BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MATTHEW MAZZONE, Claimant, v. TEXAS ROADHOUSE, INC., Employer, and HARTFORD INSURANCE COMPANY OF THE MIDWEST, Surety, Defendants.	)	**IC 2005-012469** **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** Filed August 5, 2011

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Idaho Falls on December 9, 2010. Claimant, Matthew Mazzone, was present in person and represented by Stephen A. Meikle of Idaho Falls. Defendant Employer, Texas Roadhouse, Inc. (Employer), and Defendant Surety, the Hartford Insurance Company of the Midwest, were represented by Alan R. Gardner of Boise. The parties presented oral and documentary evidence. Post-hearing depositions were taken and briefs were later submitted. The matter came under advisement on May 23, 2011.

ISSUE

The sole issue to be decided by the Commission is whether, and to what extent, Claimant's November 13, 2005 injury includes a psychological condition pursuant to Idaho Code § 72-451. All other issues are reserved.

CONTENTIONS OF THE PARTIES

Claimant contends that he suffers from Post-Traumatic Stress Disorder (PTSD) as a result of a severe industrial burn injury he suffered on November 13, 2005, and his subsequent treatment which required several weeks of a very painful daily debriding and dressing process. He argues that he cannot function due to recurrent nightmares and flashbacks related to his ordeal, headaches, and other symptoms, all of which he attributes to PTSD and his industrial injury. He relies upon the opinions of Chad Murdock, M.D. and Mary Beth Ostrom, M.D., both psychiatrists, to support his claims.

Defendants counter that Claimant has failed to establish either that his industrial burn injury is the predominant cause of his PTSD or that he has proven by clear and convincing evidence that he suffers a resultant psychological injury arising out of and in the course of his employment. They argue that Claimant has a long history of psychiatric difficulties, that he is not a credible witness, and that his symptoms before the industrial accident are not significantly different from those he now suffers. Defendants rely upon the opinion of Michael Enright, Ph.D., a psychologist, in support of their defense.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. The pre-hearing deposition testimony of Claimant, taken May 22, 2008, and admitted into evidence as Defendants' Exhibit 33;
3. The testimony of Claimant and of Claimant's wife, Randi Mazzone, taken at the December 9, 2010 hearing;

4. Claimant's Exhibits A through H and Defendants' Exhibits 1 through 36, admitted at the hearing;
5. The post-hearing deposition testimony of Mary Beth Ostrom, M.D., taken December 15, 2010;
6. The post-hearing deposition testimony of Chad Murdock, taken January 17, 2011; and
7. The post-hearing deposition testimony of Michael F. Enright, Ph.D., taken February 24, 2011.

MOTIONS TO EXCLUDE

On December 7, 2010, Defendants filed a Motion to Exclude Exhibit, Or Portions Thereof, seeking to exclude from evidence any diagnostic opinion evidence from any person other than qualified psychologists and psychiatrists and, specifically, Defendants' Exhibit G. On December 8, 2010, Claimant filed Claimant's Motion to Exclude Testimony And/Or Exhibit, seeking to exclude from evidence Defendants' Exhibit 34. Both motions were argued at the hearing and the Referee took the matters under advisement. The parties' motions are well-taken given the array of opinions and qualifications backing them in the record. Both motions are overruled; however, to the extent that any individual who is not a psychologist or psychiatrist seeks to advance an unqualified diagnostic opinion, such opinion will be given no weight.

OBJECTIONS

The following objections are sustained: (Ostrom Dep.): Defendants' objections recorded at pages 19, 21, and 23; and (Murdock Dep.): Defendants' objections recorded at pages 19, 24-26. All other pending objections are overruled.

After having considered the above evidence and the arguments of the parties, the Referee submits the following findings of fact and conclusion of law for review by the Commission.

FINDINGS OF FACT

1. Claimant was 34 years of age and residing in Idaho Falls at the time of the hearing. On November 13, 2005, he suffered a severe burn when he tripped at work, plunging his right forearm into a deep fat fryer. His hand is now symptom-free except that it aches in the cold of winter. Claimant's Dep., p. 93. However, Claimant believes he suffers PTSD as a result of this injury and subsequent treatment, which he described as an excruciatingly painful debriding process that he had to undergo every day for several weeks. His wife confirms that Claimant has endured a physically and psychologically painful ordeal, that he has nightmares and other symptoms, and that his psychological condition has worsened since his industrial burn injury.

2. Claimant has a history of psychiatric treatment, including inpatient care and medications, for bipolar disorder, depression and anxiety since 2001. He failed to accurately report this history when he sought treatment for PTSD. Significantly, although he testified he was diagnosed with bipolar disorder when he was 18 or 19, and his medical records in evidence confirm that he received treatment and medication for bipolar disorder, anxiety disorder and depression well before his burn injury, he only disclosed depression due to bereavement over the stillbirth of his daughter. In addition, there are inconsistencies in his subjective reports contained within his medical records that are too numerous to be found to be inadvertent errors. The Referee finds Claimant is not a reliable historian with respect to his medical history. Therefore, where Claimant's testimony differs from the information contained in his medical records, more weight is allotted to the information in the records.

3. Claimant returned to work for Employer following his burn injury in March 2006. However, he explained, he left that job and moved to Massachusetts because he was uncomfortable working in the same environment. The kitchen smells, particularly the odors emanating from the four fryers, induced a fear reaction. He tried working up front and just working prep hours, but the reaction persisted. He thought he could change his reaction by changing his environment.

4. On arrival in Massachusetts, Claimant took a job in another of Employer's Texas Roadhouse restaurants, but soon felt he needed a change, so he left. Thereafter, Claimant took a job with Legal Sea Foods, a restaurant which had 12 fryers. At the beginning of that employment he felt better because, as he described it, he thought he would. But Claimant soon left that job as well, for reasons he attributes to his burn injury.

5. While Claimant was in Massachusetts, his son was born. His son's cleft palate condition and surgeries to correct it have been a significant stressor for Claimant, as have financial concerns.

6. Claimant then returned to Idaho, where he took a job with Ruby River Steakhouse. After six months, he left that job due to interpersonal issues. He cited his inability to trust; moment to moment he did not know whether someone was going to hurt him.

7. Subsequently, Claimant took a job as a sprinkler pipe fitter, but that did not work out because it was outside his skill set. Next, he was employed refilling printer cartridges, but he left that job when he fell off a ladder and got hurt. Claimant cited trust issues with coworkers as a reason impacting his departure from both of these jobs, the second one in particular. He believed a coworker was supposed to be holding the ladder to prevent him from falling, so after he fell, he felt his trust difficulty issues were reinforced.

8. Following these jobs, Claimant took various temporary positions working for a staffing agency.

Claimant's Relevant Preinjury Medical and Psychiatric Care Records

9. **Pharmacy.** Claimant has a prescription history at Walgreen's Pharmacy prior to November 13, 2005 indicating treatment for sleeplessness, bipolar disorder, anxiety disorder, migraines and depression. Beginning in 2001, Claimant received Lorazepam pills, commonly prescribed for short-term treatment of severe anxiety and panic attacks, as well as migraines; Zoloft anti-depressant pills; Zyprexa pills, commonly prescribed to treat bipolar disorder; temazepam pills, commonly prescribed for insomnia; clonazepam pills, commonly prescribed to treat seizures and panic disorder, as well as migraines; Topamax pills, commonly prescribed for epileptic seizures and migraines; Gabitril pills, commonly prescribed to treat partial epileptic seizures and migraines; and Ambien sleep aid pills. Claimant purchased medications from Walgreen's sporadically; however, he received an undetermined amount of medications from other sources, as well. For instance, he received Zyprexa samples on November 10, 2005 from Darin Leslie, PA-C, physician assistant to Robert J. Brock, M.D., psychiatrist. DE 17, p. 276.

10. **Inpatient treatment.** From September 26 through 30, 2002, Claimant was admitted to Thunderbird Samaritan Hospital in Arizona for treatment of severe psychological symptoms. Claimant reported "I just cannot take it anymore." DE 7, p. 175. During intake, Claimant disclosed that he had received counseling and inpatient psychiatric treatment in the past when he was 18 or 19 following a break-up. He cited the stillbirth of his daughter in May 2002 as a causal factor in his current symptomatology, including inability to function because he was extremely depressed. Claimant also reported and that he had not slept in the previous 48 hours. He had vague suicidal thoughts with a diminished appetite and weight loss of 40 pounds over the previous two months. In addition, Claimant reported rageful periods of head-banging. Claimant

rated his depression and anxiety each at "10" on a 1-10 scale. On admission, Claimant's medications included Zyprexa, Restoril (temazepam), Zoloft and Topomax. His Global Assessment of Functioning (GAF) Scale was scored at 35.[1] By the time Claimant was discharged, his GAF score had improved to 55.[2] His discharge diagnosis was mood disorder, not otherwise specified, and his medications on discharge included Zoloft, Klonopin (clonazepam) and Zyprexa. Claimant participated in an aftercare program following his discharge.

11. **Emergent and general care.** On January 11, 2003, Claimant presented to the EIRMC emergency department for evaluation of vague symptomatology. He reported a history of bipolar disorder and PTSD and had been out of his prescriptions for Zyprexa, Zoloft and Gabitril five days. The attending physician refilled his medications.

12. Magic Valley Regional Medical Center (MVRMC) records from June 2003 indicate Claimant has a history of bipolar disorder. They also indicate suspicion of exaggerated pain response from Claimant in connection with a headache. Daniel Preucil, M.D. prescribed Klonopin, which helped significantly with Claimant's anxiety so he could sleep. Without it, Claimant's headaches were apparently waking him up in the middle of the night and making him vomit.

13. In February 2004, Claimant established care in Colorado with Caitlin M. Ahern, M.D., in part because he sought medication for his bipolar disorder. He had been unable to

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[1] The GAF Scale is a rating of overall psychological functioning on a scale 1-100, with 100 signifying superior functioning. *Diagnostic and Statistics Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, p. 34. A GAF score between 31 and 40 indicates: "Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work…)." *Id.,* (emphasis excluded).

[2] A GAF score of 51-60 indicates: "Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers)." *DSM-IV-TR,* p. 34, (emphasis excluded).

purchase any because he had no insurance. Dr. Ahern's assistant provided Claimant's wife with information as to how to find a psychiatrist for Claimant.

14. In April 2004, Claimant reported insomnia even with Zyprexa. Dr. Ahern surmised that his insomnia would improve with better control of his mania and prescribed Ambien.

15. Also in April 2004, Claimant sought treatment for his bipolar disorder and insomnia at Health Reach, a Wyoming healthcare service provider, and from Harris Jensen, M.D., a psychiatrist. Claimant reported a history of bipolar disorder and recent depression, sleep difficulty and mania. Stressors included the memory of his stillborn daughter, his year-old son's cleft palate condition requiring several surgeries, and debt. Dr. Jensen diagnosed rapid cycling bipolar disorder and prescribed Zyprexa and Depakote. Approximately one week later, Dr. Jensen again saw Claimant, noted improvement and continued his medications.

16. In July 2004, Claimant reported to Dr. Ahern that his headache was worse at night and that his depression and mood swings had improved with medication.

17. On April 6, 2005, Claimant was evaluated at the EIRMC emergency department for a headache. He reported a head injury in 1998 for which he underwent a CT imaging scan. Another CT scan was performed, returning normal findings. Chart notes that month from three subsequent appointments with Tony C. Roisum, M.D. indicate Claimant continued to have difficulty with headache, insomnia, fatigue and other symptoms.

18. On November 11, 2005, Claimant underwent a psychiatric evaluation by Mr. Leslie at Dr. Brock's office. Claimant was 29 years of age at the time and complaining of manic symptoms including sleep deprivation for two weeks (in spite of receiving Ambien a few days earlier), difficulty concentrating, and feelings of being overwhelmed. He had lost 18 pounds in

three weeks and was having suicidal thoughts, but no intention or plans to act on those thoughts. He was also seeing things out of the corners of his eyes that were not there. Claimant described a similar episode five years earlier following the stillbirth of his first child, milder than his current symptoms, for which he was hospitalized for four days. He also described significant current psychosocial stressors including the health of his 2-year-old son, who was experiencing an unknown illness and who had also already undergone nine surgeries in his short life to correct a cleft palate, as well as his high-stress job as a restaurant manager, at which he worked 70 hours per week with only one day off. Mr. Leslie diagnosed adjustment disorder, mixed. Claimant's medications included Lithium, clonazepam and Zoloft. He was previously taking Depakote, Zyprexa, Topamax, Valium and Wellbutrin.

19. Mr. Leslie assessed Claimant's GAF score at 55 as compared to a high of 85[3] for the year (55/85). His only source for assessing Claimant's year-high was Claimant's reports, and he was apparently unaware of Claimant's history of bipolar disorder and other lingering symptoms following his 2001 bereavement event. Mr. Leslie regularly reports his GAF scores in terms of "(current assessment)/(high score for the year)."

<u>Claimant's Industrial Burn Injury and Treatment Records</u>

20. Two days after his initial evaluation at Dr. Brock's office, on November 13, 2005, Claimant suffered his above-described industrial burn injury. A coworker drove him to the Eastern Idaho Regional Medical Center emergency room, where his injury was assessed as a full-thickness burn. As a result, Claimant was flown to the University of Utah Hospital (UUH)

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[3] A GAF score of 81-90 indicates: "Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members)." *DSM-IV-TR*, p. 34, (emphasis excluded).

in Salt Lake City where, on November 14, his burn was evaluated as a partial-thickness wound running the length of his forearm with no vascular compromise. Claimant's wound was debrided and dressed daily. He was given intravenous Fentanyl for pain.

21. Claimant was discharged from UUH on November 18, 2005. During his four-day stay, he received both medical care and counseling. He was noted in a medical evaluation on November 15 to have exhibited exaggerated pain behaviors and in a counseling chart note on November 17 to have an exaggerated impression of his injury, as well as other mental issues:

> Matthew presented with pressured speech, nonlinear and repetitive in questions, and had a difficult time keeping information straight. He seemed to have difficulty focusing and was almost grandiose in his impression of his injury. I continually had to re-focuss [sic] and redirect him. There were several times that I provided information that I know nursing had already provided and he stated "no one has told me this before." His wife seems to respond to his spontaneous decision making by pulling back and not making any decisions.

DE 18, p. 298.

22. Following discharge from UUH, Claimant stayed at a hotel in Salt Lake City through at least November 28 in order to receive follow-up wound care, including daily debriding and dressing.

23. On November 23, the attending physician noted Claimant's wound was healing well, with the dorsal part of his right hand lagging behind his forearm. Claimant was doing well in physical therapy and reported that it was the first day his pain was well-controlled. He was taking oxycodone and concerned about running out.

24. On November 28, Claimant's pain was still well-controlled with oxycodone and Ibuprofen. He demonstrated good range of motion and wound-healing and expressed a desire to return home to Idaho.

25. Claimant followed up at UUH on December 13, 2005. On exam, he exhibited hypersensitivity over his healed burns. Claimant had been weaning off his opioid medications, and then quit cold turkey two days before this appointment, causing him to develop withdrawal symptoms. Also after weaning off his narcotic medication, Claimant began having nightmares and flashbacks. He associated the flashbacks with sleep deprivation. Along those lines, Claimant reported his problem with falling asleep was "not being able to turn off." DE 18, p. 318. The counselor at UUH encouraged Claimant to follow up with his psychiatrist (Dr. Brock) and counselor in Idaho.

26. Claimant was treated by Mr. Leslie under the auspices of Dr. Brock several times after his injury. According to chart notes, on December 19, 2005 Claimant was healing well from his burn. Dr. Brock's notes, like the UUH records, indicate Claimant reported he had thrown all of his pre-injury medications away, but he now sought new prescriptions because his pain was increasing, he was beginning to have nightmares, and he was feeling more anxious and overwhelmed. In a June 9, 2008 letter to Claimant's counsel, Mr. Leslie elaborated on the nature of Claimant's symptoms. He recalled that Claimant's nightmares and anxiety were related to returning to work, but his arm injury was not a primary concern during any of his post-injury visits. Mr. Leslie diagnosed adjustment disorder, mixed, and prescribed Lithium, Zyprexa, clonazepam, Lunesta and tramadol. He assessed Claimant's GAF at 55/85, the same level he assessed on November 10, 2005.

27. On January 9, 2006, Mr. Leslie noted that Claimant had recently returned to work, with attendant anxiety, worse on Wednesdays when he did inventory. Claimant was sleeping better, only taking Lunesta every other night, and his nightmares were improving. Mr. Leslie maintained his diagnosis, adjusted Claimant's medications, and assessed an improved GAF of

65[4]/85. On January 23, 2006, Claimant reported continued improvement. He was feeling better, and wanted to try working some full shifts. He was sleeping well without Lunesta. Although he had occasional nightmares, he was able to fall back to sleep afterward. Mr. Leslie maintained Claimant's diagnosis, adjusted his medication dosages and assessed a further improved GAF of 75[5]/85.

28. R. Timothy Thurman, M.D., a hand surgeon, treated Claimant from December 21, 2005 through May 17, 2006. On January 24, 2006, Dr. Thurman released Claimant to gradually return to full-duty work, starting January 30, with no restrictions other than to wear a protective glove as needed. On February 21, 2006, Claimant indicated he had some swelling in his right hand after work, but nevertheless he wished to increase his work schedule. Dr. Thurman released Claimant to work 40 hours per week with two consecutive days off.

29. Claimant maintained his improved GAF of 75/85 following his March 1, 2006 follow-up with Mr. Leslie. Mr. Leslie noted:

> Has been doing quite well recently. Is back to work 5 days a week now and hasn't needed to take a Xanax for the last week. Continues to have some waves of anxiety when at work, but has continued to decrease over time. Sleeping difficulty following work at times, "can't wind down." Has been taking Lunesta for sleep, but not Xanax.

DE 17, p. 280. Mr. Leslie maintained his diagnosis of adjustment disorder, mixed, and discontinued Claimant's Lithium.

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[4] A GAF score of 61-70 indicates: "Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships." *DSM-IV-TR,* p. 34, (emphasis excluded).

[5] A GAF score of 71-80 indicates: "If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork)." *DSM-IV-TR,* p. 34, (emphasis excluded).

30. On March 21, 2006 Claimant reported to Dr. Thurman swelling and some pain following long 10-12 hour shifts at work. Claimant requested a new work release to allow him a limited-hour day following his 2 days off, which Dr. Thurman issued.

31. On April 9, 2006, Claimant was treated at the Madison Memorial Hospital emergency department after he had a seizure, his second that week. Claimant had no prior history of seizures. The treating physician posited the seizures were due to Zyprexa, with Claimant's head trauma from several years back possibly playing a part. Claimant's Zyprexa and Xanax were replaced with Dilantin and Ativan.

32. Claimant saw Mr. Leslie for the final time on April 12, 2006. The focus of the visit was to assess Claimant's prescriptions in light of two recent medication-related seizures. Mr. Leslie noted that Claimant continued to take Lunesta as needed for sleep and that he had continued to work without a problem, only taking Ativan at night. Mr. Leslie changed his diagnosis to major depressive disorder (recurrent, moderate) and generalized anxiety disorder, altered Claimant's medications, and assessed a GAF of 65/85.

33. Also on April 12, 2006, Claimant saw Dr. Thurman. He reported doing well at work and sought release for a normal work schedule with one five-hour day, which Dr. Thurman issued. On May 17, 2006, Claimant attended his final appointment with Dr. Thurman. Claimant continued to experience intermittent burning pain on the dorsum of his right hand but had no significant limitations with his return to work. Dr. Thurman opined Claimant had reached maximum medical stability and that he had normal wrist motion measurements. He assessed 3% permanent partial impairment of the whole person based upon abnormal sensitivity, subjectively and on pinwheel testing, as well as skin disfigurement due to pigmentation changes.

34. Claimant followed up with a counselor, Bret V. Wixom, L.C.S.W., from January 17, 2006 through March 10, 2006. Mr. Wixom noted that Claimant's anxiety increased with his return to work. On January 17, Mr. Wixom wrote an open letter recommending that Claimant be given two weeks off work to gain better control of his anxiety, but he generally encouraged Claimant to increase his time at work while providing desensitization and other coping skills. At their last session, Mr. Wixom noted that Claimant had met his treatment goals.

35. Claimant attended physical therapy with Deb West, P.T., until the beginning of February 2006. He failed to appear at, or cancelled, approximately three appointments, then ceased attending, so Ms. West eventually discharged him from care. Her treatment notes from January 25, 2006 indicate Claimant's burn was healed, with a barely visible scar. Claimant commented, "You can hardly see it where they glued it together!" and reported that his condition was improving. DE 22, p. 353.

36. From April through June 2006, Claimant saw Dr. Roisum four times for migraines or other headaches and migraine symptoms. In June 2006, Dr. Roisum treated Claimant for headache and fatigue. He noted Claimant was moving to New England. In August 2007, Dr. Roisum treated Claimant for headache, fatigue, neck pain and hyperglycemia, providing samples of Ambien and Effexor. In September 2007, Claimant presented with neck pain, headache, fatigue and insomnia. Dr. Roisum provided more Effexor samples.

Claimant's Relevant Post-Injury Medical and Psychiatric Care Records

37. **Pharmacy.** Claimant has a prescription history at Walgreen's Pharmacy following November 13, 2005, indicating treatment for sleeplessness, bipolar disorder, anxiety disorder, seizures, and depression. In 2007 and 2008, Claimant received Sonata sleeping aid pills; Alprazolam pills, commonly prescribed to treat anxiety disorder and panic attacks;

Diazepam pills, commonly prescribed to treat anxiety, nervousness and seizures; Lamictal pills, commonly prescribed for epilepsy and bipolar disorder; Lorazepam pills; Seroquel pills, commonly prescribed for bipolar disorder and depression; Zyprexa pills; temazepam pills; and Lithium pills, commonly prescribed to treat manic episodes associated with bipolar disorder. His medical records document additional prescriptions to treat his psychiatric conditions through 2009.

38. **Emergent and general care.** In August 2006, Claimant sought treatment for neck and back pain. He reported having a seizure the previous week and taking a recent deep sea fishing trip.

39. In September 2006, Claimant sought treatment for headache and loss of consciousness twice during the previous 12 hours. Seizures were suspected. Claimant reported his prior burn injury and denied he had suffered a simultaneous head injury. Claimant was evaluated by a neurologist who ordered an ambulatory electroencephalogram and a brain MRI, both of which returned normal results.

40. In January and February 2007, Claimant sought treatment for cervical pain with intermittent left arm paresthesias which persisted even with pain medication. He reported onset before his burn injury and that he was told he had an old fracture at C6 after a fall from a horse. X-ray imaging showed mild degenerative changes. The attending physician reported, "The patient's pain is disproportionate to his exam" and ordered an MRI neck scan, which returned normal results. DE 26, p. 395. Chart notes indicate Claimant took a one-month leave of absence from work, apparently due to his neck pain. Jeffrey G. Swift, D.C., diagnosed cervical apophysitis, cervical headaches with occipital neuralgia and right temporomandibular joint syndrome.

41. In July 2007, Claimant sought treatment for chronic cervical pain from an urgent care facility. He reported he hurt his neck as a teenager when he jumped off a cliff into the water, and again as a college student when he rolled his car and got whiplash.

42. On October 3, 2007, Claimant first sought psychological treatment for what he described as PTSD symptoms, through the Department of Health and Welfare Regional Behavioral Health Services (Behavioral Health). The Contact Sheet records Claimant's reasons for calling:

> Matthew got our phone # out of the phone book. Calling to request help- At end of his rope – Doesn't know what to do, where to go for help – Fell into deep fat fryer a couple of years ago - $4,000 check for hand & arm – "Heads [sic] not right" – can't sleep at night because of nightmares, phobias – can't work, can't leave house – Feels like a failure – can't take care of wife & 2 kids & doesn't like to ask for help – but has to do something…[illegible]…"

CE E, p. 195.

43. Also on October 3, Claimant underwent an intake evaluation. He reported ongoing symptoms, with onset as of his burn injury, of nightmares, foreshortened sense of the future, crying spells, mood instability, anxiety, flashbacks, intrusive memories, sleep problems, hypersensitivity and feeling as if his body and psyche are much more fragile. He also reported periods of lost time, memory difficulties, hot or cold sensations precipitating his flashbacks, severe headaches, visual distortions including "auras or wavy little lines" precipitating his bad headaches, difficulty eating fried foods because the smell triggers flashbacks of the smell of burning flesh, and resultant marital discord. DE 30, p. 412. Claimant attributed his recent firing and other employment problems to PTSD due to the burn injury. He indicated he was hopeless, depressed and overwhelmed. In addition, Claimant attributed his sleep difficulties and nightmares to the industrial accident: "Since his accident he has difficulty with sleep onset and maintenance." *Id.* He had poor appetite and believed he had lost weight. Other than treatment

for childhood hyperactivity and depression following the stillbirth of his daughter, Claimant reported no psychiatric or psychological treatment history.

44. On October 4, 2007, Claimant sought medication from Dr. Roisum because he was feeling anxious and hadn't slept in six days. Dr. Roisum called in a Xanax prescription.

45. On October 5, 2007, Claimant underwent a diagnostic evaluation by a family health nurse practitioner at Behavioral Health. Claimant reported no significant psychological history other than that surrounding his stillborn daughter. "…he reports he's "happy and healthy," until two years ago when he had an accident at work." DE 30, p. 420. Claimant went on to describe his current symptomatology in detail. The nurse practitioner suspected there may be some bipolar-type component to Claimant's condition based on the fact that he reported Lithium helped him more than any other drug because it helped him feel stable. She did not conduct any psychological testing. She diagnosed PTSD and major depressive disorder (recurrent, severe) without psychotic features.

46. On October 7, 2007, Claimant presented at the MMH emergency department complaining of anxiety and PTSD with confusion. Claimant also reported a seizure just prior to arrival and that he had recently been to Behavioral Health. The chart note history reports his anxiety and PTSD started after Claimant's burn and some head injury. Claimant denied depression, insomnia and other symptoms. A CT head scan returned normal results. The attending physician diagnosed panic attack.

47. By October 11, 2007, when Claimant followed up at Behavioral Health, his diagnosis was altered to generalized anxiety disorder, PTSD and memory loss. By October 18, tension headaches secondary to stress disorder was added. Another head CT returned normal

results. On December 10, 2007 Claimant reported another seizure, precipitated this time by a sulphur taste.

48. Claimant telephoned Dr. Roisum's office once more in 2007 and saw him once more in 2008. The chart notes do not indicate Claimant was experiencing any psychological or sleep disturbance symptoms on either occasion.

49. Claimant treated at Behavioral Health through January 2009, receiving medications and therapy. Depression over Claimant's inability to function at work and provide for his family is a dominant theme to the sparse and sometimes illegible chart notes. Sleep disturbance is sometimes mentioned, not always involving nightmares. The subject matter of Claimant's nightmares is rarely addressed. Claimant reported on diagnostic evaluation that he had awakened in the night asking for someone to get him out of the hot. On October 11, 2007, he discussed his nightmares in detail, specifically relating them to his burn injury. He also reported episodes of blacking out, explaining that they are preceded by thoughts of the burn injury. On October 30, 2007, he reported that his flashbacks were triggered by cooking smells. On November 8, 2007, Claimant began feeling anxious about the upcoming second anniversary of his burn injury. On February 21, 2008, he reported that his flashbacks were triggered both by cooking smells and by turning on the gas fireplace.

50. Claimant received additional psychological treatment from Mary Beth Ostrom, M.D., a psychiatrist, and Jessica Waldren, L.C.P.C., beginning in 2009. Records associated with treatment from those providers are not in evidence.

51. **Inpatient.** On May 1, 2008, Claimant called Behavioral Health, feeling suicidal. Thereafter, he took an accidental[6] overdose in an attempt to control his symptoms and was subsequently hospitalized. Claimant identified stress and PTSD as his main issues on discharge on May 12, 2008. There is no indication that Claimant ever disclosed his extensive psychological treatment history in connection with this episode

DISCUSSION AND FURTHER FINDINGS

52. The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. Haldiman v. American Fine Foods, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. Ogden v. Thompson, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. Aldrich v. Lamb-Weston, Inc., 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

Idaho Code § 72-451 Psychological Accidents and Injuries

53. In 1994, the Idaho State Legislature adopted Idaho Code § 72-451, treating the compensability of certain types of psychological injuries. Generally, the statute recognizes the compensability of so called "physical/mental" and "mental/physical" injuries, yet forecloses claims for "mental/mental" injuries. The instant case posits a "physical/mental" injury. Compensable psychological claims, because of their subjectivity, must meet certain elements to be recognized. Specifically, the statute provides:

> **Psychological accidents and injuries. - -** Psychological injuries, disorders or conditions shall not be compensated under this title, unless the following conditions are met:

[6] According to Dr. Enright, Claimant's medical records document he ingested 80 Xanax pills, which should be considered a suicide attempt. However, Claimant's treatment records at Behavioral Health ultimately do not endorse that conclusion.

(1) Such injuries of any kind or nature emanating from the workplace shall be compensated only if caused by an accident and physical injury as defined in section 72-102(18)(a) through 18(c), Idaho Code, or only if accompanying an occupational disease with resultant physical injury, except that a psychological mishap or event may constitute an accident where (i) it results in resultant physical injury so long as the psychological mishap or event meets the other criteria of this section, and (ii) it is readily recognized and identifiable as having occurred in the workplace, and (iii) it must be the product of a sudden and extraordinary event; and

(2) No compensation shall be paid for such injuries arising from conditions generally inherent in every working situation or from personnel related action including, but not limited to, disciplinary action, changes in duty, job evaluation or employment termination; and

(3) Such accident and injury must be the **predominant cause** as compared to all other causes combined of any consequence for which benefits are claimed under this section; and

(4) Where psychological causes or injuries are recognized by this section, such causes or injuries must exist in a real and objective sense; and

(5) Any permanent impairment or permanent disability for psychological injury recognizable under the Idaho workers' compensation law must be based on a condition sufficient to constitute a diagnosis using the terminology and criteria of the American psychiatric association's diagnostic and statistics manual of mental disorders, third edition revised, or any successor manual promulgated by the American psychiatric association, and must be made by a psychologist, or psychiatrist duly licensed to practice in the jurisdiction in which treatment in rendered, and

(6) **Clear and convincing evidence** that the psychological injuries arose out of and in the course of the employment from an accident or occupational disease as contemplated in this section is required.

Nothing herein shall be construed as allowing compensation for psychological injuries from psychological causes without accompanying physical injury.

This section shall apply to accidents and injuries occurring on or after July 1, 1994, and to causes of action for benefits accruing on or after July 1, 1994, notwithstanding that the original worker's compensation claim may have occurred prior to July 1, 1994.

Id., (emphases added).

54. **Disputed elements.** Of the six required elements enumerated in Idaho Code § 72-451, two are particularly disputed by the parties herein, and a third is obviously implicated

by the facts of this case and findings reached herein. The first is whether Claimant's industrial burn injury is the predominant cause of his psychological condition.

55. Idaho Code § 72-451(3) does not present a "but for" standard of causation. The Commission described the proof necessary to establish a predominant cause in *Smith, 2009 IIC 0179.1.*:

> Under the predominant cause standard, it is not sufficient that the industrial injury be merely the proverbial "straw that breaks the camel's back." Although an employer takes an employee as he is, in determining the predominant cause of a psychological condition, the contribution of all of the employee's pre-accident factors must be weighed against the contribution of the industrial accident. To be the predominant cause, the work injury must be a greater cause of the psychological condition than all other causes combined. Thus, if a percentage of contribution were assigned to each and every factor which collectively produce a claimant's psychological condition, the contribution of the industrial accident must be more than 50% of the total of all of the causes. Against this standard, the evidence, including expert testimony, produced by the parties must be evaluated.

Id.

56. The second issue in dispute is whether Claimant has proven by clear and convincing evidence that the psychological injury arose out of and in the course of employment from an accident or occupational disease. The "clear and convincing" standard is defined in *Luttrell v. Clearwater County Sheriff's Office*, 140 Idaho 581 97 P.3d 448 (2004) as "a degree of proof greater than a mere preponderance."

57. The third issue is whether the evidence in the record is sufficient to establish that Claimant has a condition constituting a *DSM-IV-TR* diagnosis made by a qualified psychologist or psychiatrist.

58. All three disputed issues turn on expert opinion evidence regarding Claimant's post-industrial injury psychological condition. Proper evaluation of the effect of Claimant's preexisting bipolar disorder, anxiety and depression on his post-injury condition is necessary to

the first two determinations; proper evaluation of Claimant's current condition is necessary to the third.

Expert Opinion Evidence

59. Three experts provided opinions in this case. Drs. Murdock and Ostrom, two of Claimant's treating psychiatrists, and Dr. Enright, a psychologist providing an independent medical evaluation at Defendants' request, are all qualified to assess psychological conditions. Their knowledge of Claimant and their positions are summarized below.

60. Claimant alleges he sustained PTSD as a result of his burn injury. The *DSM-IV-TR* sets forth diagnostic criteria for PTSD:

> **DSM-IV Criteria for Posttraumatic Stress Disorder**
>
> A. The person has been exposed to a traumatic event in which both of the following have been present:
>
> (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.
>
> B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
>
> (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
>
> (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content. (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
>
> (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(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 and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(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

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal **(not present before the trauma)**, as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep (2) irritability or outbursts of anger (3) difficulty concentrating (4) hypervigilance (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

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

Specify if: Acute: if duration of symptoms is less than 3 months Chronic: if duration of symptoms is 3 months or more

Specify if: With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Id. at pp. 467-468 (emphasis added). In addition, the *DSM-IV-TR* provides that malingering should be ruled out in situations implicating secondary gain motivations. *Id.* at p. 467.

61. **Dr. Murdock.** Dr. Murdock treated Claimant as an outpatient at Behavioral Health once or twice a month, sometimes skipping a month, from October 2007 through January 2009. His treatment goal was to manage Claimant's symptoms with medications. As of the date of his deposition, Dr. Murdock had not reviewed any of Claimant's prior records and he did not perform an intake evaluation or psychological testing. He relied upon the intake assessments prepared by two other Behavioral Health employees and Claimant's in-person statements in developing his diagnosis and treatment plan.

62. The intake assessments Dr. Murdock relied upon indicate Claimant incorrectly reported no history of psychological disorders other than a period of depression following the stillbirth of his daughter. In addition, on intake Claimant reported he was having "PTSD" symptoms as a result of his industrial burn injury and other problems related to employment difficulties and debt. The record holds no evidence of a prior PTSD diagnosis, but it does indicate that Claimant had previously sought treatment for what he reported as "PTSD" symptoms in 2003. Dr. Murdock was unaware of any of this history. There is no evidence that Dr. Murdock made any attempt to rule out malingering or to confirm the PTSD diagnosis which apparently originated with Claimant.

63. Against this background, Dr. Murdock diagnosed PTSD and major depression (severe). As well, he noted Claimant had a history of complex partial seizures and that additional conditions should be ruled out, including bipolar disorder, dissociative disorder and anxiety disorder. It is unclear what, if anything, he did to follow up on ruling out these conditions. In the 15 months or so that he treated Claimant, Dr. Murdock never diagnosed bipolar disorder, although several other psychiatrists did, including Dr. Ostrom.

64. Dr. Murdock recalled Claimant reporting symptoms consistent with PTSD such as sleep disturbances, including nightmares in which he would act out, thrash around or sleep walk; flashbacks in which he relived different aspects of his trauma; and feelings of hopelessness and being a failure. Dr. Murdock did not record the subject matter of Claimant's nightmares, but he did detail Claimant's employment difficulties and his firings from two recent jobs. He relied upon the notes of Vicki Meacham, L.C.S.W., a social worker at Behavioral Health, which detailed Claimant's nightmares as work-related.

65. Dr. Murdock was unaware that Claimant had a history of sleep disturbances, suicidal ideations, and feeling overwhelmed with life that preexisted his burn injury. He did not document which, if any, *DSM-IV-TR* symptoms of persistent increased arousal Claimant exhibited, and the evidence in the record indicates only one possible qualifying symptom – irritability or outbursts of anger – while the criteria requires two or more. Claimant's preexisting sleep difficulties and difficulty concentrating would likely disqualify any similar post-burn symptoms from satisfying the criteria, and there is no evidence that Dr. Murdock observed any occasion when Claimant was hypervigilant or exhibited an exaggerated startle response.

66. Dr. Murdock placed a great deal of weight on Claimant's trouble going back to restaurant work because he was sensitive to deep fat fryer smells and restaurants generally make him severely anxious and distressed. However, it is unknown whether Dr. Murdock considered the employment problems also presented by Claimant's general trust issues or other psychopathology, or the fact that Claimant left his last restaurant job at Ruby River Steakhouse for reasons unrelated to fryer smells, or anything else clearly related to his burn injury.

67. Dr. Murdock also relied on Claimant's reports that his symptoms worsened in October 2008, in anticipation of the second anniversary of his burn. The *DSM-IV-TR* criteria, readily available through the Internet and other sources, clearly states that PTSD sufferers may dread the anniversary of their inciting event. However, there is no indication in Claimant's records that he had a similar reaction at the first anniversary of his burn. Although he obtained treatment for his medication-related seizures and other conditions in June, August and September 2006, he did not report any nightmares, flashbacks or other PTSD-like symptoms until October 2007. Dr. Murdock described Claimant as "…a person that was, I think, pretty open in sharing his distress. I mean, he wasn't a guy that kind of hid his frustration about all of this." Murdock Dep., p. 26. Had Claimant been experiencing PTSD symptoms, he likely would have reported them. He did not report such symptoms, so he likely was not experiencing any.

68. Dr. Murdock's assumption that Claimant was experiencing symptoms all along, since the burn injury, is not supported by the evidence in the record. Although the *DSM-IV-TR* provides that PTSD symptom onset may be delayed, Dr. Murdock did not diagnose delayed-onset PTSD. And, while Claimant's medical records indicate he had some nightmares and flashbacks before 2007, they do not establish he had sufficient symptoms for a PTSD diagnosis. Further, neither Mr. Leslie nor Mr. Wixom, each of whom treated Claimant following the burn injury, diagnosed PTSD.

69. Dr. Murdock conceded that Claimant's treatment records related to his burn injury, which he had not seen, would be the most detailed documentation of Claimant's actual experiences during his care and recovery. Nevertheless, he did not review these records to determine whether the injury and treatment were sufficient to trigger PTSD. Instead, he relied on the reports, two years after the injury, of Claimant and his wife.

70. Dr. Murdock reasoned that Claimant had prior difficulties following the stillbirth of his daughter, but that he was still functional. After the burn, Dr. Murdock opined, Claimant was significantly less functional. However, there is significant evidence in the record not considered by Dr. Murdock that indicates Claimant had significant preexisting psychological difficulties impacting his ability to function. Mr. Leslie's chart note history from November 10, 2005 indicates Claimant was in crisis, similar to the one following the stillbirth of his daughter, just three days before his burn:

> 29-year old male who complains of manic symptoms including sleep deprivation, difficulty concentrating, feeling overwhelmed with life and current situation. Describes significant psychosocial stressors including 2-year old son who is currently hospitalized with unknown illness. Son also has a cleft lip and palate, has gone through 9 surgeries so far. Also describes a very high stress job as a restaurant manager, working 70 hours/week with one day off. In the last two weeks has has [sic] very little to no sleep whatsoever. Having difficulty thinking, seeing things out of the corners of his eyes that aren't there. Went to Emergency Department three days ago, was given Ambien for sleep, which was not helpful. Has had recurrent suicidal ideation, but not plans and not intention. Describes similar episode approximately 5 years ago following stillbirth of first child. Was hospitalized for 4 days…

DE 17, p. 275. He did not know that Mr. Leslie had assigned a GAF score of 55/85 at this visit, or that Claimant had improved that score to 75/85 during his recovery, and to 65/85 by his last visit with Mr. Leslie on April 12, 2006.

71. Dr. Murdock's opinion fails to account for the effects of Claimant's significant preexisting psychiatric history. He failed to follow-up on a bipolar disorder diagnosis. He diagnosed PTSD without confirming symptoms sufficient to establish that diagnosis under the *DSM-IV-TR*.

72. Dr. Murdock's opinion lacks foundation and is insufficient to establish a *DSM-IV-TR* diagnosis of PTSD. Further, because it does not accurately account for Claimant's prior psychological history, it lacks credibility to the extent it posits Claimant's industrial burn injury

was more significant than any other factor in the development of PTSD or any other psychological condition, or that Claimant suffered a psychological injury arising out of and in the course of his employment.

73. **Dr. Ostrom.** Dr. Ostrom is the medical director at Behavioral Health. She provided Claimant with inpatient treatment in 2008 for 10-12 days, for depression, PTSD, suicidal ideation and medical problems; in 2010 for increased depression symptoms, including suicidal ideations preventing him from working at his janitorial job; and, on four follow-up visits, she treated Claimant on an out-patient basis. However, there is no documentation in the record of Dr. Ostrom's care.

74. Dr. Ostrom did not review Claimant's prior medical records, other than those from Behavioral Health.[7] Neither did she conduct, nor was she aware of, any psychological testing. Dr. Ostrom did not formally assess Claimant's condition on her initial treatment, accepting the already-established diagnoses by Dr. Murdock and Dr. Layman, including PTSD. As of the date of her deposition, Dr. Ostrom believed Claimant's only psychological history involved his bereavement and depression over his stillborn child. She believed Claimant was first diagnosed with bipolar disorder in 2010.

75. Similar to Dr. Murdock, Dr. Ostrom diagnosed PTSD based upon the history of Claimant's industrial burn injury and his reports of subsequent intrusive recollections, frequent nightmares related to the burn event, changes in his affect, and the daily impact of these symptoms on his ability to function. She opined that Claimant's PTSD was caused by his burn injury because his symptom onset occurred after that event and, further, because his symptom

[7] Dr. Ostrom also references records from "Dr. Layman." It is assumed she is referring to Howard Layman, M.D., a psychiatrist treating patients at Behavioral Health and other locations in the Idaho Falls area. There are no records in evidence obviously prepared by or under the supervision of Dr. Layman, so it is unclear exactly to which records, in addition to the Behavioral Health records in evidence (if any), Dr. Ostrom refers.

triggers are associated with it. Dr. Ostrom further opined that Claimant's PTSD is permanent because his symptoms have persisted since the injury despite treatment.

76. There is no evidence in the record that Dr. Ostrom ever confirmed *DSM-IV-TR* criteria for PTSD in reaching her diagnosis. Further, like Dr. Murdock, Dr. Ostrom was unaware that Claimant's first PTSD symptom reports were made in fall 2007 or that his GAF score actually improved following his burn injury. This information would have likely had a significant impact on Dr. Ostrom's opinion since she relied, in part, on Claimant's GAF score in her assessment.[8] Ostrom Dep., p. 30.

77. Dr. Ostrom admitted that she would need to see Claimant's prior mental healthcare records to determine the effect his preexisting mental health condition has on his post-burn injury mental condition. As a result, because she did not review these records, Dr. Ostrom's opinions as to any change in Claimant's psychological condition post-burn injury lack foundation and have been excluded from evidence. This exclusion is academic, since Dr. Ostrom ultimately declined to opine that Claimant's burn injury was a more predominant factor than his preexisting psychological condition in his development of PTSD anyway:

> In my opinion, Matthew's Post Traumatic Stress Disorder is related to his accident, however, his Bipolar Disorder type I is not. Matthew's pre-existing issues with mood instability may have predisposed him to be more likely to develop Post Traumatic Stress Disorder symptoms. However, I am unable to quantify any percentages of impairment due to either diagnosis.

CE H, p. 244. Dr. Ostrom elaborated on her inability to quantify the causal factors leading to Claimant's PTSD at her deposition:

> It's very hard in someone who has multiple psychiatric issues to determine how those are interacting with one another in terms of the severity of the illness. So it is unclear or I don't feel I can apportion a percentage. If Matthew didn't have

[8] There is no evidence in the record of the specific GAF score Dr. Ostrom assessed.

> bipolar disorder, would his PTSD be as severe as it is? But, clearly, he did have the injury and he had a marked decline of function after the injury.

Ostrom Dep., p. 22. Dr. Ostrom is speaking, above, in terms of severity of the condition as opposed to the relative significance of onset contributors. However, her testimony, read together with her letter, establish that she is unable to separate the effects of Claimant's preexisting conditions from the effects of his burn injury on the persistence of his PTSD symptoms.

78. Dr. Ostrom did opine that Claimant's PTSD is entirely responsible for his inability to return to work in a restaurant; however, this is a "damages" question which cannot be reached unless the Claimant first establishes that his burn injury is the predominant cause of his PTSD. Further, Dr. Ostrom was apparently unaware that Claimant left his last restaurant job due to trust issues which are not obviously related to his burn injury experience, given his history of anxiety.

79. The Referee finds Dr. Ostrom's testimony lacks proper foundation and fails to establish that Claimant carries a *DSM-IV-TR* diagnosis of PTSD, that his burn injury is the predominant factor contributing to any of his current psychological conditions, or that he sustained any psychological condition arising out of and in the course of his employment.

80. The experts proffered by Claimant failed to render adequate evidence to support his *prima facie* case. Dr. Enright, proffered by Defendants, provides further evidence establishing that Claimant has failed to meet his burden of proof in this case.

81. **Dr. Enright.** Dr. Enright, a clinical psychologist, is also licensed as an advanced practice nurse in the state of Wyoming. As such, unlike most psychologists, he has knowledge and experience prescribing medications to treat psychiatric conditions. In preparing his IME

opinions, Dr. Enright evaluated Claimant on two[9] separate dates: February 26, 2008 and July 29, 2009. He ultimately determined that Claimant does not exhibit the criteria for a clinical diagnosis of PTSD and, further, that he has somatization tendencies, ongoing life stresses, a long-standing psychiatric disorder, and unmet dependency needs that account for the symptoms he attributes to the industrial injury.

82. On their first visit, Dr. Enright interviewed Claimant and administered psychological testing.[10] He also reviewed certain of Claimant's medical records related to his 2005 burn injury, and subsequent treatment for that and other conditions through October 2007. These medical records informed Dr. Enright of Claimant's burn injury, prescription history, anxiety on returning to work, medication-related seizures, sleep problems, treatment at Madison Memorial Hospital in October 2007 for anxiety and PTSD, and medical record evidence that Claimant may have exhibited exaggerated pain behaviors at UUH, among other things.

83. During the interview, Dr. Enright noted inconsistencies in Claimant's responses:

> Mr. Mazzone often gave contradictory information, changed the facts included in his answers, was evasive and defensive from time to time. His answers were vague on occasion and quite specific and clear regarding historical facts on other occasions.

DE 32, p. 452. Jessica Waldron, L.C.P.C., a counselor who saw Claimant in May 2009 and for an undetermined number of visits thereafter, believes this type of observation indicates Dr. Enright is biased against Claimant. The Referee disagrees. There is no evidence that Dr. Enright falsely reported or otherwise distorted his impressions of Claimant in his report or at his deposition. Further, Dr. Enright's report provides multiple specific examples consisting of

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[9] The second evaluation was originally scheduled for May 26, 2009. On this date, Dr. Enright saw Claimant briefly before Claimant abruptly left, explaining that he needed to attend his son's kindergarten graduation.

[10] Dr. Enright administered the Depression Screening Questionnaire, Patient Rated Anxiety Scale, Clinician-Administered PTSD Scale (modified form) and Mental Status Examination.

quotes from Claimant to support his above-referenced conclusions. A particularly significant example of information provided by Claimant which is contradictory is his assertion that all of his symptoms are new since the burn injury:

> When asked what his current symptoms were following the accident, he reported that he had pain in his hand, that he suffers from seizures, that he suffers from "tension headaches," that he has numerous mental health problems consisting of "being anxious and depressed, crying bouts, can't keep a job, nightmares on a religious basis from this." He went on to state that he had none of these problems prior to his accident.

DE 32, p. 455. While there is no evidence in the record that Claimant suffered from hand pain or seizures prior to his burn injury, there is significant evidence of a long preexisting history of headache pain, anxiety, depression, work difficulties and sleep problems.

84. Dr. Enright also noted that when he recounted his burn injury, Claimant was vague about the details, but was very specific about other facts, such as the size of the fryer and the temperature of the grease. In Dr. Enright's experience, PTSD patients remember every detail of the inciting event, and Claimant did not present this way:

> A. …I've met with him three times and I've attempted to bore down and say, "What are the memories? What's going on here?" And I get kind of a vague response. I don't really know what it is that when he goes to a counselor now and says I'm having a flashback, what is flashing back?
>
> When I've dealt with the combat veterans and I say – they say I've had a flashback, I can say "What flashes back?" And they say, "A flare goes off and I'm back in the ground, and I can smell the dirt." They're very specific. And it goes across all of the senses; what they hear, what they smell, what they see.
>
> Mr. Mazzone cannot – I haven't seen any documentation of anything that even approximates that. He just says he has a flashback. So beyond the fact that something about sizzling bacon caused some kind of emotional distress, I really don't know what he's talking about.
>
> Enright Dep., p. 94.

Dr. Enright elaborated, responding on cross-examination, on the significance of his observations that Claimant only vaguely described his burn injury:

> Q. All right. Now, on page 14 of your first report, on the '08 report, you say that your clinician administered PTSD scale did not confirm the existence of the Post-Traumatic Stress Disorder, a criteria for making this diagnosis in existence of a traumatic event. And then you go on to talk about Mr. Mazzone's description of how painful it was in the treatment phase. But it looks like you bypassed the actual burn event itself. So my question to you was did you consider the burn event itself where he sticks his hand in a 360 deep-fat fryer as a significant traumatic event for purposes of your analysis in your conclusion here?
>
> …
>
> A. Well, I'll read the full statement. "When asked to describe the traumatic event that was responsible for his current psychological state, the claimant stated, 'I was in intensive care. I was getting painful treatment every day. I missed a fraction of my life, basically. There was a month or two that I didn't know what happened to my life.'"
>
> So I asked him to describe it. I wasn't considering what the event was. I wanted to have him consider – tell me what the event was. And he didn't say anything about the burn. He told me he was in intensive care, that that was the event.
>
> …
>
> A. So he didn't seem to have a memory of it. Once again, Counselor, I've interviewed many, many people with post-traumatic symptoms. And in each case, they say to me, "This is what I experienced." They don't say, "I was in intensive care two days later." They say, "This is what I experienced. This is what's bothering me." This man did not do that.
>
> *Id.,* pp. 118-121.

85. Claimant's psychological testing results failed to confirm a PTSD diagnosis. Dr. Enright explained:

> The claimant's response to the Clinician-Administered PTSD Scale did not confirm the existence of Post-Traumatic Stress Disorder. The A criteria for making this diagnosis is the existence of a traumatic event. When asked to describe the traumatic event that was responsible for his current psychological state, the claimant stated, "I was in Intensive Care – I was getting painful treatment every day. I missed a fraction of my life basically. There is a month or two that I don't know what happened in my life." The claimant's description of nightmares at the frequency of "every night" are of questionable validity and were not a re-enactment of any specific painful or traumatic life experience in his past. The claimant did not appear to be suffering from hypervigilance, gave no

> confirmation of any startle response and met no other criteria for the diagnosis of Post-Traumatic Stress Disorder.

DE 32, p. 464-465.

86. Dr. Enright opined that Claimant is overall somatically focused and presents himself as a victim. He believed Claimant was making "…a conscious and willful attempt…to blame all of his difficulties on the industrial accident of November 13, 2005." DE 32, p. 467. He also opined that Claimant's psychiatric condition preexisted his burn injury and that his presentation is consistent with "…malingering in an attempt to avoid adult work responsibilities, receive free medical care and have time to pursue his hobbies and parental activities." *Id.*

87. Dr. Enright specifically opined that the industrial burn injury of November 13, 2005 is not the predominant factor contributing to his reported pain and psychiatric symptoms:

> The events of November 13, 2005 did not serve as the predominant factor above all other factors combined that account for the level of distress experienced by the claimant. There are other psychological, cognitive and behavioral factors contributing to and impacting Mr. Mazzone's reported pain and psychiatric symptoms. These include: a deliberate attempt on his part to attribute all of his current physical, emotional and psychological difficulties to the industrial accident of November 13th, ongoing life stresses; unmet dependency needs and somatization tendencies.

DE 32, pp. 467-468.

88. Following his second evaluation, for which he reviewed Claimant's medical records dating back to 2002 and performed additional testing,[11] Dr. Enright backed off his opinion that Claimant is a malingerer. However, he continued to note inconsistencies between Claimant's reports and his medical records including, interestingly, Claimant's report that Dr. Murdock had required him to obtain a companion dog, which is not confirmed in Dr. Murdock's records.

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[11] At his second evaluation, Dr. Enright again administered the Depression Screening Questionnaire and Patient-Related Anxiety Scale. In addition, he administered the MMPI-2 (2nd Ed.), Test of Memory Malingering and Brief Cognitive Status Exam.

89. Dr. Enright again concluded that Claimant does not have PTSD and that his industrial burn injury is not the predominant cause of his psychiatric condition, which is the result of other psychological, cognitive, behavioral and emotional factors including "…a deliberate attempt on his part to attribute all of his current physical, emotional, and psychological difficulties to the industrial accident of November 13, 2005 in the face of contradictory medical records, ongoing life stresses, a longstanding psychiatric disorder, significant unmet dependency needs, and pervasive somatization tendencies." DE 32, p. 483.

90. Prior to his deposition, Dr. Enright reviewed the transcripts from the depositions of Drs. Murdock and Ostrom, as well as the rest of the exhibits offered into evidence in this case. His opinions at his deposition were consistent with those stated in his earlier reports.

91. Dr. Enright is the only expert who tested Claimant to determine whether he qualified for a clinical diagnosis of PTSD. He is also the only expert who reviewed Claimant's medical records related to his burn injury and his prior psychiatric condition. The Referee finds Dr. Enright's opinion more credible than those of the other two expert witnesses.

92. Based upon Dr. Enright's opinion, the Referee finds Claimant does not qualify for a diagnosis of PTSD under the *DSM-IV-TR*, that the November 13, 2005 industrial burn injury was not the predominant cause of his current psychological condition, and that Claimant did not suffer a psychological injury arising out of and in the course of his employment.

CONCLUSION OF LAW

1. Claimant has failed to prove that he is entitled to compensation for a psychological injury as a result of the November 13, 2005 industrial accident and injury pursuant to Idaho Code §72-451.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Referee recommends that the Commission adopt such findings and conclusion as its own and issue an appropriate final order.

DATED this __19th____ day of July, 2011.

INDUSTRIAL COMMISSION

__/s/______________________________
LaDawn Marsters, Referee

ATTEST:
__/s/_____________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __5th____ day of ___August____, 2011, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

STEPHEN A MEIKLE
PO BOX 51137
IDAHO FALLS ID 83405-1137

ALAN R GARDNER
PO BOX 2528
BOISE ID 83701-2528

srn __/s/_________________________________

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MATTHEW MAZZONE, Claimant, v. TEXAS ROADHOUSE, INC., Employer, and HARTFORD INSURANCE COMPANY OF THE MIDWEST, Surety, Defendants.	**IC 2005-012469** **ORDER** Filed August 5, 2011

Pursuant to Idaho Code § 72-717, Referee Marsters submitted the record in the above-entitled matter, together with her recommended findings of fact and conclusion of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusion of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has failed to prove that he is entitled to compensation for a psychological injury as a result of the November 13, 2005 industrial accident and injury pursuant to Idaho Code §72-451.

2. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this __5th____ day of __August___, 2011.

INDUSTRIAL COMMISSION

__/s/_________________________________
Thomas E. Limbaugh, Chairman

__/s/_________________________________
Thomas P. Baskin, Commissioner

__/s/_________________________________
R.D. Maynard, Commissioner

ATTEST:

___/s/__________________________
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __5th____ day of __August__, 2011, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

STEPHEN A MEIKLE
PO BOX 51137
IDAHO FALLS ID 83405-1137

ALAN R GARDNER
PO BOX 2528
BOISE ID 83701-2528

srn ___/s/___________________________