ATTACHMENT C

RESPONDENTS ARGUMENT

RESPONDENT'S ARGUMENT

July 29, 2017

Ref No. 2015-0019

Cheree Swedensky, Assistant to the Board
CalPERS Executive Office
P.O. Box 942701
Sacramento, CA 94229-2701

SUBJECT:

In the Matter of the Application for Industrial Disability Retirement of LINDA MOSLEY, Respondent, and CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, HIGH DESERT STATE PRISON, Respondent.

Dear Ms. Swedensky,

This is a written argument to the Proposed Decision made on June 5, 2017 by the Administrative Law Judge that my application for industrial disability retirement be denied, based on a failure to establish my permanently disability for performance of duties as a Psychologist Clinical with the Department of Corrections.

I filed bankruptcy (Enclosure) March 31, 2015 as a direct result of my inability to work while I was temporarily living with my mother in Detroit, Michigan. This bankruptcy and lack of income made prohibitive my ability to provide in and out of state accommodations for doctors willing to testify on my behalf. I also did not have the funds to hire a legal representative. I believe these competent professional testimonies would have appropriately represented my case to find me eligibility for industrial disability retirement.

I have included an abbreviated personal account of my work-related experience, submitted on October 5, 2013 to Vickie Pender, adjuster; as well as documentation from several competent medical professionals who provided evaluation and treatment.

On 2/25/2010 I had (what I know now to be) Pre-seizure aura's related to my deteriorating medical condition derived from critical and continuing job-related stress and harassment. By the following morning I had been helicoptered and admitted to Reknown Hospital for a once in a lifetime, unexplained seizure. Since that time to the present time I have not been able to work. After the three-day hospitalization, I was on medical leave from 2/26 to 8/31/10; modified schedule 9/1/10 to 10/21/10; medical leave 10/22/10 to 2/27/11; and medical leave from 9/16/11 to 10/30/11. I repeatedly tried to return to work because I enjoyed working with and had great success with patient/inmates.

Before I reported excessive force by the correctional staff, I had worked at High Desert State Prison 4 years, 6 months and 20 days with excellent Performance Evaluations, Peer rating approvals and accolades posted on my wall from patients I had treated.

However, after I witnessed excessive force of a patient/inmate complaining of sexual groping by a correctional officer and was compelled to report it, my work environment had worsened to the point that I was regularly being called "nigger bitch" by staff members, made to wait extended long periods to see patients, and put in dangerous situations. My supervisors ignored my complaints. Colleagues I had befriended all left, one by one to pursue other position in other locations. After my work environment became dangerous I went on at least 5-7 interviews, over about a period of 2 years in California prisons but by that time my reputation had been ruined by High Desert State Prison. Despite my prior excellent performance reports, I was rejected from every single prison interview. Slowly but surely my hair began to fall out, I lost weight, and could not get out of bed even to get grocery. I was scheduled to return to work just before I went to see Dr. Dillon, Psychologist. At that time Dr. Dillon diagnosed me with PTSD and Major Depression, which added to my diagnosis of Chronic Fatigue Syndrome by physician Dr. Uppal. Both doctors consulted and immediately knew that to return to work would devastate my already fragile health condition. I retired and filed for Industrial disability retirement.

On August 9, 2014 Maria Acenas, M.D., Performed a psychiatric Independent Medical Evaluation that lasted less an hour. She diagnosed PTSD and Major Depression but concluded no specific duties I was unable to perform as a clinical psychologist at the prison. How can specific duties not be impaired with a diagnosis of Major Depression? That doesn't make sense. Further, Dr. Acenas' report was nowhere near as in-depth and comprehensive as the evaluation completed by Dr. Stephen Heckman (Enclosures) on December 13, 2013, and sustained on April 2, 2015. I spent 7+ hours my first mental evaluation with him, and substantial time in subsequent evaluations. Dr. Heckman completed a battery of tests in addition to his thorough evaluation that Dr. Acenas did not. Dr. Heckman concluded that I was NOT able to perform duties as a clinical psychologist at the prison, and that I was 85 percent disabled, fixed and permanent.

Additionally, Dr. Stephanie Dillon, my ongoing doctor who has scheduled weekly sessions for nearly 4 years attested to my work-related disability in her report of August 15,2015 (Enclosure). She continues to hold that I am unable to perform duties as a clinical psychologist at anyplace due to my problems with attention and concentration. It takes me 5 times as long to do what I once could in a short amount of time. I am scheduled for session with Dr. Dillon on August 3,2017.

Dr. S. K. Uppal's reports (Enclosure) were not considered in the Proposed Decision even though they show the progression and of my condition at the work site which eventually resulted in my hospitalization and subsequent decompensation.

On February 5, 2015, The U. S. Department of Education discharged my loans based on my total and permanent disability (Enclosure).

Dr. Acenas testimony is refuted by the U. S. Department of Education, Dr. Uppal, Dr. Heckman, and Dr. Dillon. My lack of financial resources to present the evidence in court should not precluded my eligibility for Industrial Disability Retirement. I am requesting that you not adopt the Proposed Decision and find my case eligible for Industrial Disability Retirement.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. The applicant for a benefit has the burden of proof to establish the right to claimed benefit; the standard of proof is a preponderance of the evidence. (McCoy v. Board of Retirement (1986) 183 Cal.App.3d 1044, 1051; Evid. Code, § 115.)

Sincerely,

Linda Mosley
[redacted]

Enclosures: Medical Reports (4)

Bankruptcy determination

U. S. Department of Education

Please do NOT designate my case a PRECEDENT case as a denial. It would not be truly representative of a Precedent case because I could not afford resources to accommodate doctors or hire an attorney to appear in court to testify on my behalf.

B18 (Official Form 18) (12/07)

United States Bankruptcy Court

Eastern District of Michigan

Case No. 14-59498-mar

Chapter 7

In re Debtor(s) (name(s) used by the debtor(s) in the last 8 years, including married, maiden, trade, and address):
Linda Mosley
[redacted]

Social Security / Individual Taxpayer ID No.:
[redacted]

Employer Tax ID / Other nos.:

DISCHARGE OF DEBTOR

It appearing that the debtor is entitled to a discharge,

IT IS ORDERED:

The debtor is granted a discharge under section 727 of title 11, United States Code, (the Bankruptcy Code).

BY THE COURT

Dated: 3/31/15

Mark A. Randon
United States Bankruptcy Judge

SEE THE BACK OF THIS ORDER FOR IMPORTANT INFORMATION.

STEPHEN J. HECKMAN, PH.D., Q.M.E.
LICENSED PSYCHOLOGIST (PSY 8001)
Qualified Medical Evaluator
Diplomate, American College of Forensic Examiners

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April 2, 2015

Mr. Julius Young, Esq.
Boxer & Gerson, LLP
300 Frank H. Ogawa Plaza
Rotunda Building #500
Oakland, CA 94612

Mr. Donovan C. Dorr, Esq.
State Compensation Insurance Fund
P.O. Box 3171
Suisun City, CA 94585

cc: Mr. Jeff Leonard
State Compensation Ins. Fund
P.O. Box 3171
Suisun City, CA 94585

RE:	Employee:	**MOSLEY, LINDA;**
	Employer:	CA Dept. of Corrections Rehabilitation;
	Insurer:	SCIF;
	DOI:	CT -> 02/25/10;
	DOB:	[redacted]
	SS#:	[redacted]
	Claim #:	05912242;
	Panel #:	1553276;
	1° Exam Date:	December 13, 2013;
	Reevaluation Date:	March 30, 2015;
	Report Date:	April 2, 2015;

PANEL QME PSYCHOLOGICAL REEVALUATION

Dear Mr. Young, Mr. Dorr, and Mr. Leonard:

I performed a Panel QME Psychological Reevaluation of Ms. Linda Mosley on Monday, March 30, 2015 at my office at 3640 Grand Avenue #209, Oakland, CA 94610. Note that I had previously evaluated her on March 30, 2015 after being selected by Dr. Mosley through the QME Panel selection process, as she was an unrepresented applicant at that time.

[*Note: As I have multiple evaluation sites throughout the Bay Area, it is requested that all correspondence be addressed to my main office in Oakland indicated in the letterhead, above.*]

The examination began at 9:30 a.m., and lasted until 2:30 p.m., for a total of 5.0 hours. The evaluation included: clinical interview; mental status exam; interval history of injury/treatment; updated assessment of medical, psychological, occupational, and legal history, and concurrent and/or subsequent factors. Dr. Mosley was also re-administered: the Rey Fifteen Item Test; Trails A & B; the Beck Depression Inventory-2; the Beck Anxiety Inventory; the Epworth Sleepiness Scale; the Minnesota Multiphasic Personality Inventory-II (MMPI-2); and the Trauma Symptom Inventory-2. Psychological testing took 4.75 hours, comprised of 2.25 hours of test administration and 2.50 hours of scoring/interpretation. Total face-to-face clinical interview took 2.75 hours. Record review took 5.00 hours, and included review of records not previously reviewed, as well as review of my prior PQME evaluation report. Written report was 10.75 hours.

Purpose of Evaluation

A letter from Mr. Young dated February 18, 2015 requested that I address the following issues: confirmation of the correct injury date as a cumulative trauma through February 25, 2010; an indication as to whether the personnel actions taken against Dr. Mosley which occurred subsequent to the date of injury are impacting her current level of permanent disability; an indication of periods of temporary total or partial disability as a result of the industrially caused or aggravated injury; if the employee is temporarily disabled, an indication of what additional treatment might be needed to bring her to permanent and stationary status; if she is now permanent and stationary, an assessment of permanent disability, utilizing the AMA Guides-5th Edition/DSM Axis V GAF; whether the applicant could return to her usual and customary occupation with or without modification; apportionment, with consideration of what percentage of the permanent disability was caused as a direct result of the work-related injury, and what portion was caused by other factors, including prior industrial injuries, non-industrial factors, and/or subsequent incidents, including disciplinary actions in 2011 and 2012, in accordance with Labor Code Sections 4663 & 4664 and the Escobedo case; and an indication as to what future medical treatment might be needed to cure or relieve from the effects of the injury or prevent future deterioration.

Complexity Factors

The present evaluation was billed at the **ML 104-95** level for a **Comprehensive Panel Qualified Medical-Legal Evaluation involving Extraordinary Circumstances** (see California Code of Regulations, Title 8: Evaluations and Medical-legal Testimony), containing 6 of the requisite minimum of 4 complexity factors, including the following complexity factors:

X (1) two or more hours of face-to-face time by the physician with the injured worker;
X (2) two or more hours of record review by the physician;
_ (3) two or more hours of medical research by the physician;

X (4) four or more hours spent on any combination of two complexity factors (1)-(3), which shall count as two complexity factors;
_ (5) six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;
X (6) addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation;
X (7) addressing the issue of apportionment;
_ (8) addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral, or biological substances;
X (9) a psychiatric or psychological evaluation was the primary focus of this medical-legal evaluation;
_(10) addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

This **ML 104 -95 Panel QME Reevaluation** entailed an updated description of the applicant's reported work-related injuries and her reported symptoms and response to stressors in her work environment; review of records, including: highly-detailed personnel records; mental status examination; psychodiagnostic testing; and assessment of disability and treatment issues.

I personally performed the following aspects of this evaluation: review of relevant records; interview and mental status examination of the applicant; administration, scoring, and interpretation of psychological tests (with the exception computer scoring of the MMPI-2 by Pearson/NCS, with interpretation by this examiner); analysis/synthesis of all of the pertinent data made available to me; all aspects involved in the preparation of the written report; and all functions involved in billing and mailing of the report to the appropriate parties.

Note that the report was prepared with the use of Dragon voice recognition software. Although I have proof-read the manuscript several times, I apologize if I did not catch any typographical errors caused by speech misrecognition of this program.

An itemization of charges is provided at the conclusion of this report.

Sources of Facts

The sources of facts upon which the following evaluation report is based include:

Comprehensive clinical interview;
Mental status examination of the applicant;
Review of personnel records as well as my prior PQME Report;
Results of psychodiagnostic testing administered to the applicant.

REVIEW OF RECORDS

Records provided by Mr. Young:

Approximately 1/2 inch of records (estimated as approximately 125 pages) were received from Mr. Young, including the following:

3/24/08: **Joseph Cummings, Ph.D., Chief Psychologist, Chief, Mental Health Department**

Dr. Cummings has been Dr. Mosley's Department head for the last 2 ½ years, during which Dr. Mosley has displayed a high degree of professional competence and knowledge, relating well to her patients and utilizing her clinical skills in a beneficial manner. She is respected by her peers and is a valuable member of the department.

12/10/08: **Joseph Cummings, Ph.D., Chief Psychologist, Chief, Mental Health Department**

Dr. Cummings has been Dr. Mosley's Department head for the past 3 years, during which Dr. Mosley has always displayed a high degree of professional competence and knowledge, relating well with her patients and utilizing her clinical skills in a beneficial manner. She is respected by her peers and is a valuable member of the department.

10/20/09: **Letter from Dr. Mosley to Care Manager Acquiviva**

Request for meeting, as there have been no changes in Dr. Mosley's work situation since the incident with patient/inmate Jones on 5/14/09. Dr. Mosley followed the chain of command, meeting already with Dr. Nolan and Dr. Dennis, both Senior Psychologists, as well as Dr. Cummings, Chief Psychologist. Dr. Mosley had been instructed by Dr. Cummings to assist the inmate in completing a Citizens Complaint against Personnel. Dr. Mosley was also instructed by Lieutenant Amero to complete an incident report as a witness to inmate Jones being tackled by custody. Prior to this incident everything on the job was going just fine. Dr. Mosley indicated her interest in carrying out her duties in a harassment free work environment as well as in conducting notably absent cultural sensitivity meetings.

No date: **Summary of meeting on December 8, 2009 with Health Care Manager Acquiviva and Dr. Cummings**

Dr. Mosley will report to Dr. Dennis rather than Dr. Nolan in A Yard. A multicultural representative from Sacramento will be called in to focus on global matters rather than cultural sensitivities related to the African-American culture, despite Dr. Mosley's interest/offer to conduct such training, and despite African-Americans historically being disproportionately incarcerated in America. Custody would no longer assist her as they have in the past 3 years in the yards. Dr. Mosley notes that it has been a significant problem seeing her patients in either the cell front or the dining area, which breeches their confidentiality.

4/20/09: **Clinical Notes by Dr. Mosley regarding patient/inmate Jones**

Inmate Jones complained of being sexually fondled by correctional officers, in addition to worrying about having a stroke, as his right arm and right leg were weak. It is noted that this patient was stressed with poor ability to manage his stress. Patient was unwilling to reveal the name of the correctional officer who was sexually touching him. Patient to complete Staff Misconduct form, to notify Dr. Mosley prior to next appointment in 7 days if necessary.

(Review of records-continued)

5/5/09: **Clinical Notes by Dr. Mosley regarding patient/inmate Jones**

It is noted that inmate Jones was seen in a holding cell with waist chains behind his back after being tackled by custody just after he turned his head and said "hey wait a minute" while being searched to come into the Program office to meet with Dr. Mosley. On the week of 4/20/09 this inmate had complained to Dr. Mosley of being sexually fondled during searches. Per consult with colleague, Dr. Scaglia, we are not to advise, but encourage patient to complete a Staff Misconduct Form, which Dr. Mosley assisted with by writing out the form for him using his own words.

5/5/09: **Clinical Notes by Dr. Mosley regarding patient/inmate Jones**

Complaint by inmate Jones indicating inappropriate sexual behavior on the part of correctional officers.

5/18/09: **Crime/Incident Report: Staff Report**

Documentation by Dr. Mosley of inmate Jones being tackled by custody simply for turning his head and saying: wait a minute." Dr. Mosley did not notice the name of the Officer. She clarified the term "tackled" as "throw(n) to the ground." Although other reports indicate that inmate Jones pushed himself off the wall back towards Officer Luna, Dr. Mosley did not observe that.

5/14/09: **Inmate/Parolee Appeal Form**

Inmate Jones indicating that a correctional officer "was feeling on me and ramming his hand up my butt." "I want him to stop feeling on me, stop grabbing my privates."

1/27/11: **Indra Uppal, M.D.**

Medical Note: Linda has been very stressed working at HDSP. She would like to transfer to facility 19 at San Luis Obispo on a hardship basis.

4/21/06: **Report of Performance for Probationary Employee: First Rating**

Dr. Mosley is rated by Dr. Cummings as Standard (Satisfactory) on all 6 of 6 relevant areas, including skill, knowledge, work habits, relationships to people, learning ability, and attitude.

4/21/06: **Report of Performance for Probationary Employee: Second Rating**

Dr. Mosley is rated by Dr. Cummings as Standard (Satisfactory) on all 6 of 6 relevant areas, including skill, knowledge, work habits, relationships to people, learning ability, and attitude. It is noted that in general she is doing an excellent job, the only recommendation being that a more thorough review of the patient's entire record would be of help to her.

4/21/06: **Report of Performance for Probationary Employee: Final Rating**

Dr. Mosley is rated by Dr. Cummings as Standard (Satisfactory) on all 6 of 6 relevant areas, including skill, knowledge, work habits, relationships to people, learning ability, and attitude. It is noted that she has continued to grow as a clinician.

(Review of records-continued)

9/28/07: **Performance Report Route Slip**

Dr. Mosley is rated as excellent in 4 of 7 relevant categories (including quality of work, quantity of work, work habits, and meeting work commitments) and rated as meeting expectations on 3 categories (relationships with people, taking action independently, and analyzing situations and materials). It is noted that she has done an excellent job organizing and conducting groups in her yard.

3/21/08: **Rick Dahl, Dahl & Associates, National Health Service Corps Loan Repayment Program**

Dr. Dahl worked with Dr. Mosley for over 2 years at High Desert State Prison as a psychologist. Dr. Mosley has been the only clinician of color working in the mental health department, which has been a tremendous attribute for her and the clinical team. She has brought a level of advocacy and perspective of working more actively with the inmate population as well as demonstrating a breadth and depth of clinical skills. She has maintained her professionalism even in difficult situations. She is highly recommended without reservation for any benefits available through the National Health Service Corps Loan Repayment Program.

6/18/09: **Typed summary of incident by Dr. Mosley**

Documentation of Dr. Mosley being yelled at, as well as spoken to in an irrational manner by Social Worker Mr. Blanthorn, including being "volunteered" to work on a specific case without making a request to Dr. Mosley, as well as continuing to introduce her without providing her the respect of introducing her by her appropriate title.

6/22/09: **Letter from Dr. Mosley to Dr. Nolan, cc: Dr. Cummings, Mr. Blanthorn**

Letter requesting that staff discuss any disagreements without raising their voices or cursing at others in the workplace; reiteration of her preference to be appropriately referred to as Dr. Mosley, rather than as "Linda."

6/22/09: **Facebook correspondence between Dr. Mosley and Jan Eggert**

It appears that Dr. Mosley was requesting feedback from Ms. Eggert regarding the letter summarized above, prior to sending it. (It is noted by this examiner that Ms. Eggert appears to offer confirmation regarding the difficulty of speaking up at work, referring to her own reputation as "trouble", as well as her indication that it hasn't gotten her anywhere but in a worse situation, and that the only thing that saves her is her being the DMH coordinator. Ms. Eggert further indicates that she is not a senior psychologist, nor will she ever be one, as she has literally been "blacklisted.")

There are 2 pages consisting of items 74-124 containing quotes of inspiration taken from the Bible.

6/9/09: **Mental Health Referral Chrono**

Custody report regarding inmate Jones, documenting increased in recent irritability and attitude towards staff.

(Review of records-continued)

6/9/09: **Memo from Dr. Mosley to Dr. Nolan**

It appears that Dr. Nolan is making it difficult for Dr. Mosley to go on vacation until she asks each reception center clinician if they will cover for her, as it seems that a Senior Psychologist would have an overview of everyone's schedule and would be more in a position to know which of the 3 reception center clinicians might be able to cover while she's on vacation. In addition, Dr. Mosley noted that a number of escorts did not show up, and Dr. Mosley was instructed to go to the buildings which have been off limits due to the swine flu and other infections.

7/8/09: **Memorandum: Response from Dr. Nolan to Dr. Mosley**

It is pointed out to Dr. Mosley that it is the clinician's responsibility to arrange for backup when taking vacation, not the supervisor's. Regarding escorts, while it is desirable that inmates may come to specific office areas, the reality may require meeting in the housing unit or making contact in the cell front, as there are not sufficient resources to assign escort officers under all circumstances. Canceling a patient due to unavailability of an escort is not acceptable.

7/8/09: **Memorandum: Letter of Expectation from Dr. Nolan to Dr. Mosley**

Letter indicating need for Dr. Mosley to correct behavior reflecting a persisting pattern of poor judgment. It is noted that, by ignoring or disregarding directions from the supervisory chain of command, Dr. Mosley has created confusion, disruption, and unnecessary effort by others to correct her mistakes. She has become argumentative and angry, making justifications that somehow the rules don't apply to her. She is directed to familiarize herself with the Department Operations Manual, etc. and provide a progress report. Additionally she will be required to meet with Dr. Nolan on a biweekly basis to review her progress. She will be expected to be familiar with procedures including: bringing contraband materials or devices on prison grounds; interfering in custody procedures, putting staff and inmates at risk for injury; behaving disrespectfully with coworkers; refusing to make proper arrangements for inmate-patients under her care during times of her extended absence from the institution; disregarding common courtesies and failing to respect and cooperate with coworkers; discounting that any disagreeing perspectives or opinion different from her own could be useful or have value; and creating tension/disharmony with colleagues to ensure that she would not have to share an office space, when most other offices had 2-3 clinicians sharing office space.

7/31/09: **Letter from Dr. Mosley to American Psychological Association (cc: California State Board; California Psychological Association)**

Letter of complaint against her supervisor at High Desert State Prison. Dr. Mosley has been the only African-American female psychologist in the mental department for the past 4 years, and a recipient of the NHSC, for which she committed to a 2-year stint. She has endured consistent ongoing harassment, including a threatening letter received 2 weeks ago. Complaints to higher prison authorities seem to lessen the harassment from time to time, but it never stops, and her supervisor's lack of cultural competence continues.

8/6/09: **State of California Board of Psychology Consumer Complaint Form**

Copy of Dr. Mosley's letter of complaint sent to American Psychological Association, summarized above.

(Review of records-continued)

8/4/09: **Memorandum: Letter of Complaint from Dr. Mosley to Dr. Nolan**

After four years of work together, Dr. Mosley indicates that Dr. Nolan's treatment towards her has risen to the level of harassment. She has found him to be abusing authorities vested in his role as a supervising psychologist according to the American Psychological Association, and in his role as a Senior Psychologist by the state of California. His capabilities and/or practices of cultural competence continue to be notably absent. Not only are his allegations against her false, but he has repeatedly failed to perform his duties as a supervising Senior Psychologist. His letter of expectation is very similar to his letter of instruction approximately 1 year ago, which was rejected by the Health Care Manager as not credible and lacking in merit.

8/4/09: **Dr. Mosley: Clinical Case Presentation: "Mr. H.": Multicultural Perspective/Black Psychology**

Clinical Paper/Case Presentation.

8/10/09: **Letter from Dr. Mosley to American Psychological Association Ethics Board: Supplement**

This is a supplement to Dr. Mosley's prior letter of 7/31/09. It is pointed out that in a meeting with the Health Care Manager and Chief Psychologist on 7/30/08 it was determined that Dr. Nolan's disciplinary letter was unwarranted. Dr. Nolan wrote another disciplinary letter on 7/20/09 attempting to damage her reputation and prevent possible promotions. It was additionally noted that Dr. Nolan was requiring her to redundantly complete tracking sheets which made her get behind in her clinical contacts. In response to her request for escorts to help her see her patients, she was told to see patients in buildings which had been confined to Swine Flu and other viral infections; Dr. Mosley has contracted infections on at least 2 prior occasions. Dr. Mosley also indicated that she was accused of interfering with custody simply by picking up an inmate's Bible and pencil off the ground after he was tackled by custody. Dr. Mosley also reported that Dr. Nolan refused to tell her where she might get access to the Departmental Operations Manual sections that were demanded by him to be cited upon threat of being terminated.

8/12/09: **Emily Laumeier, American Psychological Association: Letter to Dr. Mosley**

Letter acknowledging Dr. Mosley's letter dated August 12, 2009, expressing her interest in filing a complaint against Dr. Timothy Nolan. However, Dr. Nolan is not a member of APA and therefore not within APA's jurisdiction. It is suggested that Dr. Mosley contact the relevant state psychological association and licensing board.

8/17/09: **Memorandum: Letter of Expectation from Dr. Nolan to Dr. Mosley**

Revision of first letter dated August 17, 2009. It is noted that Dr. Mosley failed to submit 2 Time Off Requests for September 8-17 and December 21-31 with the signature of the primary clinician who has agreed to cover the "A Yard" emergencies in her absence. This is not the first time she has ignored this procedure. Additionally, on June 25, 2009 she was instructed verbally to complete the leave request form for the time period of June 29-July 7, 2009; however, she left on June 25, 2009 without any further written or verbal response to the directive to provide clinical coverage in her assigned area. She was gone again until April 20, 2009, failing to complete the leave request form with a signature from the primary covering clinician by March 26, 2009. It is further noted that on August 17, 2009 she was reportedly discourteous, unprofessional, argumentative and hostile toward custody staff, demanding escorts for a line on A yard, when she had no priority for such services.

(Review of records-continued)

8/19/09: **Memorandum: Sgt. T.R. Thompson, Health Care Access Clinic to Dr. Nolan**

On August 17, 2009 Officer Thompson was conducting his Health Care Axis rounds when he was approached by Dr. Mosley, who questioned him about who her escort officer was. Officer Thompson informed her that she did not have an escort that day, as none were available. Dr. Mosley became agitated, asking how she was supposed to get her line done. She was reminded that there are only 3 escort officers for the entire institution Mondays through Fridays, and that there are 12-15 mental health providers on the grounds daily on Second Watch. Dr. Mosley was instructed to walk to the buildings herself. Dr. Mosley stated that she was going to document this as custody's refusal to assist her. About 5 minutes later, Dr. Mosley again started making statements in a loud, hostile voice about not having an escort and threatening to write that custody is refusing to provide an escort. It appears that Dr. Mosley has a deep-seated attitude towards custody in general, with communication that is often accusatory and disdainful.

8/19/09: **Memorandum: August 6 Meeting Regarding Letter of Expectation from Dr. Nolan to Dr. Mosley**

Summary of meeting held on 8/6/09. Purpose of meeting was to review progress as directed in the July 20, 2009 memo. Dr. Nolan noted that Dr. Mosley deflected from this topic, redirecting the conversation onto her cultural competency presentation, stating: "I believe you came to that, but arrived late, didn't you?" When asked if she had come in with a clear concise typewritten outline of her accomplishments to date, Dr. Mosley indicated that she had researched the Department Operations Manual previously and did not need to do it again. She also told Dr. Nolan that he needed "to understand about cultural competence of black people and black women, and to do it quick." He replied that understanding something and/or agreeing with her unique personal interpretation of what this means to her is not necessarily the same. She then asked for the DOM sections to be provided to her, indicating that she was not familiar with Title 15 and had not read it, as it did not apply to her. In response, Dr. Nolan informed her that she is required to be familiar with it, to which Dr. Mosley responded that he "was wrong" and that he was overstepping his authority as supervisor in so doing. From her argumentative manner, tone, volume, and inflection of her voice and general presentation Dr. Nolan felt threatened by the hostility of her reactions and perceived her as creating a hostile work environment. Dr. Nolan also noted resistance to scheduling the next meeting, by which it was hoped that Dr. Mosley would have prepared, additionally noting that in response to Dr. Nolan thanking her for attending today's meeting, Dr. Mosley stated: "you are not welcome, Dr. Nolan." It is further noted that she has now been provided with a copy of Title 15 and was expected to become familiar with it. Dr. Nolan notes that he has been attempting to help her keep her job but she is not being very cooperative. Continued failure to meet job requirements may result in adverse action up to and including termination.

11/24/09: **Deborah Morales, Enforcement Analyst, State of California Department of Psychology**

The Board of Psychology has received Dr. Mosley's complaint regarding Dr. Timothy Nolan. However, the Board is only authorized to take action against its licensees who have violated the Laws and Regulations Related to the Practice Psychology. Dr. Mosley's information provided has been reviewed and it has been determined that her complaint is an employment-related issue; therefore the Board has no jurisdiction over this matter.

(Review of records-continued)

9/3/09: **Memorandum: Dr. Mosley to Dr. Nolan**

Although Dr. Nolan scheduled a meeting for 8/5/09, and was not present at that time, he approached Dr. Mosley on 8/6/09, wanting to review the DOM. He also set up a meeting for 9/10/09, a period of time during which Dr. Mosley was going to be on vacation, which Dr. Nolan was already aware of. In her discussion with Dr. Dennis on the week of 8/24/09, he thought they could cover her vacation and figure out who could handle A Yard emergencies. Dr. Mosley believes she is being harassed related to ethical and cultural matters. Dr. Donner suggested she contact ERO. She will meet with Dr. Dennis on either 9/2 or 9/3/09.

9/21/09: **Memorandum: Dr. Mosley to Dr. Nolan: Reschedule**

Dr. Mosley made every attempt to see her patients/inmates today but was informed of the unavailability of escorts. She went to the gym but would not be allowed admittance due to a strip search in progress. She then went to building A1 and A2 to conduct cell front wellness checks, but neither building had officers, therefore she had to reschedule her patients.

9/22/09: **Letter of Expectation Response: Dr. Mosley to Dr. Nolan**

Dr. Mosley points out that she works alone on A Yard, which makes it impossible to negotiate dates with another clinician to cover her for vacations. Her situation is unique in that she is the only clinician who does not partner with another clinician to share a yard. She also spoke with the Yard captain as well as several other officers who witnessed the fact that she has never been disrespectful to custody; she would like to have any accusations of being disrespectful to custody removed from her letter (sic, personnel file?). She will be consulting with Board of Psychology about patient/inmate confidentiality.

9/28/09: **Ethical Issues and Patient/Inmate Confidentiality Laws: Dr. Mosley to Dr. Nolan**

Letter indicating that Dr. Mosley is not being provided with the appropriate facilities to conduct sessions with patient/inmates without potentially violating their confidentiality, as she is left to conduct such sessions in public places where others can hear the conversation. Dr. Mosley indicated her attempts to contact the Psychological Board for consultation about how to handle the situation without losing her license.

10/15/09: **Ethical Issues Required in Psychological Practice: Dr. Mosley to Dr. Nolan, Dr. Cummings**

Dr. Mosley notes that a recent peer review found her work to be acceptable. Dr. Mosley noted that Dr. Nolan's behavior has risen to the level of harassment. Her concerns about the lack of patient confidentiality were reiterated.

10/19/09: **Memorandum from Dr. Mosley to Associate Warden Arnoskus**

Dr. Mosley expressed her shock to discover Sgt. Thompson's inappropriate attempt to defame her character in a memo to Dr. Nolan 8 weeks ago. It is expected that Sgt. Thompson be appropriately disciplined for his lack of integrity and irresponsible behavior of untruthfulness. Dr. Mosley asked Officer Switzer if she would be assisting her with 10 patients/inmates and was told "no" in a roundabout manner, appearing to be offended at even being asked.

(Review of records-continued)

10/20/09: **Memorandum from Dr. Mosley to Health Care Manager Acquaviva**

Request by Dr. Mosley to meet to discuss concerns about workplace harassment. Dr. Mosley has already followed the chain of command, meeting with Dr. Nolan, Dr. Dennis, and Dr. Cummings.

12/8/09: **3 basic outcomes of meeting with Health Care Manager Acquaviva and Mental Health Chief, J. Cummings**

Dr. Mosley will report to Dr. Dennis rather than Dr. Nolan, who will replace Dr. Nolan in responsibility for A Yard. Dr. Cummings will call in a multicultural representative from Sacramento to teach cultural sensitivity issues (despite Dr. Mosley expressing her interest in teaching this, in light of her expertise in multicultural psychology). Custody would not go back to assisting her with her line as they did in the past 3 years, as they did not assist other clinicians on other yards. If patients do not show up, she can report them missing to the Sgt. and maybe he will help.

12/10/09: **Letter of Instruction to Dr. Mosley, from J. Cummings, Ph.D., Chief Psychologist/Chief of Mental Health**

On December 9, 2009, Dr. Mosley notified J. Peterson, Correctional Capt., that she lost her State Personal Identification Card (ID). Loss of an ID card poses a serious threat to the security of the institution in the Department as a whole. The ID card can be used to gain entrance to an institution for the purpose of committing any number of felonious acts, including the escape of a prisoner. Every employee of the Department Corrections and Rehabilitation is held accountable for the security of their State Personal ID Card. It is expected that she would make a concerted effort to improve in this area of her performance immediately. To assist her in improving in these areas of her performance, her performance will be monitored with positive or negative comments when warranted. This letter of instruction will be placed in her Official Personal File for one year, expiring on December 9, 2010. Upon expiration she must submit a request in writing to the Health Care Manager for its removal.

As it has been over 1 ¼ years since I had evaluated Dr. Mosley, 1.25 additional hours were spent in review of my initial Panel QME Evaluation report dated December 23, 2013.

Review and summarization of these highly detailed records took a total of 5.00 hours.

RESULTS OF EVALUATION

Identifying Information

Ms. Linda Mosley is a 64 year old Afro-American female who appears slightly younger than her chronological age. She arrived on time for her 9:30 a.m. Panel QME Psychological Evaluation appointment on March 30, 2015, held at my office at 3640 Grand Avenue #209, Oakland CA 94610. She was professionally attired in black slacks, a black sweater, a purple blouse and black shoes. She is right-handed. She stated that she is 5' 9" inches tall, and weighs 200 lbs., which appeared accurate. She ambulated without difficulty, without the use of any assistive devices.

I explained the limits of confidentiality regarding the present evaluation, and that a copy of my findings would be submitted to her claims examiner at her employer's Workers' Compensation Insurance carrier. She appeared to demonstrate a clear understanding of the nature and purpose of this examination, that this was a medical-legal psychological evaluation, and not treatment of any kind, and that no treatment relationship was being established either explicitly or implicitly. She readily signed an authorization to release my findings to the party or parties identified above.

Dr. Mosley appeared cooperative throughout the evaluation process. She was able to maintain appropriate eye contact, as well as establish an appropriate level of emotional rapport. However, her thought processes were logical and linear for the most part, although at times tangential and circumstantial. She was once again a fair historian, as her verbal account generally coincided with the chronology of her injury and treatment reflected in the medical records reviewed. Her mood appeared mildly depressed. Her affect appeared flat, with the exception of 2 episodes of tearfulness. Her thought content reflected to reflect circumscribed delusions existing within the context of an otherwise intact clinical presentation.

Brief Summary of Occupational Injury and Treatment

By way of background, Dr. Mosley was hired to work as a Clinical Psychologist at High Desert State Prison in Susanville, within the California Department of Corrections and Rehabilitation, on August 4, 2005. This is a maximum-security prison, housing the most dangerous criminals in the state, including many inmates serving life sentences.

Dr. Mosley indicated that her industrial claim was precipitated by an incident in which she observed approximately 8 prison guards use excessive force in tackling one of her patients who was standing in the hallway outside of her office, just prior to his therapy session. This patient is an individual who Dr. Mosley had treated for approximately 3 years prior to the incident in question, but who she had not seen in a number of months. This inmate had also complained that in the course of the pat-down searches a guard had "groped" him sexually several times, which he found quite disturbing. Dr. Mosley recalled suggesting to this inmate that he file a complaint with the sergeant, but the inmate replied that he felt that doing so would make matters even worse. The incident in which this inmate was tackled to the ground occurred on approximately 5/18/09, as this inmate was about to be seen by Dr. Mosley for his therapy session. The inmate was about to be searched, when he turned his head to the side and uttered either "wait" or "no." At this point the claimant observed 8 prison guards tackle her patient to the ground, in the process breaking his eye-glasses, then chaining him, and locking him in a holding cage. Dr. Mosley stated that in the course of being knocked down to the ground, the inmate's pocket Bible and pencil had fallen out of his pocket. As she bent down to pick these items up she recalls being warned by the guards in a threatening manner to "stand back." Dr. Mosley stated that this was the first time that she had witnessed this kind of violence directly, although previously having seen guards treating inmates roughly from a distance.

She described the experience as "being in slow motion." She stated that she felt upset, shocked, stunned, and saddened. Although she attempted to continue in her work-day, she recalled experiencing great difficulty concentrating for the rest of the day. She related that she could not stop ruminating about this incident, and although engaging in other work throughout that day distracted her temporarily, her thoughts kept returning to this incident.

Dr. Mosley stated that when she returned to work the following day, she was instructed by the Chief Psychologist, Dr. Joseph Cummings, to write up an incident report and submit it to one of the sergeants. Dr. Cummings also instructed her to assist the inmate in writing up the civil complaint that he wished to pursue, as the inmate was functionally illiterate. Although she followed these directions, Dr. Mosley indicated that in the months that followed, she began being treated like a "pariah." Whereas she previously had been provided with guards who would escort inmates to her office for their appointments, Dr. Cummings suddenly denied this, which meant that Dr. Mosley would have to make several phone calls to find an available guard to transport each of her 10 patients per day to their sessions, adding significant administrative time to her day, and making it much more difficult for her to stay on schedule. When she questioned this change, she was told her that none of the other psychologists had escorts, which she states was not true. Dr. Mosley indicated that she would now have to walk considerable distances to the inmates' cells, in different buildings, spread across a large area. Whereas previously she would be let in immediately, now the guards began keeping her waiting outside, often in excessive heat (this facility is located in the desert), rain or cold.

Dr. Mosley further indicated regularly overhearing guards uttering "Nigger bitch" under their breaths, whenever they had to have contact with her, which went on for months, and which she simply tried to ignore, but which hurt her deeply. Dr. Mosley indicated that a change in administration occurred around this time, and 4 of her colleagues left for alternative employment within a few months of each other, resulting in Dr. Mosley experiencing a significant loss in her collegial support system while simultaneously feeling singled out for harassment.

Dr. Mosley further indicated that she would frequently leave her ID badge in her desk drawer in the afternoons, when she would no longer need it to move through the facility. She indicated that her badge was taken from her desk on several occasions, necessitating her having to obtain a temporary day pass on a daily basis until she could receive a replacement badge, which would take about a week. After this occurred several times, she was no longer issued a permanent ID badge, but would have to obtain a new daily pass each morning. Guards manning the entry gate, who had known her for years, would now ask her every day who she was, and what her purpose was in requesting entry to the facility. She would then be kept waiting while a temporary day pass was prepared and given to her, which she found to be blatant harassment, as these guards knew very well she was and why she was there. She reported that she subsequently was informed by one of the secretaries that she had seen someone take Dr. Mosley's identification badge from her desk and thrown it into the trash.

Dr. Mosley indicated that she continued to see her patients and function in her job, although she began looking into working at other correctional facilities, in fact indicating that she had applied

for positions at about a half-dozen other facilities, and went through the interview process, but unfortunately was not hired at any of these alternative locations.

In addition to feeling shunned at her place of employment Dr. Mosley also indicated that most of the town of Susanville consisted of employees of the prison. Furthermore, Dr. Mosley indicated that as the only Afro-American woman in town, she often felt that she would get "dirty looks" as the primarily Caucasian community was not used to encountering ethnic diversity.

On 2/25/10, the date of injury reported by the claimant, Dr. Mosley reported experiencing seizure "auras" which she described as "surreal perceptions", difficulty concentrating and feelings of derealization. She also indicated that she kept thinking that people were trying to hurt her, referring to a comment that a tower guard had made that day as she had walked across the yard, yelling down at her, calling her "a piece of meat." On the following day, 2/26/10, she stated that she experienced a seizure while in her apartment (although medical records from Renown Regional Medical Center indicate that she did not experience this seizure until taken to the ER of Susanville Banner Medical Center, and that she had been speaking on the telephone earlier in the evening to a friend who observed that she was not making sense, and called 911; the police subsequently did a welfare check and brought her to the emergency room at Susanville Banner). [At the time of my initial Panel QME evaluation, the claimant appeared quite confused about the chronology of this incident, stating her persisting belief that: *"Different officers from the prison came to my apartment to harass me. They were outside my apartment talking to me. I kept thinking they were going to kill me."* This examiner noted that the claimant did not appear to recognize that she had been in a delusional state at the time, as these beliefs persisted that officers from the prison were actually outside of her residence at the time.]

From Susanville Banner Hospital, she was med-evacuated by helicopter to Renown Regional Medical Center in Reno, Nevada, where she remained hospitalized until her discharge on March 3, 2010. She remained off work until September 1, 2010, then returning to modified duty, working approximately ½ of the hours that she previously worked (four 5-hour days per week) for approximately 7 weeks, then taken off work again from 10/22/10 until 2/27/11. She returned to regular duty on 2/28/11 until being taken off work again on 9/16/11 for 6 weeks. She returned to work on 11/1/11 and worked for another 9 months until being taken off once again, her last day worked being 7/30/12. On each of these occasions it was her PCP Dr. Uppal who had taken her off work, due to her stress. Dr. Uppal also prescribed Zolpedem (Ambien) for insomnia, and alprazolam (Xanax) for anxiety.

It is noted in my initial evaluation report dated December 23, 2013 that there had been allegations made by her mother and daughter regarding her having a history of bipolar disorder, alcohol dependence and a "breakdown" 30 years ago (which was described as a mixed, possibly manic episode, reflected in the Psychiatric Consultation notes on 2/26/10 by Nathanael Cardon, D.O./José Thekkekara, M.D. at the time of her recent psychiatric hospitalization). However, the claimant denied ever having been diagnosed with bipolar disorder. With reference to undergoing a "breakdown" when her daughter was 8 years old, the claimant indicated going through an episode of depression after having been divorced and coping with being a single parent.

She also cited as additional causative factors to her depression at that time the difficulties of living in a high crime area of Detroit and having witnessed a number of incidents of violence, including having seen a body lying in the trunk of a car on the street.

With regard to the possibility of a prior psychiatric hospitalization, in the absence of any medical records from 30 years ago documenting such a psychiatric "breakdown", the veracity of these allegations remains indeterminate; however, if records were made available, this examiner would certainly be glad to review them, although given the significant lack of temporal proximity to the events related to the subject industrial injury, it certainly appears questionable that there would be any connection.]

Interval History of Injury/Treatment

In interval history, Dr. Mosley indicated that she has never returned to work at High Desert State Prison, nor for any other employer since her last day of employment at that facility on July 30, 2012. She indicated that Dr. Dillon suggested she not return to work at that facility, as it put her through too much stress.

She continues to be treated by psychologist Dr. Stephanie Dillon in Reno, Nevada, which she indicated is about a 1½ hour drive from Susanville. She began treating with Dr. Dillon in June 2012, and at the time of my initial evaluation on December 13, 2013, Dr. Mosley indicated that she had received approximately 20 sessions of therapy from Dr. Dillon, half in person and half by telephone. Now that she has not been living in Susanville, they have been conducting most of their sessions by telephone, although the claimant indicated that occasionally she will make the drive to Reno to see Dr. Dillon in person. She believes that Dr. Dillon has assigned a diagnosis of Major Depression as well as Posttraumatic Stress Disorder. She indicated that Dr. Dillon recommended that she not return to work at High Desert State Prison at the time of her 2nd treatment session. As her industrial claim had been denied, the claimant also related that Dr. Dillon suggested she consider obtaining legal representation, which she has since done. Dr. Mosley indicated that Mr. Young agreed to represent her in approximately January or February 2014, several months following my initial Panel QME evaluation. She also noted that Dr. Dillon has been willing to continue treating her on a lien basis until her claim is settled. (*It is noted that the claimant became quite tearful at this point, reflecting upon how difficult it has been for her to no longer be able to work in her chosen occupation, due to the overwhelming stressors she has experienced*).

Dr. Mosley has not received any treatment from a psychiatrist in terms of psychotropic medication management since her emergency psychiatric hospitalization at Renown Regional Medical Center in Reno Nevada, in late February through early March 2010. However, she indicated that Dr. Dillon consulted with her Primary Care Physician, Leon Morris, M.D., in Detroit, where the claimant's mother lives, who has been prescribing the antidepressant Bupropion (Wellbutrin) 150 mg., as well as Trazodone 50 mg. since approximately December 2014, which she has described as very helpful in terms of helping her sleep better, as well as boosting her level of energy and motivation.

Dr. Mosley indicated that she applied for Disability Retirement through CalPERS, but was denied on the basis of an evaluation by psychiatrist Maria Acenas, M.D., in Mountain View, CA, who apparently believed that although Dr. Mosley had suffered a disability, she could have returned to employment.

Dr. Mosley indicated that she was approved for regular retirement through CalPERS, based upon her age/years of service, and receives approximately $1300 per month, from which $500 is deducted for her Blue Cross healthcare coverage. The claimant indicated that her financial circumstances, in which her net income has only been $800 per month, has been extremely difficult for her, and has necessitated her having to draw upon her savings and credit cards in order to pay her living expenses. She indicated that she also has had to give up her apartment in Susanville in early September 2012. She now alternates between living for several months at a time with her sister in Union City, CA, her mother in Detroit, and her daughter in Chicago, and describes herself as essentially homeless. She also indicated having filed Chapter 7 bankruptcy in December 2014, which she stated was approved. She has applied for Social Security, which was approved, and which will begin paying her approximately $1400 per month beginning in April 2015, which she anticipates should change her financial status significantly, and hopefully allow her once again to afford her own apartment.

Dr. Mosley spontaneously related additional experiences during her employment at High Desert State Prison, explaining that as a psychologist she at times would see patients who were held in "administrative segregation" (i.e., solitary confinement). She related her belief that one of the inmates who had been placed in administrative segregation had been essentially starved to death, describing him as being extremely emaciated. She also indicated having seen inmates at different times lying on the ground in a "pool of blood" after having been beaten up either by prison guards or other inmates, and feeling quite disturbed that these individuals were simply left there.

Dr. Mosley described feeling very helpless as well as isolated during her employment after 4 of her closest psychologist colleagues all left for other employment at around the same time. She also indicated that the experience working at the prison affected her, as she used to enjoy singing both with a choir as well as a band, which she no longer derives pleasure from doing.

With regard to her present living situation, the claimant indicated that she feels very anxious, especially when conflicts arise with her sister, brother-in-law, mother, or daughter, when she is staying at their homes, such as times when she unknowingly ate an item of food in the refrigerator that one of them had wanted for themselves, which they became upset about, or when she has felt she has been in the way in relatively small shared living spaces.

Dr. Mosley indicated that she has several friends in the Bay Area, specifically individuals she has met through her sister as well as through her involvement in the Allen Temple. Although she indicated previously being in touch with a number of classmates from her graduate program, she stated that she does not see them very often after having moved to Susanville, although she did indicate that she probably could reestablish contact.

In terms of present symptoms, she indicated that she continues to experience intrusive thoughts and recollections, occurring on a daily basis, regarding numerous incidents of perceived harassment at the prison. Prior to working there, she thought of herself as warm, energetic, lighthearted, outgoing, and sociable. However, she feels that this experience has changed her forever, as she now describes herself as withdrawn, serious, anxious, and hypervigilant. In addition to ruminating about specific incidents, she also described ruminations about many of the negative things occurring in the world, stating that she no longer feels optimistic.

The claimant also indicated that she experiences intense distress at exposure to stimuli which remind her of anything having to do with correctional officers, including the site of police officers or police cars, which she states sends her into "a panic" as well as makes her feel "frozen." At such times, such as when she is driving and sees a police car, she stated that she begins to have heart palpitations as well as great apprehension that they will stop her and harass her. She also described feeling hypervigilant, stating that when she goes into a grocery store, for example, she will worry that officers she previously worked with may have followed her with intentions to hurt her or harass her.

At this point in the clinical interview it became apparent to this examiner that Dr. Mosley continues to suffer from the same delusions which she experienced previously. In this regard, she indicated her persisting belief that when she resided in Susanville between 2005-2012, "drones" sent by correctional officers shined lights into her bedroom window once a month for the past 5 months that she lived there, lighting up her entire room for 5 minutes. She also indicated her belief that this also occurred on 2 occasions after she had already moved to Union City to live with her sister. Additionally, she indicated that she has seen a man following her in a car in Chicago as well as in Detroit.

She related several other incidents in which someone had spat upon her car windshield, the first such incident occurring in approximately 2005, shortly after she had begun living in Susanville, the second incident occurring a little over a year ago, at a hotel in Alameda. However, she attributed these incidents of spitting on her car to racism rather than specifically to the acts of individuals from her prior place of employment.

Current Symptoms

Dr. Mosley indicated that she continues to suffer from both initial as well as terminal insomnia, although nowhere to the degree of severity she previously reported, indicating being unable to sleep for days at a time when I initially evaluated her. She presently reports that it now takes her approximately 1 hour to fall asleep. She states that she typically wakes up after about 5 hours of sleep, although she is able to return to sleep for another 2-3 hours after being awake for about one hour. Overall, this represents a significant improvement in her sleep pattern. She reports that she takes Trazodone nightly, as well as tryptophan and Valerian root. Additionally, she states that she avoids watching television shows which might be over-stimulating. She indicated that she requires 8 hours of sleep in order to feel rested, which she is receiving.

She continues to report experiencing depressed mood every day, lasting for most or all of the day, although she rarely reports experiencing crying episodes. Additionally, she described experiencing overwhelming fatigue occurring between several times a week and almost every day, lasting most of the day when it does occur. She related this symptom to her sense of grief about the loss of her career, and the quashing of her dream of being able to help the African-American community through her work as a prison psychologist. She also described significantly diminished self-esteem as well as feelings of uselessness.

Dr. Mosley also indicated experiencing continued anxiety almost every day, although more in the form of generalized anxiety than in the form of specific panic attacks. This symptom is often precipitated when there are disagreements between the claimant and either her mother, daughter, or sister and brother-in-law, with whom she has been alternating with regard to her living arrangements. She related that she feels particularly anxious about becoming unwelcome, and being asked to leave, although the types of disagreements she related appear to be relatively minor, such as eating someone else's food in the refrigerator, or not wanting to go to church when her mother advises her to do so.

She continues to report ongoing tension in her neck, back, and shoulders occurring 2-3 times a week, as well as jaw-clenching and teeth-grinding, adding that she has been diagnosed with TMJ. She reports appetite fluctuations as well as undesired weight gain of approximately 37 lbs. over the course of the past year and a quarter (now weighing 200 lbs., compared to her prior weight of 163 lbs.)

The claimant reported continued social withdrawal from friends and activities, as well as diminished enjoyment from previously pleasurable activities, although she indicated that she is beginning to make efforts at social connection once again. She also reported difficulty concentrating as well as remembering things, occurring occasionally. Additionally, she reported feeling irritable and easily frustrated, occurring about twice daily, 3-4 times a week, particularly when around other people, although at the same time she indicates that she feels that this symptom is improving.

Dr. Mosley continued to report experiencing a number of symptoms typically associated with Post Traumatic Stress Disorder, including: intrusive thoughts or recollections of her experiences at the workplace; dread of the thought of returning to the worksite; distress at stimuli reminiscent of traumatic occurrences at work, such as the sight of law enforcement personnel; continued efforts to avoid conversations regarding stressful events at her workplace; feeling detached/ alienated and distant from other people; hypervigilance/feeling unsafe; sense of a foreshortened future (or something dreadful about to happen); and exaggerated startle response (particularly if another individual is moving towards her personal space to quickly).

Although Dr. Mosley previously reported that some of her hair fell out, she presently indicated that her hair has grown back, which she relates to being away from the stress of her workplace. She also reported significantly diminished libido, describing her sex drive as essentially "gone."

As was mentioned above, perhaps most significant is the fact that Dr. Mosley manifests continued evidence of a persistent delusional belief system in which she believes that "drones" were shining lights into her bedroom at night; that correctional officers from the prison where she was employed have been following her, even in locales as far from the worksite as Union City, and even Detroit and Chicago. She also indicated a belief that others were listening to her phone calls.

Current Medications

Dr. Mosley indicated that she presently takes the following medications:

Bupropion (Wellbutrin) 150 mg/day; Trazodone 50 mg/day HS prescribed by Leon Morris, M.D.

Interval Medical History

Dr. Mosley indicated that she broke her ankle approximately 2 months ago, when she slipped on the ice while staying with her mother in Detroit. She was treated by Dr. Daugherty, an orthopedist at Detroit Receiving Hospital. She was prescribed the medication Norco for pain, and her ankle placed in a cast, which has since come off. She did not undergo any surgery related to this injury.

The claimant indicated that she previously suffered from hypertension and was taking the medication Losartan; however, she reports that as of recent blood pressure monitoring, her blood pressure is now within normal limits and she is no longer on this medication. She indicated that she has not been involved in any motor vehicle accidents in the interval since I last evaluated her in December 2013. She denied having any other medical issues or problems.

Interval Mental Health History

Dr. Mosley indicated that she has not received any mental health treatment for any non-industrial injuries since I initially evaluated her in December 2013. She indicated that the only psychological treatment she has had has been from Dr. Dillon, discussed above.

The claimant reported no concurrent psychological or psychiatric treatment on the part of any of her family members. She denied awareness of any members of her family having a drug or alcohol problem or receiving treatment for such conditions.

Interval Occupational History

Dr. Mosley indicated that she has not worked in any capacity since her last day of employment at High Desert State Prison on July 30, 2012. As discussed above, she has officially retired through the CalPERS system.

Interval Legal History

The claimant denied ever having been arrested or incarcerated for any offense in the interval since my initial evaluation of her, or at any time in her life. She denied ever having been sued or of suing another individual or legal entity. She denied being involved in any class action lawsuits, or filing any prior Workers' Compensation claims.

However, she did indicate filing Chapter 7 bankruptcy in December 2014 to eliminate approximately $20,000 in credit card debt which she had run up for living expenses, as well as a $4500 copayment that she had been paying $15 a month on for her airlift from Susanville to Renown Hospital when she had her "seizure"/psychiatric decompensation. She indicated that the bankruptcy liquidated all of these debts. She added that this is the only time in her life that she has never been able to pay her bills, which she found extremely humiliating and upsetting.

Interval Social History

Dr. Mosley indicated that she has not been in any romantic relationships for at least the past 10 years, adding that she feels that she is not "fit" to be involved in any romantic relationship, based on her generalized feeling about men and their attitudes towards women after having worked at High Desert State Prison. She indicated that her last relationship occurred approximately 10 years ago, prior to working at the prison, when she dated a man for about six months. She described this as a casual relationship, more like a friendship than anything else. This relationship ended after she moved to Susanville for her job.

As indicated above, she has been moving around between living with her sister in Union City, her mother in Detroit, and her daughter in Chicago, after giving up her own apartment in Susanville several years ago. Her daughter is 43 years old and works as a pharmacist for the Veterans Administration Hospital in Chicago. She is single and has no children. When she is not staying with her daughter, they speak on the phone every day. Her mother is 88 years old and lives in Detroit. When not living with her, they speak on the telephone once per week. The claimant also indicated that she has another sister living in Detroit who is 67 years old, and although they are on positive terms, she is not as close with that sister. Her other sister, age 62, lives in Union City and is married. The claimant lives with this sister for part of the year.

Personal Habits

Tobacco:	None;
Coffee:	1 cup of coffee/day;
Tea:	1 cup of green tea/every several weeks;
Alcohol:	rarely (2 glasses of wine only on holidays such as Christmas or Thanksgiving);
Drugs:	denied.

Non-Industrial Stressors

The claimant was questioned about the existence of current as well as recent non-industrial stressors, including deaths or serious illnesses of significant family members or friends; legal problems/lawsuits; behavior problems or custody disputes affecting children or grandchildren; conflicts with neighbors; being the victim of a crime, etc.

Dr. Mosley indicated that there have been no recent deaths in the family; no serious illnesses affecting any family or friends; no legal, academic or behavioral problems affecting any of her extended family such as grandchildren, nieces, nephews, cousins, etc. The only stressors that Dr. Mosley indicated was her feeling that her family is beginning to get tired of her illness, which she feels they don't really understand, although they do attempt to be supportive.

Typical Day

Dr. Mosley described a typical day as follows: She usually goes to bed at 9:00 p.m., typically falling asleep by midnight. She usually wakes up at 9:00 a.m. She states that she no longer spends most of her time in bed even during the daytime as he had previously, although she does not usually shower or dress soon after waking up. She spends most of her time indoors at the home of her sister, mother, or daughter. She does household chores such as cleaning the kitchen, taking out the garbage, doing laundry, etc. She spends some time dealing with "legal paperwork" related to her appeal of the denial of her retirement disability claim. She spends some time reading the news on the Internet. She spends some time on the telephone talking to her sister, daughter, or mother. She essentially describes herself as a "hermit."

Mental Status Examination

Dr. Mosley's sensorium or level of consciousness was clear and fully alert. She was able to maintain appropriate eye contact with this examiner, as well as to establish an appropriate level of rapport. There were no signs of evasiveness, and it is believed that she provided honest responses to the questions posed to her throughout the examination.

Dr. Mosley was fully oriented to time, place, person, and the nature and purpose of the evaluation. She once again presented with sad mood as well as relatively flat affect, with the exception of 2 junctures during the evaluation when she became quite tearful: the first of these episodes related to her reflecting on how difficult it has been for her to no longer be able to continue working in her field; the second episode related to her self-assessment that she had not done well enough on one of the psychometric tests measuring visual perception and visual-motor speed and coordination (Trails A & B Test). Her thought processes were logical and coherent throughout most of the evaluation, with the exception of continued indications of a circumscribed delusional system. At times her thought processes were tangential and circumstantial, although not to the severe extent they were on initial evaluation on December 13, 2013. Thought content consisted of references to frustration with the disrupting effects on her life of her premature retirement, as well as grief over the loss of her career and her loss of sense

of purpose. She denied any suicidal or homicidal ideation, either in the form of passive fantasies or ideas involving specific plans, methodology or intention.

Her continued delusions consisted of her belief that she has been followed by correctional officers and/or law enforcement officers in the Bay Area, where she now resides, as well as during periods of months during which she has been living with her mother in Detroit as well as her daughter in Chicago. She also exhibited delusional thought, reflected in her continued belief that officers of High Desert State Prison had been spying on her with the use of drones, which would "shine lights into her window, lighting up her room for 5 minutes" before leaving, this occurring once every month over the course of the last 5 months that she lived in Susanville and worked at the prison in the Spring and Summer of 2012, as well as several times later, after she had moved in with her sister in Union City in September 2012. Additionally, this delusional system is present in her persistent belief that she has been followed by officers from the prison not only in Union City but in locales as far away as Detroit and Chicago, where she has been staying with her mother and daughter, respectively. Although aware of undergoing a psychological decompensation which makes her at high risk of relapse if she were to return to working in her prior position at HDSP, her insight into her having experienced delusional thought processes remains limited.

Her intellectual capacity is estimated once again as falling within the average range or above. Her fund of general information was intact, reflected in her ability to once again provide the names of 4 recent U.S. presidents, offering the names of Presidents John Kennedy, Richard Nixon, Clinton, and Obama.

Her concentration, as measured by Serial 7 Subtraction, was unimpaired, reflected in her ability to successfully perform 14 operations of subtraction with no errors, although she did so in a relatively slow and belabored manner. This represents a slight improvement in functioning, compared to her prior performance on December 13, 2013, on which she made 2 errors, reflecting mild impairment at that time.

Her performance on Digit Recall, a task of attention, concentration, and immediate auditory memory fell within 1 standard deviation of the Mean, with a combined score of 14 (Digits Forward, 8; Digits Backwards, 6), reflecting unimpaired performance, representing a slight improvement over her prior score of 12 (also within 1 standard deviation of the Mean, although at the lowest level within this range).

Her short-term memory was unimpaired, as reflected in delayed Object Recall, on which she was able to successfully recall the names of all of 3 common objects following a 10-minute delay without any prompting (a slight improvement from her previously being able to recall 2 objects without prompting, although requiring prompting in order to name a 3rd object, i.e., being told that it was a coin).

Her ability to engage in abstract thinking was somewhat limited, reflected in her ability to fully provide an interpretation of only 1 of 3 common proverbs. Her social judgment was well-

conceived and socially appropriate under some circumstances, impulsive and not fully-considered under others. When asked what she would do it she found an envelope on the street that was stamped, sealed and addressed, she indicated that she would mail it, a socially appropriate response . When asked what she would do if she were the first person in a movie theatre to notice smoke and fire, she indicated that she would run out and yell: "Fire!"—an impulsive response which does not take into account the likelihood of potentially creating mass panic which could endanger the lives of the theatre patrons (and interestingly, her present judgment, at least reflected in this response, appears to be more impulsive than her response on initial evaluation, in which she indicated that she would inform the manager rather than yell: "Fire!")

Results of Psychological Testing

Dr. Mosley was administered the following Psychodiagnostic Tests:

Rey Fifteen Item Test;
Trails A & B;
Epworth Sleepiness Scale;
Beck Depression Inventory-2;
Beck Anxiety Inventory;
Minnesota Multiphasic Personality Inventory-II (MMPI-2);
Trauma Symptom Inventory-2 (TSI-2);

Rey Fifteen Item Test (RFIT)

The Rey Fifteen Item Test (RFIT) consists of 15 items (comprised of the letters a, b, and c, in one row as small letters, in a 2nd row as capital letters; the numbers 1, 2, and 3 in Arabic numerals in one row, in Roman numerals in another row; and 3 geometrical shapes, including a circle, a square, and a triangle, in another row). These figures are presented on an 8 ½ by 11 inch sheet of paper, which the examinee is permitted to look at for 10 seconds; the examinee is then asked to reproduce as many of the figures as they are able to remember. The test is a brief screening found to be helpful in identifying individuals who may be malingering visual memory deficits or attempting to present themselves with greater disability than may be the case, as well as in identifying individuals who have extremely severe visual memory deficits (with consistent clinical history of significant head injury).

A cutoff score of 9 is used, with individuals scoring less than 9 indicating the possibility of malingering of memory deficits (or exhibiting legitimate extremely low scores associated with a clinical history of severe head injury). The rationale behind the test is that the stimulus items are of such simplicity (especially as the same letters and numerals are repeated in slightly varied formats, i.e., a, b, c and A, B, C; 1, 2, 3 and I, II, III) that at least 9 of them should be easily recalled—even by individuals with legitimate cognitive memory deficits including all but the most severe head injuries.

Dr. Mosley was able to correctly recall and reproduce all of the 15 items, showing no signs of having severe visual memory deficits, nor of malingering. This score is almost identical to her previous score, in which she was able to recall 14 of the 15 items.

Trails A and B

The Trail Making Test (alternately referred to as Trails A & B) has been widely used as a measure of a number of psychological functions, including visual-conceptual ability and visual motor tracking skills. It also measures: the ability to alternate mental sets and sustain attention and concentration on 2 sets of alternating sequential stimuli (cognitive flexibility, the ability to "multi-task"); visual scanning ability; visual motor coordination; and motor speed. It is a timed test requiring the examinee to sequentially locate and connect numbers of increasing value which are organized in an apparently random manner on Trails A; on Trails B the test is more complex in that it requires the examinee to alternate between numbers and letters, i.e., connecting the number 1 to A, A to 2, 2 to B, B to 3, and so on. Thus, the examinee is required to alternate 2 sets of mental operations. Utilizing the Halstead-Reitan norms, impairment is rated as either mild (Trails A: 40-51"; Trails B: 73-105") or severe (Trails A: >52"; Trails B: >106").

Dr. Mosley completed Trails A in 44 seconds with no errors, placing her at approximately the 57th % ile, reflecting mildly impaired performance, very similar to her prior score of 43 seconds with no errors, also reflecting mildly impaired performance in visual scanning/visual motor coordination/motor speed.

She completed Trails B in 69 seconds with no errors, at approximately the 87th % ile, reflecting unimpaired performance. This score represents a significant improvement from her prior score of 105 second with no errors, at approximately the 63rd % ile, reflecting mildly impaired ability to perform several alternating visual tasks (ability to alternate between 2 different "mental sets", i.e., ability to "multitask).

These findings suggest that Dr. Mosley remains mildly impaired in her ability to perform tasks requiring visual scanning, visual motor coordination, fine motor speed, and undertaking a task of new learning; however, her performance improved significantly once she acclimated to the nature of the task, with her ability to "multitask" falling in the unimpaired range.

Epworth Sleepiness Scale

The claimant was asked to rate (from no chance to a high chance, rated as 0, 1, 2, or 3) the likelihood of her experiencing daytime dozing in 8 situations. She rated all items as 0, indicating that she would not experience daytime dozing in any of the following circumstances:

Her total score of 0 falls within the average range, and does not suggest an excessive amount of daytime sleepiness. *However, it should be noted that this instrument only measures daytime sleepiness; an individual may experience significant nighttime insomnia, yet score low on this instrument, as is the case as reflected in the examinee's continuing nocturnal insomnia.*

Beck Depression Inventory-2

The Beck Depression Inventory-2 is one of the most widely used screening tests for depression. It consists of 21 statements concerning various aspects of life functioning that could be adversely affected by depression. The items are rated on a scale of 0-3 in terms of both presence as well as degree or intensity of depressive symptoms experienced by the examinee. Depressive symptoms assessed include mood, appetite and sleep patterns, sexual interest, self-esteem, guilt, ability to derive pleasure from activities, etc., and are consistent with DSM-IV-TR criteria for clinical diagnoses related to depression.

Dr. Mosley received a score of 32, placing her within the severe range of depression (0-13 = minimal; 14-19 = mild; 20-28 = moderate; 29-63 = severe). This score is quite similar to her previous score of 29, also in the severe range.

To a severe degree (rated as 3) she reported: inability to derive pleasure from things she used to enjoy; feeling that she is being punished; and complete loss of interest in sex.

To a moderate degree (rated as 2) she indicated: feeling sad all of the time; loss of most of her interest in people and things; feelings of worthlessness compared to others; lacking enough energy to do very much; irritability; increased appetite; difficulty concentrating; and feeling too tired to do many of the things she used to.

To a mild extent (rated as 1) she reported: pessimistic outlook/discouragement about her future; feeling that she has failed more than she should have; loss of self-confidence; feeling more self-critical; crying more than she used to; indecisiveness; and sleeping somewhat less than usual.

Overall, the claimant's symptoms were almost evenly distributed between the categories of mild (7 items) and moderate (8 items), with 3 items rated as severe and 3 items not at all endorsed (rated as 0), her overall distribution of varied responses suggesting that the claimant responded honestly without distortion or exaggeration.

Beck Anxiety Inventory

The Beck Anxiety Inventory is a widely used screening instrument to detect the presence and severity of anxiety symptoms. It is comprised of 21 symptoms frequently associated with anxiety. The items are rated on a scale of 0-3 in terms of presence, as well as degree or intensity of anxiety symptoms experienced by the respondent. Symptoms assessed include heart palpitations, difficulty breathing, dizziness/lightheadedness, trembling/shaking, specific fears, etc., which are correlated with DSM anxiety disorder diagnoses.

Dr. Mosley received a score of 10, placing her within the mild range of anxiety (0-7 = minimal; 8-15 = mild; 16-25 = moderate; 26-63 = severe). This score is significantly lower than her previous score of 25 in initial evaluation, at that time placing her at the upper end of the moderate range, approaching the severe range.

No items were indicated as occurring to a severe degree (rated as 3, she could barely stand it).

To a moderate extent (rated as 2, it was very unpleasant, but she could stand it) she indicated: inability to relax; catastrophic fear; and feeling scared.

To a mild degree (rated as 1, it did not bother her much) she indicated: feeling terrified; feeling nervous; dizziness/lightheadedness; and fear of losing control.

She indicated that 14 of the 21 items (comprising ⅔rds of the items) did not at all apply to her (rated as 0). Overall, there appears to be a significant diminution of symptoms of anxiety as sampled by this instrument.

Minnesota Multiphasic Personality Inventory-II (MMPI-2)

This is the current revision of the most widely used personality inventory (MMPI); it consists of 567 items to which the examinee is asked to respond with either agreement or disagreement regarding a variety of psychological symptoms, perceptions, and personal preferences. Her profile was scored and interpreted utilizing Pearson/PsychCorp's Minnesota Report for Forensic Settings, James N. Butcher, Ph.D., which is based upon The MMPI-2: Minnesota Multiphasic Personality Inventory-2: Manual for Administration, Scoring and Interpretation-Revised Edition, (Butcher, Graham, Ben-Porath, Tellegen, and Dahlstrom), University of Minnesota Press/ Pearson, 2001. The undersigned also utilized The MMPI-2/MMPI-2-RF: An Interpretive Manual, (Roger L. Greene), Allyn & Bacon/ Pearson, 2011 to provide additional interpretation.

Dr. Mosley produced an MMPI-2 profile in which her Validity Scale scores were as follows: Cannot Say (items omitted) = 0; VRIN: T = 66; TRIN: T = 50; F: T = 79; FB: T = 85; Fp: T = 49; L:T = 47; K:T = 65; S:T = 53.

It is noted that her score on Validity Scale VRIN of T = 66 suggests that her profile is valid according to the Manual, although characterized by some inconsistent responding. According to Greene, this score falls within the Moderate range, but not in a range suggesting invalidity. Her score of T = 50 on the TRIN Scale fell within a range indicating that her profile is valid according to the Manual (T = 50-64).

According to the Manual, her score of T = 79 on Scale F (Infrequency) is likely valid, although it may reflect exaggeration of symptoms, possibly as a "cry for help." However, according to Greene, this score falls in the Moderate range, reflecting acknowledgment of significant psychological distress. According to the Manual, her score of T = 85 on Scale FB (Infrequency-Back) is valid, as it falls below T ≥ 90. According to Greene, this score falls within the Markedly elevated range. The Manual notes that T scores on FB should be used to determine whether substantial changes occurred in the individual's approach to the MMPI-2 (reflected in a different response set on the latter items of this test), which would be reflected in a difference of at least 30 T-points. However, the difference between her score of T = 85 on FB and her score of T = 79 on F is only a 6-point difference; therefore, there does not appear to be a significant change in

the examinee's response-set to the letter items of this inventory. Additionally noted is her score of T = 65 on Scale K, although not considered invalid, but noted by both the Manual as well as by Greene as reflecting a moderate degree of defensiveness.

Dr. Mosley once again received scores on 7 of the 10 Basic Clinical Scales which fell in either the High or Very High/Markedly elevated ranges, with her most prominent scale elevations once again being observed on Scales 2 (D) and 3 (Hy). Her scores on the 10 Clinical Scales are as follows:

Scale 1 (Hs): T = 82 (prior score: T = 84);
Scale 2 (D): T = 103 (prior score: T = 101);
Scale 3 (Hy): T = 94 (prior score: T = 96);
Scale 4 (Pd): T = 92 (prior score: T = 76);
Scale 5 (Mf): T = 52 (prior score: T = 43);
Scale 6 (Pa): T = 89 (prior score: T = 70);
Scale 7 (Pt): T = 86 (prior score: T = 83);
Scale 8 (Sc): T = 84 (prior score: T = 73);
Scale 9 (Ma): T = 49 (prior score: T = 53);
Scale 0 (Si): T = 56 (prior score: T = 47).

As can be seen clearly above, Dr. Mosley's scores on her 2 most prominently elevated scales (Scale 2: D; Scale 3: Hy) are almost identical to the scores she previously obtained when this instrument was administered to her on initial evaluation in December 2013, with a difference of only 2 T-scores on each of these scales (current score on D is 2 T-scores higher, while current score on Hy is 2 T-scores lower). Once again, it can be stated with confidence that the examinee's profile closely matches the prototype pattern in research literature descriptive of this high-point code type pair (2-3).

According to this code type, the examinee continues to express significant depressed mood, nervousness, tension, unhappiness, and worry. She continues to experience difficulty functioning well in life, deriving very little enjoyment from interest in activities which were previously sustaining, and struggling to believe that life is worthwhile. She continues to be over-sensitive to criticism, with significant self-blame as well as feeling that she has been ill-treated. Depressed mood is accompanied by physical complaints and extreme fatigue. She finds it difficult to manage routine affairs, and reports difficulties with concentration, memory, and decision-making. She feels fatigued, with little motivation. She expresses a number of somatic concerns. She may feel somewhat estranged and alienated from people. She tends to view herself as being overwhelmed with problems to the point that functioning on a daily basis is quite difficult for her. She remains quite suspicious of the actions of others. She is passive-dependent in relationships and is easily hurt by others. She is unassertive and keeps anger bottled up, avoiding confrontation for fear of being rejected or hurt. She continues to view the world as a threatening place. She expresses a very high level of anxiety.

Her most highly elevated score of T = 103 on Scale 2 (Depression) shows her to be experiencing significant clinical depression. Examination of the Harris-Lingoes Subscales for Scale 2 reveals markedly elevated scores on 4 of these subscales. Her significantly elevated score of T = 94 (prior score: T = 82) on Subjective Depression (D_1) reflects a further intensification of her dysphoric mood, insomnia, pessimistic outlook, low self-esteem, lack of energy for coping with problems, and difficulty with attention and concentration. Her significantly elevated score of T = 90 (prior score: T = 84) on Psychomotor Retardation (D_2) also reflects further intensification of her difficulty in starting things, as well as her tendency to avoid or withdraw from social relationships. Her significantly elevated score of T = 97 (prior score: T = 84) on Mental Dullness (D_4) suggests that she is presently having greater difficulty with attention, concentration and memory, as well as motivation in beginning projects, than she did on initial examination. Her significantly elevated score of T = 78 (prior score: T = 63) on Brooding (D_5) reflects a further intensification of her ruminations regarding her sense of diminished self-esteem, feelings of uselessness, and her tendency to be easily upset by others.

Her 2nd most significantly elevated score on Scale 3 (Hy) of T = 94 reflects her tendency to develop physical symptoms in response to stress. On the Harris-Lingoes Subscales, she once again received markedly elevated scores on Lassitude-Malaise (Hy_3: T = 83; prior score: T = 87), suggesting that she continues to be tired as well as to experience sleep difficulties; and Somatic Complaints (Hy_4: T = 69; prior score: T = 73), reflecting continued somatic complaints. Her excessive concern regarding somatic complaints is also reflected in her markedly elevated score of T = 82 on Scale 1 (Hs). In the current test administration, she also received a significantly elevated score on another of the Harris-Lingoes subscales, Inhibition of Aggression (Hy_5: T = 77), suggesting that the examinee very seldom reveals anger, and is aversive to aggression and violence.

Her high level of elevation on Scale 4 (Pd: T = 92; prior score: T = 76) may result from a sense of social alienation; her response content does not reflect antisocial behavior or practices. Examination of the Harris-Lingoes Subscales shows her to continue to receive a markedly elevated score on Social Alienation (Pd_4: T = 65; prior score: T = 70), reflecting her feeling that no one understands her, as well as on Self-Alienation (Pd_5: T = 68, identical to her prior score), reflecting continued depression as well as regret about things she may have done in the past. Her score on Family Discord (Pd_1: T = 56: prior score: T = 38) reflects a moderate degree of tension with family members (*and from the clinical history, most likely is due to the claimant having to share living spaces with her mother, daughter, and sister on an alternating basis*). Her score on Authority Problems (Pd_2: T = 61; prior score: T = 46) is somewhat higher than her score previously obtained on this scale (*and which most likely reflects the claimant's anger towards individuals in positions of authority at her place of employment*) although there are no indications of behavioral acting out on the part of the examinee.

Her markedly elevated score of T = 89 (prior score: T = 70) on Scale 6 (Pa) suggests an increase in symptoms of suspiciousness, mistrust of others, being overly sensitive, guarded, with continued signs of her delusional disorder. Once again analysis of the Harris-Lingoes Subscales for Scale 6 reveals a markedly elevated score of T = 87 on Pa_1, Persecutory Ideas, reflecting the

examinee's ideas of external influence and a feeling of being persecuted by others, rather than contribution from either of the other 2 Subscales, Poignancy (Pa 2) (cherishing sensitive feelings) or Naïveté (Pa_3) (being excessively generous regarding the motives of others).

Her score of T = 86 on Scale 7 (Pt) (almost identical to her prior score of T = 83) continues to fall in the Very High/markedly elevated range, reflecting the continued presence of severe anxiety, tension, agitation, indecisiveness, difficulty concentrating, difficulty relaxing or enjoying any aspects of life, and obsessive ruminative thinking.

Her score of T = 84 (somewhat higher than her prior score of T = 73) on Scale 8 (Sc) indicates that the respondent continues to feel detached, remote, and alienated from her social environment, experiencing difficulties in both logical thinking as well as concentration. Examination of the Harris-Lingoes Subscales reveals markedly elevated scores on 3 of the 6 subscales of Scale 8. Her score of T = 67 on Sc_2 (Emotional Alienation) (reflecting a slight decline from her prior score of T = 76) suggests that she continues to feel a lack of rapport with herself, experiencing the self as alien, and experiencing flattened affect (*which was observed by this examiner during the course of the current evaluation*). However, the fact that this score has decreased by 9 T-points suggest that the examinee may be experiencing a slight increase in self-rapport, especially as time away from her stressful work environment increases.

Her score of T = 86 on Sc_3 (Lack of Ego Mastery, Cognitive) (prior score: T = 80) reflects the examinee's ongoing and perhaps worsening problems with attention, memory, concentration, autonomous thought processes and unusual thought content. Her score of T = 75 on Sc_4 (Lack of Ego Mastery, Conative) (prior score: T = 80) suggests that the claimant continues to experience inertia, massive inhibition, and regression, continuing to see herself as overwhelmed and unable to get moving, no matter how hard she tries, although the slight decrease in her score suggests that she may possibly be experiencing slight improvement in this area. Her score of T = 65 on Sc_1 (Social Alienation) suggest that she tends to withdraw from meaningful relationships with others. Her score of T = 63, in the moderate range on Sc_6 (Bizarre Sensory Experiences) suggests that, to a moderate degree, she experiences thoughts of depersonalization and estrangement from others.

Her score of T = 49 on Scale 9 (Ma) (prior score: T = 53) continues to reflect a normal level of energy (i.e. the absence of manic or hyperactive levels of energy). Her score of T = 56 on Scale 0 (Si) (prior score: T = 47) continues to fall within the normal range, reflecting an appropriate balance between social introversion and extroversion.

Also noted is the fact that the claimant once again received scores in the low range on a number of the Supplementary Scales which assess alcohol and drug abuse, including the MacAndrew Alcoholism Scale-Revised (MAC-R: T = 34; prior score: T = 37); Addiction Potential Scale (APS: T = 47; prior score: T = 44) and the Addiction Admission Scale (AAS: T = 48; prior score: T = 44), suggesting that the claimant continues not to manifest significant problems in this area.

Her scores on 2 Supplementary Scales assessing Posttraumatic Stress Disorder were also scored. Her score on Scale PK (Posttraumatic Stress-Keane: T = 69) presently fell within the markedly elevated range, reflecting significant residual symptoms of PTSD. It is noted that this score is modestly higher than her prior moderate score of T = 61. Her current score of T = 73 on Scale PS (Posttraumatic Stress-Schlenger) once again fell within the markedly elevated range, modestly higher than her prior score of T = 68, indicating the continued presence of symptoms of posttraumatic stress, possible to a slightly greater extent than previously observed.

It was further noted that Dr. Mosley endorsed 15 of the Koss-Butcher Depressed Suicidal Ideation Critical Items, and 11 of the Koss-Butcher Acute Anxiety State Critical Items, with the following items of significant clinical concern, reflecting significant symptoms of depression and anxiety:

"Most of the time I feel blue" (True); "Life is a strain for me much of the time (True); "I usually feel that life is worthwhile" (False); "These days I find it hard not to give up hope of amounting to something" (True); "I am happy most of the time" (False); "I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't get going" (True); "I have difficulty in starting to do things" (True); "Most nights I go to sleep without thoughts or ideas bothering me" (False); "Several times a week I feel as if something dreadful is about to happen" (True); "I sometimes feel that I'm about to go to pieces" (True); "I feel anxiety about something or someone almost all of the time" (True); "I certainly feel useless at times" (True); "The future seems hopeless to me" (True); "At times I think I am no good at all" (True).

It is further noted that the examinee endorsed 14 of the Lachar-Wrobel Depression and Worry Critical Items, as well as 5 of the Lachar-Wrobel Anxiety and Tension Critical Items, which reflect similar item content (and which have some degree of overlap with the Koss-Butcher Critical Items).

Finally, it is noted that the examinee endorsed 8 of the Koss-Butcher Persecutory Ideas Critical Items, with the following items of significant clinical concern:

"I believe I am being plotted against" (True); "I believe I am being followed" (True); "Someone has it in for me" (True); "I have no enemies who really wish to harm me" (False); and "People say insulting and vulgar things about me" (True).

Trauma Symptom Inventory-2 (TSI-2)

The Trauma Symptom Inventory-2 (TSI-2) is a widely used instrument developed to measure trauma-related symptoms and behaviors including but not limited to the effects of sexual and physical assaults, intimate partner violence, combat, torture, motor vehicle accidents, mass casualty events, medical trauma, witnessing violence or other trauma, traumatic losses, and early experiences of child abuse or neglect. It consists of 136 items and assesses a wide range of potentially complex symptomatology, ranging from posttraumatic stress, dissociation, and somatization to insecure attachment styles, impaired self-capacities, and dysfunctional behaviors.

Normed and standardized on a representative sample of the United States general population, it consists of 2 validity scales, 12 clinical scales, 12 subscales, and 4 factors. The TSI-2 (Briere, 2011) is a revised version of the Trauma Symptom Inventory developed by John Briere, Ph.D. (1995), and is appropriate for usage in adult men and women age 18 or over. T-scores (linear transformations of raw scale scores) are used in interpreting results of this psychometric instrument, with a Mean of 50 and a standard deviation of 10. T-scores falling within the range from 60-64 are considered problematic, reflecting above-average symptom endorsement likely to have clinical implications; scores of T = 65 or greater are considered clinically elevated, reflecting symptom endorsement of sufficient extremity representing significant clinical concern.

As noted above, there are 2 Validity Scales. The Response Level (RL) Scale assesses the extent to which an individual denies behaviors, thoughts, or feelings that most other respondents would report. Individuals scoring very high on the RL Scale are likely to be especially defensive or avoidant, oppositional regarding test-taking, or otherwise unwilling to endorse commonly-endorsed items. The Manual recommends that profiles with T scores of 75 or more on the RL Scale be considered invalid. The other Validity Scale, the Atypical Response (ATR) Scale evaluates the tendency of the respondent to over-endorse trauma-related symptoms. A very high score on this scale may reflect either: generalized over-endorsement of all items; specific over-endorsement of PTSD items; random responding that includes endorsement of rarely endorsed items; or very high levels of distress. In clinical contexts, over-endorsement may stem from a variety of factors, including: a "cry for help", i.e. an attempt to present oneself as needing clinical assistance by reporting symptoms as being more intense; malingering; factitious disorder; or a typical and/or extensive symptomatology sometimes associated with posttraumatic disturbance. The Manual considers profiles with a raw score of 15 as invalid for clinical or forensic contexts due to excessive symptom endorsement.

On the Validity Scales, Dr. Mosley received a score of T = 54 on Scale RL (Response Level), which fell within a valid level, suggesting that the examinee was not defensive, avoidant, or oppositional in her test-taking attitude. On the other Validity Scale (ATR-Atypical Response), she received a raw score of 0 (T = 45), also falling within a valid range, with no indication of over-endorsement of trauma related symptoms.

As noted above, T-scores falling within the range of 60-64 are considered problematic, reflecting symptom endorsement with clinical implications, while scores of T = 65 or greater are considered clinically elevated, reflecting symptom endorsement of significant clinical concern. Dr. Mosley received 4 scores falling in the range of T = 65 or greater, considered clinically elevated, and 3 scores in the range between T = 60-64, considered problematic, in the current administration of this instrument.

She received a score of T = 79 on Scale D (Depression), almost identical to her previous score of T = 78) reflecting continued feelings of sadness, feelings of worthlessness and inadequacy, hopelessness/pessimistic view of the future, and social isolation. [*Once again, this score is quite consistent with her markedly elevated score on the MMPI-2 on Scale 2, as well as her score in the severe range on the Beck Depression Inventory.*]

Dr. Mosley once again received scores of significant clinical concern on both Scale IE (Intrusive Experiences) as well as Scale DA (Defensive Avoidance), although her present scores were significantly lower than those obtained during the course of her initial QME evaluation approximately 1¼th years ago. Whereas she previously obtained a score of T = 89 on Scale IE (Intrusive Experiences), reflecting a clinically very high level of symptoms such as flashbacks, upsetting memories that are easily triggered by current events, and repetitive thoughts of an unpleasant previous experience intruding into awareness, she now received a score of T = 65. Whereas she previously obtained a score of T = 75 on Scale DA (Defensive Avoidance), also in the clinically significant range, reflecting her attempts to suppress or eliminate painful thoughts the memories from awareness, as well as attempts to avoid events or stimuli in the environment that might be stimulate such thoughts or memories, she now also received a score of T = 65. It thus appears that the examinee has experienced some lessening of these symptoms over the course of the past year and a quarter, although they still remain of significant clinical concern.

Whereas she previously received a score of T = 68 on Scale IA-AR (Insecure Attachment-Relational Avoidance), in the clinically elevated range, reflecting her tendency to keep people at a distance, avoiding close relationships, and being uncomfortable with intimacy, her present score of T = 74 indicates an increase and intensification of such symptoms.

She received a score of T = 61 on the Anxious Arousal (AA) Clinical Scale, reflecting symptoms which are considered problematic. It is noted that this score is substantially lower than her prior score of T = 78, which was considered clinically elevated/of clinical concern. This scale is comprised of 2 subscales. Whereas Dr. Mosley previously received scores of T = 76 on both Subscale AA-A (Anxious Arousal-Anxiety) as well as on Subscale AA-H (Anxious Arousal-Hyperarousal), she presently received a score of T = 57 on Subscale AA-A (Anxious Arousal-Anxiety), within the normal range, and a score of T = 63 on Subscale AA-H (Anxious Arousal-Hyperarousal), in the range of symptoms that are problematic, although not to the degree of being of clinical concern. Her score on Anxious Arousal-Hyperarousal reflects continued problems with her level of autonomic hyperactivity/over activation of the sympathetic nervous system, as in the "flight or fight" response, characterized by nervousness, jumpiness, hypervigilance, irritability, and sleep disturbance—although not to the point of being of clinical concern as these symptoms had been previously, according to her score on this instrument.

It is also noted that whereas she previously received a score of T = 71 on Scale DIS (Dissociation), including cognitive disengagement, feelings of depersonalization and derealization, such as "spacing out" and feeling out of touch with her emotions and/or sense of self, her present score of T = 58 on this scale fell below the problematic range, suggesting a significant lessening of such symptoms.

Similarly, whereas she previously received a score of T = 67 on Scale SOM-G (Somatic Preoccupations-General), in the clinically elevated range, her present score of T = 39 suggests a significant lessening of such symptoms regarding general somatic preoccupations.

Her score of T = 60 is almost identical to her prior score of T = 62 on Scale IA (the parent scale within which the above-discussed Scale IA-AR is a component), reflecting the claimant's general tendency, believed to be more of a stable personality trait than a present psychological state, to maintain emotional distance from others and/or avoid close relationships, possibly arising from early relational losses and/or maltreatment/neglect. This score falls within the range considered problematic, but not of significant severity to be considered in the clinically significant range.

All of her remaining scores fell within a sub-clinical range that did not reflect either problematic levels or symptoms arising to the level of significant clinical concerns.

Overall, Dr. Mosley appears to continue to be suffering from symptoms of posttraumatic stress characterized by: continued flashbacks/intrusive thoughts, as well as attempts to avoid thinking about traumatic stimuli; hyperarousal; depression; somatic preoccupations; and caution as well as distance in interpersonal relationships with others.

Consistency of Psychometric Testing Findings

The Validity Scales on the MMPI-2 and Trauma Symptom Inventory-2 revealed that the claimant once again provided accurate and consistent responses, producing valid profiles on both of these psychometric instruments. Her score on the Rey 15 Item Test showed no signs of malingering memory deficits. Her performance in reciting digit combinations of increasing complexity varied in direct proportion to the increasing difficulty of the task, in contrast to performances by examinees in which they miss easier items but succeed on more difficult items, a pattern often associated with malingering or symptom exaggeration. Although neither the Beck Depression Inventory-2 nor the Beck Anxiety Inventory contain validity scales, Dr. Mosley's responses were not overly skewed (i.e., such as responding to all or most items as severe, which might be the case if an individual were engaging in symptom magnification or malingering). She once again appeared to put forth her best effort in taking the examination, and there were no indications of evasiveness or dissimulation.

SUMMARY

Dr. Mosley once again presented with said mood as well as relatively flat affect with the exception of 2 points during the examination when she became quite tearful. Her thought processes were logical and coherent throughout most of the evaluation, with the exception of continued indications of a circumscribed delusional system. Although her thought processes were tangential and circumstantial at times, this was not observed to the severe extent which was apparent in my initial evaluation in December 2013.

Dr. Mosley continues to manifest a very circumscribed delusional system existing side-by-side with a relatively intact personality structure. Once again, although she was able to be quite

coherent in recounting an updated history of the industrial injury and its treatment, as well as interval occupational, medical, psychological, and social history, at the same time there were continued indications of decompensation , reflected in her continued belief that correctional officers working at High Desert State Prison had been spying on her, using drones that would "shine lights into her window, lighting up her bedroom for 5 minutes" before flying off, this occurring monthly over the course of the last five months during which she worked at the prison in 2012, as well as her present delusional belief that she has been followed by the same individuals to locales as far away as Detroit and Chicago where she has been staying with her mother and daughter, respectively. Her delusional system is also apparent in a number of Critical Items on the MMPI-2, which were indicated above. In this regard, she endorsed 8 of the Koss-Butcher Persecutory Ideas Critical Items, with the following items of significant clinical concern:

"I believe I am being plotted against" (True); "I believe I am being followed" (True); "Someone has it in for me" (True); "I have no enemies who really wish to harm me" (False); and "People say insulting and vulgar things about me" (True).

Once again, there were no indications of the claimant malingering or fabricating cognitive impairments. Despite her indication of having difficulty concentrating, in fact, her concentration as measured showed no signs of impairment, reflected in her ability to successfully perform 14 operations of serial 7 subtraction with no errors. Her immediate auditory memory, reflected in her score of 12 on Digit Recall fell within the normal range. Her short-term memory showed no signs of impairment, reflected in her ability to recall the names of all of 3 objects on delayed Object Recall. Her social judgment was appropriate and well thought-out under some circumstances, impulsive and not fully-considered under others. Her abstract thinking was somewhat limited, reflected in her ability to provide a clear explanation of only 1 of 3 common proverbs.

There were no signs of severe visual memory deficits, nor of malingering as seen in her ability to recall all of the 15 items on the Rey Fifteen Item Test. Her scores on Trails A reflected mildly impaired performance in her ability to perform tasks requiring visual scanning, visual motor coordination, fine motor speed, and undertaking a task of new learning. However, once she became acclimated to the task, her ability to negotiate the performance of several such visual tasks simultaneously (i.e., the ability to "multitask), she performed this task with no indications of impairment.

Dr. Mosley received a score of 32 (quite similar to her previous score of 29) on the Beck Depression Inventory-2, both scores placing her within the severe range of depression, and with an almost even distribution of responses between the categories of mild and moderate—suggesting that the claimant responded honestly without distortion or exaggeration.

She received a score of 10 on the Beck Anxiety Inventory, in the mild range of anxiety (significantly lower than her previous score of 25 in initial evaluation, which at that time placed her at the upper limit of the moderate range, approaching the severe range of anxiety). Based on her score on this instrument, there appears to be a significant diminution of reported anxiety.

Although she once again received a score of 0 on the Epworth Sleepiness Scale, reflecting no likelihood of daytime dozing, as noted above, this instrument does not measure nocturnal insomnia, and clinically, the claimant reports both initial insomnia as well as early-morning awakening, although she is not reporting sleep deprivation (i.e., obtaining significantly less sleep than is required in order to feel rested).

Dr. Mosley produced a valid MMPI-2 profile. Dr. Mosley's scores on her 2 most prominently elevated scales (Scale 2: D; Scale 3: Hy) are almost identical to the scores she previously obtained when this instrument was administered to her on initial evaluation in December 2013, with a difference of only 2 T-scores on each of these scales (current score on D is 2 T-scores higher, while current score on Hy is 2 T-scores lower). The examinee's profile once again closely matches the prototype pattern in research literature descriptive of this high-point code type pair (2-3), reflecting the following attributes:

She continues to express significant depressed mood, nervousness, tension, unhappiness, and worry. She continues to experience difficulty functioning in life, deriving very little enjoyment from interest in activities which were previously sustaining, and struggling to believe that life is worthwhile. She continues to be over-sensitive to criticism, with significant self-blame as well as feeling that she has been ill-treated. Depressed mood is accompanied by physical complaints and extreme fatigue. She finds it difficult to manage routine affairs, and reports difficulties with concentration, memory, and decision-making. She feels fatigued, with little motivation. She expresses a number of somatic concerns. She may feel somewhat estranged and alienated from people. She tends to view herself as being overwhelmed with problems to the point that functioning on a daily basis is quite difficult for her. She remains quite suspicious of the actions of others. She is passive-dependent in relationships and is easily hurt by others. She is unassertive and keeps anger bottled up, avoiding confrontation for fear of being rejected or hurt. She continues to view the world as a threatening place. She expresses a very high level of anxiety. Her scores on the Harris-Lingoes Subscales reflect a further intensification of her dysphoric mood, insomnia, pessimistic outlook, low self-esteem, lack of energy for coping with problems, and difficulty with attention and concentration; Her scores on these subscalse also reflect intensification of her difficulty in starting things, and tendency to avoid or withdraw from social relationships. She is presently reporting greater difficulty with attention, concentration and memory as well as motivation in beginning projects, than she did on initial examination. There also appears to be an intensification of her ruminations regarding her sense of diminished self-esteem, feelings of uselessness, and her tendency to be easily upset by others.

Her high level of elevation on Scale 4 (Pd: T = 92; prior score: T = 76) may result from a sense of social alienation; her response content does not reflect antisocial behavior or practices. Examination of the Harris-Lingoes Subscales shows her to continue to receive a markedly elevated score on Social Alienation (Pd_4: T = 65), reflecting her feeling that no one understands her, as well as on Self-Alienation (Pd_5: T = 68) reflecting continued depression as well as regret about things she may have done in the past. Her score on Family Discord (Pd_1: T = 56) reflects a moderate degree of tension with family members (*and from the clinical history, most likely is due to the claimant having to share living spaces with her mother, daughter, and sister on an*

alternating basis). Her score on Authority Problems (Pd_2: T = 61) is somewhat higher than her score previously obtained on this scale (*and which most likely reflects the claimant's anger towards individuals in positions of authority at her place of employment*) although there are no indications of behavioral acting out on the part of the examinee.

Her markedly elevated score of T = 89 (prior score: T = 70) on Scale 6 (Pa) suggests an increase in symptoms of suspiciousness, mistrust of others, being overly sensitive, guarded, with continued signs of her delusional disorder. Analysis of the Harris-Lingoes Subscales for Scale 6 reveals a markedly elevated score of T = 87 on Pa_1, Persecutory Ideas, reflecting the examinee's ideas of external influence and a feeling of being persecuted by others, rather than contribution from either of the other 2 Subscales, Poignancy (Pa 2) (cherishing sensitive feelings) or Naïveté (Pa_3) (being excessively generous regarding the motives of others).

Her score of T = 86 on Scale 7 (Pt) continues to fall in the Very High/markedly elevated range, reflecting the continued presence of severe anxiety, tension, agitation, indecisiveness, difficulty concentrating, difficulty relaxing/enjoying any aspects of life, and obsessive ruminative thinking.

Her score of T = 84 on Scale 8 (Sc) indicates that the respondent continues to feel detached, remote, and alienated from her social environment, experiencing difficulties in both logical thinking as well as concentration. On the Harris-Lingoes Subscales, her score of T = 67 on Sc_2 (Emotional Alienation) suggests that she continues to feel a lack of rapport with herself, experiencing the self as alien, and experiencing flattened affect (*observed during the course of the current evaluation*). However, the fact that this score has decreased by 9 T-points suggest that the examinee may be experiencing a slight increase in self-rapport, especially as time away from her stressful work environment increases. Her score of T = 86 on Sc_3 (Lack of Ego Mastery, Cognitive) reflects the examinee's ongoing and perhaps worsening problems with attention, memory, concentration, autonomous thought processes and unusual thought content. Her score of T = 75 on Sc_4 (Lack of Ego Mastery, Conative) suggests that the claimant continues to experience inertia, massive inhibition, and regression, continuing to see herself as overwhelmed and unable to get moving, no matter how hard she tries, although the slight decrease in her score suggests that she may possibly be experiencing slight improvement in this area. Her score of T = 65 on Sc_1 (Social Alienation) suggest that she tends to withdraw from meaningful relationships with others. Her score of T = 63, in the moderate range on Sc_6 (Bizarre Sensory Experiences) suggests that, to a moderate degree, she experiences thoughts of depersonalization and estrangement from others.

The claimant once again received scores in the low range on a number of the Supplementary Scales which assess alcohol and drug abuse, including the MacAndrew Alcoholism Scale-Revised (MAC-R: T = 34; prior score: T = 37); Addiction Potential Scale (APS: T = 47; prior score: T = 44) and the Addiction Admission Scale (AAS: T = 48; prior score: T = 44), suggesting that the claimant continues not to manifest significant problems in this area. Her score on Scale PK (Posttraumatic Stress-Keane: T = 69) presently fell within the markedly elevated range, reflecting significant residual symptoms of PTSD. This score is modestly higher than her prior moderate score of T = 61. Her current score of T = 73 on Scale PS (Posttraumatic Stress-

Schlenger) once again fell within the markedly elevated range, modestly higher than her prior score of T = 68, indicating the continued presence of symptoms of posttraumatic stress, possible to a slightly greater extent than previously observed.

Dr. Mosley endorsed 15 of the Koss-Butcher Depressed Suicidal Ideation Critical Items, and 11 of the Koss-Butcher Acute Anxiety State Critical Items, with the following items of significant clinical concern, reflecting significant symptoms of depression and anxiety:

"Most of the time I feel blue" (True); "Life is a strain for me much of the time (True); "I usually feel that life is worthwhile" (False); "These days I find it hard not to give up hope of amounting to something" (True); "I am happy most of the time" (False); "I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't get going" (True); "I have difficulty in starting to do things" (True); "Most nights I go to sleep without thoughts or ideas bothering me" (False); "Several times a week I feel as if something dreadful is about to happen" (True); "I sometimes feel that I'm about to go to pieces" (True); "I feel anxiety about something or someone almost all of the time" (True); "I certainly feel useless at times" (True); "The future seems hopeless to me" (True); "At times I think I am no good at all" (True). She endorsed 14 of the Lachar-Wrobel Depression and Worry Critical Items, and 5 of the Lachar-Wrobel Anxiety and Tension Critical Items, which reflect similar item content (and which have some degree of overlap with the Koss-Butcher Critical Items). She also endorsed 8 of the Koss-Butcher Persecutory Ideas Critical Items, including: *"I believe I am being plotted against" (True); "I believe I am being followed" (True); "Someone has it in for me" (True); "I have no enemies who really wish to harm me" (False); and "People say insulting and vulgar things about me" (True).*

Overall, on the Trauma Symptoms Inventory-2, Dr. Mosley continues to manifest symptoms of posttraumatic stress characterized by: continued flashbacks/intrusive thoughts, as well as attempts to avoid thinking about traumatic stimuli; hyperarousal; depression; somatic preoccupations; and caution as well as distance in interpersonal relationships with others.

Diagnosis (DSM-IV-TR)

Axis I	296.24	Major Depressive Disorder, Single Episode, Severe with psychotic features;
	309.81	Posttraumatic Stress Disorder;
Axis II		Deferred;
Axis III		History of episode of seizure; prior history of hypertension;
Axis IV		Occupational Problem;
Axis V	40	Global Assessment of Functioning (GAF): (upper range between 31-40)(some impairment in reality testing or communication, characterized by illogical thought/speech/delusions) [Whole Person Impairment = 51]

Dr. Mosley continues to meet the criteria for a diagnosis of 296.24: Major Depressive Disorder, Single Episode, Severe with psychotic features, in that she meets the following criteria:

She experiences 6 of the minimum of 5 of 9 symptoms nearly every day for most of the day, including: (1) depressed mood; (2) markedly diminished interest or pleasure in all or almost all activities; (4) insomnia; (6) fatigue or loss of energy; (7) feelings of worthlessness; and (8) diminished ability to think or concentrate). The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms are not due to the direct physiological effects of a substance or general medical condition. The symptoms are not better accounted for by bereavement, and persist for longer than 2 months or are characterized by marked functional impairment.

Dr. Mosely is also suffering from 309.81: Posttraumatic Stress Disorder, meeting these criteria:

A (1): She witnessed an event that involved actual serious injury to others, which involved a response of intense fear, helplessness, or horror. B: The traumatic event has been persistently re-experienced in one or more way, including: (1) recurrent and intrusive distressing recollections of the event; (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; and (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. C: Persistent avoidance of stimuli associated with the trauma manifested by at least 3 symptoms, including: (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma; (2) efforts to avoid activities, places, or people that arouse recollections of the trauma; (4) markedly diminished interest or participation in activities; (5) feeling of detachment or estrangement from others; (6) restricted range of affect; D: Persistent symptoms of increased arousal, manifested by at least 2 symptoms, including: (1) difficulty falling or staying asleep; (3) difficulty concentrating; (4) hypervigilance. E: Duration of disturbance is more than 1 month; F: The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

DISCUSSION

AOE/COE/Causation

With regard to causation, it is my clinical opinion that Dr. Mosley suffered a cumulative industrial injury, which began with the group takedown of her patient, inmate Jones, by custody officers in front of her on May 8, 2009. The incident itself was described as horrifying by Dr. Mosley, as she had never observed any incidents of violence in her life at such close proximity. In addition to feeling shocked by viewing her patient tackled to the ground by no less than 8 prison guards for no apparent wrong-doing that she could discern, Dr. Mosley felt threatened by the directive given to her by one of the guards to "back off" when she picked up her patient's Bible and pencil, which landed on the floor after he was tackled. Furthermore, Dr. Mosley indicated that although she had not been advocating for this inmate to file formal

complaints about his treatment during this incident, her assisting him (as he was functionally illiterate) upon the direction of the Chief Psychologist apparently resulted in her being perceived as "bucking the establishment" or as a "rogue" who was not in alignment with the overall mission of the prison; alternatively, it is possible that she was "set up" by the Chief Psychologist in giving her such an assignment. In any case, it was apparently after this point that Dr. Mosley began experiencing significantly decreasing cooperation from the prison staff in terms of no longer providing escorts in order for her to see her patients, while being told that none of her colleagues received escorts, which from her previous experience, Dr. Mosley knew to be untrue. Dr. Mosley further indicated that shortly after this, she would be kept waiting outside in excessive temperatures before the guards would allow her into the facility where she was to conduct her therapy sessions. At about the same time, Dr. Mosley began experiencing a deterioration in her relationship with her supervisor, psychologist Dr. Nolan (which is confirmed by a review of the claimant's personnel records).

Additionally, it is noted by this examiner that the claimant had received satisfactory performance evaluations on a number of occasions prior to the incident with inmate Jones; however, following that incident, it does appear to this examiner that the claimant became burdened with a number of demands by Dr. Nolan (i.e., such as having to review the entire Department Operations Manual and report back on it, as well as having to document all of her activities, which took time away from her clinical work), and which does appear to have a punitive flavor. Additionally, although I do not know if the records I was provided with for review constituted the entirety of her personnel file, this examiner is struck by the fact that none of the documents involving her clinical supervisor Dr. Nolan appear to relate to issues of clinical supervision, which I would think would constitute the most important aspect of the relationship between a clinician and her clinical supervisor. Furthermore, it did appear from reviewing these records that the conflictual relationship with Dr. Nolan began shortly after the incident with inmate Jones and continued for most of the remainder of 2009. Her self-described episode of "seizure", as well as her friend observing that her telephone conversation with the claimant on 2/25/10 did not make sense, resulted in an emergency welfare check upon her, culminating in her emergency psychiatric hospitalization, initially at Susanville Banner Hospital, then at Renown Regional Medical Center, not long after her ongoing conflict with Dr. Nolan for many months.

After slightly less than a week's admission, she was discharged and remained off work until September 1, 2010, then return to modified duty working four 5-hour days per week rather than her usual four 10-hour days, until returning to regular duty on 2/28/11. She managed to continue regular duty until taken off work again on September 16, 2011 for approximately 6 weeks. She returned to work once again on November 1, 2011, and worked another 9 months until her last day worked on July 30, 2012.

Although there may have been some personnel issues, it is my opinion that these occurred after the development of the claimant's Posttraumatic Stress Disorder—which arose out of the incident involving inmate Jones on 5/8/09, and therefore arising out of her employment. It is my opinion that her Major Depressive Disorder with psychotic features also arose out of her employment, in response to her indication of ongoing mistreatment as a result of her involvement in assisting

inmate Jones--albeit not a task she volunteered for.

In any case, it is my clinical opinion that her psychiatric injuries, consisting of both Posttraumatic Stress Disorder as well as Major Depressive Disorder with psychotic features, (presently manifested in the form of a circumscribed paranoid delusional system) arose out of her employment predominantly, with industrial factors comprising greater than 51% of all causative factors of her injury.

As I had previously mentioned, Dr. Mosley's response to the initial violent incident involving patient/inmate Jones is certainly consistent with symptomatology most accurately described as Posttraumatic Stress Disorder, confirmed by both the MMPI-2 as well as the Trauma Symptoms Inventory-2. Her response to the subsequent and ongoing shunning and harassment is also consistent with symptomatology most accurately described as Major Depressive Disorder with psychotic features, representing a continued circumscribed delusional system within an otherwise intact personality structure.

Also, as I had previously indicated, if Dr. Mosley's account is accurate, the theft of her identification badge and the refusal by the administration to issue her a new permanent pass, instead having her go through the daily humiliation of being asked who she is, and what her business was at the prison every day upon her arrival at work at the prison entrance, is considered by this examiner as incontrovertible evidence of harassment and retaliation.

I also previously indicated that the fact that 4 psychologist colleagues of the claimant all left for alternative jobs around the same time that a change in administration occurred, suggests that although they may not have been subject to the same pattern of retaliation, Dr. Mosley did not appear to be the only dissatisfied professional in an otherwise happy environment—lending credence to the likelihood of Dr. Mosley's account of ongoing harassment reflecting actual events of employment.

With regard to the mechanism of injury, it is my clinical opinion that she initially suffered Posttraumatic Stress Disorder as a consequence of witnessing the violent group "take-down" of her inmate patient. Over the next several years, as a result of enduring ongoing harassment and humiliation, she then suffered her Major Depressive Disorder with psychotic features consisting of circumscribed delusions within an otherwise intact personality structure. It is my clinical opinion that in all reasonable medical probability, both conditions have arisen on an industrial basis due to the circumstances described above.

I continue to hold my previously-expressed opinion that there was no naturally-progressing psychological illness which would better account for her symptoms. There were no indications of disturbances from her childhood or upbringing in any way responsible for the sudden eruption of her Posttraumatic or Depressive symptoms. It is also highly unlikely that the claimant developed an endogenous psychotic process arising from a progressive psychological illness, due to the fact that at age 62 it is statistically very unlikely that she would suffer such a decompensation (which would have occurred at a much earlier age had she suffered from schizophrenia, as such

conditions develop well before the age of 45).

I also previously indicated that, although the claimant was prescribed the antidepressant medication Prozac 20 mg on 7/6/06 by Dr. Uppal, as her psychology licensing boards were coming up and she was feeling quite stressed, this was a temporary stressor. It is my understanding that although she remained on similar medication, she discontinued such after about eight or nine months.

I previously noted that, even if she had such symptoms prior to the seizure incident of 2/25/10, Dr. Mosley had been able to function in her work. From a review of records provided, it appears that she had been taken off work only for a very brief 2-week period between 7/16/08-7/28/08, prior to the incident of excessive force used on her patient in May, 2009, and the subsequent precipitation of her seizure in February 2010, with her eventual decompensation in functioning. Most of her periods of temporary disability occurred after this point in time.

With regard to the issue of alcohol abuse, it is noted from review of the medical records that when tested at Renown Regional Medical Center, her blood alcohol level was zero. Dr. Mosley further indicated that when she was "pulled" for drug and alcohol testing in a 6-hour ordeal during the middle of her workday, her blood alcohol level was also zero, and there was no indication of her having ingested any other nonprescription drugs. In psychometric testing in both initial evaluation as well as in present reevaluation, there were no positive findings on any of 3 Supplementary Scales of the MMPI-2 designed to assess alcohol abuse. There is no convincing evidence to support the hypothesis that she abuses substances.

I previously noted that there were no non-industrial factors of significance which provided more compelling explanations regarding the etiology of the claimant's symptomatology. She was not engaged in any other secondary employment or any other outside activities that would reasonably be responsible for her psychiatric symptoms. Additionally, as I previously noted, there were no indications from psychometric testing to suggest that the claimant had any ongoing issues relating to conflict, rebelliousness or oppositionalism towards authority figures which might be related to difficulties in interpersonal relationships, or that she orchestrated her problems in the workplace. There were no indications that her symptomatology was related to non-discriminatory, good-faith personnel actions, although it is very possible that personnel actions which were not performed in good faith aggravated her symptomatology.

In consideration of the discussion above, it is my clinical opinion that in all reasonable medical probability, the cumulative trauma of 2/25/10 with their antecedents occurring in May 2009 with the incident involving inmate Jones, as well as the ongoing consequences of her association with him, comprised predominant (greater than 51 %) causation of the claimant's industrially-compensable psychiatric injury, as defined by the injury causing both temporary disability as well as the need for psychological treatment.

Permanent and Stationary Status

It is my clinical opinion that Dr. Mosley has reached permanent and stationary status from a psychological standpoint, as of the date of the present Panel QME Psychological Reevaluation on March 30, 2015. She has participated in ongoing psychotherapeutic treatment with psychologist Stephanie Dillon, Ph.D. approximately 1 and ½ years.

In arriving at this conclusion, I note that the Physician's Guide: Medical Practice in the California Workers' Compensation System (third edition 2001) published by the State of California Department of Industrial Relations, Industrial Medical Council, page 38, states: "a worker's medical condition is considered permanent and stationary after it has medically stabilized (sometimes called "maximal medical improvement," although some slight medical improvement might be anticipated in the future), ***or when the condition has been stationary for a "reasonable period of time"*** (8 Cal Code Regs Sec. 10152)."

From both clinical interview, as well as re-administration of the same battery of psychometric instruments that I administered to the claimant in initial evaluation in December 2013, her condition appears to have remained stationary, or in other words, relatively unchanged for a reasonable period of time. Results of clinical interview, mental status examination and the predominance of findings from psychometric testing show Dr. Mosley could be functioning at essentially the same level of functioning as noted in initial evaluation, despite some minor variations in test scores.

With regard to her psychotherapeutic treatment to cure or relieve the effects of the industrial injury, I recommend that all of the psychotherapy sessions that she has received from Dr. Dillon be provided on an industrial basis. I also recommend that the cost of her prescriptions for Wellbutrin and trazodone taken after the date of industrial injury be covered on an industrial basis.

Temporary Psychiatric Disability

It is my opinion that the claimant was temporarily totally disabled on an industrial basis for all of the various periods of time during which she was off work after the summer of 2009. From my understanding, these periods of total temporary disability include the following: 2/26/10-8/31/10; 10/22/10-2/27/11; 9/16/11-10/30/11 (and permanent disability following her last day of work on 7/30/12).

Work Preclusions

Although I am aware that Dr. Mosley has since retired, if she did wish to continue working, I am of the strong opinion that she would not be able to return to work at the High Desert State Prison. It is my opinion that she remains at high risk of further decompensation were she to resume or continue to have exposure to such a work environment. It is my further opinion that, on a

prophylactic basis, Dr. Mosley should not work in any correctional/prison environment, due to the strong possibility of suffering a relapse in her symptoms, as a result of exposure to the same type of environment which led to her psychiatric decompensation. This is a permanent work preclusion.

Permanent Disability

I rate her Global Assessment of Functioning (GAF) as 40, at a level of functioning in the range from 31-40, reflecting some impairment in reality testing or communication, characterized by illogical thought/speech/delusions. This corresponds to a Whole Person Impairment rating of 51. Note that her functioning is at the upper end of this range, approaching the range of serious symptoms (41-50).

With regard to the AMA Guides-5th Edition, Table 14-1, P. 363: Classes of Impairment due to Mental and Behavioral Disorders, I have provided the following:

1. Activities of Daily Living: Class 4: Marked Impairment (presence of delusional thought processes; severe clinical depression; insomnia; fatigue; significant social withdrawal).

2. Social Functioning: Class 4: Marked Impairment (delusional thought processes/illogical thinking; significant social withdrawal).

3. Concentration, Persistence, Pace: Class 2: Mild Impairment (relatively intact cognitive functioning despite delusions/depression).

4. Deterioration/Decompensation in Complex/Work-like Settings: Class 3: Moderate Impairment (distraction of delusional thoughts, clinical depression; social withdrawal).

Taking into account recent case law based on Almaraz/Guzman, which would allow rating of disability by analogy to chapters of the AMA Guides other than those specified for a particular body part, as well as to utilize clinical judgment and impact on job performance if the AMA Guides do not adequately measure the true functional impairment pertaining to a patient, my opinion is that the AMA Guides or GAF would in fact provide reasonable and appropriate assessments of the disability pertaining to this claimant.

Apportionment

Pursuant to Labor Code Section 4663, apportionment of permanent disability is based on causation. Apportionment determination is made by determining the approximate percentage of the permanent disability that was caused as a direct result of the work-related injury, and what portion was caused by other factors, including prior industrial injuries, other non-industrial factors, or subsequent factors. Pursuant to Labor Code Section 4664, a discussion will be provided regarding the approximate percentage of the applicant's current disability that is due to the industrial injuries, and which percentage is due to a) any previous industrial injury; b) any

subsequent industrial injuries; c) and any non-industrial injuries including asymptomatic prior conditions, retroactive prophylactic work preclusions, illnesses or pathology.

First, I note that there were no asymptomatic prior psychiatric conditions, or any naturally-progressing psychiatric illness. There were no recent deaths within the family at the time the claimant's industrial injury arose, nor were there other significant stressors such as serious medical or psychological issues affecting family members, legal problems, etc.

There were no previous psychological injuries that I am aware of arising either industrially or non-industrially. It is highly debatable whether the claimant was subject to non-discriminatory, "good faith" personnel actions. In any event, my understanding is that the employer takes the employee as they find him or her. In this case, Dr. Mosley had already experienced her episode of posttraumatic stress disorder prior to the series of adversarial documents from her supervisor and chief psychologist which appear in her personnel file, and thus had already suffered the first component of her industrial injury; her subsequent treatment following the incident involving her patient, inmate Jones, whether termed "personnel actions" or not, in any event appeared to aggravate the claimant's posttraumatic stress disorder, resulting in her Major Depressive Disorder with psychotic features. Whether or not Dr. Mosley was "predisposed" to experiencing such a psychological decompensation is also highly debatable, as she was clearly functioning well in her position, with positive performance evaluations prior to the industrial incidents.

Therefore, it is my opinion that 100% of her psychological disability is due to the industrial injury of CT through 2/25/10, and that 0% of her psychological disability is due to any non-industrial injuries, asymptomatic conditions, retroactive prophylactic work preclusions, illnesses or pathology.

Future Treatment

It is my opinion that Dr. Mosley should be provided with 30 additional individual psychotherapy sessions, preferably with Dr. Dillon, with whom she appears to have developed a positive therapeutic rapport, on an industrial basis. In light of Dr. Mosley's continued delusions, however, I do have concerns regarding her medication, noting from records reviewed that she improved significantly after being prescribed Zyprexa, a medication which has been used effectively to treat symptoms of posttraumatic stress disorder, as well as psychotic symptoms and bipolar disorders. In contrast, although my understanding is that she is presently being treated with Wellbutrin and Trazodone, at the same time, she continues to exhibit persisting delusions. It is my hope that there might be a better medication or combination of medications that may help her more effectively. For this reason I recommend that she be provided with sessions with a psychiatrist to determine the most effective medications to treat her depression, delusions, and insomnia. This should be provided on an industrial basis for the next 2 years, with frequency of visits to be determined by the treating psychiatrist.

Finally—I continue to recommend that she be evaluated by a neuropsychologist, as certain neurological deficits which are not detectable through neurological exams can emerge on

neuropsychological test batteries. Given that her deterioration in functioning essentially began with her atypical seizure, it would be important to determine if there is any neuropsychological component to her disability. ***For this type of evaluation I would recommend Neuropsychologist James Bryant, Ph.D. in San Jose (408)356-2363.***

These recommendations are in accord with *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery of Workers, Second Edition, American College of Occupational and Environmental Medicine, Beverly Farms, Massachusetts: OEM Press, 2004.*

I hope that the above information is of assistance. Please do not hesitate to contact me if I may be of further assistance.

I declare under penalty of perjury that this report was prepared in compliance with Labor Code Section 4628, and 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, except as noted herein, that I believe it to be true. I further declare under penalty of perjury that I personally performed the evaluation of this patient on March 30, 2015, 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 have no financial interest in any other entities involved in the administration of workers' compensation claims in accordance with California Labor Code §139.32. I declare under penalty of perjury that I have not violated Section 139.3 of the Labor Code of the State of California, and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation. I further declare under penalty of perjury that the name and qualifications of each person who performed any services in the connection with the report, including diagnostic studies, other than clinical preparation, are as follows: None

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

A. Records Review & Summary	5.00 hours
B. Clinical interview	2.75 hours
C. Preparing written report	10.75 hours
D. Administering/scoring/interpreting psychological tests	4.75 hours

Signed this 2nd day of April, 2015 in the County of Alameda in the State of California.

Sincerely,

Stephen J. Heckman, Ph.D.
Licensed Clinical Psychologist
Qualified Medical Evaluator

STEPHEN J. HECKMAN, PH.D., Q.M.E.
LICENSED PSYCHOLOGIST (PSY 9081)
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December 23, 2013

Ms. Sheila Monson
SCIF
P.O. Box 3171
Suisun City, CA 94585

RE:	Employee:	**MOSLEY, LINDA**
	Employer:	California Dept. of Corrections/Rehabilitation
	Insurer:	SCIF
	DOI:	02/28/10
	DOB:	[redacted]
	SS#:	
	Claim #:	05912242
	Panel #:	1553276
	Exam Date:	December 13, 2013
	Report Date:	December 23, 2013

PANEL QME PSYCHOLOGICAL EVALUATION

Dear Ms. Monson:

I performed a Panel QME Psychological Evaluation of Ms. Linda Mosley on Friday, December 13, 2013, at my office at 1345 B Street, Hayward CA 94541. I had been contacted for this evaluation by Dr. Mosley on October 21, 2013, at which time she indicated that my name had come up on a panel that she had requested from the Division of Workers' Compensation. Although an attempt was made to initially schedule the evaluation on November 15, 2013, due to the unavailability of any medical records by that date, the evaluation had to be postponed to December 13, 2013.

[***Note**: As I have multiple evaluation sites throughout the Bay Area, it is requested that all future correspondence—including letters/additional records regarding this case (as well as all other cases)—be addressed to my main office in Oakland, indicated in the letterhead, above.*]

The examination began at 9:30 a.m., and lasted until 3:45 p.m., for a total of 6.00 hours (minus a ¼th hour break. One additional hour was spent in telephone interview following the exam to clarify a number of issues raised during the evaluation. The evaluation included: clinical interview; mental status exam; history of injury/treatment; assessment of medical, psychological, developmental, occupational, and legal history, as well as concurrent and subsequent factors. Dr. Mosley was also administered: Trails A & B; the Rey Fifteen Item Test; the Minnesota Multiphasic Personality Inventory-II (MMPI-2); the Trauma Symptom Inventory-2; the Beck Depression Inventory-2; the Beck Anxiety Inventory; and the Epworth Sleepiness Scale. Psychological testing took 4.75 hours, comprised of 2.0 hours of administration and 2.75 hours of scoring/interpretation. Total clinical interview was 5.0 hours. Record review was 6.75 hours. Medical research was 1.0 hour. Written report was 12.75 hours, reflecting a very complex case.

Purpose of Evaluation

The current evaluation was conducted to determine a number of issues with regard to Dr. Mosley's claim for Workers' Compensation benefits, including: clinical diagnoses; addressing the issue of whether there is a mental disorder which causes disability or need for treatment which is diagnosable per the DSM-IV-TR; whether my medical findings are consistent with the industrial injury alleged by the claimant; whether the claimant sustained an injury to the psyche that meets the standard of predominance for a finding of industrial causation of the psychiatric injury, or for injuries resulting from direct exposure to a significant violent act, a finding of substantial causation, with "substantial" defined as at least 35-40% causation from all sources combined; whether the employee's condition has caused temporary disability; whether actual events of employment were the "predominant cause" or "substantial cause" of the psychiatric injury; whether personnel actions were a substantial cause of the psychiatric injury; an indication of any periods of temporary total or partial disability as a result of the industrially caused or aggravated injury; if the employee is temporarily disabled, an indication of what additional treatment might be needed to bring her to permanent and stationary status; if she is now permanent and stationary, an assessment of permanent disability, utilizing the DSM Axis V GAF; whether the applicant could return to her usual and customary occupation with or without modification; apportionment, with consideration of what percentage of the permanent disability was caused as a direct result of the work-related injury, and what portion was caused by other factors, including prior industrial injuries or other non-industrial factors in accordance with Labor Code Sections 4663 & 4664 and the Escobedo case, taking into account any prior awards of permanent disability; an indication as to what future medical treatment might be needed to cure or relieve from the effects of the injury or prevent future deterioration.

Complexity Factors

The present evaluation was billed at the **ML 104-95** level for a **Comprehensive Panel Qualified Medical-Legal Evaluation involving Extraordinary Circumstances** (see California Code of Regulations, Title 8: Evaluations and Medical-legal Testimony), containing 6 of the requisite minimum of 4 complexity factors, including the following complexity factors:

X (1) two or more hours of face-to-face time by the physician with the injured worker;
X (2) two or more hours of record review by the physician;
_ (3) two or more hours of medical research by the physician;
X (4) four or more hours spent on any combination of two complexity factors (1)-(3), which shall count as two complexity factors;
_ (5) six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;
X (6) addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation;
X (7) addressing the issue of apportionment;
_ (8) addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral, or biological substances;
X (9) a psychiatric or psychological evaluation was the primary focus of this medical-legal evaluation;
_(10) addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

This **ML 104 -95 Panel QME Evaluation** entailed a detailed description of the applicant's reported work-related injuries and her reported symptoms and response to stressors in her work environment; review of records, including: detailed medical and psychological treatment and evaluation reports; mental status examination; psychodiagnostic testing; medical research; and assessment of disability and treatment issues.

I personally performed the following aspects of this evaluation: review of relevant records; interview and mental status examination of the applicant; administration, scoring, and interpretation of psychological tests (with the exception of computerized scoring/interpretation of the MMPI-2 augmented by additional interpretation from this examiner); analysis/synthesis of all of the pertinent data made available to me; all aspects involved in the preparation of the written report; and all functions involved in billing and mailing of the report to the appropriate parties.

Note that the report was prepared with the use of voice recognition software. Although I have proof-read the manuscript several times, I apologize if I did not catch any typographical errors caused by speech misrecognition of this program.

An itemization of charges is provided at the conclusion of this report.

Sources of Facts

The sources of facts upon which the following evaluation report is based include:

Comprehensive clinical interview;
Mental status examination of the applicant;
Review of medical and psychological treatment/evaluation records;
Results of psychodiagnostic testing administered to the applicant.

REVIEW OF RECORDS

Records provided by Ms. Monson:

Approximately 3 inches of records were received (estimated as approximately 750 pages) from Ms. Monson, including the following:

Indra Uppal, M.D., Medical Records (H.L.P.) (383 pages):

There are a number of Refill Authorization Requests from Dr. Uppal for the medications phentermine 37.5 mg (appetite suppressant) (request dates: 2/27/08; 2/29/08; 3/4/08) and Ambien 10 mg (request dates: 2/27/08; 6/17/08; 8/25/08; 11/10/08; 12/10/08). There is also a Refill Authorization Request for Rozerem 8 mg (Lunesta) on 7/24/08. There is a prescription for Wellbutrin 300 mg on 1/25/07.

7/6/06: Dr. Uppal: Visit Note:

Patient is doing her doctorate in psychology and has boards coming up and is stressed, wondering if she could start on Prozac. She would also like an annual checkup. Patient was told that her blood pressure is borderline high and she is also overweight, which needs to be addressed. Patient is symptoms of depression, mood swings, etc.; thyroid tests would be indicated. Patient prescribed Prozac 20 mg per day for 90 days.

7/20/06: Dr. Uppal: Visit Note: Annual checkup:

Patient was given multiple examinations. Impression: easy fatigue ability; hyperlipidemia; postmenopausal. Plan: screen for osteoporosis; instructions given on low-cholesterol/low-fat diet.

10/19/06: Dr. Uppal: Visit Note:

Patient prescribed Celexa 20 mg.

11/7/06: Dr. Uppal: Visit Note:

Celexa had made her gain weight. Impression: hyperlipidemia; depression. Patient Instructions: Discontinue Celexa, begin trial of Cymbalta 30 mg.

12/7/06: Dr. Uppal: Visit Note:

Cymbalta also made her gain weight. Patient Instructions: Discontinue Cymbalta XL, start Wellbutrin 150 mg.

4/4/07: Dr. Uppal: Visit Note:

Impression: Insomnia, depression. Patient Instructions: phentermine 37.5 mg; Wellbutrin 300 XL; Rozerem 8 mg.

4/4/07: Dr. Uppal: FSA Letter of Medical Necessity

Ongoing treatment for depression. Light therapy, antidepressant medication, vitamins/minerals to alleviate symptoms of overeating, oversleeping, lethargy, lack of energy.

(Review of records-continued)

There are a number of handwritten notes of marginal legibility on 5/2/07; 6/6/07; 7/5/07; 8/2/07; 10/30/07; 1/10/08; 3/5/08; 3/31/08; 7/16/08; 7/23/08; 10/13/08; 11/10/08; 9/25/09; 10/5/09; 12/28/09; 10/5/12; 10/12/12; 11/7/12; 6/19/13; 7/31/13;

9/25/07: Dr. Uppal: Visit Note:

Patient Complaints: cannot sleep at night. Impression: Insomnia. Patient Instructions: phentermine 37.5 mg

11/10/07: Dr. Uppal: Visit Note:

Patient Instructions: Ambien, phentermine 37.5 mg.

3/04/08: Dr. Uppal: Visit Note: Annual checkup:

Impression: abnormal renal function (borderline). Plan: repeat renal test in 3 months.

7/17/08: Dr. Uppal: Work Slip: Patient off work 7/16/08-7/23/08.

7/22/08: Dr. Uppal: Work Slip: Patient off work 7/16/08-7/25/08, regular duty 7/28/08, no restrictions.

9/09/08: Dr. Uppal: Visit Note:

Patient Instructions: phentermine 37.5 mg.

12/12/08: Dr. Uppal: Visit Note:

Patient Instructions: phentermine 37.5 mg.

1/19/09: Dr. Uppal: Visit Note:

Patient cannot sleep well. Impression: Insomnia. Patient Instructions: phentermine 37.5 mg.

3/05/09: Dr. Uppal: Visit Note:

Patient Instructions: phentermine 37.5 mg.

4/29/09: Dr. Uppal: Visit Note:

Patient Instructions: phentermine 37.5 mg.

6/11/09: Dr. Uppal: Visit Note:

Patient feeling tired.... *Illegible.* Patient Instructions: phentermine 37.5 mg.

10/05/09: Dr. Uppal: Work Slip: Patient off work 10/5/09-10/07/09.

10/05/09: Dr. Uppal: Work Slip: Patient off work 10/05/09-10/08/09.

(Review of records-continued)

12/28/09: Lab Test: EKG. Impression: Cardiac Arrhythmia; hyperlipidemia (?). Patient Instructions: Holter monitor.

1/08/10: Robert Coronado, M.D.: Holter Summary

A 24-hour Holter monitor showed no significant ventricular arrhythmias or supraventricular arrhythmias. For the most part an unremarkable Holter monitor. Patient complained of palpitations and fast heartbeat as well as feeling lethargic, and at different times experiencing chest discomfort. No significant arrhythmia correlated with the above-mentioned complaints.

9/04/12: Dr. Uppal: Work Slip: Patient off work 9/17/12-9/18/12.

10/01/12: Dr. Uppal: Work Slip: Patient off work 10/2/12-10/9/12

10/02/12: State of California: Memorandum: Approved Designation of Family Medical Leave:

Patient approved for FMLA continuously July 31, 2012-August 31, 2012; and intermittently 1-3 days per month, September 1/2012-June 30, 2013.

10/14/12: Dr. Uppal: Certification of Health Care Provider

Estimate of requested leave: As needed to treat serious medical condition for 1 year, from 8/1/12 to 7/31/13 continuously.

11/12/12: Dr. Uppal: Work Slip: Patient off work through 11/12/12.

11/7/12: Dr. Uppal: Work Slip: Patient off work 11/7/12 through 12/10/12, to return to regular/modified duty on 12/11/12.

12/05/12: Dr. Uppal: Visit Note:

DXA scan shows osteopenia. Patient will have to start on medication and needs to do regular weight-bearing exercises. She is presently not exercising at all as she always feels tired and has many interviews to go to, etc. Her BMI puts her in the overweight range so she was advised to lose some weight. Plan: repeat DXA scan in 2 years.

12/10/12: Dr. Uppal: Visit Note:

Patient complains that she does not feel she can work at HDSP. Impression: Insomnia, stress... *Illegible.*

12/10/12: Dr. Uppal: Work Slip: Patient off work through 1/30/13.

1/30/13: Dr. Uppal: Visit Note:

Patient has not worked since October 2012. Says she does not want to work... *Illegible...* Feels very tired, depressed, and does not feel she can go to work.

1/30/13: Dr. Uppal: Work Slip: Patient off work through 2/16/13.

(Review of records-continued)

2/15/13: Dr. Uppal: Visit Note:

Patient feels anxious ... *Illegible* ...Insomnia. (?) Off work until 5/1/13 (?) Need to send for counseling.

2/15/13: Dr. Uppal: Work Slip: Patient off work through 5/1/13.

2/15/13: Dr. Uppal: Incident Report

This is a 62-year-old psychologist at CCC who went off work in November 2012 because of stress. Prior to that, she had suspicious seizure activity because of an overdose of medication. She has been off work since November and a discussion was held today with her about her really needing to go back to work, as the more she stays away, the more difficult it will be for her to return. She claims that she is applying at many other places. It was brought to her attention that in each interview when she mentions that she is stressed and off work, it does not go in her favor. She has not gone for any counseling because she feels she is a counselor and she talks to her friends. She was told that that is not enough and that she really needs to go to a bona fide counselor. After talking with her for half an hour patient was provided with work slip taking her off work 5/1/13. However, it was insisted on that she go for counseling.

4/29/13: Letter from Dr. Mosley to Return to Work Coordinator:

Patient works as Clinical Psychologist at High Desert State Prison. She has been on FMLA for several months, scheduled to return to work May 5, 2013. However, her chronic fatigue is ongoing in this climate, and she is requesting reasonable accommodation to perform her job duties. She knows that the altitude at HDSP has progressively affected her health. She applied for medical transfer to other facility several years ago, signed by Dr. Nolan, but Personnel said they no longer did this. The desert conditions of the prison, together with her chronic fatigue, prevent her from walking the many miles from building to building to see inmates/patients and attend off-site meetings. She needs to see inmates and complete related paperwork in one specific area; she would also need breaks in between the long hours at HDSP in her 10 hour work days. Her medical disability began in February 2009.

5/2/13: Dr. Uppal: Work Slip: Patient off work 5/1/13 through 5/15/13.

5/7/13: Dr. Uppal: Visit Note:

Patient is asking for reasonable accommodation... *Illegible*... Impression: *Illegible* ...stress.

5/7/13: Dr. Uppal: Letter to State of California HDSP:

Patient works as a psychologist but has not worked for some time because of stressful situation at work. She says her last work schedule was 10 hours, 4 days a week. She was assigned to yard A. She has been on FMLA for the past several months, scheduled to return to work on 5/29/13. She has been diagnosed with chronic fatigue syndrome which is worse during the winter. HDSP has progressively been affecting her chronic fatigue syndrome and she has applied for a transfer to other correctional center facilities. In the meantime she needs some reasonable accommodation. She would like to see inmates and complete paperwork for one specific area at HDP. She will also need breaks in between the long hours at HDSP, of 15 minutes every 4 hours for each break. She needs to be re-entered (*sic, reoriented*) to the new state policies and procedures that developed at HDSP when she was away. She would like to return to work with reasonable accommodations.

(Review of records-continued)

5/9/13: Dr. Uppal: Refer to Stephanie Dillon for counseling.

5/16/13: Dr. Uppal: Work Slip: Patient off work through 6/3/13.

6/03/13: Dr. Uppal: Visit Note:

Patient wants reasonable accommodation. Still feels tired, not able to get out of town. (?) Has been getting counseling informally from a friend (?) (*marginal legibility*).

6/5/13: Letter from Dr. Mosley to Dr. Uppal

In this letter Dr. Mosley points out that rather than having her health affected by the critical job functions of her role, it is rather the lack of cooperating staff and lack of administrative support that affects her health more. In addition to walking for miles from building to building in desert conditions, at times she would not be let into the building, or when let in, would find the patient was not there. She further notes that physicians and psychiatrist have escorts, which she rarely does. She spends most of her time "chasing down patients." She will have put in 8 years of service as of this August. A reasonable accommodation would be for her to see patients in one specific area. Her professional skills have grown exponentially and she is now listed with the National Health Service Psychologist and is licensed to practice independently in 3 states, in addition to having expertise in cultural competency and supervision. She has an appointment with Dr. Dillon, a psychologist, on June 17, 2013.

6/8/13: Letter from Karen Bains, Return-to-Work Coordinator, to Dr. Uppal

Dr. Uppal's input was solicited regarding work limitations relevant to Dr. Mosley's return to work. Limitations indicated included: to avoid too much walking; either she works in one building or inmates are brought to her in one location. These limitations are temporary, for 1 year.

6/11/13: Dr. Uppal: Visit Note:

Feels very tired. Does not feel she can work. *Remainder of note illegible.*

6/13/13: Letter from Dr. Mosley to Dr. Uppal

Patient was hospitalized for 3 days on 2/26/10, which she believes was the onset of her chronic fatigue, with symptoms including sore throats, dry eyes, headaches, muscle and joint pain, poor sleep and lethargy 4 days after physical exertion. Physical exertion at HDSP significantly affected her health. She notes that walking miles back and forth in desert conditions from building to building is not an essential job function. She notes that she was on FMLA from 2/26/10-8/31/10; on modified duty from 9/1/10-10/21/10; on FMLA from 10/22/10-2/27/11; back at work from 2/28/11-9/15/11; on FMLA from 9/16/11-10/30/11; and back at work from 10/31/11-7/30/12. She enjoys essential functions of her work and earnestly tried to return 3 times. She has travelled to many other CDCR prisons hoping to find a better work climate. However, although some prisons were better, all of them appear to be unstable environments with unpredictable violence and requiring a great deal of walking. Her acute injury and illness began 2/26/10 hospitalization. Her illness has progressed. She is able to perform the essential functions of her job involving the assessment and treatment of adults, program development/evaluation, clinical research, professional training and consultation, maintaining order and supervision of inmates in protecting the safety of persons and property. She requested reasonable accommodations on May 22, 2013.

(Review of records-continued)

According to policy, CDCR would submit an employer-generated disability retirement application if reasonable accommodation was not available due to hardship on the employer.

7/01/13: Dr. Uppal: Visit Note:

Depression. Patient Instructions: Off work through 7/31/13 (?) (*Marginal legibility*).

7/1/13: Dr. Uppal: Work Slip: Patient off work through 7/30/13.

7/21/13: Stephanie Dillon, Ph.D., License Psychologist, Reno, NV: Letter to Dr. Uppal

Dr. Mosley was seen for 2 extended sessions on 6/17/13 and on 7/11/13. Dr. Mosley works as a psychologist in a maximum security prison. She had 5 positive years of employment there, experiencing good collegial and personal relationships. On June 30, 2009 she referred an inmate for treatment who alleged that a guard was sexually groping him. She conducted individual therapy with this inmate over a period of months. In September 2009 she observed an incident of excessive use of force by guards who had escorted the same inmate to her office for his therapy appointment with her. The inmate was outside her office door, turned his head to the side and the guards jumped on him. Dr. Mosley felt that excessive and unnecessary force was used to subdue the inmate and felt ethically obliged to report the incident, informing her chief and writing it up. Several weeks later Dr. Mosley noticed that she began to be treated quite differently by guards and professionals; she was made to wait outside of buildings whereas before the incident she was quickly escorted by the guards to her office in each building. This led her to feel anxious and uneasy about her safety and doing her job. Her colleagues avoided her; the guards called her names including: "nigger bitch" and all personnel shunned her, including nurses, secretaries, and support staff. Additionally, she resided in Susanville, a town of about 18,000, where this prison is located, and where most of the adults who work for the prison reside. Consequently she became profoundly socially as well as professionally isolated. Her commanding officers became distant and cool, whereas before they were friendly and supportive. On February 26, 2010 she had what appeared to be a seizure. The police broke down her door and she was helicoptered to Renown Medical Center in Reno, NV, where she was stabilized over a period of 3 days. She stayed with her sister in the Bay Area to recuperate and returned back to work about 6 months later, where she was once again shunned. She became depressed and anxious, and was treated for chronic fatigue syndrome. She meets the criteria for Post-traumatic Stress Disorder (DSM 4309.81). She has not returned to the workplace where she was subject to ongoing heinous psychological harassment.

7/21/13: Stephanie Dillon, Ph.D., License Psychologist, Reno, NV: Letter to Dr. Uppal

This appears to be a 2nd, briefer letter, in which it is noted that Dr. Mosley meets criteria for a diagnosis of Posttraumatic Stress Disorder (DSM-IV: 309.81). Her condition was caused by ongoing harassment in the workplace beginning in 2009, and she is permanently precluded from returning to that workplace. There is an attached sheet outlining the DSM IV criteria for Post Traumatic Stress Disorder.

7/31/13: Dr. Uppal: Work Slip: Patient off work through 9/30/13.

8/01/13: Letter from Karan Bains to Dr. Uppal

A request is made for more specific information regarding the distances that Dr. Mosley is able to ambulate throughout her shift, as well as how many hours within an 8 hour shift. Dr. Uppal's

(Review of records-continued)

response is that Dr. Mosley saw her psychologist who indicated that she cannot function at HDSP.

8/14/13: Dr. Uppal: Visit Note:

Not sleeping well; eating too much. ? Gained too much weight? Going to counseling (?) (*Marginal legibility*)

9/17/13: Dr. Uppal: Visit Note:

Patient is 62-year-old female who works as a psychologist at High Desert State Prison under the supervision of Timothy Nolan. She complains of cumulative stress, seizures, 3 days of hospitalizations, and multiple leaves of absence with a diagnosis of chronic fatigue syndrome and PTSD resulting from retaliatory hostile work environment after filing a report because she observed excessive force on inmates. Following this, she saw lack of management support. She began having anxiety spells and insomnia. Plan: patient was given note to be off work through 11/30/13 and a prescription of Ambien 10 mg as well as alprazolam (Xanax) .25 mg.

9/17/13: Dr. Uppal: Work Slip: Patient off work through 11/31/13.

9/26/13: Dr. Uppal: Request for Authorization for Medical Treatment

Diagnosis: Emotional Stress (309.9), Insomnia (780.52). Procedure Requested: Ambien 10 mg, alprazolam .25.

9/12/13: Employee's Report of Injury

Date of injury: 2/26/10. Last date worked: 2/25/10. Injury occurred through: hostile work environment and daily harassment, isolation, lack of management support subsequent to reporting and excessive force incident. Nature of injury: nervous system, cumulative stress, chronic fatigue, PTSD/Whole Body.

Dr. Uppal: Doctor's First Report of Occupational Injury or Illness

Patient was seen on 2/26/10 for injury of 2/25/10. Description of accident: Aoras at work prior to seizure and 3 day hospitalization, FMLA. Subjective Complaints: chronic fatigue, anxiety, depression, headaches, sore throat, insomnia. Chronic fatigue and PTSD resulting from retaliatory hostile work environment after filing excessive force incident, with lack of management support.

Renown Regional Medical Center, Reno NV: Medical Records (H.I.P.) (278 pages):

2/26/10: ED Notes

Patient brought in by medical flight from Susanville Banner Medical Center. Friend called 911 after speaking with patient on the phone, and noticed she "was not making any sense." Patient had tonic-clonic seizure in front of ERP at Banner. Patient presents with disorganized thought, unable to answer questions appropriately but does follow commands.

(Review of records-continued)

2/26/10: Wayne Hardwick, M.D.: ED Report

Patient is 59-year-old female who had grand mal seizure, both arms, both legs. She is disoriented and cannot give a history. Was seen in the emergency room at Susanville and transferred here, said to have bizarre behavior. Urine was positive for tricyclic antidepressants, alcohol level was zero. Final impression: Seizure disorder; Disorientation.

2/26/10: Wayne Hardwick, M.D.: Addendum to Emergency Department Report

Unable to obtain CAT scan results from Susanville, radiologist has neglected to read the CAT scan here, still attempting to get CAT scan results.

2/26/10: David Brock, D.O.: Admission History and Physical

Patient is 59-year-old psychologist brought in after a friend talking with her on the telephone observed that she was not making sense, and called 911. Other emergency room notes mention the patient was yelling at the police. She had a tonic clonic seizure in the emergency room with physical findings of a bitten tongue. Per her daughter, Shakura, she had a seizure in the past about 20 years ago, of unknown etiology. Patient is an alcoholic; unknown if the patient has recently stopped drinking or not. She has mild confusion, but there are no acute signs of agitation. Workup in the emergency room finds tricyclic antidepressant positive, otherwise urine drug screen was negative. Her white count is normal, no findings to suggest infection as an etiology. Alcohol level is zero. Patient relates recent chronic sinus infection. Denies illicit drug use. Denies any trauma recently. Unable to answer appropriately on alcohol ingestion recently. Assessment and plan: altered mental status, likely secondary to seizure, witnessed tonic clonic in Susanville Hospital. Patient to begin Dilantin. Consult with neurology; question if this is secondary to recent alcohol cessation. Consider EEG. Bipolar disease history per daughter.

2/26/10: Nathanael Cardon, D.O./José Thekkekara, M.D.: Psychiatric Consultation/Evaluation:

Reason for Admission: Seizure and altered mental status. Reason for Consultation: Altered mental status, rule out psychosis. Source of Information: the patient; the family; referring physician; treatment team; staff; medical records; chart; admitting history and physical. Chief Complaint: She is a markedly poor historian, guarded, unwilling to reveal information, who had been crying, laughing, talking at the walls, and also some aggressive behavior toward staff in the hospital.

History of Present Illness: Patient vacillates between confusion, word-finding difficulties, and clearly answering, and then not clearly answering questions. She denies any memory of events leading to the hospitalization. Patient reports antagonistic relationship with her employer for past 5 years, referring to the Ledbetter Act in relation to equal pay for equal work. Patient describes possibly recent burglary in her home. Considerable stress reported from working with inmates at the prison on a daily basis. Using alcohol, Flexeril, Ambien, and Norco. Patient improved considerably overnight after receiving 5 mg of Zyprexa followed by an additional 10 mg. Patient's daughter indicates that her mother has a history of bipolar disorder, alcohol dependence, and that 30 years ago she had a breakdown described as mixed, possibly manic episode that she had to deal with when she was 8 years old. The daughter also states that dealing with her mother throughout her life has incurred some stress, although her mother has been generally stable without any other medications and consuming what sounds to be a large amount of alcohol which is also undefined. The daughter lives back East; the sister lives locally and plans to take her home when she is able to be stabilized. Due to patient's combativeness, altered mental status, paranoia, talking to walls,

(Review of records-continued)

and potential suicide attempt, the patient was placed on a legal hold and started on Zyprexa as stated above. Patient appears guarded, suspicious, with mood dysphoric and flat affect her accompanied by decreased volume and quantity of speech. Thought process appears to be normal. Thought content difficult to assess, somewhat illogical per paranoia and guarded manner. Insight, judgment, and impulse control appear poor.

Assessment: Axis I: Psychosis, not otherwise specified. History of bipolar, very possibly a mixed manic state. Also, likely recent withdrawal from alcohol, Flexeril, and Norco. Alcohol dependence and other possible substance abuse. Axis II: Deferred. Axis IV: various psychosocial stressors including difficult work environment, possible recent burglary, possible legal lawsuit. Axis V: Global Assessment of Functioning = 35. Discussion: Patient has improved markedly since last night and is expected to improve on Zyprexa. Her family is involved in her care, very much interested in helping her received rehab and avoid hospitalization, if possible. If patient continues to improve, legal hold can be discontinued and patient discharged.

2/26/10: Multidisciplinary Progress Notes

Highlights of these notes include observations of hospital staff noting that patient was upset and crying on the phone. She was previously laughing and saying that she was "having a baby." She asked one of the staff if she was President Obama's niece or daughter. However, she knew where she was. On another occasion she was laughing manically all the way down the hall. Tried to walk out front doors, grabbing onto CNA inappropriately. Periods of extreme hallucinations and inappropriate behavior, becoming tearful, then laughing loudly; at other times, confused, disoriented to time, place, and situation. During the course of her hospitalization hallucinations and bizarre behavior subsided, with increased orientation, decreased confusion, and calmer behavior exhibited. However, upon discharge, she was very upset about DMV notification and instructions not to drive. Was reassured by M.D., but refused to sign form until provided with a work note. Patient denies alcohol dependency but admits to possible issues with Ambien. Patient discharged under care of her sister, to seek follow-up medical care at sister's locale.

2/27/10: Bernard Hersheye, D.O.: Neurology Consultation:

Patient was speaking on the phone with a friend who observed her to be confused, and called 911. Upon arrival of police at her residence, patient became combative and was subsequently taken to Lassen Banner Hospital where, in the emergency room she had a generalized tonic clonic seizure which lasted for several minutes. Patient has history of alcohol consumption and it is questioned whether or not this is secondary to alcohol withdrawal. Patient reports having a seizure 20 years ago. No prior history of stroke, tumor, neoplasm. No history of illicit drug use. No history of hypertension or diabetes. Patient describes herself as social drinker. In mental status her speech was fluent. Insight, comprehension and judgment were normal. There were no indications of the initial combativeness which was observed upon admission. CT scan of the brain was performed on 2/26/10, which was normal. Assessment: generalized tonic clonic seizure; differential diagnosis: idiopathic seizure disorder vs. alcohol withdrawal seizure disorder. It is also important to exclude stroke, tumor, arteriovenous malformation. Recommendations: MRI scan of brain; thiamine 100 mg daily; multivitamin; EEG during wakefulness and sleep; no driving; Dilantin 300 mg daily.

3/02/10: David Brock, D.O.: Discharge Summary

Discharge diagnosis: Status post seizure; query psychosis versus post external event; bipolar disorder; alcohol use. Imaging Procedures: MRI of brain with MRA of the head. Impression: Mild

(Review of records-continued)

high signal in deep white matter consistent with age and small-vessel ischemic change. AP chest x-ray normal. EEG official results pending.

Patient is 59-year-old female psychologist at a local prison in Susanville, brought in after tonic-clonic seizure. Upon arrival was alert and oriented but had flight of ideas. Patient had been at a friend's party celebration and had several drinks. She has also taken her Soma, Flexeril, and Ativan that night. There is a question of whether the seizure was secondary to the addition of medications and alcohol combination. Patient was given Dilantin and medical leave of absence from work until cleared by psychiatry and neurology. Patient seems psychologically intact without hallucinations or paranoia. Patient discharged with instructions not to drive until cleared by neurology. Dr. Paul Katz, general neurologist, was recommended. Patient was advised to stop prior outpatient medications of Diovan/Hctz as well as Soma, Flexeril, Bupropion and Ambien. Discharge medications: Zyprexa 10 mg and Dilantin 200 mg, both to be taken in the evening.

Banner Lassen Medical Center: Medical Records (approximately 150 pages)

2/26/10: Leon Jackson, M.D.: Head CT Without Contrast

History: Altered level of consciousness with concern about a seizure. Impression: unremarkable noncontrast head CT with note made of small retention cysts in maxillary sinuses.

2/26/10: Marc Bracy, M.D.: ED Report

Patient transported by air ambulance. Status: 51/50. Diagnosis: Primary: Seizure disorder (convulsive); altered level of consciousness not associated with post ictal changes. History obtained from police. Per police officer, patient was talking on phone to a friend and was having difficulty talking. The friend contacted police dispatch; when they arrived, the patient was in her house screaming. Patient awoke combative but more coherent and less combative when she arrived in ER. Patient had grand mal seizure lasting approximately 1 minute involving all her limbs. Her eyes had a vacant look. Patient continued with nonsensical words, later talking about the KKK and rednecks "F---ing me..."

State Compensation Insurance Fund: Faxed records (approximately 45 pages)

12/11/13: Sheila R. Magnson, Senior Adjuster, SCIF: Cover Letter:

Linda Mosley alleges psychiatric injury sustained on 2/28/10. She was employed by High Desert State Prison as a clinical psychologist. Her claim includes once-in-a-lifetime seizure Whole body. Medical report from Dr. Uppal diagnosed PTSD, chronic fatigue, stress at work and history of seizures. The present Panel QME Evaluation was scheduled to clarify disputed causation of her injury of 2/28/10. A request is made to clarify whether Dr. Mosley sustained an industrial injury on February 28, 2010 and if so, if it was the predominant cause, with additional discussion regarding potential good faith personnel issues. I am also asked to indicate whether actual events of employment are predominant as to all causes combined of the psychiatric injury. In the case of employees whose injuries resulted from being a victim of a violent act or from direct exposure to a significant violent act, the employee shall be required to demonstrate by a preponderance of evidence that actual events of employment were a substantial cause (35-40%) of the injury.

(Review of records-continued)

Handwritten notes from Dr. Mosley

10/5/13: Letter to Vicki Pender, SCIF.

Facts of her case include the following:

On 2/25/10 she had pre-seizure auras while at work. She was informed later by the chief in a staff meeting… needed to squash a rumor started about her that she had "lost her mind." She was hospitalized the following day for 3 days at Renown Hospital as a result of this seizure. She was helicoptered there from Susanville. She experienced a temporary psychosis for 3 days, which she feels were related to the work environment. The antipsychotic medications prescribed during those 3 days were discontinued by a neurologist several months later. Prior to the injury she had worked at High Desert State Prison for 4 years, 6 months, and 20 days with excellent performance evaluations, peer approval ratings and praise from patients that she had treated.

After the injury she was on Family Medical Leave from 2/26/10-8/31/10. She attempted to return to work on a Modified Schedule from 9/1/10-10/21/10 but was unsuccessful, as the work environment had worsened. She was away on FMLA again from 10/22/10-2/27/11. She returned to work from 2/28/11-9/15/11, and was away again on FMLA from 9/16/11-10/30/11. Her request for Reasonable Accommodation was not granted. She filed Worker's Compensation on 8/1/13.

What triggered her illness was an incident that occurred in summer 2009 when an inmate patient of hers complained to her about being sexually groped during searches by a particular officer. His complaints to the other officers were shrugged off. Dr. Mosley began seeing this patient more frequently to provide support and in an attempt to rule out delusions. As this patient was waiting outside of her office door one day, another attempt was made to search him, which he mildly resisted by saying either "wait" or "no." Suddenly about 8 officers pounced on this inmate. He was knocked to the ground and his eye glasses were broken. He was chained up and then locked in a cage. Dr. Mosley was warned to "stand back" after picking up the inmate's pocket Bible and pencil which had fallen to the ground. Shortly thereafter, the inmate wanted to file a Citizen's Complaint which Dr. Mosley was required to write for him. She also had to write an incident report in which she noted that the amount of force was unnecessary to contain the event.

Within 3 days after this, her work environment changed drastically. She was now made to wait longer time at the gates by the tower officers when going to conduct her therapy sessions. Building officers either did not let her into the buildings, or made her wait outside longer. She complained about this, both verbally as well as through emails to her supervisor, all of which were ignored. She heard staff refer to her as "Nigger bitch" under their breaths. Finally they began taking her identification. Her psychologist friends/colleagues began leaving to find positions elsewhere. Her hair began to fall out and she had difficulty sleeping. She was constantly fatigued and not revived by rest. There were periods during which she could not get out of bed for days at time, could barely get groceries or keep her hygiene up. When she had to go to the worksite she noticed her anxiety and blood pressure increasing exponentially. Dr. Uppal continued to urge her to see a psychologist, but as she is one herself, she was not sure if this would help. Dr. Uppal finally insisted upon it, and she found Dr. Dillon in Reno, who felt that she met the criteria for Post Traumatic Stress Disorder, and believed immediately that her injury was related to work. The claimant felt it would be difficult if not impossible to find a psychologist as competent as Dr. Dillon; additionally, not being able to see Dr. Uppal will be like losing a lifelong friend after treating her for 8 years.

(Review of records-continued)

1/27/11: S.K. Uppal, M.D.:

Linda has been very stressed working at HDSP. She would like to be transferred to a facility at San Luis Obispo on a hardship basis.

10/15/13: Dr. Uppal: Visit Note:

Patient reports pending QME evaluation. She complains that losartan gives her muscle spasms, so she wants to change it. She is now living with her sister in Union City. Workers' compensation told her she will have to see a doctor there, as they do not want to keep paying for her visits with Dr. Uppal. She continues to have anxiety spells, and is worried about not being able to see her psychologist in Reno anymore. She will have to live with that. She has history of high blood pressure and insomnia, as well as unexplained seizures in 2009 for which she was hospitalized. Patient also has history of chronic fatigue syndrome and stress. Patient does not smoke, drinks alcohol minimally. Impression: stress at work, PTSD, history of seizures, insomnia, hostile atmosphere. Patient advised to stop taking losartan and try Diovan 80 mg/day. Plan: Patient to continue taking alprazolam and Ambien. Patient provided with note to take her off work through 1/15/14. It remains unclear whether patient will continue to be seen here.

RESULTS OF EVALUATION

Identifying Information

Ms. Linda Mosley is a 62 year old Afro-American female who appears slightly younger than her chronological age. She arrived on time for her 9:30 a.m. Panel QME Psychological Evaluation appointment on December 13, 2013, held at my office at 1345 B Street, Hayward, CA 94541. She was professionally attired in black slacks, a black sweater, blue blouse and black shoes. She is right-handed. She stated that she is 5' 9" inches tall, and weighs 163 lbs., which appeared accurate. She ambulated without difficulty, and without the use of any assistive devices.

I explained the limits of confidentiality regarding the present evaluation, and that a copy of my findings would be submitted to her claims examiner at her employer's Workers' Compensation Insurance carrier. She appeared to demonstrate a clear understanding of the nature and purpose of this examination, that this was a medical-legal psychological evaluation, and not treatment of any kind, and that no treatment relationship was being established either explicitly or implicitly. She readily signed both a consent form to undergo the current psychological examination, as well as an authorization to release my findings to the party or parties identified above.

Dr. Mosley appeared cooperative throughout the evaluation process. She was able to maintain appropriate eye contact, as well as establish an appropriate level of emotional rapport. However, her thought processes alternated between being logical and linear, and being vague, tangential and circumstantial, requiring repeated redirection and requests for clarification and specification by this examiner. The claimant's difficulty in responding to many questions presented to her

made the interview process more time-consuming than the most clinical interviews, requiring repeated efforts prompting her to refocus on a number of occasions, as well as necessitating an additional one-hour long telephone follow-up, conducted on Monday, December 16, 2013, to obtain clarification about a number of points that remained unclear. She was a fair historian, as her verbal account generally coincided with the chronology of her injury and treatment reflected in the medical records reviewed, given the limitations in her thought processes as described above. Her mood appeared mildly depressed. Her thought content reflected ongoing concerns about her safety in her present work environment, as well as considerable distress about her experiences in her work environment. Her affect appeared flat, with the exception of one episode of tearfulness. There were no signs of over-dramatization or exaggeration of her symptoms.

History of Occupational Injury and Treatment as Provided by Claimant

By way of background, Dr. Mosley indicated that she attended the California School of Professional Psychology in Alameda and received her Doctorate in Psychology in 2004. She was hired to work as a Clinical Psychologist at High Desert State Prison, under the auspices of the California Department of Corrections and Rehabilitation, on August 4, 2005. She stated that she sought this position, as she wanted to learn about the experience of Afro-American males in prisons, although she denied having any exposure to this experience during her upbringing. The prison is located in Susanville, in a very rural area approximately 1 ½ hours from Reno, Nevada. This is a maximum-security prison, housing the most dangerous criminals in the state, including many inmates serving life sentences.

Dr. Mosley indicated that she typically worked four 10-hour days per week, from 6:30 a.m. until 4:30 p.m. She earned a salary of approximately $92,000 per year. She indicated that she would see approximately 10 patients per day, the length of their sessions varying anywhere from 15 minutes to an hour. She would see a combination of both voluntary as well as involuntary participants. She stated that she had a caseload of approximately 100-125 patients, and served as a primary case manager. She indicated that she loved her work with the inmates prior to her date of injury, and that she felt rewarded by progress she saw in her patients. She described receiving excellent performance reviews during her first 4-5 years of employment, which then deteriorated after she filed a report documenting the use of excessive force on one of her patients by approximately 8 prison guards. She also indicated that there was a change of management, which resulted in a number of her colleagues leaving the prison to seek employment elsewhere.

She further explained that she assisted inmates with a variety of personal issues, including health issues, family problems, anxiety, preparation for adjustment back to society for inmates about to be released, as well as more serious psychiatric problems, including inmates experiencing hallucinations. She stated that she also would discuss with the inmates their complaints of racism regarding the prison staff, as the inmate population was predominantly Afro-American, whereas the prison security staff was comprised of approximately 99% Caucasians.

Dr. Mosley indicated that although she did have a supervisor, she worked relatively independently with regard to her patient caseload. However, she often sought consultation from

her supervisor or colleagues when necessary. There were also periodic staff meetings held for the clinical staff to discuss cases.

Dr. Mosley indicated that her industrial claim was precipitated by an incident in which she observed approximately 8 prison guards use excessive force in tackling one of her patients who was standing in the hallway outside of her office, just prior to his therapy session. This patient is an individual who Dr. Mosley had treated for approximately 3 years prior to the incident in question, but who she had not seen in a number of months. This patient had been referred back to her in late spring or early summer of 2009 by Dr. Kraft, a staff psychiatrist, who observed this inmate to be suffering from increasing anxiety.

Dr. Mosley indicated that she began conducting therapy sessions with this individual again, during which he complained that in the course of the pat-down searches that inmates must undergo during transitions from the yard or kitchen back to their cells, a guard had "groped" him sexually several times, which he found quite disturbing. Dr. Mosley recalled suggesting to this inmate that he file a complaint with the sergeant, but the inmate replied that he felt that doing so would make matters even worse. Dr. Mosley stated that she assumed that this inmate had also mentioned the groping incident to the psychiatrist as well as a nurse he had seen recently, although Dr. Mosley admitted that she did not know this for certain. She stated that she attempted to be supportive with this inmate. She stated that she also consulted with several colleagues about how to best assist this inmate. Although one of colleagues with whom she consulted regarding this case had warned her of the possibility that the patient may have fabricated this complaint in an attempt to manipulate her, Dr. Mosley noted that this patient appeared very tense, anxious, hypervigilant, and appeared to be deteriorating psychologically; although she initially considered the possibility that this complaint was fabricated, the inmate's symptoms appeared genuine and authentic.

The initial incident precipitating Dr. Mosley's claim occurred as this inmate was about to be seen by her for his therapy session. The door to Dr. Mosley's office was already open. The inmate was about to be searched, when he turned his head to the side and uttered either "wait" or "no." At this point the claimant observed 8 prison guards tackle her patient to the ground, in the process breaking his eye-glasses, then chaining him, and locking him in a holding cage. Dr. Mosley stated that in the course of being knocked down to the ground, the inmate's pocket Bible and pencil had fallen out of his pocket. As she bent down to pick these items up she recalls being warned by the guards in a threatening manner to "stand back." (*It is noted that Dr. Mosley became tearful at this point in the clinical interview; in fact this was the only time during the course of the 6 hour evaluation she openly displayed tearfulness, or any emotion other than what was observed by this examiner to be a typically flat affect*). Dr. Mosley further indicated that this was the first time that she had witnessed this kind of violence directly, although she indicated having seen guards treating inmates roughly from a distance. She described the experience as "being in slow motion." She stated that she found the experience quite upsetting. She described herself as feeling shocked, stunned, and saddened. When questioned by this examiner as to whether she had also cried at the time of the incident, the claimant responded: "You do not cry in a prison."

Dr. Mosley described herself as feeling quite helpless to do anything to assist this inmate, who she felt had been treated very unjustly. Although she attempted to continue in her work-day, she recounted experiencing great difficulty concentrating for the rest of the day. She related that she could not stop ruminating about this incident, and although engaging in other work throughout that day distracted her temporarily, her thoughts kept returning to this incident.

Dr. Mosley stated that she returned to work the following day and discussed the incident with the Chief Psychologist, Dr. Joseph Cummings. He informed her that she would have to write up an incident report, at which time Dr. Mosley indicated that she began to feel very apprehensive, as it seemed unavoidable for her to have to use the phrase "excessive force", which she felt could stir controversy and place her in a potentially compromised position. She did write up the incident report and submitted it to one of the sergeants. Dr. Mosley also indicated that Dr. Cummings instructed her to assist the inmate in writing up the civil complaint that he wished to pursue, as the inmate was functionally illiterate. She did so, and submitted it to one of the administrative secretaries.

Following this incident, Dr. Mosley stated that she sought consultation from Dr. Scalia, another psychologist. She stated that she felt that talking about this upsetting occurrence helped her calm down somewhat. After submitting her incident report, she was subsequently contacted by a lieutenant who had her to fill out additional paperwork in addition to interviewing her for approximately ½ hour regarding the incident.

In the months that followed, Dr. Mosley indicated that she deeply regretted having been "dragged into this entire mess", as she was suddenly treated like a "pariah" in that, whereas she previously had a very positive relationship with all of the guards, as well as her supervisors, this changed dramatically. She explained that she previously had been provided with escorts (guards who would be provided with her schedule for each day, and who would escort inmates to her office for their appointments); Dr. Cummings suddenly denied her use of regularly-scheduled escorts, which meant that Dr. Mosley would have to make several phone calls to find an available guard to transport each of her 10 patients per day to their sessions, adding significant administrative time to her day, and making it much more difficult for her to stay on schedule. When she questioned Dr. Cummings about this change, she related that he told her that none of the other psychologists had escorts, which the claimant adamantly insisted was untrue. After this change, Dr. Mosley indicated that she would now have to walk considerable distances to the inmates' cells, which were in different buildings spread across a large area. Additionally, she indicated that whereas in the past, when she had to walk to these buildings, she would be let in immediately; now, however, the guards would keep her waiting outside for up to 5 minutes, often in excessive heat (this facility is located in the desert), rain or cold.

Dr. Mosley further indicated that she regularly overheard a number of guards just barely audibly muttering "Nigger bitch" under their breaths, whenever they had to have contact with her, which went on for months, and which she simply tried to ignore, but which hurt her deeply.

Dr. Mosley indicated that a significant change in administration occurred around this same point in time. Her supervisor, Dr. Nolan, retired. Mr. Charles Young replaced the previous Chief Medical Director, whom the claimant felt had been supportive of her, while Dr. Todd Murray replaced Dr. Cummings as the Chief Psychologist. Among the custody staff, Capt. Hale replaced Capt. Dower, who the claimant also reported that been supportive of her. Shortly after this change, 4 of her colleagues who felt that the administrative staff had become less supportive began to leave for alternative employment, all within a few months of each other. Psychologist Dr. Kahn relocated to Seattle; Dr. Scalia, mentioned above, found a position at San Quentin; Dr. Liberty moved to Maine; and Dr. Ault went into private practice. Another colleague, Dr. Markowitz, was promoted. Thus, Dr. Mosley experienced a significant loss in her collegial support system within a short span of time, while simultaneously feeling singled out for harassment.

Dr. Mosley further indicated that she would frequently leave her ID badge in her desk drawer in the afternoons, when she would no longer need it to move through the facility. She indicated that her badge was taken from her desk on several occasions, necessitating her having to obtain a temporary day pass on a daily basis until she could receive a replacement badge, which would take about a week. However, after this occurred several times, she was then no longer issued a permanent identification badge, but would have to obtain a new daily pass each morning. Guards manning the entry gate, who had known her for years, would ask her every day who she was, and what her purpose was in requesting entry to the facility. She would then be kept waiting while a temporary day pass was prepared and given to her, which she found to be blatant harassment, as these guards knew very well she was and why she was there. She reported that she subsequently was informed by one of the secretaries that she had seen someone take Dr. Mosley's identification badge from her desk and thrown it into the trash.

Dr. Mosley indicated experiencing additional harassment, in that at one point administration informed her that complaints had been made about erratic behavior on her part. Dr. Mosley indicated that on the day of this occurrence, she was summoned at about 3:00 p.m., and detained for 6 hours, during which she had to attend a meeting with Dr. Hale, Dr. Murray, one of the clinical staff, and HR, and in which she was repeatedly questioned about drug and alcohol use. She was then told that she would have to undergo drug/alcohol screening. Dr. Mosley indicated feeling quite humiliated as she was escorted down the halls, past the inmate facilities, her colleagues' offices, and the secretarial offices. She was then driven to Lassen Banner Hospital, where the testing was performed. She recalls that, as the hospital was changing shifts when she arrived, the testing was not completed until 9:00 p.m., thus using up 6 hours of her time. She further indicated that when the testing was complete, lab results showed no evidence of any alcohol or drugs in her system.

Dr. Mosley indicated that she made a complaint to her union about all of this harassing treatment. She stated that she attended a number of meetings, accompanied by her union representative with management, in which she filed a grievance. She subsequently attended several hearings, but the claimant stated that ultimately her complaints were dismissed as being "invalid."

Despite this treatment, Dr. Mosley indicated that she continued to see her patients and function in her job, although she began looking into working at other correctional facilities, in fact indicating that she had applied for positions at about a half-dozen other facilities, and went through the interview process, but unfortunately was not hired at any of these alternative locations.

In addition to feeling shunned at her place of employment Dr. Mosley also indicated that most of the town of Susanville consists of employees of the prison. As this is a small town, "word gets around." Although she had several friends, after the incidents described above at the prison, these friendships also deteriorated. One woman, Cheryl, was the wife of one of the prison guards. Dr. Mosley got to know her when she was looking into qualifying for a loan to buy a house in the area, as Cheryl is a real estate agent. However, Dr. Mosley ultimately decided not to buy a property in this area and the friendship gradually "faded away." The claimant also indicated that she had been friends with Margot, one of the secretaries who worked at the prison. This individual had invited the claimant to attend her church, which she did on several occasions. Again, however, following the incident, Margot stopped returning Dr. Mosley's phone messages whenever she would call. Dr. Mosley further indicated that, as she was the only Afro-American woman in the town, she felt that she would get "dirty looks" as the mostly Caucasian town was not used to encountering ethnic diversity.

On 2/25/10, the date of injury reported by the claimant, Dr. Mosley reported experiencing seizure "auras" which she described as "surreal perceptions", difficulty concentrating and feelings of derealization. She also indicated that she kept thinking that people were trying to hurt her, referring to a comment that a tower guard had made that day as she had walked across the yard, yelling down at her, calling her "a piece of meat."

On the following day, 2/26/10, the claimant indicated that she experienced a seizure while in her apartment (although medical records from Renown Regional Medical Center indicate that she did not experience this seizure until taken to the emergency room of Susanville Banner Medical Center, and that she had been speaking on the telephone earlier in the evening to a friend who observed that she was not making sense, and called 911; the police subsequently did a welfare check and brought her to the emergency room at Susanville Banner). [This examiner noted that the claimant appeared quite confused about the chronology of this incident, stating her present and enduring belief that: *"Different officers from the prison came to my apartment to harass me. They were outside my apartment talking to me. I kept thinking they were going to kill me."* It is further noted by this examiner that the claimant thus does not presently appear to recognize that she was in a delusional state at the time, as she appears to currently believe that officers from the prison were actually outside of her residence at the time.]

From Susanville Banner Hospital, she was med-evacuated by helicopter to Renown Regional Medical Center in Reno, Nevada, where she remained hospitalized until her discharge on March 3, 2010. She remained off work until September 1, 2010, at which time she returned to modified duty, working approximately ½ of the hours that she previously worked (four 5-hour days per week) for approximately 7 weeks, but then taken off work again from 10/22/10 until 2/27/11.

She returned again, this time to regular duty on 2/28/11 and remained for slightly more than 6 months, until being taken off work again on 9/16/11 for another 6 weeks. She returned to work again on 11/1/11 and continued working for another 9 months, until being taken off work once again on 8/1/12. She remains on temporary disability and has not returned to work since 7/30/12. On each of these occasions, it was Dr. Uppal who took her off work due to stress, as each time she returned to work, hoping that the harassment would have subsided during her absence and with the passage of time, only to be quite disappointed in experiencing continued mistreatment.

The claimant was questioned regarding her alcohol use, as this issue has been referred to in the medical records reviewed, specifically a reference by her daughter to the claimant being "alcoholic." (*At the same time, medical records from Renowned Regional Medical Center showed her blood alcohol content to be zero, contradicting the assertion that the claimant had been under the influence of alcohol at the time of this incident*). In response to this question, the claimant indicated that she considers herself as a social drinker. She states that she will typically drink 1-2 glasses of brandy on a weekend evening, but does not drink anything during the week-nights. She also clarified that she had been at Dr. Scalia's going away party one week prior to her seizure, which was the last time she had consumed any alcohol prior to the date of industrial injury. She further indicated that she will frequently go for many months without having any alcoholic beverages.

In response to the allegations by her mother and daughter regarding her having a history of bipolar disorder, alcohol dependence and a "breakdown" 30 years ago described as a mixed, possibly manic episode (reflected in the Psychiatric Consultation notes on 2/26/10 by Nathanael Cardon, D.O./José Thekkekara, M.D.), the claimant described both her mother and daughter as very conservative and very religious, further explaining that they consider anyone who drinks at all as "an alcoholic." The claimant also explained that she had never been diagnosed with bipolar disorder. With reference to undergoing a "breakdown" when her daughter was 8 years old, the claimant indicated that she did not suffer a "breakdown" but rather an episode of depression as a result from a number of different factors, including: having been divorced; being a single parent and having to earn a living; and coping with living in a high crime area (the claimant related having seen the body lying in the trunk car on the street in Detroit) as well as hearing about many incidents of violence. She indicated that she did not get therapy at the time of her depression as, at that time "Blacks did not believe in therapy", and simply "toughed it out."

Subsequent to 2/25/10 injury, and extending to the present time, the claimant indicated that she continues to experience symptoms of chronic fatigue and as well as posttraumatic stress disorder. She explained that she will stay in bed all day for several days at a time. She stated that, with all her friends leaving for other psychologist positions, she began to question her self-esteem and self-worth, "*which would poorly allow me to instill a sense of self-esteem and self-worth in those who I was treating. Hopelessness disallows an ability to instill a sense of hope to my patients.*"

Dr. Mosley was first treated by Dr. SK Uppal in Susanville, who conducted her physical examinations, blood/lab tests, CT scan, EKG, heart monitor. She was provided with losartan 25 mg (hypertension) Zolpedem (Ambien for insomnia), and alprazolam (Xanax, for anxiety).

Dr. Mosley began seeing psychologist Stephanie Dillon, Ph.D. in Reno, Nevada beginning in June 2013. She believes that she has had approximately 20 sessions, about 10 of these in person and about 10 by telephone. Therapy has focused on her difficulty dealing with being repeatedly shunned in the workplace each time she has managed to return to duty.

Current Symptoms

Dr. Mosley indicated that she experiences chronic tension in her neck, back and shoulders. She also described suffering a severe sleep disturbance, stating that she is unable to sleep at all for 2 nights in a row, then will sleep through the night on the 3rd night, is then up for 2 consecutive nights again, sleeps the 3rd day again, etc. During the nights that she is unable to sleep, she states that states that she is in bed and is not up engaged in activity (as might be the case in an individual suffering from a manic episode). This is true even with taking Ambien. She stated that this has been going on since suffering her seizure on Feb 26, 2010 (for the past 3 ½ years). She indicated that prior to the seizure episode she did not experience these kind of sleep difficulties. She further related that Dr. Uppal told her that "it would be okay if she slept only every other night." (*Examiner's comment: It is highly improbable that any physician would advise a patient that sleeping only every other night would be okay unless they worked in a field in which they were emergency responders or ER surgeons* — from this clinician's perspective, this account appears to possibly reflect another aspect of her delusional system).

She also complained of experiencing depressed mood, occurring daily and lasting for most or all of the day. When asked to explain what precipitates this mood, she stated that she often experiences sadness that her coworkers could and would behave in the manner they did towards her at her workplace. Additionally, she described experiencing overwhelming fatigue occurring every day and lasting most of the day.

Dr. Mosley also indicated experiencing anxiety, both generalized anxiety as well as specific panic attacks accompanied by hyperventilation and heart palpitations, occurring several times per day. She explained that these symptoms occur when she reflects upon having gone through prolonged and dedicated effort to obtain her doctorate, only to be treated in such a degrading and demeaning manner. She explained that she becomes anxious when she begins to doubt herself and question her self-worth. She also experienced significant anxiety when she was working.

She is less frequently bothered by headaches, which occur only occasionally, but which last for several hours at a time, as well as occasional dizziness, light-headedness and eye twitches. She also reported social withdrawal from friends and activities, as well as diminished enjoyment from previously pleasurable activities. She describes ongoing difficulties with concentration, occurring on a daily basis.

She described a number of symptoms typically associated with acute stress disorder or Post Traumatic Stress Disorder, including: feelings of dread at approaching the worksite; distress at stimuli reminiscent of traumatic occurrences at work, such as "the sight of individuals who give the appearance of being vulnerable to victimization by others", or the sight of law enforcement

personnel; attempts to avoid conversations regarding the stressful events at her workplace; feeling detached and alienated from other people; hypervigilance/feeling unsafe; sense of a foreshortened future; and exaggerated startle response. Her extreme sleeplessness, which may be related to her feeling hypervigilant, unsafe, and consequently too frightened to relax, described above, is another symptom related to these syndromes.

Additionally, she indicated that some of her hair fell out and never grew back. She further indicated that she feels that her hypervigilance has negatively affected her ability to exude a professional countenance which she feels is necessary to be effective as a psychologist treating other individuals. She further indicated that she currently feels no tolerance for racist, sexist behaviors, whereas before the injury she felt that she "could manage" to deal with such behavior.

Current Medications

Dr. Mosley indicated that she presently takes the following medications:

Losartan 25 mg/day (blood pressure); Zolpedem 10 mg for insomnia (Ambien); alprazolam .25 mg (Xanax) for anxiety.

Medical History

The claimant indicated that she underwent an appendectomy at age 12, with no complications. She indicated that she is borderline hypertensive. She further indicated that her mother suffered from hypertension as well as diabetes. She denied ever having been seriously injured in a motor vehicle accident. She denied ever having suffered a blow to the head or loss of consciousness. She denied ever suffering a previous injury similar to the current Workers' Compensation claim.

Mental Health History

Dr. Mosley indicated that as a requirement for completion of her doctoral program in clinical psychology through the California School of Professional Psychology, she had to participate in one year of personal psychotherapy. She denied having any other mental health treatment or being on any psychotropic medication previously, although in the course of questioning regarding her history, she did acknowledge undergoing a bout of depression around the time of her first divorce when she was about 28 years old, for which she did not receive treatment, stating that she simply "toughed it out."

She denied awareness of any member of her family ever receiving psychological or psychiatric treatment or being on psychotropic medication. She denied ever having a drug or alcohol problem or been treated for such a condition. She denied awareness of any members of her family ever having a drug or alcohol problem or receiving treatment for such conditions.

Occupational History

Dr. Mosley provided the following occupational history:

8/5/04-present:	High Desert State Prison, Susanville, CA: Clinical Psychologist;
3/1/01-6/30/04:	Santa Rita Jail, Pleasanton, CA: Psychologist/Social Worker;
(Approx) 1987-1996:	Northville State Hospital, Detroit Michigan: Social Worker;

She also provided the following list of internships through her graduate program at California School of Professional Psychology:

9/1/01-6/30/04:	Ann Martin Children's Center, Piedmont, CA (postdoctoral internship);
9/1/00-8/30/01:	Olinda School, El Sobrante, CA;
9/1/99-8/30/00:	Psychological Services Center, Oakland, CA;

Personal Habits

Tobacco:	None;
Coffee:	3 cups of coffee/week;
Tea:	occasional green tea;
Alcohol:	none currently; previously 2 drinks/week, weekends only;
Drugs:	denied.

Legal History

The claimant denied ever having been arrested or incarcerated for any offense at any time in her life. She denied ever having been sued or of suing another individual or legal entity. She denied being involved in any class action lawsuits, or filing any prior Workers' Compensation claims.

Social History

Linda Mosley was born in Detroit, Michigan on January 31, 1951. She was the 4th of 6 children born to her mother, Ernestine McShephard and her father, Holloway Mosley. She was raised by both parents. Her mother worked as a nurse. Her father worked in a steel mill. Her mother is 87, and is in reasonably good health considering her age, and having both hypertension as well as diabetes. She presently resides in Michigan. Her father died in approximately 2003 at the age of 84 due to chronic obstructive pulmonary disease believed by the claimant to be related to working for many years in factories.

The claimant described her family as very warm and loving. She described positive relationships with both her mother and father. She described her mother as warm and engaging, spontaneous, wise, helpful, loving, supportive, strong, and strict. She described her as having a great sense of humor as well as deeply involved in helping her neighbors as well as her community. She described her father as a good provider and protector, kindhearted, patient, sensitive, and caring.

He was a deacon in the church and spent much of his time helping others.

Two of her brothers are deceased. Her brother Larry was murdered at the age of 23 by his own wife, when the claimant was about 19 years old, which occurred over 4 years ago. Her other brother, Benny, who was heartbroken over the death of his younger brother, committed suicide while in his 30s several years later. The claimant has 3 surviving sisters. Her eldest sister, Marie Mosley, is 65 and lives in Michigan. She is presently retired. She has 2 children. Her youngest sister, Diane Johnson, is 54, and also resides in Michigan, where she is employed as a nurse. She has one child. The claimant presently lives with her other sister, Deborah Lattimore, age 61, in her house in Union City, along with Deborah's retired husband. The claimant's sister presently works as a tax specialist, and has 2 children.

Dr. Mosley indicated that she attended the following schools:

Grade K-5:	Davison Elementary School, Detroit, MI;
Grade 6-8:	Cleveland Junior High School, Detroit, MI;
Grade 9-12:	Pershing High School, Detroit, MI;
1978-80:	Wayne County Community College, Detroit MI; Associate of Arts degree;
1982-1987:	Wayne State University, Detroit, MI; Bachelor's degree and MSW;
1998-2004:	California School of Professional Psychology, Alameda, Psy.D., 2004.

Dr. Mosley indicated being licensed as a Psychologist in California, Illinois, and Hawaii, as well as being listed in the National Register.

The claimant described herself active in extracurricular activities including basketball, tennis, swimming team, modern dance, choir, dramatics, mentoring, and modeling during school years.

Dr. Mosley indicated that she was previously married on 2 occasions. She was about 19 when she married her first husband, Sylvester Brown, who was 20 years old at the time. He owned a plumbing business. She indicated that they married in part due to her being pregnant. She cited the reason for their divorce approximately 8 years later as due to a "mismatch", explaining that her desire to pursue a profession in psychology ran counter to his hope of having her remain a full-time housewife. They lived in Detroit Michigan during the time of their marriage. They have one daughter from this marriage, Shakura, age 41, presently working for the Veteran's Administration in Chicago, with a doctorate in Pharmacy. The claimant married a 2nd time approximately 14 years after the end of her first marriage. Her husband, Brian Thavenin, worked as a nurse in Detroit. Dr. Mosley described this as another "mismatch", in that she continued to pursue her professional goals, resulting in her ultimately being accepted at the California School of Professional Psychology, which would have necessitated her husband relocating to California if they were to keep their relationship intact. However, the claimant indicated that her husband had difficulty "sharing her" with her professional aspirations.

The claimant stated that she is close with her sisters and speaks to the 2 sisters living in Michigan at least once a month by telephone or Skype. She sees her other sister Deborah every

day, as she has been living with her for the past 3 months. She indicated that she speaks with her daughter in Chicago every day, and with her mother in Michigan, on a weekly basis. Dr. Mosley described presently having a very positive relationship with both her mother as well as her daughter.

Dr. Mosley indicated that she is not involved in any current romantic relationships, and has not been since prior to beginning her work at the prison in Susanville. She indicated that after her 2 marriages, she decided to focus predominantly upon her career.

The claimant denied ever having been abused as a child, or at any time during her life, physically, emotionally, or sexually. She indicated being of average popularity growing up. The claimant indicated that she has never served in the military.

Non-Industrial Stressors

The claimant was questioned about the existence of current as well as recent non-industrial stressors, including deaths or serious illnesses of significant family members or friends; legal problems/lawsuits; behavior problems or custody disputes affecting children or grandchildren; conflicts with neighbors; being the victim of a crime, etc.

Dr. Mosley indicated that there have been no recent deaths in the family; no serious illnesses affecting any family or friends; no legal, academic or behavioral problems affecting any of her extended family such as grandchildren, nieces, nephews, cousins, etc. She denied the existence of any non-industrial stressors occurring at the present time or occurring at the time of her industrially-claimed injury.

Typical Day

Dr. Mosley described a typical day as follows: She usually goes to bed at 8:00 p.m., but as discussed above, will typically not be able to fall asleep at all for 2 nights, then will be so exhausted that she will sleep through the night on the 3rd night, then repeating this cycle again. This is true despite her taking the medication Ambien. She states that she spends most of her time in bed even during the daytime. She spends most of her time indoors at her sister's house, while her sister is busy working as a tax specialist, and while her retired husband spends much of his time out of the house, doing a variety of community activities such as volunteering. She spends much of her time reading, taking walks, going to church, and resting. She has occasional doctors' appointments.

Mental Status Examination

Dr. Mosley's sensorium or level of consciousness was clear and fully alert. She was able to maintain appropriate eye contact with this examiner, as well as to establish an appropriate level of rapport. There were no signs of evasiveness, and it is believed that she provided honest responses to the questions posed throughout the examination.

Dr. Mosley was fully oriented to time, place, person, and the nature and purpose of the evaluation. Thought content was comprised of reiterations of her fear and anxiety regarding her safety at the workplace. Her mood was mildly dysphoric. Her thought processes and speech alternated between being logical and linear at times, and vague, tangential and circumstantial at other times, requiring repeated redirection and requests for clarification and specifics by this examiner. Her affect was flat throughout most of the clinical interview with the exception of one episode of brief tearfulness.

When questioned about ever experiencing visual/auditory/tactile hallucinations, delusions, or ideas of reference, she indicated only that she had experienced "pre-seizure auras the on the day of her injury." [*However, from this examiner's perspective, the claimant appears to manifest very circumscribed delusions existing side-by-side with a relatively intact personality structure, such that these indicators of decompensation could easily go undetected in the absence of careful scrutiny of the claimant's responses. For example, the claimant's indication of her primary care physician advising her that her sleep pattern of alternating 1 night of sleep with 2 nights staying up all night is "okay" clearly suggests the presence of delusional thinking; additionally, her continuing belief that officers from the High Desert State Prison were outside her apartment, plotting to kill her on the evening of her seizure also represents delusional thought).*

The claimant denied ever experiencing any suicidal ideation, including either passive ideation, i.e., imagining what it would be like if she simply "did not exist", nor ideation involving a specific plan, method or intention. She denied experiencing any homicidal ideation.

Her intellectual capacity is estimated as within the average range or above. General fund of information was intact, reflected in her ability to easily provide the names of 4 recent U.S. presidents, including Presidents Obama, Clinton, Bush, and Reagan.

She was able to perform serial 7 subtraction from 100 over the course of 14 operations of subtraction with only 2 errors, reflecting only mildly impaired concentration on this task.

Her performance on Digit Recall Forward and Backwards, a task of attention, concentration, and immediate auditory recall, fell within 1 standard deviation of the Mean, with a combined score of 12; (Digits Forward, 6; Digits Backwards, 6), reflecting unimpaired performance, although falling at the lowest end within the normal range.

Her short-term memory showed signs of mild impairment, reflected in her ability to recall the names of only 2, but not all 3 of 3 common objects (Apple; Table; Penny) following a 10 minute delay without prompting. However, she was able to recall the 3rd object with prompting (i.e., being told that the 3rd object was a coin).

Her social judgment was appropriate and well-considered. When asked what she would do if she found an envelope on the street that was sealed, stamped, and addressed, she appropriately indicated that she would put it in a mailbox. When asked what she would do if she were the first person to notice smoke and fire in a theater, she indicated that she would run and tell the

manager, thus indicating her awareness of the importance of avoiding mass panic as the all too common response of yelling: "Fire" would do.

She experienced considerable difficulty in providing interpretations of several common proverbs further suggesting that she is experiencing some degree of interference with her thought processes. Her insight regarding the presence of the delusions discussed above was limited.

Results of Psychological Testing

Dr. Mosley was administered the following Psychodiagnostic Tests:

Rey Fifteen Item Test;
Trails A & B;
Beck Depression Inventory-2;
Beck Anxiety Inventory;
Epworth Sleepiness Scale;
Minnesota Multiphasic Personality Inventory-II (MMPI-2);
Trauma Symptom Inventory-2 (TSI-2);

Rey Fifteen Item Test

The Rey Fifteen Item Test (RFIT) consists of 15 items (comprised of the letters a, b, and c, in one row as small letters, in a 2nd row as capital letters; the numbers 1, 2, and 3 in Arabic numerals in one row, in Roman numerals in another row; and 3 geometrical shapes, including a circle, a square, and a triangle, in another row). These figures are presented on an 8 ½ by 11 inch sheet of paper, which the examinee is permitted to look at for 10 seconds; the examinee is then asked to reproduce as many of the figures as they are able to remember. The test is a brief screening found to be helpful in identifying individuals who may be malingering visual memory deficits or attempting to present themselves with greater disability than may be the case, as well as in identifying individuals who have extremely severe visual memory deficits (with consistent clinical history of significant head injury).

A cutoff score of 9 is used, with individuals scoring less than 9 indicating the possibility of malingering of memory deficits (or exhibiting legitimate extremely low scores associated with a clinical history of severe head injury). The rationale behind the test is that the stimulus items are of such simplicity (especially as the same letters and numerals are repeated in slightly varied formats, i.e., a, b, c and A, B, C; 1, 2, 3 and I, II, III) that at least 9 of them should be easily recalled—even by individuals with legitimate cognitive memory deficits including all but the most severe head injuries.

Dr. Mosley was able to correctly recall and reproduce 14 of the 15 items, showing no signs of having severe visual memory deficits, nor of malingering.

Trails A and B

The Trail Making Test (alternately referred to as Trails A & B) has been widely used as a measure of a number of psychological functions, including visual-conceptual ability and visual motor tracking skills. It also measures: the ability to alternate mental sets and sustain attention and concentration on 2 sets of alternating sequential stimuli (cognitive flexibility, the ability to "multi-task"); visual scanning ability; visual motor coordination; and motor speed. It is a timed test requiring the examinee to sequentially locate and connect numbers of increasing value which are organized in an apparently random manner on Trails A; on Trails B the test is more complex in that it requires the examinee to alternate between numbers and letters, i.e., connecting the number 1 to A, A to 2, 2 to B, B to 3, and so on. Thus, the examinee is required to alternate 2 sets of mental operations. Utilizing the Halstead-Reitan norms, impairment is rated as either mild (Trails A: 40-51"; Trails B: 73-105") or severe (Trails A: >52"; Trails B: >106").

Dr. Mosley completed Trails A in 43 seconds with no errors, placing her at approximately the 44th % ile, reflecting mildly impaired performance. She completed Trails B in 105 second with no errors, at approximately the 63rd % ile, again reflecting mildly impaired performance. These findings suggest that Dr. Mosley is mildly impaired both in her ability to perform tasks requiring visual scanning, visual motor coordination, fine motor speed, and undertaking a task of new learning, as well as in her ability to negotiate the performance of several such visual tasks simultaneously (ability to alternate between 2 different "mental sets", i.e., ability to "multitask).

Beck Depression Inventory-2

The Beck Depression Inventory-2 is one of the most widely used screening tests for depression. It consists of 21 statements concerning various aspects of life functioning that could be adversely affected by depression. The items are rated on a scale of 0-3 in terms of both presence as well as degree or intensity of depressive symptoms experienced by the examinee. A wide range of depressive symptoms are assessed, including mood, appetite and sleep patterns, sexual interest, self-esteem, guilt, ability to derive pleasure from activities, etc. The items are consistent with DSM-IV-TR criteria for clinical diagnoses related to depression.

Dr. Mosley received a score of 29, placing her just within the severe range of depression (0-13 = minimal; 14-19 = mild; 20-28 = moderate; 29-63 = severe).

To a severe extent (rated as 3) she indicated: inability to derive pleasure from things she used to enjoy; a feeling of being punished; difficulty getting interested in anything; and feeling too tired to do most of the things she used to.

To a moderate extent (rated as 2) she indicated: feeling sad all the time; indecisiveness; lacking enough energy to do very much; sleeping a lot less than usual; and diminished appetite.

To a mild extent (rated as 1) she indicated: pessimistic future outlook; crying more than she used to; restlessness/agitation; irritability; difficulty concentrating; and diminished interest in sex.

Overall, the claimant's symptoms were almost evenly distributed between the categories of mild (4 items), moderate (5 items) and severe (6 items), with 5 items not at all endorsed (rated as 0), suggesting that the claimant responded honestly without distortion or exaggeration.

Beck Anxiety Inventory

The Beck Anxiety Inventory is a widely used screening instrument to detect the presence and severity of anxiety symptoms. It is comprised of 21 symptoms frequently associated with anxiety. The items are rated on a scale of 0-3 in terms of presence, as well as degree or intensity of anxiety symptoms experienced by the respondent. A wide range of symptoms are assessed, including heart palpitations, difficulty breathing, dizziness/lightheadedness, trembling/shaking, specific fears, etc., and which are correlated with diagnostic criteria for a number of anxiety-related disorders described in the DSM-IV-TR.

Dr. Mosley received a score of 25, at the upper limit of the moderate range, approaching the severe range (0-7 = minimal; 8-15 = mild; 16-25 = moderate; 26-63 = severe) of anxiety.

To a severe degree (rated as 3, she could barely stand it) she reported: catastrophic fear.

To a moderate degree (rated as 2, it was very unpleasant but she could stand it) she indicated: inability to relax; heart pounding/racing; feeling unsteady; feeling terrified; feeling nervous; fear of dying; and feeling scared.

To a mild degree (rated as 1, it did not bother her much) she indicated: numbness or tingling; feeling hot; wobbliness in legs; dizziness/lightheadedness; trembling hands; feeling shaky; fear of losing control; and feeling faint.

Her responses appear to be relatively evenly distributed between severe/moderate (8 items) and mild (8 items), with 6 items not at all endorsed (rated as 0), suggesting that the claimant responded without distortion or exaggeration.

Epworth Sleepiness Scale

This questionnaire consists of 8 items which describe various situations in which the examinee may find himself or herself dozing during the daytime. The subject is asked to rate the likelihood of daytime dozing from 0 (indicating no chance of dozing) to 1 (indicating a slight chance of dozing) to 2 (indicating a moderate chance of dozing) to 3 (indicating a high chance of daytime dozing). The 8 scenarios consist of the following:

1. Sitting and reading; 2. watching TV; 3. Sitting inactive in a public place: 4. As a passenger in a car for an hour without a break; 5. lying down in the afternoon when circumstances permit; 6. Sitting and talking to someone; 7. Sitting quietly after a lunch without alcohol; 8. In a car while stopped for a few minutes in traffic.

She received a score of 0, indicating no likelihood of daytime dozing in any of the 8 scenarios presented, reflecting a normal amount of sleepiness, according to this instrument.

[*It should be noted that this instrument measures only daytime sleepiness; consequently, an individual may suffer from severe nocturnal insomnia, yet may not experience sleepiness during the daytime at all, which would not negate the seriousness of their sleep difficulty; however, if in fact the claimant is indicating alternating between staying up for 2 nights, sleeping for 1 night, then repeating this pattern, this would be indicative of a very severe sleep disturbance*].

Minnesota Multiphasic Personality Inventory-II (MMPI-2)

This is the current revision of the most widely used personality inventory (MMPI); it consists of 567 items to which the examinee is asked to respond with either agreement or disagreement regarding a variety of psychological symptoms, perceptions, and personal preferences. Her profile was scored and interpreted utilizing Pearson/PsychCorp's Minnesota Report for Forensic Settings, James N. Butcher, Ph.D., which is based upon The MMPI-2: Minnesota Multiphasic Personality Inventory-2: Manual for Administration, Scoring and Interpretation-Revised Edition, (Butcher, Graham, Ben-Porath, Tellegen, and Dahlstrom), University of Minnesota Press/ Pearson, 2001. The undersigned also utilized The MMPI-2/MMPI-2-RF: An Interpretive Manual, (Roger L. Greene), Allyn & Bacon/ Pearson, 2011 to provide additional interpretation.

Dr. Mosley produced a valid MMPI-2 profile. This examiner notes that, with regard to the Validity Scales of the MMPI-2, the respondent's scores of T = 68 on Scale F and T = 77 on Scale FB (F Back) represent Moderate score elevations, in which she is acknowledging psychological symptomatology to a degree greater than that of the typical individual; at the same time, her scores on these scales are not so extremely elevated as to reflect an invalid profile. The remainder of her Validity Scale scores all fall within normal limits as follows: Cannot Say (items omitted) = 0; VRIN:T = 62; TRIN:T = 58T; Fp:T = 49; L:T = 52; K:T = 63; S:T = 53.

She received high or very high/markedly elevated scores on 7 of the 10 Basic Clinical Scales comprising this instrument, with her most prominent scale elevations on Scales 2 (D) and 3 (Hy). Her scores on the 10 Clinical Scales are as follows:

Scale 1 (Hs): T = 84; Scale 2 (D): T = 101; Scale 3 (Hy): T = 96; Scale 4 (Pd): T = 76; Scale 5 (Mf): T = 43; Scale 6 (Pa): T = 70; Scale 7 (Pt): T = 83; Scale 8 (Sc): T = 73; Scale 9 (Ma): T = 53; Scale 0 (Si): T = 47.

The narrative report notes that this profile configuration has very high definition; consequently, a high degree of confidence can be placed in the behavioral descriptions from the clinical scales that are provided in this report, as the examinee's profile closely matches the prototype pattern in research literature that defines this profile type.

Physical concerns and depressed mood appear to be primary problems emerging from a somewhat mixed symptom pattern. The client reports feeling nervous, tense, and unhappy, and

she is quite worried at this time. She also appears to be quite indifferent to many of the things she once enjoyed and believes she is no longer able to function well in life. Overly sensitive to criticism, she tends to blame herself a great deal and feels that she has not been treated well. Depressed mood is accompanied by physical complaints and extreme fatigue. She finds it difficult to manage routine affairs, and the items she endorsed suggest a *poor memory, concentration problems, and inability to make decisions. She appears to be immobilized and withdrawn and has no energy for life.* She views her physical health as failing and reports numerous somatic concerns. She feels that life is no longer worthwhile *and that she is losing control of her thought processes. She may feel somewhat estranged and alienated from people.*

She is suspicious of the actions of others. She is passive-dependent in relationships and is easily hurt by others. She is unassertive and keeps anger bottled up, avoiding confrontation for fear of being rejected or hurt. *She tends to view the world as a threatening place, sees herself as having been unjustly blamed for others' problems, and feels that she is getting a raw deal from life.* Her high endorsement of general anxiety content is likely to be important to understanding her clinical picture. *She views herself as having so many problems that she is no longer able to function effectively in day to day situations. Her low mood and pessimistic outlook on life weigh heavily on her and seemingly keep her from acting to better her situation.*

Her most highly elevated score on Scale 2 (Depression) shows her to be experiencing significant clinical depression. Examination of the Harris-Lingoes Subscales for Scale 2 reveals markedly elevated scores on 4 of these subscales, and a moderately elevated score on the 5th subscale. Her significantly elevated score of T = 82 on Subjective Depression (D1) reflects her sad mood, difficulty sleeping, pessimistic outlook, low self-esteem, lack of energy for coping with problems, and difficulty with attention and concentration. Her significantly elevated score of T = 84 on Psychomotor Retardation (D2) suggests that she has difficulty in starting things; additionally, she tends to avoid or withdraw from social relationship. Her significantly elevated score of T = 93 on Physical Malfunctioning (D3) reflects her concerns about perceived health difficulties. Her significantly elevated score of T = 84 on Mental Dullness (D4) suggests that she is presently having difficulties with attention, concentration and memory, as well as motivation in beginning projects. Her moderately elevated score of T = 63 on Brooding (D5) suggests that she feels diminished self-esteem, uselessness, and is easily upset by others.

Her 2nd most significantly elevated score on Scale 3 (Hy) of T = 96 reflects her tendency to develop physical symptoms in response to stress. On the Harris-Lingoes Subscales, she received markedly elevated scores on 2 of the 5 subscales, Lassitude-Malaise (Hy 3: T = 87), suggesting that she is tired and fatigues easily, as well as experiences sleep difficulties; and Somatic Complaints (Hy 4: T = 73), reflecting a variety of somatic complaints. Her excessive concern regarding somatic complaints is also reflected in her markedly elevated score of T = 84 on Scale 1 (Hs).

Her high level of elevation on Scale 4 (Pd: T = 76) may result from a sense of social alienation; her response content does not reflect antisocial behavior or practices. Such a score reflects <u>no</u> indication of the claimant manifesting oppositionalism, resistance to authority, or in any other

respect having orchestrated her interpersonal difficulties in the workplace. Examination of the Harris-Lingoes Subscales shows her scores in the area of Family Discord (Pd 1: T = 38) and Authority Problems (Pd 2: T = 46) as falling in the low and normal ranges respectively, reflecting the absence of rebelliousness towards authority figures or a tendency to seek out or precipitate conflictual relationships. However, she received markedly elevated scores on Social Alienation (Pd 4: T = 70), as well as on Self-Alienation (Pd 5: T = 68), reflecting her feeling that no one understands her, and reflecting her regret about things she may have done.

Her markedly elevated score of T = 70 on Scale 6 (Pa) suggests that she is suspicious, overly sensitive, guarded, and distrustful, with a possible delusional or thought disorder. Further examination of this score through analysis of the Harris-Lingoes Subscales reveals a markedly elevated score on Pa 1, Persecutory Ideas, reflecting the examinee's ideas of external influence and a feeling of being persecuted by others, rather than contribution from either of the other 2 Subscales, Poignancy (Pa 2) (cherishing sensitive feelings) or Naïveté (Pa 3) (being excessively generous regarding the motives of others).

Her score of T = 83 on Scale 7 (Pt), falling in the Very High/markedly elevated range, reflects the presence of severe anxiety, tension, agitation, indecisiveness, difficulty concentrating, difficulty relaxing or enjoying any aspects of life, and obsessive ruminative thinking.

Her score of T = 73 on Scale 8 (Sc) suggests that the respondent feels detached, remote, and alienated from her social environment, accompanied by difficulties in logic and concentration. Examination of the Harris-Lingoes Subscales reveals markedly elevated scores on 3 of the 6 subscales of Scale 8. Her score of T = 76 on Sc 2 (Emotional Alienation) suggest that she feels a lack of rapport with herself, experiencing the self as alien, and experiencing flattened affect (*which was observed by this examiner during the course of the current evaluation*). Her score of T = 80 on Sc 3 (Lack of Ego Mastery, Cognitive) reflects the examinee's problems with attention, memory, concentration, autonomous thought processes and unusual thought content. Her score of T = 80 on Sc 4 (Lack of Ego Mastery, Conative) suggests that the claimant experiences inertia, massive inhibition, and regression; she sees herself as overwhelmed and unable to get moving, no matter how hard she tries.

Her score of T = 53 on Scale 9 (Ma) reflects a normal level of energy. Her score of T = 47 falls within the normal range, reflecting an appropriate balance between social introversion and extroversion.

Of note also is the fact that the claimant received scores in the low range on a number of the Supplementary Scales which assess alcohol and drug abuse, including the MacAndrew Alcoholism Scale-Revised (MAC-R: T = 37); Addiction Potential Scale (APS: T = 44) and the Addiction Admission Scale (AAS: T = 44), suggesting that the claimant does not manifest significant problems in this area.

Her scores on 2 Supplementary Scales assessing Posttraumatic Stress Disorder were also scored. Her score on Scale PK (Posttraumatic Stress-Keane: T = 61) fell within the Moderate range,

while her score on Scale PS (Posttraumatic Stress-Schlenger: T = 68) fell within the markedly elevated range, indicating the presence of some residual symptoms of posttraumatic stress.

Trauma Symptom Inventory-2 (TSI-2)

The Trauma Symptom Inventory-2 (TSI-2) is a widely used instrument developed to measure trauma-related symptoms and behaviors including but not limited to the effects of sexual and physical assaults, intimate partner violence, combat, torture, motor vehicle accidents, mass casualty events, medical trauma, witnessing violence or other trauma, traumatic losses, and early experiences of child abuse or neglect. It consists of 136 items and assesses a wide range of potentially complex symptomatology, ranging from posttraumatic stress, dissociation, and somatization to insecure attachment styles, impaired self-capacities, and dysfunctional behaviors.

Normed and standardized on a representative sample of the United States general population, it consists of 2 validity scales, 12 clinical scales, 12 subscales, and 4 factors. The TSI-2 (Briere, 2011) is a revised version of the Trauma Symptom Inventory developed by John Briere, Ph.D. (1995), and is appropriate for usage in adult men and women age 18 or over. T-scores (linear transformations of raw scale scores) are used in interpreting results of this psychometric instrument, with a Mean of 50 and a standard deviation of 10. T-scores falling within the range from 60-64 are considered problematic, reflecting above-average symptom endorsement likely to have clinical implications; scores of T = 65 or greater are considered clinically elevated, reflecting symptom endorsement of sufficient extremity representing significant clinical concern.

As noted above, there are 2 Validity Scales. The Response Level (RL) Scale assesses the extent to which an individual denies behaviors, thoughts, or feelings that most other respondents would report. Individuals scoring very high on the RL Scale are likely to be especially defensive or avoidant, oppositional regarding test-taking, or otherwise unwilling to endorse commonly-endorsed items. The Manual recommends that profiles with T scores of 75 or more on the RL Scale be considered invalid. The other Validity Scale, the Atypical Response (ATR) Scale evaluates the tendency of the respondent to over-endorse trauma-related symptoms. A very high score on this scale may reflect either: generalized over-endorsement of all items; specific over-endorsement of PTSD items; random responding that includes endorsement of rarely endorsed items; or very high levels of distress. In clinical contexts, over-endorsement may stem from a variety of factors, including: a "cry for help", i.e. an attempt to present oneself as needing clinical assistance by reporting symptoms as being more intense; malingering; factitious disorder; or a typical and/or extensive symptomatology sometimes associated with posttraumatic disturbance. The Manual considers profiles with a raw score of 15 as invalid for clinical or forensic contexts due to excessive symptom endorsement.

On the Validity Scales, Dr. Mosley received a score of T = 49 on Scale RL (Response Level), which fell within a valid level, suggesting that the examinee was not defensive, avoidant, or oppositional in her test-taking attitude. On the other Validity Scale (ATR-Atypical Response), she received a raw score of 9, also falling within a valid range, with no indication of over-endorsement of trauma related symptoms.

As noted above, T-scores falling within the range of 60-64 are considered problematic, reflecting symptom endorsement with clinical implications, while scores of T = 65 or greater are considered clinically elevated, reflecting symptom endorsement of significant clinical concern.

Dr. Mosley received a number of scores falling in the range of T = 65 or greater, considered clinically elevated, and several scores in the range between T = 60-64, which would be considered problematic, in the current administration of this instrument.

She received a score of T = 78 on the Anxious Arousal (AA) Clinical Scale, reflecting symptoms which are clinically elevated/of significant clinical concern. This scale is comprised of 2 subscales. She received scores of T = 76 on both Subscale AA-A (Anxious Arousal-Anxiety) as well as on Subscale AA-H (Anxious Arousal-Hyperarousal). Her score on Anxious Arousal-Anxiety reflects a significantly high level of worrying, fears, nervousness and possible panic attacks. Her score on Anxious Arousal-Hyperarousal reflects a significantly high level of autonomic hyperactivity/over activation of the sympathetic nervous system, as in the "flight or fight" response, characterized by nervousness, jumpiness, hypervigilance, irritability, and sleep disturbance.

She received a score of T = 78 on Scale D (Depression), reflecting frequent feelings of sadness, feelings of worthlessness and inadequacy, hopelessness/pessimistic view of the future, and social isolation. [*This score is quite consistent with her markedly elevated score on the MMPI-2 on Scale 2, as well as her score in the severe range on the Beck Depression Inventory.*]

Dr. Mosley received a score of T = 89 on Scale IE (Intrusive Experiences), reflecting a clinically very high level of symptoms such as flashbacks, upsetting memories that are easily triggered by current events, and repetitive thoughts of an unpleasant previous experience intruding into awareness. She received a score of T = 75 on Scale DA (Defensive Avoidance), also in the clinically significant range, reflecting her attempts to suppress or eliminate painful thoughts and memories from awareness, as well as attempts to avoid events or stimuli in the environment that might be stimulate such thoughts or memories.

Her score of T = 71 on Scale DIS (Dissociation) also fell in the clinically elevated range reflecting a largely unconscious, defensive alteration in awareness, developed as an avoidance response to overwhelming and often posttraumatic psychological distress, including cognitive disengagement, feelings of depersonalization and derealization, such as "spacing out" and feeling out of touch with her emotions and/or sense of self.

Her score of T = 67 on Scale SOM-G (Somatic Preoccupations-General), in the clinically elevated range, reflects a general preoccupation with physical and health symptoms which may not be accompanied by any real medical illness or injury.

Her score of T = 68 on Scale IA-AR (Insecure Attachment-Relational Avoidance), in the clinically elevated range, reflects her tendencies to keep people at a distance, avoiding close relationships, and being uncomfortable with intimacy.

She received 2 scores considered to fall within the problematic range (T = 60-64). Her score of T = 62 on Scale IA (the parent scale within which the above-discussed Scale IA-AR is a component) reflects the claimant's general tendency, believed to be more of a stable personality trait than a present psychological state, to maintain emotional distance from others and/or avoid close relationships, possibly arising from early relational losses and/or maltreatment/neglect.

Her score of T = 62 on Scale ISR-RSA (Impaired Self-Reference-Reduced Self-Awareness), is reflective of a possible tendency to view others as more immediately relevant and valid than one self, with resultant susceptibility to influence, boundary issues, and inadequate self-determination; she may experience confusion over her own thoughts and beliefs, as well as difficulty in accessing an internal-separate self.

All of her remaining scores fell within a sub-clinical range that did not reflect either problematic levels or symptoms arising to the level of significant clinical concerns.

In summary, in viewing the results of this instrument, there do appear to be a number of aspects of posttraumatic stress that Dr. Mosley is presently experiencing, particularly in the areas of autonomic hyperarousal, depression, intrusive thoughts, somatic preoccupations, and caution as well as distance in interpersonal relationships with others.

Consistency of Psychometric Testing Findings

The Validity Scales on the MMPI-2 and Trauma Symptom Inventory-2 revealed that the claimant provided accurate and consistent responses, producing valid profiles on both of these psychometric instruments. Her score on the Rey 15 Item Test showed no signs of malingering memory deficits. Her performance in reciting digit combinations of increasing complexity varied in direct proportion to the increasing difficulty of the task, in contrast to performances by examinees in which they miss easier items but succeed on more difficult items, a pattern often associated with malingering or symptom exaggeration. Although neither the Beck Depression Inventory-2 nor the Beck Anxiety Inventory contain validity scales, Dr. Mosley's responses were not overly skewed (i.e., such as responding to all or most items as severe, which might be the case if an individual were engaging in symptom magnification or malingering). She appeared to put forth her best effort in taking the examination, and there were no indications of evasiveness or dissimulation.

SUMMARY

Dr. Mosley's thought processes and speech alternated between being logical and linear at times, and vague, tangential and circumstantial at other times, requiring repeated redirection and requests for clarification and specifics by this examiner. Her affect was flat throughout most of the clinical interview with the exception of one episode of brief tearfulness.

From this examiner's perspective, the claimant appears to manifest very circumscribed delusions existing side-by-side with a relatively intact personality structure. Thus, while she was able to be quite coherent in recounting a very extensive and detailed history of industrial injury, at the same time there were indications of decompensation reflected in a number of statements made by the claimant which appeared to reflect delusional thinking. For example, in one instance the claimant related being told by her primary care physician that her pattern of being unable to sleep for an entire night is "okay" and not at all problematic. Additionally, her *persisting belief* that officers from the High Desert State Prison were outside her apartment, plotting to kill her, on the evening of her seizure, also represents delusional thought. (Note: it was not related by the claimant that she maintained this belief at the time of her episode, but has since come to recognize its invalidity; but rather the claimant presented this as a belief continuing to the present time, the validity of which has never been questioned by the claimant).

There were no indications of the claimant malingering or fabricating cognitive impairments, despite her indication of having difficulty concentrating. In fact, her concentration as measured by serial 7 subtraction showed signs of only mild impairment; her immediate auditory memory, although falling at the low end of the spectrum, was still within the normal range; her short-term memory showed signs of only mild impairment on delayed object recall. Her social judgment appeared intact, appropriate, and well thought-out, although her abstract thinking was somewhat limited, reflected in her difficulty providing clear explanations of several common proverbs.

There were no signs of severe visual memory deficits, nor of malingering as seen in her ability to recall 14 of the 15 items on the Rey Fifteen Item Test. Her scores on Trails A and Trails B both reflected mildly impaired performance in her ability to perform tasks requiring visual scanning, visual motor coordination, fine motor speed, and undertaking a task of new learning, as well as in her ability to negotiate the performance of several such visual tasks simultaneously (the ability to alternate between 2 different "mental sets", i.e., the ability to "multitask).

Dr. Mosley received a score of 29 on the Beck Depression Inventory-2, placing her just within the severe range of depression with an almost even distribution of responses between the categories of mild, moderate, severe, and not at all endorsed—suggesting that the claimant responded honestly without distortion or exaggeration. Significant symptoms endorsed included: anhedonia; a feeling of being punished; loss of interest; fatigue; constant sadness; indecisiveness; insomnia; diminished appetite; pessimistic future outlook; crying episodes; restlessness/agitation; irritability; difficulty concentrating; and diminished interest in sex.

Dr. Mosley received a score of 25 on the Beck Anxiety Inventory, at the upper limit of the moderate range, approaching the severe range of anxiety. Her responses were relatively evenly distributed between severe/moderate; mild; and not at all endorsed—suggesting that the claimant responded without distortion or exaggeration. Significant symptoms endorsed included: catastrophic fear; inability to relax; heart palpitations; feeling unsteady; feeling terrified; feeling nervous; fear of dying; feeling scared; numbness/tingling; feeling hot; wobbliness in legs; dizziness/lightheadedness; trembling hands; shakiness; fear of losing control; and feeling faint.

Although she received a score of 0 on the Epworth Sleepiness Scale, reflecting no likelihood of daytime dozing, the clinical history presents a completely divergent picture, with the claimant indicating complete inability to sleep for 2 nights in a row, alternating with sleeping 1 night, and with a repetition of this pattern on a constant basis– which seems indicative of a severe sleep disturbance.

Dr. Mosley produced a valid MMPI-2 profile. She received high or very high/markedly elevated scores on 7 of the 10 Basic Clinical Scales. Physical concerns and depressed mood appear to be primary problems emerging from a mixed symptom pattern. She reports feeling nervous, tense, and unhappy, and she is quite worried. She appears to be quite indifferent to many things she once enjoyed and believes she is no longer able to function well in life. Overly sensitive to criticism, she tends to blame herself a great deal and feels that she has not been treated well. Depressed mood is accompanied by physical complaints and extreme fatigue. She finds it difficult to manage routine affairs, and the items endorsed suggest poor memory, concentration problems, and inability to make decisions. She appears to be immobilized and withdrawn and has no energy for life. She views her physical health as failing and reports numerous somatic concerns. She feels that life is no longer worthwhile and that she is losing control of her thought processes. She may feel somewhat estranged and alienated from people. She is suspicious of the actions of others. She tends to view the world as a threatening place, sees herself as having been unjustly blamed for others' problems, and feels that she is getting a raw deal from life. She views herself as having so many problems that she is no longer able to function effectively in day to day situations. Her low mood and pessimistic outlook on life weigh heavily on her and seemingly keep her from acting to better her situation.

Her most highly elevated score on Scale 2 (Depression) shows her to be experiencing significant clinical depression. Her 2nd most significantly elevated score, on Scale 3 (Hy) reflects her tendency to develop physical symptoms in response to stress. She is tired and fatigues easily, as well as experiences sleep difficulties. Her excessive concern regarding somatic complaints is also reflected in her markedly elevated score on Scale 1 (Hs). Her high level of elevation on Scale 4 (Pd) may result from a sense of social alienation; her response content does not reflect antisocial behavior or practices. Such a score reflects <u>no</u> indication of the claimant manifesting oppositionalism, resistance to authority, or in any other respect having orchestrated her interpersonal difficulties in the workplace.

Her markedly elevated score of T = 70 on Scale 6 (Pa) suggests that she is suspicious, overly sensitive, guarded, and distrustful, with a possible delusional or thought disorder. Further examination of this score through analysis of the Harris-Lingoes Subscales reveals a markedly elevated score on Pa 1, Persecutory Ideas, reflecting the examinee's ideas of external influence and a feeling of being persecuted by others, rather than contribution from either of the other 2 Subscales, Poignancy (Pa 2) (cherishing sensitive feelings) or Naïveté (Pa 3) (being excessively generous regarding the motives of others).

Her score on Scale 7 (Pt), falling in the Very High/markedly elevated range, reflects the presence of severe anxiety, tension, agitation, indecisiveness, difficulty concentrating, difficulty relaxing

or enjoying any aspects of life, and obsessive ruminative thinking. Her low score on Scale 9 (Ma) suggests a low level of energy that may reflect situational circumstances. Her markedly elevated score on Scale 8 (Sc) suggests that she feels detached, remote, and alienated from her social environment, accompanied by difficulties in logic that concentration. Examination of the Harris-Lingoes Subscales reveals markedly elevated scores on 3 of the 6 subscales of Scale 8. Her score on Sc 2 (Emotional Alienation) suggest that she feels a lack of rapport with herself, experiencing the self as alien, and experiencing flattened affect (***which was observed by this examiner during the course of the current evaluation***). Her score on Sc 3 (Lack of Ego Mastery, Cognitive) reflects the examinee's problems with attention, memory, concentration, autonomous thought processes and unusual thought content. Her score on Sc 4 (Lack of Ego Mastery, Conative) suggests that the claimant experiences inertia, massive inhibition and regression; she sees herself as overwhelmed, unable to get moving no matter how hard she tries.

Of note also is the fact that the claimant received scores in the low range on a number of the Supplementary Scales which assess alcohol and drug abuse, including the MacAndrew Alcoholism Scale-Revised (MAC-R); Addiction Potential Scale (APS) and the Addiction Admission Scale (AAS), suggesting that the claimant does not manifest significant problems in this area.

Her scores on 2 Supplementary Scales assessing Posttraumatic Stress Disorder were also scored. Her score on Scale PK (Posttraumatic Stress-Keane) fell within the Moderate range, while her score on Scale PS (Posttraumatic Stress-Schlenger) fell within the markedly elevated range, indicating the presence of some residual symptoms of posttraumatic stress.

Dr. Mosley produced a valid Trauma Symptom Inventory-2 (TSI-2) profile. She received a number of scores falling in the range of T = 65 or greater, considered clinically elevated, and several scores in the range between T = 60-64, which would be considered problematic, in the current administration of this instrument.

She received a score on the Anxious Arousal (AA) Clinical Scale, reflecting symptoms which are clinically elevated/of significant clinical concern. This scale is comprised of 2 subscales. Her score on the Anxious Arousal-Anxiety subscale reflects a significantly high level of worrying, fears, nervousness and possible panic attacks. Her score on the Anxious Arousal-Hyperarousal subscale reflects a significantly high level of autonomic hyperactivity/over-activation of the sympathetic nervous system, as in the "flight or fight" response, characterized by nervousness, jumpiness, hyper-vigilance, and sleep disturbance.

She received a significantly elevated score on Scale D (Depression), reflecting frequent feelings of sadness, feelings of worthlessness and inadequacy, hopelessness/pessimistic view of the future, and social isolation. This score is consistent with her markedly elevated score on the MMPI-2 on Scale 2, as well as her score in the severe range on the Beck Depression Inventory.

Dr. Mosley received a markedly elevated score on Scale IE (Intrusive Experiences), reflecting a clinically high level of symptoms such as flashbacks, upsetting memories that are easily

triggered by current events, and repetitive thoughts of an unpleasant previous experience intruding into awareness. She received a score on Scale DA (Defensive Avoidance), also in the clinically significant range, reflecting her attempts to suppress or eliminate painful thoughts or memories from awareness as well as attempts to avoid events or stimuli in the environment that might be stimulate such thoughts or memories. Her markedly elevated score on Scale DIS (Dissociation) reflects a defensive alteration in awareness, developed as an avoidance response to overwhelming and often posttraumatic psychological distress, including cognitive disengagement, feelings of depersonalization/derealization, i.e., "spacing out" and feeling out of touch with her emotions and/or sense of self.

Her significantly clinically elevated score on Scale SOM-G (Somatic Preoccupations-General), reflects a general preoccupation with physical and health symptoms which may not be accompanied by any real medical illness or injury. Her score on Scale IA-AR (Insecure Attachment-Relational Avoidance), in the clinically elevated range, reflects her tendencies to keep people at a distance, avoiding close relationship and being uncomfortable with intimacy.

She received 2 scores considered to fall within the problematic range (T = 60-64). Her score on Scale IA (the parent scale within which the above-discussed Scale IA-AR is a component) reflects the claimant's general tendency, believed to be more of a stable personality trait than a present psychological state, to maintain emotional distance from others and/or avoid close relationships. Her score on Scale ISR-RSA (Impaired Self-Reference-Reduced Self-Awareness) is reflective of a possible tendency to view others as more immediately relevant and valid than oneself, with a resultant susceptibility to influence, boundary issues, and inadequate self-determination; she may experience confusion over her own thoughts and beliefs, as well as difficulty in accessing an internal-separate self. In summary, there appear to be a number of aspects of posttraumatic stress that Dr. Mosley is presently experiencing, particularly in the areas of autonomic hyperarousal, depression, intrusive thoughts, somatic preoccupations, and caution as well as distance in interpersonal relationships with others.

Diagnosis (DSM-IV-TR)

Axis I	296.24	Major Depressive Disorder, Single Episode, Severe with psychotic features;
	309.81	Posttraumatic Stress Disorder; Rule Out: Bipolar Disorder;
Axis II		Deferred;
Axis III		History of episode of seizure;
Axis IV		Occupational Problem;
Axis V	40	Global Assessment of Functioning (GAF): (upper range between 31-40)(some impairment in reality testing or communication, characterized by illogical thought/speech/delusions) [Whole Person Impairment = 51]

Dr. Mosley is assigned a diagnosis of 296.24: Major Depressive Disorder, Single Episode, Severe with psychotic features in that she meets the following criteria: she experiences 6 of the minimum of 5 of 9 symptoms nearly every day for most of the day, including the following: (1) depressed mood; (2) markedly diminished interest or pleasure in all or almost all activities; (4) insomnia; (6) fatigue or loss of energy; (7) feelings of worthlessness; and (8) diminished ability to think or concentrate).

Additionally, the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms are not due to the direct physiological effects of a substance or general medical condition. The symptoms are not better accounted for by Bereavement, and persist for longer than 2 months or are characterized by marked functional impairment.

Due to the absence of manic characteristics (such as inflated self-esteem/grandiosity, excessive involvement in pleasurable activities, diminished sleep which is an aspect of decreased need for sleep rather than insomnia), it is questionable to this examiner that the claimant suffers from a bipolar disorder. The claimant's insomnia appears to be ego dystonic (i.e., causing her distress) rather than ego syntonic (in harmony with or acceptable to her typical view of how she functions normally) and she does not appear to experience much if any pleasure in her life, nor experience elevated self-esteem, but rather significantly diminished self-esteem, in contrast to the euphoric moods which often characterize the manic aspects of bipolar disorders. However, I have also listed Bipolar Disorder as a "rule out" diagnostic possibility. In my recommendations, below, I indicated the need for Dr. Mosley to be evaluated by a psychiatrist with regard to the most appropriate medication regimen, given her current symptomatology. In many instances a bipolar diagnosis is made on the basis of a patient's response to particular psychotropic medications. It seems most reasonable from a clinical standpoint to either confirm the exclusion of this diagnosis, or include it, based upon additional information obtained from medication response.

It is also my clinical opinion that the claimant is suffering from 309.81: Posttraumatic Stress Disorder, in that she meets the following criteria:

A (1): She witnessed an event that involved actual serious injury to others, which involved a response of intense fear, helplessness, or horror.

B: The traumatic event has been persistently reexperienced in one or more way, including:

(1) recurrent and intrusive distressing recollections of the event; (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; and (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C: Persistent avoidance of stimuli associated with the trauma manifested by at least 3 symptoms, including: (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma; (2) efforts to avoid activities, places, or people that arouse recollections of the trauma;

(4) markedly diminished interest or participation in activities; (5) feeling of detachment or estrangement from others; (6) restricted range of affect;

D: Persistent symptoms of increased arousal, manifested by at least 2 symptoms, including: (1) difficulty falling or staying asleep; (3) difficulty concentrating; (4) hypervigilance.

E: Duration of disturbance is more than 1 month;

F: The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

DISCUSSION

AOE/COE/Causation

In the absence of any prior psychiatric history apparent from my review of extensive records; and in the absence of any records indicating personnel difficulties suggesting inadequate performance of her job duties, it is my clinical opinion that in all reasonable probability, Dr. Mosley's Major Depressive Disorder and Posttraumatic Stress Disorder arose out of her employment, with substantial causation (35-40%) due to industrial factors.

Dr. Mosley outlined a history of events initially precipitated by her witnessing an extremely violent and very likely excessively forceful assault upon one of her inmate patients in the summer of 2009, if her account of the events related is accurate, followed by an immediate response of shunning and harassment by her colleagues in the non-clinical (i.e. custodial/law enforcement) branch of the prison at which she was employed, which has gone on for years. Her response to the initial violent incident is certainly consistent with symptomatology most accurately described as Posttraumatic Stress Disorder, confirmed by at least 2 different psychometric assessment instruments. Her response to the subsequent and ongoing shunning and harassment is also consistent with symptomatology most accurately described as Major Depressive Disorder with psychotic features, representing a continued circumscribed delusional system within an otherwise intact personality structure.

This examiner conducted research into the subject of "whistleblowing" as well as the "code of silence" which frequently exists within law enforcement agencies. Although not a great deal has been written on these topics, there have been a number of studies which document the fact that such a "code of silence" does exist within the law enforcement field, which makes "whistle-blowing" a risky course of action. Studies documenting the existence of such phenomena within the law enforcement and correctional fields include the following:

Gottschalk, P, and Holgersson, S: "Whistle-blowing in the police." Police Practice & Research: And International Journal, Vol. 12 (5), October 2011, 397-409; Gonzales, D: "The act and impact of whistle-blowing on the Los Angeles Police Department", Dissertation Abstracts

International Section A: Humanities and Social Sciences, Vol. 71 (8-A), 2011, 2951; Ivkovic, S and O'Connor, S : "The police code of silence and different paths towards democratic policing", Policing & Society, Vol. 18 (4), December 2008, 445-473; Kaariainen, J, Lintonen, T, Laitinen, A and Pollock, J: "The 'code of silence': Are self-report surveys a viable means for studying police misconducts?", Journal of Scandinavian Studies in Criminology and Crime Prevention, Vol. 9 (2), 2008, 86-96; Seaton, L: "The effect of law enforcement's socialization process on the whistle-blowing behavior of police officers", Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol. 68 (12-A), 2008, 5135; Rothwell, G, and Baldwin, J: "Whistle-blowing and the code of silence and police agencies: Policy and structural predictors", Crime & Delinquency, Vol. 70 (4), Feb 2007, 341-361; Westmarland, L: "Police Ethics and Integrity: Breaking the Blue Code of Silence", Policing & Society, Vol. 15 (2), June 2005, 145-165; Ekenvall, B: "Police attitudes towards fellow officers' misconduct: The Swedish case and a comparison with the USA and Croatia", Journal of Scandinavian Studies in Criminology and Crime Prevention, Vol. 3 (2), 2002, 210-232. There is thus some precedent in the medical literature documenting the fact that such a "code of silence" certainly does exist.

As Dr. Mosley recounted the history of injury, she did not assume the role of being an active advocate for her inmate patient initially—and in fact, it appears to this examiner that she was cast into that role merely by reporting the occurrence—which then led to her being instructed by her superiors to write up a formal complaint on behalf of the injured inmate as well as documents relating to that individual's civil suit, assuming her account is accurate. All of this apparently led to her suddenly being the recipient of dramatically different treatment than she had received previously as a respected member of the Psychology Staff, according to her account. She was now treated somewhat like a "pariah", shunned by the custodial staff, and now having to spend an inordinate time tracking down her patients rather than having them brought to her office.

Additionally, if her account is accurate, the theft of her identification badge and the refusal by the administration to issue her a new permanent pass, instead having her go through the daily humiliation of being asked who she is, and what her business was at the prison every day upon her arrival at work at the prison entrance, would be considered by this examiner as incontrovertibly constituting harassment and retaliation; Dr. Mosley's symptoms are quite consistent with the mechanism of injury described above by such treatment. Although Dr. Mosley claimed not to know all of the details of why 4 psychologist colleagues all left for alternative employment during the same general time frame, if this is an accurate accounting of factual occurrences, it also suggests to this examiner the likelihood of administrative changes which would more likely than not have been less than supportive, if not definitively antagonistic to the clinical practice of psychology within the prison environment. Although these colleagues may not have been subject to the same pattern of retaliation that the claimant appears to have suffered, the fact that Dr. Mosley is not the lone voice of dissatisfaction in an otherwise happy environment does lend credence in this examiner's view to the likelihood of Dr. Mosley's account of ongoing harassment reflecting actual events of employment.

With regard to her injury, from my conceptualization of this case, the injury, or certainly the groundwork for the injury occurred when she witnessed 8 guards tackling her patient, followed

by her being drawn into assuming the role of advocacy for this patient which she did not necessarily seek out, by virtue of being instructed to process a number of documents. This apparently was followed by many months of demeaning treatment, which in addition to being treated as if she were no longer a member of the permanent staff (i.e., by having to obtain a temporary day pass each time she arrived at work, which none of her colleagues apparently were required to do), consisted also of having to walk extensive distances within the prison to fetch her patients, and being subject to insulting remarks such as demeaning racial epithets.

Assuming her account to be accurate with regard to the treatment she received over the next several years, she then suffered an episode of decompensation on 2/25/10, experiencing a seizure along with a delusional episode necessitating her hospitalization for almost a week thereafter. She was then off work for an extended period of time, but unfortunately upon her return to her job, continued to experience the same derogatory treatment. It is a testament to her resilience that she was able to tolerate this as long as she did, making several attempts at remaining in the work environment, despite the unrelenting stressors she was subjected to.

In terms of diagnosis, it is my clinical opinion that she initially suffered Posttraumatic Stress Disorder as a consequence of witnessing the group assault upon her inmate patient; over the next several years as a result of enduring ongoing harassment and humiliation, she then suffered from her presently-persisting Major Depressive Disorder with psychotic features consisting of circumscribed delusions within an otherwise intact personality structure. It is my clinical opinion that in all reasonable medical probability, both conditions have arisen on an industrial basis due to the circumstances described above.

There was no naturally-progressing psychological illness which would better account for her symptoms. There were no indications of disturbances from her childhood or upbringing being in any way responsible for the sudden eruption of her Posttraumatic or Depressive symptoms. It is also highly unlikely that the claimant developed an endogenous psychotic process arising from a progressive psychological illness, due to the fact that at age 62 it is statistically very unlikely that she would suffer such a decompensation (which would have occurred at a much earlier age had she suffered from schizophrenia, as such conditions develop well before the age of 45).

In reviewing the records, I note that the claimant was prescribed the antidepressant medication Prozac 20 mg on 7/6/06 by Dr. Uppal, as her psychology licensing boards were coming up and she was feeling quite stressed. This medication was prescribed for 90 days. Then, on 10/19/06 the prescription was changed to Celexa 20 mg. However, this made her gain weight and was discontinued on 11/7/06, at which time she began a trial of Cymbalta. That also made her gain weight and was changed to Wellbutrin 300 mg on 4/4/07, which I believe she was on for about another 4 months through 11/10/07. Clinical notes from Dr. Uppal also indicate that she was experiencing difficulty sleeping around this time-frame. There is another entry on January 19, 2009 by Dr. Uppal indicating that she was once again having difficulty sleeping.

Thus, it appears that the claimant did have some prior issues with depression and insomnia. However, even if she had such symptoms prior to the seizure incident of 2/25/10, Dr. Mosley

had been able to function in her work. From a review of records provided, it appears that she had been taken off work only for a very brief 2-week period between 7/16/08-7/28/08, prior to the incident of excessive force in the summer of 2009, and the subsequent precipitation of her seizure in February 2010 and eventual decompensation in functioning (although she had been taken off work on multiple occasions following that timeframe, in all reasonable probability due to her being worn down by ongoing shunning and harassment—which are industrial factors).

With regard to the issue of alcohol abuse, it is noted from review of the medical records that when tested at Renown Regional Medical Center, her blood alcohol level was zero. Dr. Mosley further indicated that when she was "pulled" for drug and alcohol testing in a 6-hour ordeal during the middle of her workday, her blood alcohol level was also zero, and there was no indication of her having ingested any other nonprescription drugs. In psychometric testing on the MMPI-2, there were no positives findings on any of 3 Supplementary Scales designed to assess alcohol abuse. There is no convincing evidence to support the hypothesis that she abuses substances.

There were no non-industrial factors of significance which provide more compelling explanations with regard to the etiology of the claimant's symptomatology. From my understanding, she was engaged in no other secondary employment or any other outside activities that would reasonably be responsible for these psychiatric symptoms.

Additionally, as I noted above, there were no indications from psychometric testing to suggest that the claimant had any ongoing issues relating to conflict, rebelliousness or oppositionalism towards authority figures which might be related to difficulties in interpersonal relationships, or that she orchestrated her problems in the workplace. There were no indications that her symptomatology was related to non-discriminatory, good-faith personnel actions.

In consideration of the discussion above, it is my clinical opinion that in all reasonable medical probability, the events of 2/25/10 as well as their ongoing consequences comprised substantial (35-40%) causation of the claimant's industrially-compensable psychiatric injury as defined by the injury causing both temporary disability as well as the need for psychological treatment.

Permanent and Stationary Status

It is my clinical opinion that Dr. Mosley has not yet reached permanent and stationary status from a psychological standpoint as of the date of the present Panel QME Psychological Evaluation on December 13, 2013. From a review of the records as well as by the claimant's indication, she essentially tried to "tough it out" by herself without seeking professional assistance until beginning psychotherapeutic treatment with psychologist Stephanie Dillon, Ph.D. on July 21, 2013, only about 5 months ago. The claimant indicated that she believes she has now had approximately 20 sessions, about 10 in person and 10 by telephone.

Although I consider such treatment necessary, I do not consider it sufficient. In addition, due to the claimant's signs of continued difficulties concentrating, as well as her persistent

circumscribed delusional system, Dr. Mosley also needs to be treated by a psychiatrist well-versed in prescribing appropriate psychotropic medication. From the records reviewed, it appears that she improved significantly during the course of her hospitalization at Renown Regional Medical Center after being administered Zyprexa, a medication which has been used effectively to treat symptoms of posttraumatic stress disorder, as well as psychotic symptoms and bipolar disorders. ***It is crucial that she be evaluated by a psychiatrist and start on an appropriate regimen of psychotropic medication immediately.*** This should be provided on an industrial basis—as should her psychotherapeutic treatment—as there are no clear indications that these symptoms have arisen from any etiology other than from the trauma and harassment she has experienced in her employment environment.

In this regard, I recommend that the 20 sessions that she has received from Dr. Dillon be provided on an industrial basis; I recommend that she receive an additional 35 sessions of treatment from Dr. Dillon or if she wishes to change providers to someone located closer within the immediate Bay Area I would highly recommend any of the following psychologists:

Helena Weil, Ph.D, Albany/Castro Valley (510-525-3529); Stephen Francis, Ph.D., Oakland (510-336-0513); or Dr. Joan Erwin, Hayward.

I would also highly recommend psychiatrist Morey Weingarten, M.D. in Oakland for psychotropic medication management, with the number and frequency of visits over the course of the next 9-12 months of treatment to be determined by the treating psychiatrist.

I would roughly estimate that Dr. Mosley could achieve maximal medical improvement within approximately 9-12 months from the date at which psychotropic management treatment is begun, with the concurrent continuation of her psychotherapeutic sessions.

Finally—I would also recommend that she be seen by a neuropsychologist for evaluation, as certain neurological deficits which are not detectable through neurological exams can emerge on neuropsychological test batteries. Given that her deterioration in functioning essentially began with her atypical seizure, it would be important to determine if there is any neuropsychological component to her disability. ***For this type of evaluation I would recommend Neuropsychologist James Bryant, Ph.D. in San Jose (408)356-2363.***

These recommendations are in accord with *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery of Workers, Second Edition, American College of Occupational and Environmental Medicine, Beverly Farms, Massachusetts: OEM Press, 2004.*

Temporary Psychiatric Disability

It is my opinion that the claimant was temporarily totally disabled on an industrial basis for all of the various periods of time during which she was off work after the summer of 2009. My understanding, these periods of total temporary disability include the following:

2/26/10-8/31/10; 10/22/10-2/27/11; 9/16/11-10/30/11; and 7/30/12-present (projected return per Dr. Uppal on 1/15/14). In my opinion, all of these periods of temporary total disability should be covered on an industrial basis.

However, although Dr. Mosley is slated to return on 1/15/14, in my opinion, she will not be ready to resume work at that time, as I would estimate that it would likely take another month before she could get in to see a psychiatrist and begin an appropriate regimen of psychotropic medication, and then at least an additional 2 months (or possibly more; I would defer to the prescribing psychiatrist in this regard) before she would be stabilized enough to make a return to work. Making a rough estimation, and assuming that she could begin appropriate medication by 1/15/14, it is possible that she might be able to return to work on 3/15/14. Again, however, I would defer to the prescribing psychiatrist and treating psychologist with regard to her actual return-to-work date.

Work Preclusions

When she does return to work, however, I am of the strong opinion that she would not be able to return to work at the High Desert State Prison, but would need to be transferred to a different location, as I would not anticipate that she would encounter any difference in treatment than that which she has already been subjected to at that environment. It is my opinion that she remains at high risk of further decompensation were she subjected to resumed or continued exposure to such a work environment. This is a permanent work preclusion.

Permanent Disability

As the claimant has not yet achieved permanent and stationary status, this topic is deferred until such time as she has reached maximum medical improvement, the preconditions of which have been outlined above. I would certainly be glad to reevaluate her at such a point in time.

Apportionment

As apportionment pertains only to permanent disability, this topic will also be by necessity deferred until such time as the claimant has reached maximal medical improvement/permanent and stationary status, and if she sustains permanent disability.

Future Treatment

Once again, it is indeterminate as to what Dr. Mosley's treatment needs would be in the future until she attains permanent and stationary status. This topic therefore we will also by necessity have to be deferred until she reaches maximum medical improvement, at which time I would be willing to perform a reevaluation.

I hope that the above information is of assistance. Please do not hesitate to contact me if I may be of further assistance.

I declare under penalty of perjury that this report was prepared in compliance with Labor Code Section 4628, and 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, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I personally performed the evaluation of this patient on December 13, 2013, 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 have no financial interest in any other entities involved in the administration of workers' compensation claims in accordance with California Labor Code §139.32.

I declare under penalty of perjury that I have not violated Section 139.3 of the Labor Code of the State of California, and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

I further declare under penalty of perjury that the name and qualifications of each person who performed any services in the connection with the report, including diagnostic studies, other than clinical preparation, are as follows: None

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

A. Records Review & Summary		6.75 hours
B. Clinical interview		5.00 hours
C. Clinical Research		1.00 hours
D. Preparing written report		12.75 hours
	Subtotal =	25.50 hours
E. Administering/scoring/interpreting psychological tests	+	4.75 hours
	=	30.25 hours

Signed this 23rd day of December, 2013 in the County of Alameda in the State of California.

Sincerely,

Stephen J. Heckman, Ph.D.
Licensed Clinical Psychologist
Qualified Medical Evaluator

STEPHANIE DILLON, Ph.D.
LICENSED PSYCHOLOGIST

Attorney Mark Singer
Calpers Representative for Calpers
Disability Retirement
12501 Chandler Blvd. Ste. 200
North Hollywood, Ca.

August 15, 2015

Re: Dr. Linda Mosley

I am writing in regard to the current condition of Dr. Linda Mosley, whom I began treating in psychotherapy on 6-17-13. Dr. Mosley was injured in the workplace after having reported the use of excessive force used on her inmate patient by guards at High Desert Maximum Security prison. Dr. Mosley's injuries were caused by ongoing psychological torment of her by nearly all personnel in the institution, after she had reported the incident of undue use of force on her patient by the guards. (Please see my detailed reports to S.K Uppal, M.D. for more specific information). The institutional shunning and damaging prejudicial treatment of Dr. Mosley by prison staff eventuated in her having a seizure and a psychotic break. She was medivaced to Renown Medical Center in Reno, Nv., where she was stabilized over a period of three days. She recuperated for six months and then returned to work.

I have continued to treat Dr. Mosley weekly in psychotherapy. She carries the diagnoses of Post-traumatic Stress Disorder, Major Depression, and Anxiety Disorder. Her trauma was caused by ongoing harassment in the workplace, beginning in 2009. She continues to be disabled and she was disabled while working for the State of California. She takes Wellbutrin and Lunesta to assist her in functioning. Dr. Mosley has made gains in her functioning (e.g. now gets up and dressed every day, when initially she would be unable to get out of bed for days at a time). She is a courageous psychologist who stood up for the rights of her patient and has suffered enormously for doing the ethically correct thing.

Please contact me if you have any questions.

Sincerely,

Stephanie Dillon, Ph.D.

Enclosed are copies of my reports to S.K.Uppal, M.D.

1065 HASKELL ST. • RENO, NEVADA 89509 • (775) 329 - 4345 • FAX: (775) 324 - 7849

S.K. Uppal, M.D.
P) Box 1150
103 Fair Drive
Susanville, Ca. 96130

July 21, 2013

Re: Dr. Linda Mosley

I have seen Dr. Mosley for two extended sessions, on 6-17-13, and 7-11-13. Dr. Mosley was injured in the workplace, a maximum-security prison where she works as a psychologist. She had five positive years of employment there, experiencing good colleagueal and personal relationships. On June 30, 2009 she was referred an inmate for treatment who alleged that a guard was sexually groping him. She conducted individual therapy with this inmate over a period of months. In September of 2009, Dr. Mosley observed an incident of excessive use of force by the guards who had escorted this same inmate to her office for his therapy appointment with her. The inmate was outside her office door, turned his head to the side, and the guards jumped on him. Dr. Mosley felt that excessive and unnecessary force was used to subdue the inmate and she felt an ethical obligation to report the incident, as any courageous psychologist would. She told her chief about the incident and he stated that she had to write it up which she did.

Several weeks elapsed and then Dr. Mosley noticed that she began to be treated very differently by guards and professionals, than prior to her report of excessive use of force by the guards. She was made to wait outside of buildings, whereas before the incident, she was quickly escorted by the guards to her office in each building. This of course caused her to feel anxious and uneasy about her safety in doing her job. Her professional friends avoided her and no one stood up for her. The guards called her names, including "nigger bitch," and all personnel shunned her, including nurses and secretaries and support staff. She lived in Susanville, a town of about 18,000, where this maximum security prison is, and where most of the adults in the town work for the prisons that are there. She became profoundly socially and professionally isolated. Her professional friends transferred to other institutions. In addition, she had to go to work and be exposed to the very situation where the ongoing psychological torment of her was occurring. Her commanding officers turned distant and cool whereas before they had been friendly and supportive.

On February 26, 2010, she had what appeared to be a seizure, the police broke down her door and she was helicoptered out to Renown Medical Center in Reno, Nevada, where she was stabilized over a period of three days. She then went to stay with her sister in the Bay area, in order to recuperate. She returned to work about six months later. Dr. Mosley has repeatedly returned to work where her constant exposure to being shunned depletes and damages her, as it would anyone. She had become depressed and anxious and is being treated for chronic fatigue syndrome, brought about by these events in the workplace.

Dr. Mosley meets all criteria for Post-traumatic Stress Disorder (DSM IV 309.81). In order to heal, Dr. Mosley must not return to the workplace where she is subject to ongoing heinous psychological harassment.

Please contact me if you have any questions.

Sincerely,

Stephanie Dillon, Ph.D.

S.K. Uppal, M.D.
PO Box 1150
103 Fair Drive
Susanville, Ca. 96130

July 21, 2013

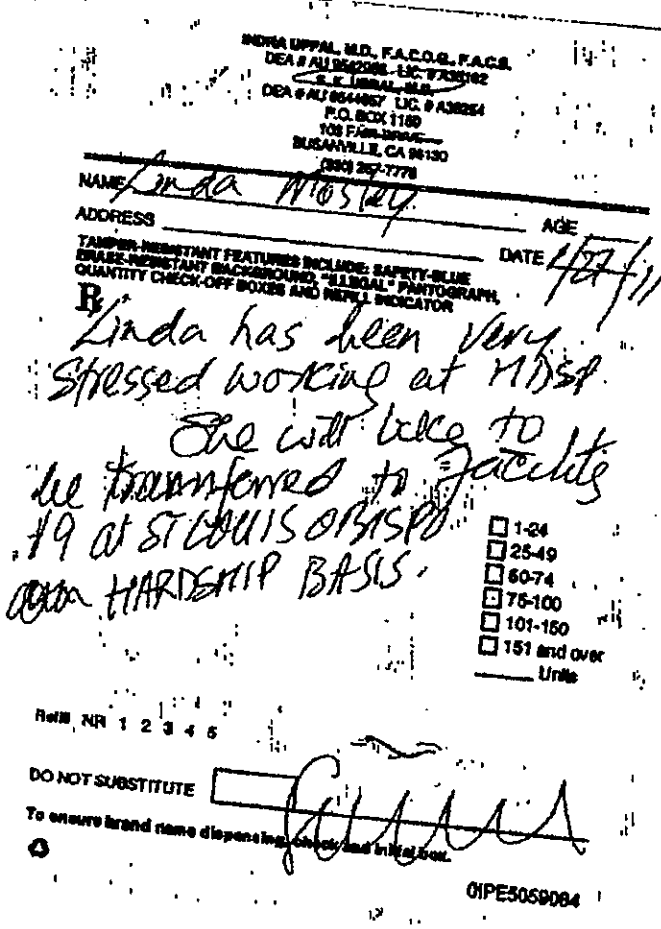
Re: Dr. Linda Mosley

I have seen Dr. Linda Mosley since 6-17-13. She meets criteria for the diagnosis of Post-traumatic Stress Disorder (DSM IV 309.81). Her trauma was caused by ongoing harassment in the workplace, beginning in 2009. She was injured in the workplace and in order to heal she can never return to that workplace.

Please contact me if you have any questions.

Sincerely,

Stephanie Dillon, Ph.D.



INDRA UPPAL, M.D., F.A.C.O.G., F.A.C.S.
DEA # AU [illegible] LIC # [illegible]
R. K. UPPAL, M.D.
DEA # AU 8644957 LIC. # A38264
P.O. BOX 1169
108 Fabian Street
SUSANVILLE, CA 96130
(530) 257-7778

NAME Linda Mosley AGE
ADDRESS DATE 4/27/11

TAMPER-RESISTANT FEATURES INCLUDE: SAFETY-BLUE BRAZE-RESISTANT BACKGROUND, "ILLEGAL" PANTOGRAPH, QUANTITY CHECK-OFF BOXES AND REFILL INDICATOR

℞ Linda has been very stressed working at MDSP. She will like to be transferred to Facility 19 at St Louis Obispo asa HARDSHIP BASIS.

- ☐ 1-24
- ☐ 25-49
- ☐ 50-74
- ☒ 75-100
- ☐ 101-150
- ☐ 151 and over

_____ Units

Refill NR 1 2 3 4 5

DO NOT SUBSTITUTE ☐

To ensure brand name dispensing, check and initial box.

0IPE5059084

§ 9785.5. Request for Authorization

State of California
Division of Workers' Compensation
Request for Authorization for Medical Treatment (DWC Form RFA)

To accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

☐ **Check box if the patient faces an imminent and serious threat to his or her health.**
☐ **Check box if request is written confirmation of a prior oral request.**

Patient Information
Patient Name: Linda Mosley
Date of Birth: [redacted]
Date of Injury: 3/25/10 Accumulative
Employer: HDSP
Claim Number: 059/2242

Claims Administrator Information
Claims Administrator: State Fund Compensation
Adjustor Name (if known):
Address: P O Box 3171
City, State, Zip: Suisun City, CA 94585
Telephone Number:
Fax Number: 707-646-0584

Provider Information
Provider Name: S. K. Uppal, M.D.
Practice Name:
Address: 103 Fair Drive
City, State, Zip Code: Susanville, CA 96130
Telephone Number: 530-257-7773
Fax Number: 530-257-2939
Provider Specialty:
Provider State License Number: A-35254
National Provider ID Number: 1063585792

Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)
Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Include supporting evidence as necessary. More than one treatment request may be included.

Diagnosis:	Emotional Stress, Insomnia
ICD Code:	309.9, 780.52
Procedure Requested:	
CPT/HCPCS Code:	
Other Information: (Frequency, Duration Quantity, Facility, etc.)	

9/26/13
Date of Request

Provider Signature

Claim Administrator Response Approving Treatment:
You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all timeframes and requirements set forth in California Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.9 and 9792.9.1.

A decision on the requested medical treatment must be made within five (5) working days from receipt of this request for authorization, or 14 calendar days with a timely request for information necessary to render a decision. For an expedited request, one made in a case of imminent or serious health threat, the maximum is 72 hours. Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information.

☐ **The requested treatment(s) is approved**

☐ **The request has been previously denied by utilization review**

Date request for authorization received

Claims Administrator/Authorized Agent Signature

Date of response to request

Adjuster/Authorized Agent Name (print)

Patient: Linda Mosley
DOS: 09/17/2013
DOI: 02/25/2010 Cumulative
Claim #: 05912242

Subjective: This 62 year old female patient comes back today. She works as a psychologist at High Desert State Prison under the supervision of Timothy Nolan. She complains of cumulative stress, seizures, three days hospitalizations, and multiple leave of absences with a diagnosis of chronic fatigue syndrome and PTSD resulting from retaliatory hostile work environment after filing a report because she observed excessive force on inmates. Following which, she saw lack of management support. She started having anxiety spells, and insomnia.

Past History: She had an appendectomy at age 12. She has history of high blood pressure, and insomnia. History of unexplained seizures in 2009 for which she was hospitalized. History of chronic fatigue syndrome, and stress.

Personal History: Patient does not smoke, drinks alcohol minimally.

Family History: There is history of diabetes, and high blood pressure.

Allergies: Penicillin.

Systematic Review: No cold or cough, no headache, no visual or auditory symptoms. No chest pain. No diarrhea, vomiting, or constipation. No dysuria or polyuria. No hemoptysis or hematocyst.

General: Patient is alert, active, good color.

Vitals:

B.P.: 127/82	Temp.: 98.1	Resp.: 16
Pulse: 74	Height: 5' 9"	Weight: 189.4

HEENT: Head is normocephalic, atraumatic. Eyes - cranial nerves 2-6 intact. Sclera and conjunctiva are clear. Somewhat hard of hearing, no lesions, clear ears. Throat normal.

Neck: JVP is not raised, no carotid bruit, no lymphadenopathy. No thyromegaly.

Chest: Normal looking chest. Equal air entry. No adventitious sounds.

Heart: Both heart sounds well heard. No definite heart murmur.

Abdomen: Patient has soft abdomen, no masses, no hernia.

Patient: Linda Mosley
DOS: 09/17/2013

GU:	Normal looking.
Extremities:	Peripheral pulses well felt, no peripheral edema. Extremities reveals no abnormality.
CNS:	Patient is well oriented to time, place and person. Cranial nerves are intact.
Impression:	Stress at work, PTSD, history of seizures, insomnia, hostile atmosphere.
Plan:	At this point, I gave her a note to be off work through 11/30/2013. I gave her a Rx of Ambien 10mg HS PRN, Alprazolam 0.25mg BID PRN. I'll see her back in a month.

Thank You,

S.K. Uppal, MD
S.K./ms

I have no[illegible]violated Labor Code [illegible] and the contents of this report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

DATE OF REPORT / CLAIM 2-25-10
Dated this 17 day of 9-2013
in Susanville, California

S. K. Uppal, M.D.
Indra Uppal, M.D.
103 Fair Drive
P. O. Box 1150
Susanville, CA 96130

February 05, 2015

nelnet
EDUCATION PLANNING & FINANCING

U.S. Department of Education
Information about your federal student loan

Total and Permanent Disability Servicing Unit

>02213 4990147 001 008187

LINDA MOSLEY
[redacted]

Account Number [redacted]

Dear LINDA MOSLEY:

The U.S. Department of Education (the Department) has completed its review of your Total and Permanent Disability (TPD) discharge application requesting discharge of your William D. Ford Federal Direct Loan (Direct Loan) Program loan, Federal Family Education Loan (FFEL) Program loan, Federal Perkins Loan (Perkins Loan) Program loan, and/or your Teacher Education Assistance for College and Higher Education (TEACH) Grant Program service obligation. Throughout this letter, we use the term "loan" to refer to one or more loans. In addition, we use the terms "you" and "your" to refer to the disabled individual who applied for discharge, LINDA MOSLEY.

Nelnet assists the Department in administering the TPD discharge process, and we will communicate with you on behalf of the Department concerning your discharge request.

Effective 02/05/2015, the Department has approved your application for discharge of the federal student loan or TEACH Grant service obligation identified below on the basis of your total and permanent disability. This letter contains important information regarding the TPD discharge.

Your holder(s) will now transfer your loan and/or your TEACH Grant service obligation to us for discharge and a 3-year post-discharge monitoring period, as described below. We will notify you again when we have discharged your loan and/or TEACH Grant service obligation.

We have instructed your loan holder(s) to return any loan payments that were received after your disability date to the person who made the payments. For this purpose, your "disability date" is the date we received the documentation of your Social Security Administration (SSA) notice of award for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits, or the date the physician certified your discharge application, depending on the type of documentation you provided to show that you are totally and permanently disabled.

WHAT YOU NEED TO DO:

- Information about your loan and/or TEACH Grant service obligation that will be discharged is shown below. Carefully review this information and notify us immediately if you do not see one of your loan holders or TEACH Grant service obligation holders included in the list. Also let us know if you do not see one of your loans or TEACH Grant service obligations included in the list, or if you continue to receive bills from your loan holder(s).

- Review the requirements for the 3-year post-discharge monitoring period and the conditions under which your obligation to repay your loan or complete your TEACH Grant service obligation may be reinstated

Holder Name	Holder Phone	Type	Date	Amount	School ID
AES	(800)-233-0557	FFEL Consolidated	04/27/2005	$143,972	N/A
AES	(800)-233-0557	FFEL Consolidated	04/27/2005	$50,720	N/A