INDEPENDENT PSYCHOLOGICAL EVALUATION

PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
DATE OF IME: August 16, 2021
DATE OF INJURY: [redacted]
EXAMINING PHYSICIAN: Eric Lydon, M.D.
CLINIC LOCATION: 9900 Corporate Campus Dr., #3000, Louisville, KY 40223
ATTORNEY: [redacted]

REASON/PURPOSE/CONSENT OF EXAM: The patient was examined for psychiatric sequelae from injury acquired on April 12, 2019, while working as a security officer for Jefferson County Public High School. The patient understands this is not a therapeutic relationship, but simply an evaluation part of our determination of Workers' Compensation benefits. There is no implied treatment or treatment recommendations to be made and the patient was understanding. She also voices an understanding that this is not a confidential evaluation and the results to be shared.

RECORDS REVIEWED:
1. Previous IME from Dr. Nazar concerning her physical injuries.
2. Reviewed from The Brook Hospital Intensive Outpatient Treatment.
3. Records from Dr. Finizio.
4. Letter from Dr. Figa.
5. Records from Dr. Jeffrey Frank with Norton Neurology.

HISTORY OF PRESENT ILLNESS: The patient was working as a security guard at a high school in Louisville, Kentucky. She responded to a potential altercation. A male student was attempting to flee after being in an altercation. He turned and stiff-armed [redacted] in her chest area, knocking her backwards into the ground. She sustained a lumbar and cervical strain, as well as a possible mild concussion as physical manifestations of the injury. She was also noted to have possible posttraumatic stress disorder from the injury.

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The patient was off work until August of 2019, which was some four months later. She was at work for three days and had what she describes as a panic attack. They took her to the emergency room, where she was diagnosed with vertigo. The patient was placed off work at that time. She followed up with the Employee Assistance Program for counseling and referred to The Brook Hospital.

In October of 2019, the patient returned to work for the second time. She continued in her previous job, but reports she was very ineffective and began looking for new employment and was transferred to the Bus Depot in December of 2019.

On change of venue, her panic attacks slowed down, but she continued to have periods of panic and anxiety. She worked in that job until March of 2020, at which time the COVID pandemic caused a shutdown in the school system, and she was out of work until July of 2020. She had a difficult time at work and felt very overwhelmed and had to change her shifts. The patient was unable to tolerate the work experience and began looking for another position.

The patient then in April of 2021, began looking for a new job and found another position within Jefferson County Public School System and started that job in June of 2021, and continues in that employment until today.

After her initial injury, the patient reports having panic attacks. This led to her having to leave work after having returned for just three days from the initial injury. She describes the panic attacks as getting dizzy and having nausea and vomiting. She reports she felt like she was suffocating, and the room was collapsing in on her. She described her body tensing up and her brain feeling woozy, eyesight getting blurry, feeling very disconnected, like she is in a dream state, and a fear of having to flee the scene and get out of where she was. She also describes some deep personalization, feeling that she was watching herself or she was another entity outside of her own body and not fully engaged in the experience. She reports she had to go sit in the principal's office frequently when she had these panic attacks.

She reports increased stimulation with class changes and multiple kids being in the hallway would get her very upset and nervous. She also describes if she heard anyone holler or there was a loud noise that she would get significant symptoms. She reports this anxiety would last anywhere from 30 to 120 minutes. She reports once she moved out of her job, she continued to have difficulty with relationships with peers. She would argue very easily and was much more irritable. She also reported feeling very overwhelmed with decreased concentration and focus and had a hard time completing tasks. She reports lack of fulfillment in the position she has had now because she does not have a direct impact with students and misses that.

The patient also describes feelings of hopelessness because she has been to lots of doctors, and no one seemed able to come up with a fix for her physical ailments. The patient reports that she feels like she wants this "to all be over." However, she in no way has any suicidal ideation and she has never had those or anything like it. She reports that she just wants the pain and the treatment to be over.

A lot of the patient's pain and current problems also have to do with a leak from a breast implant that she sustained when being stiff-armed by the student on the date of the injury of April 12, 2019. She reports there is a very slow leak. The fluid became encapsulated and then the muscle began growing over it. She continues to have pain and limited mobility with her arm.

CURRENT SYMPTOMS: The patient reports that she continues to have difficulty getting along with people. She reports that she feels "weird" like she never has before. She reports that she does not want to be bothered by anyone. She reports that she gets up, goes to work, comes home to her house, and then just isolates and does not do anything. She reports that she has a close-knit family and she always used to see her father and spend time with him, but she has been avoidant of seeing her father.

She reports that her sleep has been disturbed and that she has had a recent improvement in that because she has had some alleviation from back pain that was keeping her awake. She reports a very high frustration level and feeling very irritable. Again, she is denying any suicidal ideations. She reports poor appetite and craving sugars and carbs and overall poor diet. She also reports that she has no mood and emotion and that her mood is just, "la-te-da." The patient reports she is isolative and alone. She reports she stays isolative and alone because she does not want to get upset. She reports a decrease in interest and activities.

Despite her decrease in interest and activities, she reports that she does continue to paint, work in her garden, and does jigsaw puzzles to keep her mind occupied. She reports if she does not keep her mind occupied, she gets upset. The patient reports that she does not want to go back to the level of panic and anxiety she has had in the past. She reports that she is very easily triggered and that she avoids triggers. The patient reports that she does not do well in groups, and she is avoidant of pulling out at times when there are more people and, as an example, states that she will go to the grocery store early in the morning or late at night.

She also reports she always needs to know where the exits are or needs to face a door. She reports she is very vigilant and always looking over her shoulder to know if there is anyone coming up behind her or know where everyone is in a room around her. She reports that she is very cautious and watches people constantly.

She reports that if she is out cutting the grass and she sees someone walking down the sidewalk she will keep an eyeball on them until they are well out of view and away from her. She reports that she also sits in her home sometimes at the front window and monitors to look to make sure no one is coming at or towards her. She reports her concentration is not any good and she is inattentive.

She reports that she will write the wrong date on things. She reports that she has mood swings. She also reports she has been weepy. She reports that she ruminates about what could have been different or how she could be different and cries. She reports that she overall has no enthusiasm. The patient reports that she just wants to be herself again. She reports that she was previously a fun-loving person but is no longer that way. She reports that she lives in fear of something happening to her.

The patient reports that she had two previous assaults in her job as a security officer. One was in August of 2007, and the other was in April of 2019. She never had any problems or sequelae from these. The patient also reports after her injury, as it pertains to this evaluation that it was not about the student that made her so upset. She reports that she has dealt with unruly students and had difficult encounters with people throughout her career as a security guard. She reports the situation of being knocked out and injured that made a change in her to where she gets very overwhelmed.

She reports the anxiety has had a significant impact on her. She reports that she thinks about going back or she thought about going back to her previous job, but every time she did, she would get very anxious, nervous, and feeling overwhelmed and could not go back. She reports that she would love to go back working with children, but just cannot do it because of the symptoms that she experiences in her ongoing current symptomatology.

CURRENT LEVEL OF FUNCTIONING/ADLs: The patient can care for herself and maintain her ADLs in an appropriate fashion. She can cook and clean appropriately. However, she often or sometimes does not do these things, but it is more of an unwillingness or lack of desire to do them and not from an inability.

PREVIOUS LEVEL OF FUNCTIONING/ADLs: Normal.

PSYCHIATRIC HISTORY PRIOR TO INJURY: None.

PSYCHIATRIC HISTORY POST INJURY: She has been to the Employee Assistance Program through Jefferson County Public Schools. She was admitted to the Intensive Outpatient Program at The Brook Hospital. She has also seen an individual therapist. She saw an individual therapist in October of 2019, after being discharged from The Brook Hospital. However, there is a private therapist she was seeing weekly, and she had a high deductible on her insurance and could not afford weekly or biweekly psychotherapy and discontinued it.

The patient was started on citalopram by her primary care provider in October of 2019. He continued medication until May of 2020, when she stopped it. She reports she stopped it because she had emotional blunting and felt numb. She gives an example of watching her father and her daughter having an argument and she just stood and watched without any feeling towards either one of them.

She reports she did not react at all. She reports that she was very blunted with no emotion. She did not like the feeling that she had on the medication and discontinued the medicine.

MEDICAL HISTORY:
1. Breast cancer.
2. Hypothyroidism.
3. Lumbar and cervical spinal strain.

MEDICATIONS: Levothyroxine, Advil, Zyrtec, Flonase, and Ventolin

ALLERGIES: No known medical allergies.

SOCIAL HISTORY: The patient was born and raised in Louisville, Kentucky. She is a high school graduate and reports that she has a college degree in Social and Criminal Justice that she earned online. She has been married and divorced on two occasions. She has three children. She lives alone. She has never been in the military. She reports she is a religious or spiritual person, no particular denomination, but identifies as Christian. She denies any history of abuse in her background. She reports her second husband was a drinker and used very bad language, but no physical or other abuse noted. The patient reports that she went through a restorative justice program in July of 2019, when she met with a student that had stepped on her and caused her injury. She reports that they worked it out and that she holds no animosity towards him. She reports that he was placed in alternative placement and was able to graduate.

WORK HISTORY: As above in the history of presenting illness.

LEGAL HISTORY: The patient is with no legal problems or history.

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SUBSTANCE USE HISTORY: The patient reports very rare use of alcohol and denies the use of drugs. She does use tobacco.

MENTAL STATUS EXAM: The patient is a well-developed, well-nourished female that appears appropriate for her stated age. She participates freely and willingly in the interview. There is no acute psychomotor restlessness or agitation. She is appropriately dressed and groomed and very neat in appearance. She is cordial and conversational. She walks with a steady gait. She appears to be of average intelligence and a reliable historian. Her speech is articulate, fluent, normal rate, and volume. Language is appropriate and relevant. Mood is described as rather bland and aemotional. Affect is euthymic and is able to show full range of affect. Thought processes are linear in nature, sequential, and goal directed. Thought content: There is no thought disorganization or thought disorder. She has no delusions or paranoia. She denied suicidal or homicidal ideation. There are no acute hallucinations noted during the evaluation and she denies any hallucinations. Insight is good. Judgment is appropriate and good.

TESTING: No testing done.

DIAGNOSIS: From the Diagnostic and Statistical Manual of Mental Disorders, known as DSM-5, the patient is diagnosed with the following:

1. Posttraumatic stress disorder, ICD-10 Code: F43.10.
2. Other specified anxiety disorder. ICD-10 Code: F41.8.

CAUSATION: The patient had no previous diagnosis or treatment of any psychiatric disorders prior to her injury in April of 2019. The causation of her current diagnosis is due to her injury sustained in April of 2019. No part of the impairment is due to other events outside of the injury of April 12, 2019.

PREVIOUS IMPAIRMENT TO INJURY: There was no previous impairment to the injury of April 12, 2019.

IMPAIRMENT RATING: Using the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, and the Mental and Behavioral Health Disorders, Table 14.1, Page 363, the patient would have a Class II mild impairment.

According to the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 2nd Edition, Table 1, Page 220, the patient would have a Class I impairment with a whole person impairment of 5%.

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MAXIMUM MEDICAL IMPROVEMENT: The patient may not have yet reached maximum medical improvement. She has had limited psychotherapy, as well as limited medication trials. I suspect she should show some improvement with ongoing psychotherapy, as well as initiation and management with medications for anxiety and posttraumatic stress disorder.

CONCLUSIONS AND RECOMMENDATIONS: I cannot make an assessment on restrictions due to physical limitations of returning to her previous job. From a psychiatric or mental health standpoint, she would have difficulty dealing with high intensity and stressful situations due to her anxiety and PTSD and the associated symptoms including the feeling of needing to flee such situations. Her work environment should be calm with little to no crisis situations or require her to respond to events where physical aggression is likely.

I do not feel [redacted] can return to her previous job due to her current psychiatric diagnosis. She has been able to maintain in other positions since her injury successfully with some periods of having symptoms of anxiety. However, with treatment she should be able to maintain the capacity to participate in her current job. [redacted] should have a non-chaotic work environment.

Finally, the opinions expressed in this report are all within a reasonable degree of medical probability.

Sincerely,

Eric Lydon MD

Eric Lydon, M.D.
Physiatrist
Kentucky Worker's Claim Physician Index Number 6393

EL/tmh