 years old and is also a retired.

He revealed that his parents divorced when he was very young and both had since remarried. He has two brothers who are both healthy. He enjoyed a good relationship with his siblings as well as family members. He has been married to his wife, who is a Cosmetologist, for eight years. She is healthy. It was noted that the couple enjoyed a healthy and god relationship and were happily married. He reported that his wife has two children from a previous marriage who were both adults living on their own. He was previously married for seven years between 1982 and 1989. He has two grown children from that marriage; two girls. He reported that he has a good relationship with his children and was close to his stepchildren as well.

Past medical history was remarkable for asthma when he was a child. He denied having an asthma attack in the past ten years. He was hospitalized two-and-a-half years prior to date when he had an injury to his right foot which required removal of a cyst and surgery. He did not require any ongoing treatment for this injury and was completely healed.

With regard to orthopedic injuries, the Claimant recalled that approximately ten years prior to this date, he suffered from a slightly compressed disc. He did not receive treatment for this condition and reported occasional low back pain due to this condition. Otherwise, he had been in a good general health for most of his life. Since working for U.S. Food Services and the anxiety related difficulties, he had also been diagnosed with high blood pressure which started with severe headaches. He reported that his General Practitioner gave him some medication for his high blood pressure which stabilized his condition and was no longer taking medication.

Under developmental and educational history, the Claimant completed approximately eighteen years of schooling, participating in regular classes. He denied having any learning difficulties requiring special classes or other assistance. He did not have problems paying attention in school and did not get into trouble while in school. He graduated and received his high school diploma in 1981. Under personal habits, it was indicated that he began smoking cigarettes approximately six months prior to date to relieve stress, but that since then he tried to quit smoking. He was down to smoking approximately less than a pack per day. He noted that his only "nervous habit" at this time was smoking.

The Claimant's activities and hobbies included playing golf and tennis prior to the injury. He also enjoyed being outdoor and spending time with his wife, family, and friends. Since the injury, he had been unable to enjoy the same activities such as golf and tennis and had not been participating in these types of sports. He spent most of his time by reading and had begun to practice meditation. He was very uncertain abut his future at this time and was uncertain about his capability to return to work.

Under personality traits, the Claimant described himself as friendly and a good person. He reported that others would describe him as being intelligent, honest, and reliable, and someone who always tried to do the right thing. He indicated that this was his first Workers' Compensation claim. He denied filing any previous lawsuit, or having been sent to jail or prison. He informed that he was not currently having any acute financial difficulties. He was receiving short term disability, but was concerned about his future and his ability to return to work and gainful employment.

As to work history, the Claimant discussed that he had never been fired from a job. Prior to working for U.S. Food Services, he worked for a different freight system as Director of Transportation and Safety between December 1999 and March 2007. He left the job because the company closed and he was offered a position at U.S. Food Services. He also worked for Gilbert West between November 1998 and December 1999 as a Safety Assistant. He left the position for a better offer at the freight system.

On Mental Status Examination, the Claimant's posture appeared rigid and tense indicative of anxiety. His facial expression also suggested anxiety apprehension, depression, sadness, and anger. His general body movements were restless and fidgety, also indicative of anxiety. He had word retrieval difficulties on occasions. As to affect and mood, the Claimant showed appropriate anxiety and depression when discussing his difficulties at work. At some point, he became teary eyed when discussing the frequent headaches and difficulties he had experienced at work. He described his own mood as being depressed and anxious. He had clear difficulty with attention span. When instructed to count backwards from 100 by 7's, he was visibly shaken. Initially, he indicated that he could not do it and could not concentrate. He became anxious when instructed to calculate number of nickels in $1.35, and indicated that he could not possibly do the kind of calculation, that he had not had enough sleep the night prior to this examination date, and he refused to even take a guess as to the number of nickels in $1.35. He reported that initially, he did not understand the relationship between his headaches and stress and the anxiety that he was experiencing on a regular basis, but since going to therapy, he had been able to make those connections and understand how his psychological problems were affecting his day to day functioning. He indicated that he had been informed by his wife and some of his family members that he had become slightly paranoid. He attributed this feeling to anxiety about his future and his ability to return to work. His thought flow was slightly increased.

Psychological tests administered were as follows: (1) Beck Depression Inventory (BDI); (2) Beck Anxiety Inventory (BAI); (3) Beck Hopelessness Scale (BHS); and (4) Millon Clinical Multiaxial Inventory-III (MCMI-III).

On BDI, the Claimant obtained a score of 5, indicative of an individual experiencing a minimal amount of depression. On BAI, the Claimant obtained a score of 4, indicative of

an individual experiencing a mild amount of anxiety. On BHS, the Claimant obtained a score of 2, suggestive of an individual experiencing a minimal amount of hopelessness.

On MCMI-III, the Claimant obtained the following BR scores: Disclosure (59), Desirability (85), Debasement (49), Schizoid (24), Avoidant (24), Depressive (20), Dependent (70), Histrionic (63), Narcissistic (52), Anti-Social (12), Sadistic (0), Compulsive (91), Negativistic (20), Masochistic (29), Schizotypal (60), Borderline (40), Paranoid (60), Anxiety Disorder (90), Somatoform (68), Bipolar Manic (60), Dysthymic (64), Alcohol Dependence (0), Drug Dependence (20), Post-Traumatic Stress (65), Thought Disorder (44), Major Depression (85), and Delusional Disorder (0).

Diagnostic Impressions were as follows: Axis I: "General" Anxiety Disorder with Depression: Psychological Factors Affecting General Medical Condition: (GI Symptoms Including Vomiting and "Increase in High Blood Pressure" Along with Frequent and Severe Headaches) Defer to Appropriate Medical Specialist: and Sleep Disorder Secondary to Mental Disorder, Anxiety, Insomnia Type: Axis II: Deferred; Axis III: Chronic Headaches and "Increase in High Blood Pressure." Defer to Appropriate Medical Specialist: Axis IV: Financial Difficulty and Interpersonal Difficulties: and Axis V: GAF: 53.

It was Dr. Nehorayan's opinion that the Claimant's psychiatric symptoms were a direct result of the cumulative injury, mainly stress and anxiety at work that occurred while employed at U.S. Food Services. These injuries and the severe stress at work had caused and resulted to anxiety, depression, insomnia, as well as headaches and gastrointestinal symptoms. The symptoms had also created feelings of worthlessness and had lowered the Claimant's overall self-esteem. Psychiatric and psychological care was recommended along with continued medical care. A preponderance of the evidence showed that greater than 51% of the cause of the Claimant's psychiatric injury was industrially related or related to the incidents that occurred between November 03, 2009 and November 03, 2010. Dr. Nehorayan noted that there was psychiatric disability in this case, and that it was a legitimate claim.

At this time, the Claimant was temporarily totally disabled worker on a psychiatric basis. His degree of disability was mild to moderate. There were no work restrictions that could return him to his usual and customary work. The Claimant required psychiatric care and supportive psychotherapy. As the Claimant had formed therapeutic alliance with his Therapist at Kaiser Permanente and at this time, it was Dr. Nehorayan's opinion that it was in the Claimant's best interest to continue with his weekly therapy and psychiatric care at Kaiser Permanente. The Claimant should continue taking his medications as prescribed by his Neurologist, Psychiatrist, and Physicians.

A pair of "Office Evaluations" indicated that on January 19, 2011, the Claimant reportedly continued his treatment with Kaiser Permanente. It was noted that he was having medications and therapy. The Claimant identified at the time of the initial evaluation that he did not really wanted to be removed from the intervention and treatment because of the connection that he had with his doctors and clinician "there."

Ultimately, the Claimant was not sure what was going to happen to such care. He stated that "they" extended his FMLA leave and extended time off until February 04, 2011. He noted that he continued feeling emotionally about the same. He was worried about being out back in the same environment. He was also worried about further hostilities and harassment. He indicated that the company had already "cut him off" from his short-term disability. "Prudential" indicated that as this was a Workers' Compensation claim, that they were not willing to continue that. The Claimant was receiving State Disability at this time and was searching alternatives in regard to supplemental monies associated with disability including getting money back on his vacation time.

On this examination date, physically, the Claimant complained of being fatigued, nauseous, and having headaches. Emotionally, he complained of anxiety, fear, uncertainty, depression, loss of emotional control, apprehension, and feeling overwhelmed. Cognitively, he complained of experiencing confusion, having nightmares, lowered alertness, poor concentration, poor problem-solving, and poor abstract thinking. Behaviorally, the Claimant complained of withdrawal, loss of appetite, increased appetite, and inability to rest.

On Mental Status Examination, the Claimant continued to be notably comprehensive and anxious. He appeared to be more contained than on initial evaluation. He identified the underlying demeanor in terms of being discouraged and hopeless and helpless.

The Claimant was to continue to follow among primary set of clinicians associated with his medication regimen. It was not Dr. Nehorayan's belief that the Gabapentin was likely effective. At the end of the FMLA, Dr. Nehorayan planned to transition the Claimant, as it was not evident that the Claimant would be able to continue to use Kaiser. In the meantime, the Claimant was referred to a Therapist within the scope of Dr. Nehorayan's office. The Claimant continued to be temporarily totally disabled on psychiatric basis.

On April 05, 2011, the Claimant additionally complained of anger, poor attention, changes in activities, and nonspecific bodily complaints. He stated that nothing seemed to be right in regard to his mood, particularly the anxiety. He felt more anxious over the week prior to date, but he identified that some of this continued to be notably the financial state and financial concern that had been created. It was noted that there was absolutely no way that the Claimant nor Dr. Nehorayan designated that the Claimant could actually return to the prior work condition.

Dr. Nehorayan explained that the issues at this time were the Claimant's need to really begin to focus on what he could do in the future and where he could actually be employed in the future. This in itself seemed to be problematic as he could not have the focus and the concentration, and part of this was the issue associated with his disruption of sleep as well as his anxiety. He indicated that he was doing everything that he was supposed to be doing, that he felt he could take control of exercising daily. The Claimant reported eating well, and had not gained or loss any significant amount of weight. However, at the same time, he stated that he was in a state of mind where he just wanted to lock the door and sometimes, he thought about just taking all of his pills.

It was not to indicate that he felt a desire or intent and plan, the Claimant just thought about it. The Claimant noted that this was depression, but he did not feel any significant differences or degree of differences from the medication. He reported that some of this was about when the bills came up and he had to juggle everything that he was going on in terms of just the bills. His wife was trying to be supportive and helpful, and she had been helping in terms of the financial state, taking over on some of the bills. He had limited income because he was on State Disability. Although he was sleeping at 9:00, he would always wake up at 5:30. He was not sleeping well through the course of the night, and although would try to take a nap after breakfast, even after this did not seem to be working because his mind continued to race. On Mental Status Examination, the Claimant continued to be apprehensive and anxious in mood and affect, evident in his facial expressions. He almost had a sweaty quality about him, particularly in regards to his face.

A May 24, 2011 "Extended Office Evaluation" indicated that the Claimant identified that he was really having difficult time in regard to his cognitive functioning. He noted that he actually had written notes for Dr. Nehorayan in order to organize himself so that he could actually able to discuss everything that he wanted to discuss. He indicated that he had a lot of problems sleeping and increasing headaches upwards of three to four times per week. He stated that he continued having constant awakening upwards at 3:00 a.m. He also continued to have panic symptoms where he began to sweat a lot even under the slightest bit of perceived stress. He indicated that his stress level seemed to be increased. He had passive thoughts about wanting to die and he felt really ashamed and guilty in regards to even expressing this.

The Claimant reported that it was difficult for him to focus on even small tasks that his wife actually had to leave notes for him in order to be able to follow through in terms of his activities of daily living, and to recall to eat. The Claimant noted that part of this was the concentration and part of this was just feeling very overwhelmed. He reportedly felt like his body was "giving up," and as he turned to look at e-mails from employers, his

mind just "goes blank" and he would start stressing because he could not concentrate and did not really have a future for himself.

On Mental Status Examination, the Claimant indicated passive suicidality, no intent or plan. He was remarkably tremulous. Under action plan, the Claimant was to start as an adjunct to his antidepressant. He was initially having problems with the antidepressant, but this seemed to go away, although he identified that what was resumed were the irritable bowel symptoms that he had been expressing in terms of alternation between diarrhea and constipation. Informed consent for Risperdal was obtained while Celexa was discontinued.

A pair of "Office Evaluations" indicated that on June 14, 2011, the Claimant reported some marginal indication of improvement associated with the Risperdal. He had not had any further suicidal thinking or suicidal ideation. He reported that he had been exercising and that he sometimes overdose it to the point that he felt like he was in more pain than he should be; his whole body then hurt.

The Claimant reported that there was one point that he felt very irritable and out of control and that there were some episodes of feeling confused when he woke up in the morning. The Claimant indicated that he had some visual deficits and difficulties, although it might correspond to the Risperdal in terms of the anti-cholinergic component of this medication, for which Dr. Nehorayan believed to be going away and improve as he continued to take the medication and adjust to the medication.

The Claimant reportedly gained ten pounds since he started the last medication, for which Dr. Nehorayan needed to be careful, although he was trying to exercise as regularly as he could. The Claimant further reported that there was financial strain as he noted to be creating anxiety. There had been some strain in the relationship with his wife. The Claimant explained that although his wife was quite supportive, he felt and perceived that she was bothered upon coming home in the afternoon and found him at home; thus he had been trying to do some small projects in the garage such as making one functional computer out of the three servers that he pieced together. He stated that he was really doing this to see if he could stimulate his brain and see what he was actually capable of. On Mental Status Examination, the Claimant was preservative in his speech. Under action plan, Dr. Nehorayan encouraged the Claimant to continue doing small projects that regain his confidence.

On August 01, 2011, the Claimant reported having been in ongoing contact with his Therapist, Jill Adler. While Dr. Nehorayan was off service, it was noted that the Claimant continued having severe difficulties associated with sleep and had developed issues associated with paranoia, suspiciousness, as well as irrational thinking.

It was not evident, however, that the Claimant was notably an indication to be either suicidal, homicidal, not an indication to be a danger to self or danger to others. Dr. Nehorayan, however, in contact with the Therapist as well as with the Claimant, and that the medication had been additionally prescribed including Seroquel. With Risperdal, the Claimant reported negligible effects such as sleeping upwards the prior week for two hours per night, and that he was extremely anxious, agitated and was having significant difficulties associated with ongoing generalized anxiety as well as panic and excessive worry, which he could not continue to control, which he associated with, once again, with aspect of how he was treated and the hostilities towards him in the workplace environment.

Dr. Nehorayan discussed that there was no question that there appeared to have been the essence of additional decompensation, although the Celexa had been discontinued, moving to mood stabilizing agents appeared to have been the realm of importance in terms of further stabilizing the Claimant's condition, particularly with the psychotic features that had been notable.

The Claimant added that he had the best night of sleep upon initially taking the Seroquel. He reported that being off from work had not been easy or beneficial, particularly in terms of his relationship with his wife; his wife was also having difficult time associated with his illness, his inability to return to open labor market, and ultimately the continued struggle that associated with panic and anxiety, which definitively affected the relationship. In fact, his wife had been having difficulties and identified that she herself had actually gone to Kaiser in order to receive additional help associated with the Claimant's condition. The fact that he had been intimate for the last six months, he identified that there had been both a loss of interest and a noteworthy guilt. He noted a lot of pressure on his wife to continue to work due to the financial problems.

The Claimant had brought in Social Security paperwork and Dr. Nehorayan agreed with him that he should file for Social Security as Dr. Nehorayan believed that the Claimant would continue to be psychologically impaired to a point that he was unable to return to open labor market from a psychological standpoint. He was too easily overwhelmed.

A September 28, 2011 Treating Physician's Evaluation and Maximized Medical Improvement Report with Psychological Test Results and with a Request for Authorization for Further Psychiatric Treatment indicated that the Claimant had been set for Social Security evaluation by a Psychiatrist and he was examined by Dr. Reznick.

The Claimant reported that that he was "kicked out" of the Social Security Disability evaluation. He alleged that Dr. Reznick was gruff in the course of the examination. He stated that he was not allowed to fill out the paperwork and informed him that he [Dr. Reznick] would help the Claimant fill out the paperwork when he got into session.

During the session, he offered his list of medications but Dr. Reznick refused to look at the list at that time and indicated to him that he [Dr. Reznick] was going to obtain the list at the end of the examination. The Claimant then became increasingly upset and threw his water bottle on the floor. Consequently, he was removed from the evaluation and he contacted his SSI Attorney associated with the aspects of the evaluation; he also contacted a person from Social Security Disability.

Indeed, Dr. Nehorayan evaluated the Claimant identifying the occurrences that occurred upon follow-up call with the Claimant in "Friday" noting that he had not had any active intent or desire to hurt himself or others, and that he made appropriate report to the Social Security disability Personnel who indicated that "they" would file a report on his behalf with regard to his complaint and grievance. It was noted that the Claimant understood that "they" were supposed to re-establish a new clinician to further evaluate him in regards to Social Security Disability benefits.

On this examination date, the Claimant additionally complained of weakness, muscle tremors. He also complained of anxiety, grief, and emotional outbursts. On Mental Status Examination, the Claimant was observed to be gaining weight since the time that he was initially evaluated. It was noticeable that he broke into a sweat in regards to the evaluation. Although constantly apologetic he seemed to be wiping himself. His facial expressions showed moderate to marked anxiety, apprehension, irritability, and psychomotor agitation. He appeared restless through the course of the interview. Speech pattern was perseverative and hesitant that it affected his intonation and at times difficult to understand and Dr. Nehorayan would have him repeat himself. In the doctor-patient relationship, the Claimant was domineering at times. He appeared to be trying to verbalize his thoughts and had difficulty answering questions in a specific manner. He had been circumstantial in this thought processing. He was depressed and his affect showed him to be moderate to markedly dysphoric and anxious.

When instructed to count backwards from 100, the Claimant began with 93, 86, 79, and then skipped to 73 and miscounted thereafter. He was increasingly agitated and shaky when asked about serial 7's. He became easily distractible soon thereafter. He tends to increase in his fidgetiness and thought blocking in the course of the examination. His judgment showed slight impairment in managing daily living activities and moderate impairment in making reasonable life decisions. He indicated fleeting suicidal ideation but no intent or plan. His thought flow showed mild to moderate associational disturbance, which seemed to worsen and he became increasingly tearful and labile in his range in the course of the interview, trying to use breathing techniques to try to slow the apprehension and anxiety. He was circumstantial in his thought processing.

Psychological tests administered were as follows: (1) Beck Depression Inventory (BDI); (2) Beck Anxiety Inventory (BAI): (3) Beck Hopelessness Scale (BHS); and (4) Epworth Sleepiness Scale.

On BDI, the Claimant obtained a score of 40, indicative of an individual experiencing a severe amount of depression. On BAI, the Claimant obtained a score of 43, indicative of an individual experiencing a severe amount of anxiety.

On BHS, the Claimant obtained a score of 13, suggestive of an individual experiencing a moderate amount of hopelessness. On Epworth Sleepiness Scale, the Claimant obtained a score of 18.

Diagnostic Impressions were as follows: Axis I: Anxiety Disorder Not Otherwise Specified; Depressive Disorder Not Otherwise Specified: Psychological Factors Affecting General Medical Condition: Headaches, Acceleration of High Blood Pressure, Associated Weight Gain, Defer to Appropriate Medical Specialist; and Sleep Disorder Not Otherwise Specified: Axis II: Deferred: Axis III: Chronic Headaches, "Increase in High Blood Pressure," Weight Gain, Defer to Appropriate Medical Specialists: Axis IV: Occupational Problem, Financial Strain Creating Interpersonal Difficulties: and Axis V: GAF: 45 Identifies a Whole Person Impairment of 40%.

The Claimant was at a Maximized Medical Improvement. Overall Permanent Impairment Rating was Class 4. With respect to Causation, it was within reasonable medical probability to identify that greater than 51% of the Claimant's psychiatric injuries were a compensable consequence of the overwork and overload associated with his job position and continuous trauma injury that he sustained between November 03, 2009 and November 03, 2010. Indeed, the detail of the Claimant's job duties, job structure, and job nature was overwhelming that his capability and mental capacity simply could not continue to cope and deal with the stress of such work environment; which was the particular reason why he continued to have the ongoing severity of psychological difficulties that he presented.

As to issue of Apportionment, it was Dr. Nehorayan's medical opinion that 90% of the Claimant's residual psychiatric disability was caused by the direct result of the injury arising out of and occurring in the course of employment with U.S. Food Services as a Logistic Supervisor. Indeed, there were other factors that would recognize pre-existing conditions that would change the percentage of the industrially related permanent disability by 10%. It was recognized however, in regards to pre-existing conditions, that was really more notable in the Claimant's MCMI-II testing and his personality traits, for which Dr. Nehorayan believed that there was evidence of his obsessive/compulsive personality features in addition to dependent and histrionic personality features associated with his characterologic features.

The basis of which was the Claimant's consistency in presentation, as well as the manner he presented himself through the course of not only to the multiple evaluations with his physicians, but also to the manner associated with personality features sensitized him to the extent of his difficulties with depression and anxiety. Dr. Nehorayan noted that although in and of itself it never required intervention and treatment on a psychiatric basis at any point in his life, it was not to exclude or dismiss the extent of his MCMI-III testing nor the manner it sensitized him even to a minor point associated with aggravating his current psychological distress, for which Dr. Nehorayan had taken into consideration for medical opinions.

There were no work restrictions identified on a psychiatric basis that could return the Claimant to the open labor market. He had filed for Social Security Disability income and Dr. Nehorayan would endorse him from a psychiatric basis of recognizing him as being currently permanently disabled upon his current emotional condition. The Claimant required continued psychiatric care. Due to his level of agitation and anxiety, he was having difficulties even with the Therapist that he had been referred to in Dr. Nehorayan's office. Thus, he continued to be followed by Dr. Nehorayan for pharmacologic management as well as support. He would be re-evaluated every four to six weeks until there was further stabilization.

It was well representative of the Claimant's difficulties with the public and public places, in interacting not only in formal examinations, and his incapability due to the significant deficits that he had cognitive difficulties, rapid decompensation in such arenas even in terms of examination on this date, which simply precluded him from returning to open labor market.

The Claimant was deemed Qualified Injured Worker on a psychiatric basis. Dr. Nehorayan did not believe that the Claimant could be adequately retrained based upon his current set of emotional deficits and difficulties.

Daniel Capen, M.D. – Orthopedic Surgery

A December 10, 2010 Secondary Treating Physician's Initial Orthopedic Evaluation indicated that the Claimant reportedly developed headaches, as well as pain to his neck, shoulders and upper back during the course and scope of his employment with U.S. Food Service in the capacity of a Logistics Supervisor. He attributed his headaches to the mental pressure he was under to meet certain goals. He attributed the pain to his neck, shoulders and upper back pain to the nature and the physical demands of his job.

The Claimant stated that he reported his symptoms to his Manager, however, no medical treatment was offered. He sought medical attention on his own through his primary care

physician at Kaiser Permanente. He continued to work with pain and discomfort until November "03," 2010, when his pain became more intense and intolerable. He reported his worsening condition to his employer but there was no medical referral offered.

The Claimant indicated that he was under the care of Dr. David Kliger, a Clinician at the Psychiatric Department of Kaiser Permanente, since March 08, 2008, in regards to his depression and anxiety. He noted that he was provided psychiatric therapy sessions by Dr. "Sonny" Toshkov, a Psychiatrist at Kaiser Permanente. He reported that on November 04, 2010, he was evaluated by. Dr. Anthony Tan, also a Clinician at the Psychiatric Department of Kaiser Permanente, who subsequently placed him off work and on "disability."

On this examination date, the Claimant complained of intermittent pain and stiffness to his neck, with pain radiating to the upper back and shoulders, left more than right. He also had frequent headaches, as well as constant pain to his shoulders, left greater than right. He noted weakness and occasional "popping" to the shoulders, as well as limited range of motion due to pain. He noted that his upper back pain radiates to the neck and across the shoulders. He also expressed feeling of anxiety and depression.

The Claimant also complained of difficulty getting to sleep and staying asleep. He noted frequent awakening at night secondary to pain and worry over his health. He further complained of epigastric "burning" pain that occurred daily, especially during the morning hours, which sometimes lasted all day, and that it was associated with nausea and diarrhea. He reported having headaches.

With regard to Activities of Daily Living, the Claimant stated that he was having problems in driving for prolonged periods. He had problems with sexual dysfunction and had difficulty sleeping and being awakened due to pain and discomfort to his neck, shoulder and upper back.

Diagnosis was Cervical Sprain/Strain. As to Causation, it was noted that the Claimant's injury was consistent with the cumulative trauma. The duration of employment and frequency of activities were both of sufficient intensity to result in cumulative trauma injuries. Therefore, Dr. Capen found sufficient evidence of industrial causation. Amitriptyline/Tramadol was provided.

A group of three Secondary Treating Physician's Progress Reports indicated that on February 04, 2011, the Claimant complained of ongoing pain to his left neck and upper extremities. Additional Diagnosis was Rule out Cervical Discopathy.
On April 22, 2011, the Claimant's condition remained unchanged. Medical records were reviewed including the following: (1) A Progress Note dated August 05, 2009 by David Kliger, M.D., indicating that the Claimant's Xanax dose was increased, while Ativan was

discontinued. Therapist was changed to Ken Reiter; and (2) A Psychotherapy Session dated "October 03, 2009" by Fany Toshkov, L.C.S.W., indicating that the Claimant received psychotherapy sessions on October 03, 2009, November 21, 2009, January 09, 2010, February 06, 2010, March 06, 2010, April 17 2010, May 29, 2010, July 10, 2010, August 07, 2010, August 28, 2010, October 02, 2010, and November 20, 2010. Diagnoses were as follows: Axis I: Anxiety Disorder Generalized; Axis II: Defer; Axis III: "See Pt Med Rec.;" Axis IV: Problems with Primary Support Group; and Occupational Problems; and Axis V: GAF = "60-51."

On August 25, 2011, the Claimant reported feeling much better since receiving extracorporeal shockwave therapy; however, he continued to have ongoing neck pain with some mild radiations to the right upper trapezius muscle.

A September 30, 2011 Secondary Treating Physician's Final Report and Request for Authorization indicated that the Claimant complained of neck symptomatology and bilateral shoulder pain. Dr. Capen indicated that at this point, from an orthopedic standpoint, the Claimant had reached a plateau. Additional care for his emotional distress would be provided by Dr. Nehorayan.

As to Impairment Rating, Dr. Capen discussed that the Claimant had II-C discs in the cervical spine which warranted 20% Whole Person Impairment. Realistically, it was also to consider that he had also lost two disc functions in the cervical spine which entirely was an 80% Whole Person Impairment. Since C1-2 was not a disc, this was a 25% impairment which would be a 20% impairment rating.

Work restriction indicated that the Claimant was precluded from heavy work activity. With respect to Causation and Apportionment, it was Dr. Capen's opinion that 100% of the Claimant's permanent disability/impairment was a direct result of the injury that occurred on a cumulative trauma basis from November 03, 2009 through November 03, 2010. There was no apportionment to non-industrial or pre-existing factors.

Workers' Compensation Appeals Board – State of California

A January 21, 2011 39-page Deposition of Timothy Smith revealed the following information.

Pages 01-09: The Claimant stated his full name as Timothy Brian Smith. He admitted to drinking alcohol containing beverages in the last 24 hours. He had also taken medications as prescribed by Dr. Anthony Tan such as Clonazepam, and "Lortazepam," as well as Lorazepam, and Gabapentin as prescribed by Dr. Tiplea.

Pages 10-15: The Claimant testified that he was currently employed with U.S. Foodservice, La Mirada Division as a Logistics Supervisor since June 11, 2007, but that he had been on "disability" since November 04, 2010. His job duties included making sure the freight rates in the system were correct. He supervised increasing managed cases by converting non-managed loads to managed, as well as supervising the O.S.M.D. clerk. He managed the loads as per how the buyer purchased orders at a vendor. He explained that the buyer created a purchase order through a computer in Chicago, and came back to him through a transportation inbound planning system, for which he distributed to the transportation department to have it back hauled. He agreed that his job was basically a desk job. Most of the days, he spent eleven to twelve hours at work.

The Claimant attested that he was directly managing one person and indirectly managing 200 drivers. He described that if there was a problem with the load, the drivers would call him. He pointed out that his position was inside the procurement department and when there was a problem with the purchased order, the transportation department would put the driver "in touch" with him. He would subsequently spoke with the buyers and have the problem corrected so business would continue as planned.

The Claimant testified that prior to working for U.S. Food Service, he worked for Pro-line Freight Systems as a Director of Safety and Transportation Manager for seven years. He subsequently left the job when the company closed.

Prior to working for Pro-line, he worked for Gilbert West as an Assistant of the Director of Safety for one year. He left the job for a better position at Pro-line. He admitted to obtaining a certificate that qualified him to perform the job of a Director of Safety through Keller Services. Prior to Gilbert West, he worked for Crescent Trunk Lines as a Dispatcher for three-and-a-half years.

Pages 16-28: The Claimant testified that his injuries sustained while working for U.S. Foodservices developed over the time. He indicated that he had "a lot" of tension to his neck and shoulder and back, headaches, diarrhea, insomnia, anxiety, and depression; for which he sought treatment with Dr. Tiplea, Dr. Kliger, Dr. Tan, Dr. Toshkov, Dr. Cohen, and "Dr. Neherang." The Claimant reported that he had an appointment on the "26th" for a psychiatric evaluation.

The Claimant explained that he started having headaches in approximately the fourth quarter of 2007. He sought treatment with an ENT doctor through the HMO at Kaiser Permanente on two to three occasions wherein MRI of the sinus was obtained, for which he believed was negative. He was also prescribed medication for migraine headaches, which he claimed to be not helping.

Subsequently, the Claimant was referred to Dr. Tiplea, a Neurologist, in the fourth quarter of 2007, who obtained a few tests and prescribed him several medications. He believed that the tests came back negative. He was sent back to the ENT doctor and more tests were performed, for which he further believed to be negative. Consequently, he was referred again to Dr. Tiplea who then referred him to the Psychiatry Department of Kaiser Permanente.

The Claimant was examined by three doctors in the Psychiatry department, but that there was no opinion developed regarding the cause of his headaches. He recalled being examined by Dr. Kliger who referred him to Dr. Toshkov. He noted that Dr. Toshkov came up with an opinion that his headaches were work-related. He recalled being advised to take time "away from his desk," for which he tried to do and had a temporary relief. Upon consulting again with Dr. Toshkov, he was suggested to switch Dr. Kliger to Dr. Tan, Psychiatrist.

The Claimant was last examined by Dr. Tan on December 23, 2010, reporting that his condition remained the same. He cited that he received a course of fourteen therapy sessions with Dr. Toshkov, wherein they spent an hour together and tried to put him on the track to getting better. He admitted to noticing improvement with his general well-being. He also recalled being advised to diet and exercise as his medication made him hungry.

The Claimant also indicated that, to deal with the tension, stress, and anxiety, he did exercise everyday by walking, playing golf, lifting weights with a barbell and a dumbbell he had at home, and rode his bicycle around the park.

Pages 29-39: The Claimant confirmed that he had been married for eight years. His wife is a Cosmetologist, Hair Stylist. He indicated that he has two daughters from his previous marriage, ages 22 and 21. His current wife also has two sons ages 26 and 22 from her former partner.

The Claimant clarified that when he went golfing, he had four buddies that played with him on a regular basis. He cited that he had particular course next to his house that he liked to go to.

The Claimant testified that Dr. Toshkov referred him to a new doctor for psychotherapy at Kaiser. He was informed by Dr Toshkov that his next examination would be an interview to see if he could be included into the next group sessions where he could be a part of a group.

The Claimant reiterated that when he started having headaches in approximately 2007, the rest of his symptoms appeared. He noted that it was also in 2007 that he initially reported his problems to his employer, to Alan Trantham, a Chain Manager, and to Bob Nash.

The Claimant then went on "disability" on November 04, 2010 when his symptoms increased that he could no longer take it. He noted however, that even if he was off work, he did not feel "getting better." He recalled having an "appointment group" scheduled in "February 4th" with Dr. "Cohen," for which he believed to be related to a "Psychiatric Medical." He believed that he also had an appointment scheduled on February 22, 2011. He noted that the intensity of his symptoms since he stopped working had not changed. "Dr. Neherang" suggested him to be in a group therapy with one of his Psychiatric Group Therapists.

Robert Henry, M.D. – [Name of Facility Not Provided] (Diagnostic Studies)

April 04, 2011: EMG/NCV of the Bilateral Upper Extremities and Cervical Paraspinals revealed a normal study. There was no evidence of median or ulnar neuropathy, brachial plexopathy, or cervical radiculopathy, C5-T1, bilaterally.

Sean Leoni, M.D. – Internal Medicine – [Name of Facility Not Provided]

An April 26, 2011 Initial Comprehensive Internal Medicine Report and Review of Medical Records indicated that the Claimant was examined for the injuries sustained on "November 02, 2009" and "November 23, 2010" while employed with U.S. Food Services.

On this examination date, the Claimant reportedly had bloating, cramping and diarrhea. He reportedly had diarrhea during the past week. He reported that maybe he had nausea. He denied any melena. He complained of decreased libido. He reported he was given Viagra in the past which had helped him. He had lost about fifteen pounds since the stress and anxiety began. He reportedly had noticed that his blood pressure had been slightly elevated.

The Claimant disclosed that his parents are alive and both had knee problems. Medical records were reviewed including the following: (1) A Progress Note by Orchard Medical Offices, Behavioral Health Psychotherapy dated July 09, 2009, indicating the following Diagnoses: Axis I: Generalized Anxiety Disorder; Axis II: Deferred; Axis III: Headaches; GAF: 58. Ativan/Lorazepam dose decreased. The Claimant was referred to Therapist, Freda Lutz LCSW; (2) Progress Notes by Orchard Medical Offices, Behavioral Health Psychotherapy dated September 05, 2009, March 06, 2010, May 29, 2010, July 10, 2010, August 07, 2010, and August 28, 2010, indicating the Diagnosis as "Same as Previous." GAF: 60-51. Continued therapy was recommended; (3) A Progress Note by

Orchard Medical Offices, Behavioral Health Psychotherapy dated September 29, 2009, indicating the Diagnosis as "Same as Previous." GAF: 60. Xanax and Lorazepam were discontinued. Continued therapy was recommended: (4) Progress Notes by Orchard Medical Offices, Behavioral Health Psychotherapy dated October 03, 2009, November 21, 2009, January 09, 2010, and February 06, 2010, indicating the Diagnosis as "Same as Previous." GAF: 70-61. Continued therapy was recommended.

(5) A Progress Note by Orchard Medical Offices, Behavioral Health Psychotherapy dated April 17, 2010, indicating the Diagnosis as "Same as Previous." GAF: 65. Continued therapy was recommended; (6) A Progress Note by Orchard Medical Offices. Behavioral Health Psychotherapy dated September 24, 2009, indicating the following Diagnoses: Axis I: Anxiety Disorder; Axis II: Deferred; Axis III: Headache; Axis IV: Occupational Problems: and Axis V: GAF: 63. Clonazepam and Remeron dosages were increased. Lorazepam was to be restarted. Support therapy and counseling was provided.

(7) A Progress Note by Orchard Medical Offices, Behavioral Health Psychotherapy dated October 02, 2010, indicating the additional Diagnoses as follows: Axis III: Headache: BPH. Not Current Smoker, and Asthma; Axis IV: Problems with Primary Support Group. Problems Related to the Social Environment and Occupational Problems; and Axis V: 60-51: (8) A Progress Note by Orchard Medical Offices. Behavioral Health Psychotherapy dated November 04, 2010, indicating the Diagnosis: Axis II: "Occupational Problems or Work Circumstances; Counseling On Smoking Cessation;" Smoker; Axis V: GAF: 54. Support therapy and counseling was provided.

(9) A Progress Note by Orchard Medical Offices. Behavioral Health Psychotherapy dated November 20, 2010, indicating the following Diagnosis: Axis V: GAF: 60-51. Support therapy and counseling was provided. Continued therapy was recommended; (10) A Progress Note by Orchard Medical Offices, Behavioral Health Psychotherapy dated December 02, 2010, indicating that support therapy and counseling was provided. Continued therapy with Dr. Toshkov was recommended; and (11) Initial Psychiatric Evaluation by Dr. Anthony Soon Aun Tan dated August 10, 2010, indicating the following Diagnoses: Axis I: Anxiety Disorder, Generalized; Axis II: "Occupational Problems or Work Circumstances; Counseling on Smoking Cessation; Smoker;" Axis II: Deferred; Axis III: Headache, BPH, Not Current Smoker and Asthma; Axis IV: Occupational Problems; Axis V: GAF: 54. The Claimant was to continue with Clonazepam, Remeron, and Lorazepam. Support therapy and counseling was provided. Continued therapy with Dr. Toshkov was recommended.

Diagnoses were as follows: (1) Irritable Bowel Syndrome; (2) Borderline Hypertension; (3) Sexual Dysfunction; and (4) Psychiatric Diathesis. Dr. Leoni explained that the Claimant developed gastrointestinal problems in the form of irritable bowel syndrome, and that the events of anxiety and stress that the Claimant had endured had caused an

intestinal neuronal and neural enteric contribution to visceral hypersensitivity and caused irritable bowel syndrome. Therefore, irritable bowel syndrome must be considered industrial. and it needed to be treated on an industrial basis.

The Claimant also had borderline hypertension. It was reasonable that his borderline hypertension, irritable bowel syndrome and sexual dysfunction were a direct result of the stress and anxiety he sustained at work and must be viewed as work-related.

A July 26, 2011 Primary Treating Physician's Progress Report indicated that the Claimant continued to have bloating, constipation, and diarrhea. He started taking Seroquel. It was noted that his blood pressure "went up." Additional Diagnosis was "Irritable Bowel Syndrome + Borderline Hypertension." The Claimant was placed off work.

A September 06. 2011 Internal Medicine Final Report indicated that the Claimant reportedly had good days and bad days regarding his constipation. He reportedly gained 50 pounds since the "injury," and that he had borderline high blood pressure but did not want to take medication. The Claimant complained of numbness in his lower extremity on the right thigh area. as well as lack of libido and sexual dysfunction. He reported that Viagra did help.

Additional Diagnosis was Right Lateral Femoral Numbness. The Claimant had reached a Permanent and Stationary status. Subjective Factors of Disability included abdominal pain, constipation, sexual dysfunction, and numbness of right leg. Objective Factors of Disability included decreased sensation of the right lateral thigh and elevated blood pressure.

Dr. Leoni indicated that as to history obtained from the Claimant and with absence to the contrary, the Causation was industrial. Work restriction indicated that the Claimant should avoid undue emotional stress. With respect to Impairment ratings, the Claimant warranted 7% Whole Person Impairment in regard to his hypertension, 10% Whole Person Impairment in regard to his irritable bowel syndrome, and constipation secondary to analgesic use, and 9% Whole Person Impairment in regard to his sexual dysfunction.

Apportionment, in regard to gastrointestinal problems and hypertension, was 25% non-industrial, "70%" industrial. Sexual dysfunction was deemed secondary to chronic stress and psychiatric diathesis. The Claimant was not a qualified injured worker.

Michael Grigoriou, D.C. – L.A. Mediwave

A pair of ESWT Procedure Reports indicated that the Claimant received extracorporeal shock wave therapy (ESWT) to his neck dated on May 20, 2011 and June 13, 2011. Post ESWT therapy instructions were provided.

Subrosa Review

1/14/12

7:22 AM – Subject is seen wearing grey zippered jacket, sitting on a step outside a house holding a cell phone. After a couple minutes he gets up and goes into house.

7:28 – Subject is seen sitting outside the house smoking a cigarette and drinking something out of a mug. He is mostly looking down at his phone. He occasionally rolls his head around. He sits for about 15 minutes.

7:59 – Subject is seen walking out of house and then sitting again. looking at his phone. His smokes a cigarette and after five minutes walks into the house.

8:49 – Subject is seen sitting out front of house then stands and walks into the doorway and after a moment turns around with a paper in his hand and sits back down in front of house. He reads the paper and smokes a cigarette for about five minutes. He gets up and moves into doorway.

9:25 - Subject is seen walking on sidewalk, then up to a house. He pauses at the doorway, and then enters.

11:37 – Subject exits that house and walks stiffly down the sidewalk to the house he was sitting in front of. He stands in that doorway for a few moments. He then walks back down the sidewalk to the other house. An older lady is seen gardening.

12:20 PM – A young lady is seen at the doorway speaking with subject.

12:28 – Subject is seen walking down sidewalk to first house. He then speaks with a woman in a white jacket. They both bend down several times and are looking down at something on the ground that is out of view. The woman pushes a child on a kiddie car into view. Subject keeps up with them and then lifts the baby, holding the baby with his left arm. They walk back to the house and he puts the baby down. He then bounces a tennis ball while talking with the woman for several minutes. Subject is seen carrying baby into house followed by the woman. They take their shoes off at the door.

1/17/12

10:02 AM – Subject is seen sitting on step in front of house looking at his cell phone. He is wearing a checkered shirt. He looks up for several moments. He is smoking a cigarette.

1/28/12

9:10 AM – Subject is seen walking out of door, sitting on front step of house smoking cigarette and looking at cell phone. He is wearing blue tank top. He looks up periodically. Fifteen minutes later, he picks up a paper from the ground and reads it for a few minutes. He then picks back up his cell phone and smokes another cigarette. After another few moments, he stands and goes into house.

1/29/12

8:24 AM – Subject is seen walking out of front door and sitting on step. He is wearing red tank top. He rotates his head around. He smokes a cigarette. He looks at his cell phone and periodically drinks from a mug. He gets up and bends over to touch something on the ground. He pulls a coiled hose over to the step and then walks to the wall of house and touches something on the wall two times. He sits back on the step for several minutes looking at cell phone. He gets up and walks to wall again, touching something, then picks up coiled hose and moves it back into yard. He sits on step again and smokes another cigarette. His breathing is shallow. He removes his socks, gets up, and enters house.

9:13 – Subject is seen standing at doorway speaking to woman in black outfit who is holding a child. Subject steps down onto sidewalk and woman places child on front step. He smokes a cigarette and walks down the sidewalk. He walks to street and looks at car, walking around it. He then walks back down sidewalk to house. He goes into house.

9:18 – Subject walks out of house with child on his hip. He walks with baby down sidewalk. He then puts baby on his shoulders and holds him with two hands up over his head. He walks around car with baby and then back to house. He walks up the steps and into house carrying baby.

10:32 – Subject is seen carrying baby on his shoulders out of house and down the sidewalk to the car. He then carries baby on his hip with one hand back into the house several minutes later.

10:44 – Subject exits house alone and walks down sidewalk to house next door.

11:15 – Subject exits house next door and walks back to his house.

11:29 – Subject is seen walking through a store, and then purchasing something. He is then seen walking out of store with plastic bags in one hand. He gets into a car.

2/11/12

8:47 AM – Subject is seen walking barefoot from neighbors house to his front step. He sits on his step. He is smoking a cigarette. He goes into his house several minutes later.

11:14 – Subject is seen wearing blue shirt walking through parking lot and into a store. He is then seen inside store looking around.

11:51 – Silver car is seen driving and then stopped at a red light.

12:27 – Silver car is seen parked for several minutes then drives off.

2/12/12

10:33 – Subject is seen bent over with his head inside the trunk of a car, apparently inspecting something while holding some papers. He is in a parking lot. He then walks with papers in hand into a store.

10:45 – Subject is seen inside store, standing in line for a couple minutes. He is then seen walking out of the store. He enters the driver's seat of silver car.
10:49 - Subject is seen walking into gas station, and then getting into silver car.

12:43 PM – Subject is seen carrying baby on hip and walking into neighbor's house. Five minutes later he exits doorway with baby. He walks down the two steps and puts baby up on shoulders. He then walks back down sidewalk to his house.

2/18/12

8:52 AM – Subject is seen carrying baby on hip in front of house. He puts baby up on his shoulders. He walks around cars for a few minutes then back toward house.

2/29/12

8:50 AM – Subject is seen driving silver car.

3/3/12

9:58 – Subject is seen entering silver car, driver's seat carrying paper bag.

3/4/12

7:52 AM – Subject is seen walking down sidewalk and sitting on front step of house. He is wearing red t-shirt. He is looking at cell phone and smoking a cigarette for several minutes. Someone hands him a mug through the front door. After 15 minutes, he smokes another cigarette. After another 15 minutes, he gets up, drops something, picks it up off the ground, and walks into house.

8:35 – Subject is seen sitting on front porch smoking cigarette for several minutes. He then walks into house.

9:03 – Subject is seen sitting on front porch smoking cigarette for several minutes. He then walks into house.

9:28 – Subject is seen sitting on front porch smoking cigarette for several minutes. He periodically drinks from a mug. He then walks into house.

11:13 – Subject is seen inside store, standing in line, and then purchasing something. He then walks out of store.

11:18 – Subject is seen walking across parking lot to silver car. He is carrying a plastic bag. He walks to a trash can, then into the driver's seat of car. Car then drives out of parking lot.

1:05 PM – Subject is seen walking up to house and through door into house.
2:46 – Subject is seen with baby on shoulders, walking on sidewalk in front of house.

3/15/12

10:55 AM – Subject is seen exiting house and sitting on front step. He is wearing blue tank top. He smokes a cigarette for several minutes. He then gets up and goes into doorway, pulling on some rugs from the floor. He sits back down on front step with cell phone. He sits, looking at cell phone and smoking cigarette for several minutes. He appears to sneeze and then rubs his eye. He periodically drinks from a mug. He smokes another cigarette. After 20 minutes, he stands and goes in the house momentarily, then comes back out to sit on step. He smokes another cigarette. After several minutes, he goes inside after touching the flower box.

11:22 – Subject is seen walking to street and handling the trash bins. He pushes the bins off curb and pulls them back up to house. He pulls one in each hand.

12:22 PM – Subject is seen walking down sidewalk in front of house carrying a water bottle. He enters neighbor's house.

1:30 – He is seen exiting neighbor's house and walking back to his house. He detours in between houses, out of view. He walks back into view and into his house.

1:37 – Subject is seen in parking lot of strip mall, at silver car. He then is seen walking across parking lot into store.

1:41 – Subject is seen inside store looking at items for several minutes. We then see him in line, then purchasing something. He then exits store.

1:44 – Silver car is seen backing out of parking space.

1:48 – Subject is seen entering silver car drivers' seat.

2:02 – Subject is seen sitting on front step of house. He smokes a cigarette for several minutes. He picks up cell phone, puts on sunglasses and walks into house.

3:15 – Subject is seen walking from his house to his neighbor's. He goes into neighbor's house.

5:06 – Subject is seen walking from neighbor's house to his house.

3/17/12

9:29 AM – Subject is seen with baby on shoulders, walking down sidewalk and back to the house. It is raining. After a few minutes, he goes back into house with baby.

END OF RECORD REVIEW

PLEASE GO TO NEXT PAGE FOR DISCUSSION SECTION

VIII. DISCUSSION

A. INTRODUCTION

On Axis I, Mr. Smith meets DSM-IV-TR criteria for a Major Depressive Disorder, Single Episode, moderate and chronic in severity. Additionally, on Axis I, we are diagnosing an Anxiety Disorder, Not Otherwise Specified (NOS), also moderate and chronic in severity. Finally, on Axis I, the applicant is diagnosed with Psychological Factors Affecting a General Medical Condition.

On Axis II, there is a diagnosis of a Personality Disorder, Not Otherwise Specified (NOS), with Compulsive and Dependent Features; this condition was aggravated in association with the applicant's industrial exposures. Based on the available history, the applicant's pre-existing mental condition produced impairment reflected in a pre-existing Global Assessment of Functioning (GAF) score of 67, which is equivalent to a pre-existing Whole Person Impairment rating of 5% before adjustments for Future Earning Capacity, occupation and age.

As noted, in our opinion, there was an industrial aggravation of the long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS), along with the development of the newly-acquired Major Depressive Disorder, Anxiety Disorder, Not Otherwise Specified (NOS), and Psychological Factors Affecting a General Medical Condition in association with the applicant's workplace exposure. These mental disorders produced a period of temporary total psychological disability beginning on November 3, 2010, the last day the applicant worked, and ending on September 28, 2011, when his treating psychiatrist, Dr. Nehorayan, found his condition had reached Maximal Medical Improvement. In our opinion, the applicant's mental disorders gradually stabilized with moderate residuals, reaching Maximal Medical Improvement as of this same date, September 28, 2011.

The applicant's mental disorder and chronic residuals is reflected in a current Global Assessment of Functioning (GAF) score of 57, which is equivalent to a current Whole Person Impairment rating of 20% before adjustments for Future Earning Capacity, occupation and age.

With respect to AOE/COE causation, in our opinion, the predominant cause (greater than 50%) for the development of the applicant's mood disturbance diagnoses and Psychological Factors Affecting a General Medical Condition along with the aggravation of the long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS), was the stress associated with the alleged harassment and work overload that he reportedly experienced during the CT period November 3, 2009 through November 3, 2010 while working for U.S. Foodservice, Inc. and sequelae. We defer to a Trier of Fact

to determine if the claimant's allegations of harassment and work overload are accurate. If they are, then in our opinion, the claimant has sustained an industrial injury to his psyche.

As to apportionment of permanent psychological impairment, 25% of the cause of the permanent psychological impairment ratings is due to the applicant's long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS), with Compulsive and Dependent Features (i.e., pre-existing WPI = 5%/current WPI = 20% x 100 = 25%). In addition, 10% of the permanent psychological impairment is apportioned to the January 2011 termination action and we defer to a Trier of Fact to determine whether the termination action was performed in a lawful, good faith, nondiscriminatory manner. If it was then this 10% would be apportioned to nonindustrial factors. There is an additional 5% of the permanent psychological impairment apportioned to the internal medical conditions. The applicant has been evaluated by internist, Dr. Glenn Marshak, serving as an Agreed Medical Examiner; thus, we defer the industrial compensability of this 5% to the findings of Dr. Marshak. Furthermore, there is a 5% contribution to the permanent psychological impairment ratings owing to the applicant's orthopedic injuries. Again, the applicant has been evaluated by an Agreed Medical Examiner in Orthopedic Surgery, Dr. Phillip Kanter; thus, we defer the industrial compensability of this 5% of the permanent psychological impairment to the findings of Dr. Kanter.

There remains 55% of the permanent psychological impairment and, in our opinion, is apportioned to the allegations of harassment and workplace stressors described by Mr. Smith as occurring during the CT period November 3, 2009 through November 3, 2010 in the course of his employment with U.S. Foodservice, Inc. The industrial compensability of this 55% of the permanent psychological impairment is deferred to the Trier of Fact. If a Trier of Fact determines that the claimant's account of workplace harassment and overwork were present as the claimant asserts, then this 55% should be apportioned to industrial factors.

The psychological and psychiatric treatment the applicant has received thus far has been medically necessary, but, as of yet, it is not been established that this was required on an industrial basis. In addition, the applicant should be provided an additional 18 to 36 sessions of supportive psychotherapy to assist him in further stabilizing his mood and developing more effective coping skills. Additionally, he may require ongoing psychiatric treatment (i.e., psychotropic medication management of an additional 12 to 18 sessions). If additional psychiatric or psychological treatment is requested and deemed medically necessary, then it should be provided. Please note that the determination of whether the provided and recommended psychiatric and psychological treatment should be provided on an industrial basis will depend on the findings of the Trier of Fact's determination as to whether the allegations of harassment and overwork were credible and occurred as the claimant asserts.

B. CREDIBILITY

We do not have significant credibility concerns regarding any of the five reviewed factors of credibility in this case. First, the applicant was administered a formal symptom validity test and performed within normal limits (TOMM: 48/50). Thus, there was no evidence of suboptimal effort on this well-researched symptom validity test. Mr. Smith endorsed an above-average number of unusual complaints on the MMPI-2-RF (F-r = 74T); however, the score is well within the range for individuals who are diagnosed with mental disorders. There were no indications of over-reporting of general psychological complaints or severe psychopathology (Fp-r = 42T). While the applicant's score on a measure of somatic over-reporting was somewhat elevated (FBS-r = 86T), it was not in the range indicative of somatic embellishment. Additionally, there was an indication of possible exaggeration of cognitive symptoms (RBS = 76T); this was also not in the range indicative of embellishment. Finally, on the MCMI-III, there was no evidence of exaggeration or over-reporting of psychological symptoms (Z = 61BR).

Second, Mr. Smith displayed a stable demeanor throughout the evaluation and provided consistent, relevant and detailed information. He did not display response patterns that were vague or contradictory in that he was able to provide a coherent, detailed and consistent narrative of important events that occurred during the course of his employment. Although clearly depressed about the residuals of diminished self-esteem and self-confidence reactive to the alleged workplace stressors, his presentation did not appear to be exaggerated from a clinical perspective. As well, despite reporting significant orthopedic and headache pain, he showed no signs of exaggerated pain behavior over the course of the multi-hourlong evaluation. He did not require an excessive number of breaks and appeared to be exerting his most capable effort at all times. Additionally, Mr. Smith's clinical presentation was generally consistent with the psychological test instruments.

Third, the mechanism of injury in this case (i.e., workplace stressors of an alleged excessive workload and unrealistic expectations) commonly results in depressive disorders. Clearly, this is evident in this case as the applicant was administered the Beck Inventories in September 2011, which were noteworthy for severe levels of both depression and anxiety. Additionally, what Mr. Smith finds most distressing about his life is the impact of residual mood disturbance symptoms on his employability and social and occupational functioning.

Fourth, the history Mr. Smith reported regarding the work environment and the impact of this on his physical and psychological functioning is generally consistent with information provided in the medical records. That is, the records from his treating

physicians at Kaiser Permanente, including Dr. Tiplea, Dr. Krishnamoorthy and Dr. Kliger, reflect the applicant's ongoing complaints of work stress and the provision of psychotropic medications. Additionally, progress notes from his treating psychotherapist, Ms. Toshkov, reveal the extent to which he experienced mood disturbance symptoms.

Fifth and finally, the applicant openly acknowledged a past history of emotional distress and significant potential non-industrial stressors (such as a sexual molestation as a child, a difficult first marriage and divorce and the current separation from his second wife) in a manner that would be uncharacteristic of an individual who was attempting to conceal or distort information for his own gain. Thus, the applicant's willingness to address these multiple, non-industrial stressors including his emotional reactions to each of these events openly and non-defensively, with minimal prompting strongly supports his excellent credibility.

Consequently, given all these factors, we believe that the applicant was reliable and we can formulate opinions regarding diagnosis, disability, and causation, given the information available. We would appreciate the opportunity to review any available records in this case, such as a personnel file, investigative reports, witness statements, and any records pertaining to his psychological condition, both past and present.

C. DIAGNOSIS

Presented psychological diagnoses based upon the history provided, review of records, psychological testing and clinical examination are:

Axis I: Clinical Disorders (and Other Conditions That May Be a Focus of Clinical Attention)

1. Major Depressive Disorder, Single Episode, moderate and chronic in severity.

2. Anxiety Disorder, Not Otherwise Specified (NOS), moderate and chronic in severity.

3. Psychological Factors Affecting a General Medical Condition.

Axis II: Personality Disorders and Developmental Disorders

Personality Disorder, Not Otherwise Specified (NOS), with Compulsive and Dependent Features.

Axis III: General Medical Conditions

Per Daniel Capen, M.D. – PTP Orthopedic Surgeon: Cervical sprain/strain.

Per Sean Leoni, M.D. – Treating Internal Medicine: Irritable bowel syndrome; borderline hypertension; Sexual dysfunction.

Axis IV: Psychosocial and Environmental Problems

Health, vocational and marital concerns.

Axis V: Global Assessment of Functioning

Current. GAF = 57 (Current. MMI).

Discussion of Diagnoses

On Axis I. the applicant meets DSM-IV-TR criteria for a Major Depressive Disorder. Single Episode. which is presently at a moderate and chronic level of severity. This diagnosis involves the presence of persistent depressed mood or loss of interest or pleasure for at least a two-week period and representing a change from a previous level of functioning. There may also be significant weight loss when not dieting or weight gain. insomnia or hypersomnia nearly every day. psychomotor agitation or retardation nearly every day. fatigue or loss of energy. feelings of worthlessness or excessive or inappropriate guilt. diminished ability to think or concentrate. recurrent thoughts of death or recurrent suicidal ideation. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning and are not due to the direct physiological effects of a substance. Major Depressive Disorder, Single Episode, indicates there has only been one Major Depressive Episode whereas Major Depressive Disorder, recurrent, indicates the presence of two or more Major Depressive Episodes.

Mr. Smith described the onset of emotional difficulties within several months of beginning his employment with U.S. Foodservice, Inc. He was hired as a Logistics Supervisor, responsible for the costing and revenues of all inbound freight operations associated with his employer's business warehousing grocery items. He believed it was his responsibility in his capacity as a Logistics Supervisor to make certain that costs and revenues were accurately reflected in the reports that he generated throughout his work week. He also believed it was his responsibility to perform these job duties within the parameters of trucking regulations. Thus, when he first discovered what he believed were inaccuracies in the amounts charged to customers for inbound freight services, the applicant spoke with his supervisor, believing the company would want to make

corrections. He was surprised when he was rebuffed. He was further surprised when Mr. Nash, the Director of Purchasing, obliquely suggested to him that he risked his job were he to pursue this concern any further. Thus, Mr. Smith felt he had no option other than to simply perform his job duties. In this capacity, he typically worked 60 hours a week, nearly all of it spent at a computer work station, keyboarding and looking at monitors while tracking and producing reports.

The first symptom the applicant recognized was somatic in nature, severe headaches, which began in the fall of 2007. Mr. Smith believed some of what he was asked to do was unethical at best and illegal at worst. The submitted records from his treating physicians at Kaiser Permanente reflected the extent to which he complained about these headaches. A September 8, 2007 document from Dr. Iriarte reveals that the applicant "felt miserable" and experienced severe headaches. On another occasion, September 26, 2007, Dr. Iriarte noted Mr. Smith was in tears during his consultation. Mr. Smith acknowledged that he declined Dr. Iriarte's offer to place him off work at that time. On another occasion, November 6, 2007, Dr. Ree, another Kaiser Permanente physician, also suggested the applicant go off work; again, Mr. Smith declined. Finally, on November 14, 2007, Dr. Lejano noted that the applicant was exhibiting symptoms of hypertension, and the applicant acknowledged he was placed on medication at that time. Finally, a November 23, 2007 document from Dr. Tiplea reveals her recommendation the applicant participate in stress-management classes offered by Kaiser Permanente." Mr. Smith indicated that with his work schedule, he could not participate in these classes.

Despite the fact that the applicant was awarded with Top Employee Performance recognition in 2008, he found himself continuing to be overwhelmed with somatic symptoms of anxiety associated with the work stressors. The documents from Kaiser Permanente continue to track his complaints of stress at work. Dr. Tiplea notes on February 19, 2008 that Mr. Smith complained of a lot of pressure at work and not having the ability to cope with the stress. On this occasion, Dr. Tiplea diagnosed the applicant with "stress reaction causing mixed disturbance" and referred Mr. Smith to a psychiatrist.

By the summer of 2008, Mr. Smith was experiencing erectile dysfunction, and he was prescribed the anti-anxiety agent, Ativan. He recalled that he took this medication at work on days when he had a meeting. It was always in these meetings when the managers expressed their concerns about how effective the workers were in producing the numbers the managers wanted. In the applicant's mind, this had only to do with the revenue numbers the managers wanted to see produced from inbound freight profits. In the summer of 2008, Mr. Smith rated the intensity of his emotional distress at a level of 5/10, while also recalling no changes in his neurovegetative functioning. On the other hand, he was fully aware of stress-related, severe headaches and panic feelings, particularly at work during the aforementioned meetings.

In early 2009, the President of the facility where Mr. Smith worked, along with the Director of Finance, were fired. Mr. Smith understood the termination had to do with mishandling money, and he believed that perhaps new management would bring about overall changes in the workplace. By this point in time, in addition to his headaches, Mr. Smith was experiencing persistent pain from his upper back to his neck and across both shoulders, and he believed this was entirely reactive to the combined effects of 60-hour work weeks at a computer station in addition to stress.

In the summer of 2009, there was, indeed, a change in the computer tracking of information that affected the work Mr. Smith was responsible for with respect to inbound fright revenue. However, rather than providing him an opportunity to more accurately reflect the cost of the inbound freight and, thus, avoid his ethical and legal dilemma, the new approach created a larger obstacle for the applicant. He stated, "Everything became a challenge." In order to meet his performance expectations, he had to change how he arranged for the inbound shipment of product. The choices he made, while effective in terms of improving the costs to the company, angered the union, the drivers, the Transportation Department and the buyers at his facility. All of these groups began to place pressure on the applicant for the choices he was making in terms of arranging for the transportation of inbound product. Thus, in the summer of 2009 and going into the fall of 2009, the applicant was essentially squeezed between management, still wanting high revenue dollars, and these other disparate groups in the organization, demanding that he stop the changes he had made in arranging for inbound shipments.

By the summer of 2009, the claimant was seeing a psychiatrist at Kaiser Permanente, Dr. Reiter, and he was continuing to take anti-anxiety medication. In the fall of 2009, he began weekly psychotherapy sessions with Ms. Toshkov; while he reported these to be of some benefit, he, nevertheless, felt no improvement in his symptoms because he continued to be exposed to the stressors at work.

Nevertheless, Mr. Smith worked for yet another year before he finally accepted Ms. Toshkov's recommendation that he go on a medical leave of absence. In our opinion, the maladaptive behaviors of the applicant's Personality Disorder, Not Otherwise Specified (NOS), (to be discussed in later paragraphs of this section), accounts for the fact that Mr. Smith continued working in what he experienced as a very toxic environment from a psychological perspective even with severe somatic and anxious symptoms and even in the face of recommendations from treatment providers at Kaiser Permanente that he leave. However, by the end of 2010, as Mr. Smith stated, "I was going to die at my desk." Thus, he agreed to a medical leave of absence.

Shortly thereafter, on December 6, 2010, Mr. Smith began treatment with the psychiatrist, Dr. Nehorayan. Dr. Nehorayan observed the applicant during the course of his initial evaluation to be anxious, sad and angry. Mr. Smith apparently was restless and fidgety

during the evaluation, and he demonstrated distractibility and word-finding delays as well as significant spikes in anxiety when asked to perform simple tests geared towards assessing attention span. Mr. Smith began weekly treatment with an associate of Dr. Nehorayan, Ms. Jill Adler. He explained that with therapy he came to understand the connection between the emotional problems he was having and the headaches and stress he experienced at work. While he noted that the level of his emotional distress rated an intensity of 10/10 after he was placed off work in November 2010, it improved slightly once he began mental health treatment.

However, the mood disturbance intensity increased once again in January 2011 when Mr. Smith received a letter from his employer indicating that his job had been eliminated. He experienced this as a significant insult and betrayal because he had done everything asked of him by his employer, to the point of nearly ruining his physical and emotional well-being.

As the year 2011 played out, Mr. Smith continued under the care of Dr. Nehorayan and Ms. Adler. There were periods in the spring of 2011 when he felt passive suicidal ideation, believing that his family would be better off without him and considering the possibility of taking all the medications prescribed to him at once as described to Dr. Nehorayon. However, after several months, by the summer of 2011, the suicidal ideation had passed; and in the fall of 2011, Dr. Nehorayan, as well as the orthopedic treating physician, Dr. Capen, and the internist, Dr. Leoni, released the applicant from treatment. By this point in time, the end of 2011, Mr. Smith believed that all of his physical and emotional complaints had become chronic.

Nevertheless, in the spring of 2012, there were further deteriorations in the applicant's personal life. His wife moved out of their shared home, not communicating with him as to the extent of her complaints, but, nevertheless, expressing her unwillingness to return to their shared home. At the same time, she introduced the applicant to a young woman that he learned was a daughter she had placed for adoption many years earlier. The applicant's wife essentially placed this daughter, along with this woman's own daughter, into the home that the applicant lived in, telling him she had nowhere else to live. Because he wished to please his wife to the end of perhaps reuniting, he has tolerated what is essentially an invasion in his personal life.

At the present time, Mr. Smith experiences very significant depression. He cries every day, sobbing for as long as 20 minutes at a time, in response to feelings of helplessness about his future. He believes that there is nothing that will improve either his physical or mental well-being at this point in time. Every night as he goes through his medications, he feels "bummed out" with this reminder of the extent of how drastically his life has changed. He has depleted his retirement savings, borrowed against his inheritance and feels trapped and helpless with respect to his financial security. Despite denying any

current plan or intent to harm himself, the applicant, nevertheless, stated that suicide is a "last resort." That is, he has not entirely ruled out the possibility that at some point in the future he may consider the "last resort" more seriously. He rated the intensity of his mood disturbance at the present time at a level of 7/10, indicating this is a constant, daily experience.

The objective psychological testing provides external corroboration of the symptoms the applicant has described. The MMPI-2-RF reveals significant symptoms of depression (RC2 = 73T) with a sense of helplessness (HLP = 69T), a lack of confidence and diminished self-esteem (SFD = 65T; NFC = 64T). He reported generally having a negative and pessimistic view (NEGE-r = 69T). Furthermore, the other objective psychological inventory (MCMI-III) also reveals significant issues of depression (Major Depression = 93BR; Dysthymia = 80BR).

On Axis I, the applicant also meets DSM-IV-TR criteria for an Anxiety Disorder, Not Otherwise Specified (NOS), which is presently at a moderate and chronic level of severity. This diagnostic category includes disorders with anxiety-related features that do not meet diagnostic criteria for specific anxiety syndromes, such as Generalized Anxiety Disorder, Panic Disorder, Post-Traumatic Stress Disorder, Specific Phobia, or Adjustment Disorder with Anxiety. This diagnosis may be indicated with anxiety that is atypical, underlying, prolonged, or involves a chronic course. There is often the presence of depressive or vague somatic symptoms along with the anxiety. The anxiety may be expressed through increased physiological arousal and stress-related physical complaints.

Within the chronological history of the development of Mr. Smith's mood disturbance, anxiety was the first symptom of which he was consciously aware. This is consistent with information contained within the medical records, which reveals that his first mood disturbance complaint to treating physicians at Kaiser Permanente took place in early 2008 and revealed anxiety. He was initially prescribed Ativan, and he was referred to a psychiatrist in early 2008 at which point in time, Mr. Smith rated the intensity of his anxiety at a level of 5/10. He was specifically aware of panic feelings each time he went into a meeting at work; during these meetings, he had to report on costing and revenue from his area of responsibility, inbound shipping. He began to rely on taking Ativan at work before each of these meetings in an attempt to quell the anxiety, which was accompanied by physiological correlates such as trembling and feeling weak.

The course of development of the anxiety continued following the same chronology as described above with respect to the applicant's depression throughout the balance of 2008 and 2009. He continued to rely on anxiolytics, both Ativan and Xanax, at different times to ease his anxiety. However, by July 2010, he tried another tactic; he resumed smoking after a five-year abstinence from a longer habit. It was discouraging and demoralizing to him to resume smoking after he had successfully avoided this habit for so long.

Once he was off work, the applicant's anxiety was purely driven by concerns for his financial stability. The State Disability benefits were not sufficient for his monthly needs and he began to rely upon withdrawals from his retirement accounts and his personal savings. Thus, even though he was relieved of the daily exposure to the stressors at work, which had primarily driven his anxiety before he stopped working, the anxiety, itself, did not subside. He continued to experience bouts of anxiety reactive to his concerns about his finances and always accompanied by physiological correlates such as shaking and trembling.

Currently, Mr. Smith experiences anxiety frequently, although not on a constant, daily basis. Episodes of anxiety are always reactive to reminders of his concerns over his financial situation. He always feels anxious when he is paying bills and when the due date for his rent approaches. If he allows himself to engage in extensive ruminations, anxiety builds up and physiological correlates begin as well. While he takes Ativan prophylactically once a day to maintain some minimal level of anxiety, there are additional occasions when he must take the anxiolytic to calm himself.

As with the depressive aspects of the applicant's mood disturbance, there is external corroboration of the complaints registered by Mr. Smith in the administered psychological testing. The MMPI-2-RF reveals issues of stress and worry (STW = 73T) and anxiety (AXY = 80T). Similarly, the MCMI-III reveals significant anxiety (Anxiety = 87BR).

On Axis I, the applicant also meets DSM-IV-TR criteria for Psychological Factors Affecting Medical Condition, primarily with regard to his musculoskeletal pain, gastrointestinal complaints, headaches, dizziness and erectile dysfunction. The essential feature of this disorder is that a general medical condition coded on Axis III is present and that psychological issues affect this condition. It is notable that the applicant, himself, noted that his various pains increase during periods of increased emotional stress. His primary physician apparently has noted the relationship to stress of some of his complaints. On the MMPI-2-RF and MCMI-III, the applicant showed a significant elevation on the scale measuring somatization (MMPI-2-RF: MLS = 87T; MCMI-III: Somatoform = 73BR). This diagnosis, however, is dependent upon whether other medical experts determine that there is a stress-based account for these medical conditions (see AOE/COE causation below).

On Axis II, we are diagnosing Personality Disorder, Not Otherwise Specified, (NOS), with Dependent and Compulsive Features. This category is appropriate for personality functioning that does not meet the criteria for any specific Personality Disorder. A Personality Disorder is manifest in an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to

distress or impairment. Personality Disorder, NOS, is a category used when either the individual's personality pattern meets the general criteria for a Personality Disorder with the traits of several different personality disorders present without the specific criteria for that Personality Disorder being met or the individual's personality pattern meets the general criteria for a Personality Disorder, however, the individual is considered to have a Personality Disorder that is not included in these specific classifications. These behaviors cause clinically significant distress or impairment in one or more important areas of functioning such as social or occupational. In the case of the applicant, we are noting Dependent and Compulsive Features of the Personality Disorder.

According to DSM-IV-TR, Dependent Personality Traits are manifest in a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation. The individual may have difficulty making everyday decisions without an excessive amount of advice and reassurance from others and may need others to assume responsibility for most major areas in his or her life. The individual may have difficulty expressing disagreement with others because of fear of loss of support or approval. There may be difficulty initiating projects or doing things on one's own (because of a loss of self-confidence in judgment or abilities rather than a lack of motivation or energy). The individual tends to go to excessive lengths to obtain nurturance and support from others, even to the point of volunteering to do things that are unpleasant. There may be a feeling of discomfort or helplessness when alone because of exaggerated fears of being unable to care for his or her self. There may be a tendency to urgently seek another relationship as a source of care and support when a close relationship ends. The individual may be unrealistically preoccupied with fears of being left to take care of him or herself.

According to DSM-IV-TR, Compulsive Personality Traits are manifest by a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness and efficiency. Such individuals may be preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost. Their perfectionism interferes with task completion. They have a sense of duty and may be excessively devoted to work and productivity to the exclusion of leisure activities and friendships. They tend to be overly conscientious, scrupulous and inflexible about matters of morality, ethics or values. They are often reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things. They show rigidity and stubbornness. Compulsive individuals, because they have a good work ethic, tend to be conscientious employees and to be over-identified with their career or professional life.

The maladaptive behavior associated with personality traits is known to develop during childhood and adolescence in response to chaotic experiences for which a young person is not capable of understanding or formulating an appropriate response. Often, a child's

emotional reaction to the experience is frightening or confusing. In order to create a sense of security, the child develops behaviors that serve as defense mechanisms and become enduring patterns of maladaptive behavior throughout the adult life.

The clinical history provided by Mr. Smith reveals the type of chaos or instability in his family life during his youth and adolescence that is typically associated with the development of the maladaptive behaviors associated with this diagnosis. While the applicant certainly has no memory of the first months of his life during which he was living with his grandparents because his parents had contracted a communicable disease, psychological research provides data suggesting that infants, nevertheless, recognize such instability and react to it. Throughout his first six years, he described verbal arguments between his parents and his father's physical abuse of his mother. At the age of six, he experienced further instability with his parents' divorced. Any sense of stability and security that remained for Mr. Smith vanished with the sexual molestation when he was just 12 years old, including his mother not believing him when he reported the incident.

Thus, in all psychological probability, the defense mechanisms of compulsivity and dependence emerged in response to the applicant's need, as a child, to protect himself from becoming overwhelmed with negative feelings associated with these experiences. The characteristic of a dependent individual to tolerate mistreatment in order to gain external support and nurturance has played out in Mr. Smith's adult life. Clearly, this was exhibited in the applicant's first marriage during which he was aware of his wife's infidelities, which led to the birth of at least one child, whose paternity was in doubt and a second child of whom he was certain he was not the father. Furthermore, rather than investigating the paternity of the daughter who could have been his, he accepted his wife's explanation that she was not, only to learn 13 or 14 years later that he was, in fact, the father of this child.

This pattern of dependency is also revealed in the applicant's career with U.S. Foodservice, Inc. He remained in an unmistakably toxic employment setting, hoping that corporate officials would learn of the discrepancies promoted by the management at his facility. As time passed while he coped with significant somatic as well as anxious symptoms, which he experienced reactive to the stressful work environment with U.S. Foodservice, Inc., the applicant continued to resist the recommendation of his treating physicians at Kaiser Permanente that he begin a medical leave of absence. More recently, Mr. Smith has tolerated the intrusion of a woman and her young daughter into his personal space, living in his home because his wife has introduced this woman as the daughter she placed for adoption many years ago and told her husband she has no place to live. His willingness to tolerate this woman whom he does not know and finds to be irresponsible in terms of sharing living space is further suggestive of his Dependent Personality Features.

As to the compulsive traits of the Personality Disorder diagnosis, as noted above, such individuals engage in rigid adherence to their understanding of their responsibilities, often to the point of taking an excessive amount of time or emotional energy to do so. Such individuals are often seen as hard working, dedicated employees as a consequence. However, as is the case with Mr. Smith, these individuals usually sacrifice their mental and/or physical well-being in the process of their hard work.

The MCMI-III, an objective psychological measure reveals the presence of both Dependent (87BR) and Compulsive (75BR) tendencies.

D. PRE-EXISTING IMPAIRMENT

As noted above, it is our opinion that the applicant has suffered from a long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS), with Dependent and Compulsive Personality Features, which, in our opinion, was associated with a pre-existing Global Assessment of Functioning (GAF) score of 67 and a pre-existing Whole Person Impairment rating of 5%. As discussed in the prior section, the clinical history by Mr. Smith with respect to his childhood and adolescence clearly reflects the instability or trauma during his youth and adolescence typically associated with the emergence of the personality pathology of this diagnosis. As the maladaptive behavior of the personality pathology played out across the course of the applicant's adult life, we see a pattern in which he exhibited excessively dependent behavior with respect to his interpersonal relationships in his first marriage as well as in terms of his relationships with his supervisors while working for U.S. Foodservice, Inc. This clearly suggests the presence of pre-existing pathology.

The pre-existing impairment is reflected in a pre-existing Global Assessment of Functioning (GAF) score of 67, which is equivalent to a Whole Person Impairment (WPI) rating of 5%. This rating indicates some difficulty in social, occupational or school functioning, with the individual otherwise generally functioning fairly well with some meaningful interpersonal relationships. It is important to bear in mind that the pre-existing rating reflects an aggregate of the applicant's experience of difficulty in social or occupational functioning rather than an indication of his functioning at any one point in time. On the other hand, particularly in the case of the Compulsive Personality Features associated with the applicant's Personality Disorder, Not Otherwise Specified (NOS), these were, in all psychological probability, relatively adaptive to his functioning in any workplace setting because of his reliance upon mental control to make certain that job duties were carefully attended to or executed.

E. PERIODS OF TEMPORARY DISABILITY

Based on the clinical history and review of the records. Mr. Smith has been temporarily totally disabled on a psychological basis beginning after his last day of work on November 3, 2010, through September 28, 2011, the date his treating psychiatrist, Dr. Nehorayan, found his condition had reached Maximal Medical Improvement. During this period, records and the applicant's account suggest that he was actively symptomatic from a psychological perspective. His depressive symptoms were of a degree that he could not have functioned in his usual and customary occupation or competed within the open job market. Psychiatric and psychological treatment has been somewhat effective; however, during the period from November 3, 2010 until September 28, 2011, it is unlikely that work restrictions or preclusions would have been sufficient to avoid a decompensation given the presence of his depression.

At this point, the applicant's Major Depressive Disorder, and Anxiety Disorder, Not Otherwise Specified (NOS), have stabilized to a chronic, moderate level of severity and reached Maximal Medical Improvement.

F. CURRENT (PERMANENT) IMPAIRMENT/RATINGS

As noted above, in our opinion, the applicant's Major Depressive Disorder, Anxiety Disorder, Not Otherwise Specified (NOS), and Psychological Factors Affecting a General Medical Condition have stabilized at a moderate level of severity and are now chronic. Mr. Smith reached Maximal Medical Improvement as of September 28, 2011, consistent with the findings of his treating psychiatrist, Dr. Nehorayan. His current psychological impairment is reflected in a current Global Assessment of Functioning (GAF) score of 57, which is equivalent to a current Whole Person Impairment (WPI) rating of 20% before adjustments for Future Earning Capacity, occupation and age.

We will now present a discussion of the applicant's current GAF score and how that rating was derived.

The Global Assessment of Functioning scale (GAF) is a 100-point scale that is divided into 10 categories from the most severe impairment (1-10) to superior functioning (91-100). The GAF is determined by examining two main sources of information (1) psychological symptoms, and (2) social and occupational functioning. According to the DSM-IV-TR (2000), in cases where "... the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worst of the two (pg. 32-33)."

In determining Mr. Smith's GAF score, his psychological symptoms were examined first. Based on the symptom presentation, the pertinent GAF is 57. A rating in the range of 51 to 60 is warranted when there are moderate symptoms such as a flat affect, circumstantial speech or occasional panic. A rating in the range of 41 to 50 would be too low because the applicant does not have serious symptoms, exemplified by suicidal ideation or severe obsessional rituals. A rating in the range of 61 to 70 would be too high because the applicant's symptoms are more serious than a mildly depressed mood and mild insomnia.

Mr. Smith indicated that he has disrupted sleep on a nightly basis, further stating he has no difficulty initiating sleep because of the psychotropic medications he is prescribed. However, he awakens in the middle of the night, stating, "I'm wide awake," and indicating he requires 30 to 60 minutes to return to sleep. He acknowledged that in these 30 to 60 minutes, he is typically overwhelmed with ruminations over his current situation including his separation from his wife, his financial instability and his deteriorated physical condition. He described changes in his cognitive functioning that significantly diminish his self-esteem as he struggles with distractibility, the inability to retain information he has read and forgetfulness. He cries on a daily basis, usually sobbing for as long as 20 minutes at a time in response to his feeling hopeless and trapped. While denying current suicidal ideation, he, nevertheless, acknowledged that he views suicide as a "last resort," further stating that he is not all together convinced he might not reach a point of the "last resort."

Mr. Smith rated the intensity of emotional distress at the present time at a level of 7/10, noting this is a constant, daily experience. Furthermore, he experiences bouts of anxiety, which ebb and flow throughout the day and are typically driven by reminders of his current financial standing when he must pay his bills or ruminations, which he cannot control during the day.

The next step in the analysis of the GAF concerns social and occupational functioning. In our opinion, the GAF score that pertains to the applicant's social and occupational functioning is also at a 57. Again, a score in the range of 51 to 60 is warranted with moderate difficulty in this domain exemplified by someone with few friends or who has conflicts with co-workers. The applicant's functioning is not so problematic that he would warrant a rating in the serious range of 41 to 50, which describes any serious impairment in social, occupational or school functioning such as having no friends or being unable to keep a job. Conversely, a rating in the 60s would not be warranted because the applicant has more than some difficulty in social, occupational or school functioning and is not generally functioning pretty well and has some meaningful interpersonal relationships difficulties are not merely temporary.

For Mr. Smith, he currently does not believe he is capable of functioning in any workplace setting; indeed, he does not believe he could participate in an interview process

for new employment as a consequence of his unstable mood and tendency towards anxiety and panic. Clearly, his inability to sleep restoratively each night negatively impacts his ability to function throughout the day and this has an obvious affect upon his self-esteem and self-confidence. This negative view of himself is a key factor in his discomfort in leaving his home any day other than Saturday. From his perspective, if he is seen in a public setting on a Saturday, he is viewed like most other employed people as tending to errands on a Saturday. In contrast, he views himself as appearing flawed to people in public settings on weekdays because this, in his mind, clearly reflects an individual who is not working. While he is able to engage in productive activities during the day, he is less apt to engage in independent or assertive behavior. The regular recurrence of panic episodes, particularly in terms of the physiological correlates associated with these episodes, causes some degree of embarrassment and anxiety, causing further avoidance.

In order to derive the final GAF score that should be used for the permanent impairment rating, the DSM-IV-TR requires that the examiner select the lower of the two ratings between psychological symptoms and social and occupational functioning. In this case, the two ratings are the same, current GAF of 57. Thus, the final current GAF score would be 57. This score is equivalent to a current Whole Person Impairment Rating of 20% before adjustments for Future Earning Capacity, occupation and age.

G. MEDICAL CAUSATION (AOE/COE)

In our opinion, the predominant AOE/COE cause (over 50%) of Mr. Smith's Major Depressive Disorder and Anxiety Disorder, Not Otherwise Specified (NOS), along with Psychological Factors Affecting a General Medical Condition and aggravation of the long-standing and pre-existing Personality Disorder, (NOS), with Dependent and Compulsive Features was the alleged harassment and workplace stressors of an excessive workload and unrealistic expectations to which the applicant was subjected during the CT period November 3, 2009 through November 3, 2010 in the course of his employment at U.S. Foodservice, Inc. The determination of predominant cause is based on the examination of the development of his reactive psychological symptoms on the one hand and the exposure to alleged workplace harassment as well as all other known stressors on the other (see below). Moreover, the industrial stressor of harassment and a stressful workplace environment better accounts for the development of his mental disorders than does any other known stressor. Additionally, these same factors, that is, alleged harassment and workplace stressors, are responsible, in our opinion, for the aggravation of the applicant's long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS), with Dependent and Compulsive Personality Features. There is a January 2011 personnel action in this case; Mr. Smith was notified that his position had been eliminated after he was placed off work on a medical leave of absence. In our

opinion, this termination action accounts for 10% of the development of the mood disturbance symptoms and the aggravation of the long-standing and pre-existing mental disorder. We defer to the Trier of Fact with respect to the industrial compensability of this 10%.

Additionally, there is a 10% contribution to the development of the Major Depressive Disorder and Anxiety Disorder, (NOS), along with Psychological Factors Affecting a General Medical Condition and aggravation of the Personality Disorder, Not Otherwise Specified (NOS) as a consequence of the internal medical conditions and a 5% contribution owing to the orthopedic conditions. We defer to the findings of the Agreed Medical Examiner in Orthopedic Surgery, Dr. Phillip Kanter, with respect to the industrial compensability of the 5% contribution flowing from the orthopedic injuries. We defer to the Agreed Medical Examiner in Internal Medicine, Dr. Marshak, with respect to the industrial compensability of the 10% of causation attributed to the internal medical conditions. Finally, we must defer to the Trier of Fact as to whether or not the information provided to us by Mr. Smith accurately reflects those events that transpired during the course of his employment with U.S. Foodservice, Inc. As long as the applicant's account is externally corroborated, then, in our opinion, Mr. Smith has sustained an industrial injury to his psyche.

In order to demonstrate industrial causation in this case, one must examine the level of psychological functioning prior to the alleged industrial injury and then review the course of symptoms and change in psychological functioning following the alleged industrial injury. Prior to the onset of the acute psychological symptoms at the beginning of the continuous trauma dates of injury in this case, November 3, 2009, the applicant was already experiencing a fair amount of somatic distress associated with the workplace stressors he described as taking place associated with his work responsibilities with U.S. Foodservice, Inc. Within months of his hire in June 2007, his attempt to address what he believed to be inflated shipping costs charged to customers was rebuffed. He understood a comment made by the Director of Purchasing, Mr. Nash, when he questioned him about these inflated costs, to suggest that his job would be in jeopardy if he pursued such questions any further. Thus, Mr. Smith determined to simply do the tasks that were assigned to him and report the costing and revenue associated with inbound shipments as he was directed. Nevertheless, by the fall of 2007, the applicant was experiencing headaches, which, at the time, he did not associate with an emotionally-reactive response. The stress the applicant described as being a consequence of being pressured by managers to make sure that a certain level of revenue was maintained with respect to inbound shipping costs eventually came to include stress associated with other departments in his facility (transportation and buyers as well as the union) as he attempted to find different means to keep the balance between costs and revenue for inbound shipments that made his managers happy.

A close review of the clinical history and course of symptoms suggests a marked change in Mr. Smith's functioning after the initial date associated with the continuous trauma dates in this case (November 3, 2009) as the harassment and stressors associated with unrealistic expectations and an excessive workload became more pronounced, ending when the applicant was placed off work on November 3, 2010, the end date of the continuous trauma period in this case.

By the fall of 2009, Mr. Smith was under the care of a Kaiser Permanente psychiatrist (Dr. Reiter) and a psychotherapist, Ms. Toshkov, in order to help him mediate the intense symptoms of anxiety he was experiencing. Although unaware of symptoms of depression at that point in time, Mr. Smith was experiencing somatic expressions of his emotional distress with headaches, temporomandibular joint pain and pain and tension throughout his neck and across both shoulders. By July 2010, he took up smoking again to relieve his stress and nervousness; this was a long-time habit he had successfully discontinued for five years. By November 2010, the applicant finally accepted recommendations from his treating physicians at Kaiser Permanente that he take a medical leave of absence from his work; he stated, "I was going to die at my desk."

In our opinion, there is a clear, temporal and proximate relationship between the alleged harassment by the applicant's superiors along with the unrealistic expectations and excessive workload and the development of the mental disorders along with the aggravation of the long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS). As discussed in the Pre-Existing section of this report, the applicant's tendency towards compulsivity as defined in Compulsive Personality Traits was, in all psychological probability, adaptive to his functionality in the workplace. Such individuals engage in extensive mental control in order to avoid being emotionally overwhelmed, and this is clearly reflected in the development of somatic experiences of headaches, temporomandibular joint pain, erectile dysfunction and orthopedic aches and pains in his neck and both shoulders. However, as is usually the case when individuals sublimate their emotional experiences and sense of being overwhelmed, there eventually is a point beyond which this defense mechanism is no longer effective. In the case of Mr. Smith, this appears to be by November 2010 when he finally accepted his physicians' recommendations that he go on a medical leave of absence. By that point in time, Mr. Smith had tried all available means by which to satisfy the conflicting demands of his managers who wanted to maintain revenue in order to support their bonuses and other departments within his company, such as the Transportation Department and buyers as well as the union, without success.

Research suggests that individuals subjected to a hostile workplace environment with unrealistic expectations and work overload with the inherently perceived threat of the loss of a job commonly experience a mood disorder. This clearly appears to be the case here. For Mr. Smith, there were ever-increasing somatic symptoms of severe headaches and

orthopedic pain in conjunction with pronounced anxiety as he attempted to continue working. When he finally faced the necessity of a medical leave of absence as encouraged by his treating physicians, the applicant experienced growing emotional distress as he faced depression, which produced pessimism, a loss of confidence and diminished self-esteem. He was unable to enjoy social activities with friends as he distanced himself due to discomfort around others and a preference for isolation. Mr. Smith had attached a significant amount of his identity and self-worth to his profession and to the independence he had established as a result. Thus, his inability to continue working was tremendously impacting to his emotional state. The psychological injuries have fostered the perception of a limited future and loss of purpose as the mood disturbance, with altered sleeping, daily fatigue, loss of confidence and self-esteem became chronic. Even now, he remains pessimistic and anxious regarding the impact of his psychological condition on his occupational future with a strong desire to resume some type of employment. Furthermore, he has fears that he may be unable to successfully return to the work force and that his condition may worsen as he attempts to appropriately interact with supervisors and co-workers. Consequently, the repercussions of the psychological injuries on his lifestyle, sense of identity and well-being have been considerable.

In analyzing causative factors in this case, we examined converging factors, and we considered several possible concurrent stressors as being causative or contributory to the applicant's mood disorder. Thus, we considered the potential contribution of the effective January 2011 termination action when the applicant was advised that his position with U.S. Foodservice, Inc. had been eliminated. In our opinion, there is a 10% contribution to the development of the mental disorders and aggravation of the long-standing and pre-existing Personality Disorder, (NOS) as a consequence of the applicant's loss of his job. He felt betrayed as he had conducted business exactly as his employer had asked while working under what he considered to be unethical directives from his supervisors and overall unrealistic expectations. For the bulk of the three-and-a-half years he last worked, he experienced severe headaches on a daily basis as well as orthopedic pain; however, it is noted we are not finding a higher percentage of contribution to the termination action because a close review of the clinical history reveals that Mr. Smith has been far more distraught over the change in his physical and psychological functioning as a consequence of his exposure to an allegedly stressful workplace environment while working for U.S Foodservice, Inc. Indeed, from his perspective, the largest obstacle in his ability to resume any kind of employment is his significantly diminished self-esteem, a lack of confidence and mistrust of others such that he does not believe he could even function well in an employment interview. We defer the industrial compensability of this 10% causation to the Trier of Fact.

Additionally, it is our opinion that there is 10% contribution to the development of the Major Depressive Disorder and Anxiety Disorder, (NOS), and aggravation of the long-

standing and pre-existing Personality Disorder, (NOS) flowing from the internal medical conditions, which have evolved over the course of the applicant's employment and subsequently. He has been diagnosed with hypertension and diabetes along with irritable bowel syndrome. He continues to experience significant headaches and he has gained weight, a negative factor with respect to the diabetes and hypertension conditions. While he has not yet required medication to control his blood sugar levels, he is fearful that this will be the ultimate consequence. We understand that the applicant was evaluated by the internist, Dr. Glenn Marshak, serving as an Agreed Medical Examiner in Internal Medicine. Thus, we defer the industrial compensability of this 10% to the findings of Dr. Marshak.

Finally, it is our opinion that there is a 5% contribution to the development of the mood disturbance and aggravation of the long-standing and pre-existing Personality Disorder, (NOS) as a consequence of the applicant's orthopedic complaints. In this case, we defer the industrial compensability of this 5% causation to the findings of the Agreed Medical Examiner in Orthopedic Surgery, Dr. Kanter.

Please note we are not finding a higher level of contribution to either the internal medical conditions or the orthopedic conditions following a close review of the clinical history, which suggests that, from Mr. Smith's perspective, the far greater adaptive challenge to his ability to function effectively in any workplace setting is the residuals of the psychological injuries, such as a diminished self-esteem, significant lack of confidence and difficulty trusting others.

Additionally, we considered other potential contributions to the development of the mood disturbance and aggravation of the long-standing and pre-existing Personality Disorder, (NOS). First, the Personality Disorder, Not Otherwise Specified (NOS), with Dependent and Compulsive Features, in our opinion, is contributory to the development of the mood disturbance while also not a natural progression of this condition. The applicant's occupational history suggests that, while functioning throughout his adult life with the maladaptive behavior associated with this diagnosis, he, nevertheless, maintained a stable work history. This is suggestive, as discussed earlier, that there are adaptive qualities to his personality pathology, which likely made him an effective employee. In contrast, the circumstances in which he found himself with U.S. Foodservice, Inc. were much more challenging and overwhelming and beyond his capacity for adaption. Thus, the work environment and circumstances, as described by Mr. Smith represents a stressor beyond the natural progression of this condition.

We also considered whether the applicant's injury to his right great toe, occurring many years earlier, but requiring surgery in 2009, contributed to the development of the mood disturbance. We find no basis for any contribution associated with this issue. Mr. Smith had coped for many years with the drainage of the cyst associated with the injury until the

surgery in October 2009. The surgery was successful in reconstructing his toe and eliminating the chronicity of the cyst and drainage. Thus, from his perspective, it was a positive result.

Finally, we considered as contributing to the development of the Major Depressive Disorder, Anxiety Disorder, (NOS), Psychological Factors Affecting a General Medical Condition and aggravation of the long-standing and pre-existing Personality Disorder, (NOS) the strain which evolved in the applicant's marriage as his mood deteriorated over the course of his employment and after he stopped working for U.S. Foodservice, Inc. However, this is not an independent causal factor; rather, it flows directly from the psychological injury itself with the associated changes in his mood and behavior.

In summary, as long as the applicant's account is accurate, then, in our opinion, Mr. Smith has sustained an industrial injury to his psyche. Ultimately, we defer to the Trier of Fact for a determination on industrial compensability in this case.

H. APPORTIONMENT

As noted above, in our opinion, the applicant's Major Depressive Disorder, Anxiety Disorder, Not Otherwise Specified (NOS), and Psychological Factors Affecting a General Medical Condition have stabilized at a moderate level of severity and are now chronic. Mr. Smith reached Maximal Medical Improvement as of September 28, 2011, consistent with the findings of Dr. Nehorayan. His current psychological impairment is reflected in a current Global Assessment of Functioning (GAF) score of 57, which translates to a current Whole Person Impairment (WPI) rating of 20% before adjustments for Future Earning Capacity, occupation and age.

With respect to permanent psychological impairment we first observe that under Escobedo, "Causation refers to the causation of the permanent disability, not causation of the injury, and the analysis of causal factors of permanent disability for purposes of apportionment may be different from the analysis of causal factors of the injury (Marlene Escobedo vs. Marshalls; CNA Insurance Co., (WCAB en banc), (2005)(GRO 0029816, GRO 0029817) 70 CCC. Pg. 7). In many cases, the apportionable causal factors are the same for both the cause of the psychiatric injury and the cause of the psychiatric disability, but in many cases the causal factors are different. In this case, the causal factors for apportionment of permanent psychiatric disability are different as will be discussed below.

As for apportionment of permanent impairment, 25% of the applicant's permanent psychological impairment should be apportioned to his long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS), with Dependent and Compulsive

Features. The determination of this percentage of apportionment was based on comparing the applicant's impairment associated with his long-standing and pre-existing psychological condition (i.e., GAF = 67. Whole Person Impairment rating = 5%) to his current GAF impairment rating (i.e., GAF = 57. Whole Person Impairment rating = 20%). This comparison (i.e., 5/20 x 100) yields a 25% apportionable percentage due to his long-standing and pre-existing non-industrial mental condition. The reader is referred to both Sections D and F above, which provide a detailed discussion for the basis of our opinions concerning both his pre-existing and current psychological impairment ratings.

In addition, we are apportioning 10% of the applicant's permanent psychological impairment to the January 2011 termination action. We believe this factor has been and continues to be a reasonable source of distress for Mr. Smith. Thus, the effect of this stressor remains active and continues to contribute to his mood disturbance and permanent psychological impairment ratings and, thus, should be apportioned. Please note, we are not finding a higher percentage of apportionment to this psychosocial stressor for the same reasons discussed in the AOE/COE causation section above. That is, from the applicant's perspective, the far more difficult obstacle in his path for returning to gainful employment is the sequelae of the psychological injury with pronounced poor confidence, a lack of self-esteem and significant anxiety. We defer the industrial compensability of this 10% of the permanent psychological impairment to the Trier of Fact.

Additionally, we are apportioning the permanent psychological impairment to both orthopedic and internal medical factors. It is our opinion that there is a 5% contribution to the permanent psychological impairment flowing from the orthopedic injuries and an additional 5% as a consequence of the internal medical conditions. Again, as discussed in the AOE/COE causation section above, both these factors contribute to the extent to which Mr. Smith continues to feel overwhelmed and uncertain about his future. However, we are not offering a higher percentage apportionment to either of these factors because, in the applicant's mind, neither serves as a significant obstacle to his ability to resume gainful employment. In contrast, his significant loss of self-esteem and confidence as well as ongoing issues of depression and anxiety represent the more pronounced challenge. The industrial compensability of the 5% attributed to the orthopedic injuries is deferred to the Agreed Medical Examiner in Orthopedic Surgery, Dr. Kanter; similarly, the 5% apportioned to the internal medical conditions is deferred to the Agreed Medical Examiner in Internal Medicine, Dr. Glenn Marshak.

There remains 55% of the permanent psychological impairment, which, in our opinion, is entirely apportionable to the residuals of the workplace stressors as described by Mr. Smith. It will be left to the Trier of Fact to determine industrial compensability of this 55% of the permanent psychological impairment.

As with AOE/COE causation, we considered additional, contributing factors to the permanent psychological impairment. It is our opinion that the surgery the applicant had on his right great toe in October 2009 does not contribute to the permanent psychological impairment. This follows the same reasoning as discussed in the AOE/COE causation section above. Similarly, we considered whether the strain and now current separation in his marriage serves as a contributing factor to the permanent psychological impairment. However, it is not an independent factor; it flows directly from the psychological symptoms themselves. Finally, we considered a recent, psychosocial stressor as contributing to the permanent psychological impairment in this case. This stressor is the intrusion of the applicant's wife's oldest child, a daughter who was placed for adoption, along with this young woman's toddler daughter in the applicant's personal life by means of living with him. Clearly, this is a contributing factor in terms of the current amount of anxiety and distress he experiences. However, to the extent that it does contribute, it has been captured in the 25% of the permanent psychological impairment apportioned to the long-standing and pre-existing Personality Disorder, Not Otherwise Specified (NOS).

Body Part/Stressor	Total % Psych Impairment Industrial	Total % Psych Impairment Non-Industrial	Total % Psych Impairment Deferred to appropriate medical experts and/or the Trier of Fact	Date(s) of Injury
Pre-existing condition		25%		Prior to claim
Orthopedic injuries			5%	CT 11/309–11/3/10
Internal medical conditions			5%	CT 11/309–11/3/10
Termination action			10%	January 2011
Alleged workplace stressors			55%	CT 11/3/09–11/3/10
	0% Industrial	25% Non-Industrial	75% Deferred to Medical Experts and/or Trier of Fact	**Total: 100%**

I. RECOMMENDATIONS

The psychological and psychiatric treatment the applicant has received thus far has been medically necessary, but, as of yet, it is not been established that this was required on an industrial basis. In addition, the applicant should be provided an additional 18 to 36 sessions of supportive psychotherapy to assist him in further stabilizing his mood and developing more effective coping skills. Additionally, he may require ongoing psychiatric treatment (i.e., psychotropic medication management of an additional 12 to 18 sessions). If additional psychiatric or psychological treatment is requested and deemed medically necessary, then it should be provided. Please note that the determination of whether the provided and recommended psychiatric and psychological treatment should

be provided on an industrial basis will depend on the findings of the Trier of Fact with respect to industrial compensability in this case.

J. COMMENTS ON RECORDS

The submitted records contain documentation of medical treatment the applicant has received through his personal health insurance at Kaiser Permanente. These records address issues the applicant had with chronic sinusitis and a right foot injury, both non-industrial factors. There records also contain documentation from several doctors who treated the applicant for his somatic complaints of headaches as well as the complaints of anxiety and stress associated with his alleged workplace experiences. These records are primarily consistent with his account to us.

Additionally, the records contain treating documents from the orthopedic surgeon, Dr. Daniel Capen, and the internist, Dr. Sean Leoni. These records are also consistent with information provided to us by Mr. Smith.
According to the applicant, he was evaluated by Dr. Phillip Kanter, serving as an Agreed Medical Examiner in Orthopedic Surgery, and Dr. Glenn Marshak, serving as an Agreed Medical Examiner in Internal Medicine, both in July 2012. We would appreciate having their final evaluation reports for our review and consideration.

On December 6, 2010, Mr. Smith was initially evaluated by the psychiatrist, Dr. Marc Nehorayan; Dr. Nehorayan became the applicant's primary treating physician. On September 28, 2011, Dr. Nehorayan evaluated the applicant and issued a Maximal Medical Improvement Report. In his Treating Physician's Evaluation and Maximal Medical Improvement Report with Psychological Test Results, Dr. Nehorayan discussed an interim history, conducted a Mental Status Examination, administered a battery of psychological tests, diagnosed an Anxiety Disorder, Not Otherwise Specified; a Depressive Disorder, Not Otherwise Specified; Psychological Factors Affecting a General Medical Condition; a Sleep Disorder, Not Otherwise Specified, on Axis I and rated a GAF of 45 on Axis V.

In his initial report of December 6, 2010, Dr. Nehorayan had indicated the applicant was temporarily totally disabled on a psychiatric basis; in his final report of September 28, 2011, he indicated the applicant had reached Maximal Medical Improvement, thus, defining a period of temporary total disability between December 6, 2010 and September 28, 2011. With respect to causation, Dr. Nehorayan stated that the psychiatric injuries were a compensable consequence of the overwork and overload associated with the applicant's job position.

As to apportionment, Dr. Nehorayan found 90% of the permanent psychiatric disability to be a consequence of the injuries of the applicant's employment and 10% to pre-existing factors. Future treatment was recommended to consist of ongoing pharmacological management.

In offering his opinions, Dr. Nehorayan did not specifically offer an opinion on the credibility of the applicant's presentation. This issue has bearing upon the opinions offered in that a psychiatric evaluation always involves information of both an objective and subjective nature in addition to administered testing and consideration of consistency with available records.

We are in partial agreement with the diagnoses provided by Dr. Nehorayan. We believe the diagnosis of Anxiety Disorder, Not Otherwise Specified, and Psychological Factors Affecting a General Medical Condition are accurate diagnoses given the applicant's clinical symptom presentation. However, in our opinion, diagnosis of a Depressive Disorder, Not Otherwise Specified, is inappropriate in light of the significant issue with suicidal ideation expressed by Mr. Smith. In that case, a diagnosis of Major Depressive Disorder is more appropriate. Finally, in our opinion, the additional diagnosis of Sleep Disorder, Not Otherwise Specified, is unnecessary. The disrupted pattern of sleeping Mr. Smith experiences is more accurately subsumed under the mood disorder diagnosis (Major Depressive Disorder); as in this condition, the depression is also expressed in issues with quality sleep.

We are in agreement with Dr. Nehorayan that the applicant was temporarily totally disabled on a psychological/psychiatric basis. However, we do not agree with the Global Assessment of Functioning (GAF) score of 45 provided by Dr. Nehorayan. This level of impairment, in our opinion, does not accurately reflect Mr. Smith's functioning either based upon psychological or psychiatric factors or social or occupational functioning factors. Indeed, this level of impairment suggests Mr. Smith experiences serious symptoms in both domains. We invite the reader to review our Current Disability section for a detailed explanation of our findings that the appropriate Global Assessment of Functioning (GAF) is reflected in a rating of 57.

In terms of the doctor's comments regarding AOE/COE causation, we disagree with his conclusions, as they are overly general. Dr. Nehorayan stated that the psychiatric injuries were a compensable consequence of overwork and overload associated with his job position, but he did not differentiate among other psychosocial stressors occurring within the same continuous trauma dates of injury. Specifically, Dr. Nehorayan did not address the termination action or the orthopedic and internal medical conditions that have evolved.

In the AOE/COE causation section above, we provided our reasoning for concluding that the predominant cause of the applicant's mental disorders (55%) was the alleged harassment and work stress of unrealistic expectations and excessive workload. Additionally, we addressed the relative contributions of the termination action, the internal medical conditions and the orthopedic conditions. Moreover, it cannot be assumed that alleged mechanism of injury is industrially related and one needs to defer to a Trier of Fact to make that determination given that a fact pattern needs to be determined and corroborated.

As well, we respectfully disagree with Dr. Nehorayan with respect to apportionment. While Dr. Nehorayan did recognize personality pathology in the 10% apportionment he attributed to pre-existing factors, he did not take into account the termination action, the orthopedic conditions and the internal medical conditions, which continue to be factors actively contributing to the applicant's current experience of emotional distress.

In terms of treatment, we again disagree with Dr. Nehorayan, noting that the applicant requires additional, individual psychotherapy along with ongoing psychotropic medication monitoring.

Thank you for referring Timothy Smith to us for evaluation. If we can be of any further assistance with regard to this case, please do not hesitate to contact us.

DECLARATIONS

The entire history, psychological examination, administration of psychological testing and analysis of test results, review of records, and preparation and dictation of this report were performed solely by the undersigned.

I further declare under penalty of perjury that I personally performed the evaluation of the applicant or, in the case of a supplemental report, I personally performed the cognitive services necessary to produce the attached report, based on the evaluation performed in Los Angeles County, California and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I attest under penalty of perjury that I have not violated the provisions of Labor Code Section 139.3, which relates (among other things) to referral to a person or facility in which I have any financial interest. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or any other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation, in respect to this report or any report or examination.

I further declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with this report, other than the undersigned, including diagnostic studies, other than clerical preparation, are as follows: The records listed in this report were organized, sorted, and excerpted by Marily M. Sepe, R.N. Thereafter, I personally reviewed all of the records and the time spent that is reflected in this report was my personal time.

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.

Signed in the County of Los Angeles on Oct. 17, 2012.

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