STATE OF VERMONT
DEPARTMENT OF LABOR

B.H.

v.

State of Vermont

Opinion No. 17-17WC

By: Beth A. DeBernardi, Esq.
Administrative Law Judge

For: Lindsay H. Kurrle
Commissioner

State File No. JJ-63619

OPINION AND ORDER

Hearing held in Montpelier on September 14 and 15, 2017
Record closed on November 6, 2017

APPEARANCES:

Christopher McVeigh, Esq., for Claimant[1]
Robin Ober Cooley, Esq., for Defendant

ISSUES PRESENTED:

1. Did Claimant sustain a compensable psychological injury as a result of the work-related physical assault she experienced on May 10, 2016?

2. If yes, to what workers' compensation benefits, if any, is she entitled?

EXHIBITS:

Joint Exhibit I:	Medical records
Claimant's Exhibit 1:	Preservation deposition of Kerry Stout, August 31, 2017
Defendant's Exhibit A:	Job description for Psychiatric Nurse II
Defendant's Exhibit B:	Resident incident reports[2]
Defendant's Exhibit C:	Paystubs from September 2014 to August 2017
Defendant's Exhibit D:	Absence tracking report from September 2014 to September 2017
Defendant's Exhibit E:	Warning letter concerning unauthorized leave, August 22, 2014
Defendant's Exhibit F:	Dr. Mann's *Curriculum Vitae*

[1] Based on Claimant's unopposed motion, she is identified by her initials in the above caption due to the sensitive nature of her history of childhood sexual abuse. *See J.D. v. Employer R.*, Opinion No. 22-07WC (August 2, 2007).

[2] This exhibit was admitted for the limited purpose of showing that Defendant obtained statements from its employees concerning the May 10, 2016 incident.

CLAIM:

Workers' compensation benefits referable to Claimant's psychological condition to which she proves her entitlement as causally related to the May 10, 2016 workplace assault; and

Interest, costs and attorney fees pursuant to 21 V.S.A. §§ 664 and 678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was her employer as those terms are defined in the Vermont Workers' Compensation Act.

2. Judicial notice is taken of all forms and correspondence in the Department's file relating to this claim.

Background

3. Claimant is a 62-year-old woman. She obtained her licensed practical nurse degree in 1994 and her registered nurse degree in 2000. From 1995 to 2008, she provided medical services to prisoners, including inmates of a Florida maximum security prison.

4. Claimant has a difficult personal history. Her parents were alcoholics, as were several other close family members, and she has had periods of alcohol abuse and remission throughout her adult life. She was sexually abused as a child; she was also verbally and emotionally abused, and physically assaulted, by her first husband. As an adult, she sustained serious injuries in a motor vehicle accident.

5. Claimant has mild to moderate rheumatoid arthritis. The condition manifests itself with occasional flare ups of inflammation, pain and swelling in her hands, which require her at times to miss a day or two of work.

6. Claimant's first husband died in 2007, and she moved to Vermont the following year. She first found work as a nurse in a private medical practice. In 2009, she accepted a position working with inmates in the Vermont prison system. She resigned that position in December 2010.

Claimant's Employment with Defendant as a Psychiatric Nurse at the Vermont State Hospital in Waterbury and the Green Mountain Psychiatric Hospital in Morrisville

7. In February 2011 Claimant began working full time for Defendant as a nurse at the Vermont State Hospital in Waterbury. Full-time work was 40 hours per week.

8. Defendant's Human Resources Manager, Kate Minall, credibly testified about the pay and leave time policies applicable to Claimant's employment. Employees submit their timesheets every two weeks and are paid biweekly. They earn paid annual leave and sick leave every pay period and also have an opportunity to earn paid personal time. Full-time employees are entitled to 12 weeks (480 hours) of leave time per 12-month period under

the Family and Medical Leave Act (FMLA), if they provide medical evidence of a qualifying condition.

9. FMLA leave itself is unpaid, but an employee who is absent for an FMLA-covered condition may use whatever paid leave he or she has available during those absences. Once the employee has exhausted paid leave, his or her authorized FMLA absences are unpaid. If the employee exhausts all accrued leave and FMLA leave, subsequent absences are categorized as "unauthorized, off-payroll." Defendant does not permit employees to take unauthorized, off-payroll time, and doing so subjects them to discipline.

10. Claimant liked her job at the Vermont State Hospital in Waterbury for the first six months; however, in August 2011, Tropical Storm Irene severely damaged the facility, causing its closure. As a result, Defendant reassigned Claimant and her co-workers to a series of alternate jobsites in Middlebury, Burlington, Rutland, Springfield and Williamstown. Some of these assignments resulted in lengthy commutes from Claimant's home in Vergennes.

11. From October 2013 through June 2014, Claimant worked a temporary assignment at the Green Mountain Psychiatric Hospital in Morrisville. During this assignment, she found the long commute stressful; she was drinking "a lot" of alcohol and she missed "a lot" of work. *Claimant's testimony,* September 14, 2017, at 34.[3]

Claimant's Anxiety, Stress, Depression, Poor Sleep and Rheumatoid Arthritis

12. Since 2013, Claimant's primary care physician has been Gordon Gieg, MD, of the Charlotte Family Health Center. Before Dr. Gieg joined the medical practice, she saw other providers there. Medical records from that practice document that she has sought treatment for anxiety, stress, depression, poor sleep and rheumatoid arthritis.

13. In December 2012, Claimant reported anxiety and poor sleep to the Charlotte Family Health Center. In June 2013, she reported anxiety and stress related to long working hours and commuting, and in October 2013, she reported chronic anxiety with daily episodes, for which she was prescribed medication.

14. Claimant found her work for Defendant stressful, with most of the stress coming from other staff, not the patients. She also found commuting stressful. In particular, during the winter of 2013-14, she had a long commute to Morrisville that she described as "brutal." Claimant credibly testified that her desire not to attend work started when she worked in Morrisville.

15. In March 2014, Claimant presented to Dr. Gieg with anxiety, stress and chronic depression. She reported that she was "calling in sick to work and hard to motivate to do job and affects work performance." *Joint Medical Exhibit,* at BH45. At the same visit, Dr. Gieg noted that her rheumatoid arthritis was stable with minimal pain.

[3] References to the testimony of Claimant and other witnesses are to the written transcripts of the formal hearing proceedings on September 14th and 15th, 2017.

16. For several years, Claimant had Dr. Gieg complete paperwork to support her use of FMLA leave for rheumatoid arthritis. Dr. Gieg credibly testified that her mild to moderate arthritis might cause her to miss a day or two of work on occasion; however, he did not expect her to miss more than that.

17. Although Claimant testified that she used FMLA leave for rheumatoid arthritis, she admitted that she also used it for winter driving, common respiratory infections and stress. As noted above, Dr. Gieg characterized her rheumatoid arthritis as relatively mild, and the medical records do not document any treatment for severe flare ups coinciding with her FMLA leave. I thus find that she used FMLA leave not only for absences referable to her rheumatoid arthritis, but for other absences as well.

Claimant's Employment with Defendant as a Psychiatric Nurse in Berlin

18. In July 2014, Claimant was hired to work full-time as a nurse at Defendant's new facility, the Vermont Psychiatric Care Hospital in Berlin. Around this time, she began drinking alcohol every day.[4]

19. Claimant's absences from work continued in Berlin and became so excessive that, on August 22, 2014, Defendant issued her a written warning that her unauthorized absences and failure to follow its leave policies might result in disciplinary action, including dismissal. *Defendant's Exhibit E.*

20. Despite the written warning, Claimant's attendance in Berlin did not improve. Her paystubs for the remainder of the calendar year[5] show that she worked, on average, 51.6 out of 80 scheduled hours per two-week pay period. *Defendant's Exhibit C.* The work absence report for the same period shows that after using all her available annual leave, sick leave, compensatory time, and 14 days of FMLA leave, she had another ten days of unauthorized, off-payroll absences between September and December 2014. *Defendant's Exhibit D.*

21. In December 2014, an incident occurred at the Berlin facility during which a female patient was throwing things and screaming. As Claimant and other staff were taking her to a quiet room, the patient scratched Claimant's face and neck. Claimant did not seek medical attention for the scratches.

22. Claimant testified that as a result of this incident, she did not want to go to work. However, she admitted that her reluctance to go to work had originated with her temporary assignment in Morrisville and therefore predated the December 2014 incident

[4] On July 24, 2015, Claimant reported to Dr. Gieg that she had not gone more than 24 hours without alcohol for a year. *Joint Medical Exhibit,* at BH72.

[5] Defendant's Exhibit C includes Claimant's biweekly paystubs covering September 7, 2014 through December 27, 2014. During that time span, she worked a high of 64 (out of 80) hours for the pay period ending October 4, 2014 and a low of 32.5 (out of 80) hours for the pay period ending December 13, 2014.

by some months. Further, the work absence report documents that she missed work on 14 days in December 2014; most or all these absences were prior to the incident.[6]

23. Claimant's absenteeism continued in 2015. During the first six months of the year,[7] she worked an average of 25.6 hours (out of 80) per two-week pay period. *Defendant's Exhibit C.* By May 3, 2015, she had used up her 12-week allotment of FMLA leave and had taken more unauthorized, off-payroll days. *Defendant's Exhibit D.* On May 22, 2015, Claimant saw Dr. Gieg for anxiety, panic attacks, poor sleep and bad dreams, reporting that her family priest and her cousin had died unexpectedly within the past two weeks. She also mentioned the December 2014 work incident and her driving anxiety, but Dr. Gieg attributed her anxiety to the recent deaths.[8]

24. During the second half of 2015,[9] Claimant worked an average of 43.6 hours (out of 80) per two-week pay period. *Defendant's Exhibit C.* During this six-month stretch, she had 40 unauthorized absences from work. *Defendant's Exhibit D.*

25. In July 2015, Claimant returned to Dr. Gieg, complaining of anxiety, depression and job stress from high staff turnover and severely ill patients. She reported that she was often drinking up to six beers and six shots of alcohol daily and that she wanted to stop but was concerned about withdrawal symptoms if she stopped cold turkey, which she had done before. She reported that she had not gone more than 24 hours without alcohol for the past year, that her intake was gradually increasing, and that her boyfriend was concerned. *Joint Medical Exhibit*, at BH72. Despite his testimony that he would recognize symptoms of alcohol abuse in a patient, Dr. Gieg did not recognize such symptoms in Claimant until she disclosed her condition to him.

26. Claimant continued working at the Berlin facility for the next few months. In September 2015, she reported to Dr. Gieg that she was doing better, had quit drinking except for beer on hot days,[10] and was getting married. Dr. Gieg noted that her rheumatoid arthritis was flaring "slightly," but that she was medically fit to work. *Joint Medical Exhibit*, at BH79. Despite her self-reported improvement, Claimant's work attendance at the Berlin facility continued to be erratic. *See* Finding of Fact No. 24 *supra.*

Claimant's Employment with Defendant as a Psychiatric Nurse in Middlesex

[6] Claimant testified that the incident took place on December 28, 2014, but exact date is uncertain.

[7] *See* Claimant's paystubs covering December 28, 2014 through June 27, 2015, *Defendant's Exhibit C.*

[8] Dr. Gieg and Claimant discussed the possibility of her taking workers' compensation leave due to stress at the May 2015 office visit, even though he noted that her stress was "triggered specifically" by the non-work-related deaths. *Joint Medical Exhibit*, at BH70-71.

[9] *See* Claimant's paystubs covering June 28, 2015 through December 26, 2015, *Defendant's Exhibit C.*

[10] In light of Claimant's difficulty in refraining from alcohol use in the summer of 2016 even with the Howard Center's intensive outpatient program and weekly counseling, Finding of Fact No. 44 *infra*, her statement to Dr. Gieg that she just stopped drinking in September 2015, with no program or counseling, is not credible. *Joint Medical Exhibit*, at BH79.

27. In November 2015, Claimant applied for a full-time psychiatric nurse position at the Middlesex Therapeutic Community Residence, a seven-bed secure residential facility. Defendant hired her on a full-time basis with a 40-hour per week schedule and an hourly rate of $39.68.

28. In December 2015, Claimant asked Dr. Gieg to complete paperwork to renew her FMLA leave for rheumatoid arthritis. Dr. Gieg noted that her hand joints were tender, but with no visible swelling, redness or joint deformity. He completed the FMLA form, writing "probability of occasional short absences from work due to flares of rheumatoid arthritis which may require 1-3 days off until pain eases." *Joint Medical Exhibit*, at BH88-89.

29. Claimant's absenteeism continued in Middlesex. During the first half of 2016,[11] she worked an average of 27.0 hours (out of 80) per two-week pay period, including three pay periods during which she did not work at all.[12] *Defendant's Exhibit C.* In January, she used 16 FMLA leave days; in February, she used 19 FMLA leave days (and one unauthorized, off-payroll day); in March, she used 17 FMLA leave days; and in April, she used 6 FMLA leave days, exhausting her annual allotment of FMLA leave by April 9, 2016. She then had 21 unauthorized absences through June 2016. *Defendant's Exhibit D.* Claimant later told her therapist, Kerry Stout, that she was drinking excessively between December 2014 and May 2016, including "immediately preceding" the May 10, 2016 incident. *Kerry Stout's Deposition*, August 31, 2017, at 56-57.

The May 10, 2016 Workplace Assault

30. Claimant was assaulted at work by a female patient on Tuesday, May 10, 2016. When she arrived at work that morning, the patient asked for coffee, and Claimant gave her a cup of coffee. Claimant went to the kitchen to get cream and sugar, and then to the linen closet to store her coat and keys. The patient came up to her by the linen closet, started swearing, and hit her in the face, scratching her left eye.

31. The Middlesex facility Director, Taryn Austin, credibly testified that when a patient starts engaging in violent behavior, the staff are trained to follow the Pro-ACT protocol, which involves de-escalation and soft restraint techniques. Claimant followed her Pro-ACT training on May 10, 2016, by loudly saying the patient's name and "stop," and other staff arrived on the scene within seconds. Another staff member escorted the patient to her room, while Claimant called the facility administrator and the state police.

32. Claimant worked her full eight-hour shift that day. Ms. Austin asked her if she needed to leave for medical attention, and Claimant said no; she would stop at the express-care clinic after work. Ms. Austin credibly testified that she saw no physical injury during her interaction with Claimant that day.

33. Claimant went to the express-care clinic after work, where Dr. Karlitz-Grodin recorded a mild headache and some eye irritation. He described her general appearance as "no acute distress, pleasant, cooperative." He noted no bruising on her face, and no tenderness on

[11] *See* Claimant's paystubs from December 27, 2015 through June 25, 2016, *Defendant's Exhibit C.*

[12] Claimant worked no hours for the pay periods ending January 23, February 20 and March 19.

palpation around her left forehead and orbital region, as well as left nasal bones. He diagnosed her with a corneal abrasion and released her to return to work, noting: "She feels comfortable continuing to work her normal duties." *Joint Medical Exhibit*, at BH102-03.

34. Claimant worked her regular shifts on Wednesday and Thursday of that week, but called in sick on Friday. On Monday, May 16, 2016, she saw Andrea Regan, MD, who works with Dr. Gieg. Dr. Regan noted that Claimant's symptoms were "completely resolved" and further noted: "Had missed one day [of] work for symptoms, but was unable to be seen here until Monday so missed a Saturday. Therefore needs release back to work." *Joint Medical Exhibit*, at BH104. Claimant did not report any symptoms of anxiety, stress, depression, hypervigilance, panic attacks, bad dreams or trouble sleeping; Dr. Regan noted her normal mood and affect and released her to return to work without restrictions.

35. On May 25, 2016, Claimant saw a physician's assistant for a sore throat. She did not report any symptoms of anxiety, stress, depression, hypervigilance, panic attacks, bad dreams or trouble sleeping. The physician's assistant noted that she had a normal mood and affect. *Joint Medical Exhibit*, at BH107.

36. Claimant saw Dr. Gieg on June 7, 2016. She mentioned that she was experiencing occasional panic attacks and flashbacks to her injury, as well as bad dreams and poor sleep. Dr. Gieg found her fit to return to her regular duties with no restrictions. *Joint Medical Exhibit*, at BH112-13.

37. There was no decline in Claimant's work attendance in the weeks following the May 10, 2016 assault. She worked 40 (out of 80) hours for the pay period of May 1 through May 14, having called out of work on three days *prior to* the assault. From May 15 through May 28, she also worked 40 (out of 80) hours. From May 29 through June 11, she worked 48.25 (out of 80) hours, which was substantially more than the 27.0 hours she averaged for the first half of 2016. *Defendant's Exhibits C and D.*

38. The patient who assaulted Claimant returned to the facility on May 25, 2016. Claimant never requested not to work with the patient, and on June 27, 2016, she told Dr. Gieg's office that she and the patient had a "good rapport." *Joint Medical Exhibit*, at BH120.

39. On July 11, 2016, Claimant reported to Dr. Regan that she had re-established a therapeutic relationship with the patient, who has obsessive compulsive disorder. Claimant told Dr. Regan that, when the patient starts engaging in rituals, "I just hold my hand out and bring her back to [her] room and she thanks me." *Joint Medical Exhibit*, at BH125. At the same office visit, Claimant reported that she was experiencing hypervigilance in the wake of the June 12, 2016 Orlando nightclub shooting and anxiety about driving, other people, and the police. Her work attendance declined after June 12, 2016.[13]

[13] Claimant's son, who is gay, was living in Orlando at the time of the shooting, and she worried about his safety. Following the nightclub attack, she worked 14.25 (out of 80) hours from June 12 to 25, and 16 (out of 80) hours from June 26 to July 9. From July 10 to 23, she worked 32 (out of 80) hours. *Defendant's Exhibit C.*

Claimant's Treatment for Alcohol Use Disorder

40. On Monday, July 25, 2016, Claimant drank almost an entire fifth of tequila, vomited blood, and experienced two seizures. She went to the Emergency Department at UVM Medical Center around 4:00 a.m. on July 26 with a blood alcohol concentration of 0.246 and thoughts of harming herself and others. *Joint Medical Exhibit*, at BH137. The medical records include the following:

> [Claimant] reported drinking increasing amounts of alcohol over the past eight years to the point that nearly over the last year, she drinks 1/5 of tequila per day.[14] She reported no abstinence in 8 yrs, though previous to that, remained abstinent for 7 yrs to be available for her young son. . . . She expressed concern about her drinking and stated she wants to stop. She is concerned about DTs as she sees things in [the] periphery when she isn't drinking such as while at work. *Joint Medical Exhibit*, at BH133-34.

41. A crisis clinician made a preliminary diagnosis of severe alcohol use disorder, and hospital staff discharged her on July 26, 2016 with a recommendation for a detoxification program or residential rehabilitation program.

42. Claimant followed up with Dr. Gieg the next day. She told him that her drinking had been out of control since the May 2016 assault,[15] and he urged her to go to a detoxification program. Claimant declined his advice.

43. On July 29, 2016, Claimant underwent a clinical assessment at the Howard Center. The screener diagnosed her with severe alcohol use disorder and post-traumatic stress disorder. *Joint Medical Exhibit*, at BH181. On August 4, she began a six-week intensive outpatient treatment program for alcohol abuse disorder at the Howard Center.

44. On August 24, 2016, Claimant told Dr. Gieg's office that she had quit drinking alcohol and that she never wanted to go through detoxification again. However, she failed a urine test at the Howard Center on August 25, 2016. When confronted by her counselor, Claimant denied drinking alcohol and then claimed that she had done so only on her birthday, which was not until August 28. On September 7, she told Dr. Gieg that she had starting drinking again three weeks ago, consuming two beers per day. *Joint Medical Exhibit*, at BH237. These statements contradict Claimant's testimony that she did not drink alcohol after starting the intensive outpatient program except for having three beers on her birthday, and I find that her testimony on this issue is not credible.

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[14] Claimant does not deny making this statement, but claims she only made it because she was intoxicated. I find that her statement might have been imprecise as to the exact amount of alcohol consumed over the previous year but that it accurately reflected her escalating and excessive daily consumption of alcohol during that time period.

[15] Claimant's statement to Dr. Gieg contradicts what she told the Emergency Department the night before about her alcohol consumption. It also contradicts what she told Dr. Gieg in July 2015 and what she told her therapist Kerry Stout. Accordingly, I find that her statement to Dr. Gieg was not credible.

45. After the Howard Center discovered Claimant's continued alcohol use during the intensive outpatient program, it referred her for individual counseling with licensed clinical social worker Kerry Stout. With Ms. Stout's help, Claimant has been able to remember and address many issues from her past. She testified: "We just talk about stuff. A lot of stuff has come out, in seeing her, that I didn't really remember or care to acknowledge, ignored." *Claimant's testimony*, September 14, 2017, at 118.

46. As of the hearing date, Claimant was continuing her weekly therapy sessions with Ms. Stout. Her ongoing treatment for alcohol use disorder consists of relapse prevention techniques and her treatment for stress involves cognitive behavioral therapy. By all accounts, these counseling sessions have been beneficial for her.

Summary of Claimant's Absenteeism and her Return to Work in November 2016

47. Claimant's paystubs covering her hours from September 7, 2014 through August 19, 2017 were admitted into evidence. *Defendant's Exhibit C*. They reflect that Claimant did not work a full 80 hours in a two-week pay period at any time during this almost three-year stretch.

48. Claimant received approval for 12 weeks[16] of FMLA leave in November 2014; she used up this allotment by May 3, 2015. In December 2015, she was again approved for 12 weeks of FMLA leave. She used up this allotment by April 9, 2016.

49. Claimant returned to work on November 16, 2016 after a four-month absence, and her work attendance has improved since then. For the last three pay periods of 2016,[17] she worked an average of 49.3 hours per two-week pay period. In 2017,[18] she worked an average of 50.9 hours per two-week pay period. Since her return, she has reduced her work schedule by one day per week so she can attend a 50-minute counseling session with Ms. Stout.[19]

50. Ms. Austin credibly testified that Claimant is doing a "really good job" since her return and that she does not avoid the patient who hit her in May 2016. *Ms. Austin's testimony*, September 15, 2017, at 37. Claimant credibly testified that her stress has not gone away, but the way she handles it has improved. She has not requested FMLA leave for 2017.

51. On June 12, 2016, Defendant reclassified the psychiatric nurse position and increased the pay from $38.71 to $51.27 per hour. On July 10, 2016, it applied a cost of living increase, raising the pay to $52.30 per hour. Claimant's paystubs reflect both of these changes. However, her paystubs also reflect that her hourly rate returned to $51.27 on

[16] FMLA leave is allotted per 12-month period, rather than per calendar year.

[17] The last pay period in 2016 covered December 11, 2016 through December 24, 2016. *Defendant's Exhibit C.*

[18] The payroll records for 2017 cover December 25, 2016 through August 19, 2017. *Defendant's Exhibit C.*

[19] Dr. Gieg wrote a note supporting her reduced work schedule.

November 27, 2016 and continued at that rate through at least August 19, 2017. No evidence was offered as to why the hourly rate decreased on November 27, 2016.

Work Stress Unrelated to the May 10, 2016 Physical Assault

52. Claimant provides nursing services to psychiatric patients, some of whom are acutely ill. The work is, by its very nature, stressful. She credibly testified that that she witnessed many assaults at the Vermont State Hospital in Waterbury. There were even times when patients or staff were driven to the hospital after "fairly serious" assaults. She also saw many assaults at the Morrisville and Berlin facilities. In Berlin, some patients were large strong men who would go after the staff, break furniture, and throw chairs.

53. The job description for the Psychiatric Nurse II position in Middlesex provided that the duties involved "direct interaction with patients who are identified as having a major mental illness, behavior management support needs, and may be at risk of harm to self or others." *Defendant's Exhibit A.* Claimant was aware of these environmental factors when she applied for the position. She credibly testified that the conditions were the same as those at the hospital where she had worked and that she understood that the patients could be violent or harmful to their caregivers.

54. The Middlesex patients are among the most difficult in the state. Many residents "hear voices," which makes them unpredictable. About half of them are assaultive, and assaults have occurred against both other residents and staff.[20] Ms. Austin credibly testified that the May 10, 2016 assault was not an unexpected event, given the residents' unpredictable nature. *Ms. Austin's testimony*, September 15, 2017, at 49-50.

55. As a member of the nursing staff, Claimant received Pro-ACT training on multiple occasions so she would be ready to respond when a potentially violent situation arose. Finding of Fact No. 31 *supra*. Claimant credibly testified that she does not think she has been exposed to a greater number of assaults than other psychiatric nurses; they are "all exposed to the same things." *Claimant's testimony,* September 14, 2017, at 141. She further testified that the severity of the assault she experienced at work was not worse than that experienced by the other staff; in fact, some staff have experienced more severe assaults than she has. *Id.,* at 144.

Expert Medical Opinions

56. The parties presented expert medical testimony as to whether Claimant's psychological condition was caused by the May 10, 2016 workplace assault. Claimant presented testimony from her family care physician, Gordon Gieg, MD, and her therapist, Kerry Stout. Defendant presented testimony from psychologist Steven Mann, Ph.D.

(a) Gordon Gieg, MD

[20] Staff at the facility includes nurses and technicians, both of whom have similar levels of contact with the patients, although it is usually the technicians who take patients on outings into the community.

57. Dr. Gieg graduated from the University of Saskatchewan College of Medicine in 1988 and completed a family medicine residency in 1990. From 2008 to 2012, he worked at the Vermont State Hospital in Waterbury, providing regular medical (not psychiatric) care to the patients there. Since 2012, he has worked at the Charlotte Family Health Center in Charlotte, Vermont. As a family practitioner, he will refer patients to a specialist if they need more expertise.

58. Dr. Gieg first met Claimant when they were both working at the Vermont State Hospital, and he has been her primary care physician since 2013. He has seen her for preventive care, colds, sinus infections, rheumatoid arthritis, depression and anxiety.

59. Dr. Gieg treats patients with depression and anxiety, but he has no specialized training in mental health issues and does not treat patients with serious psychological conditions. Even for depression and anxiety patients, if their treatment requires more than basic medications or a therapy referral, he will refer them to a specialist due to his lack of psychological training. Dr. Gieg sometimes sees patients with alcohol use disorders in his general practice, too, but he has no specialized training in treating alcohol abuse or addiction generally. His treatment of such patients consists of referring them to programs where they can obtain assistance.

60. On June 7, 2016, Dr. Gieg assessed Claimant with post-traumatic stress related to the May 2016 assault. *Joint Medical Exhibit,* at BH113. The basis for his assessment was "sort of a pattern of her visits, along with the symptoms that she'd been having." *Dr. Gieg's testimony,* September 14, 2017, at 83. Specifically, he thought her anxiety and stress levels were higher after the assault, and she reported having bad dreams and not wanting to go to work. *Id.*

61. Dr. Gieg is a family medicine doctor with no expertise in psychological conditions. He did not set forth any criteria for his diagnosis of post-traumatic stress, nor did he cite to any medical literature. These factors significantly weaken his opinion. Further, Dr. Gieg failed to take into consideration Claimant's significant pre-existing stress and anxiety and simply relied on her subjective report that these worsened following the assault. Finally, he failed to consider other factors in her personal history that could be the cause of any post-traumatic stress.[21] These omissions further weaken his opinion that she was suffering from post-traumatic stress causally related to the May 2016 assault.

62. Dr. Gieg also testified that Claimant's increased alcohol use in July 2016 was directly related to the May 2016 assault. He based his opinion on what seemed to be her historical pattern of using alcohol when she was stressed. *Dr. Gieg's testimony*, September 14, 2017, at 85.

63. As a family medicine practitioner, Dr. Gieg has no expertise in alcohol use disorders. He did not even recognize that Claimant had an ongoing problem with alcohol abuse until she disclosed that to him. Further, he attributed her alcohol abuse disorder to the May

[21] There is no evidence that Claimant told Dr. Gieg about the traumas she experienced earlier in life, including childhood sexual abuse and later domestic abuse, so he could consider whether these factors might have caused or contributed to her psychological symptoms.

2016 assault without exploring whether her condition predated the assault, whether there were other factors that might have caused her condition, or whether her condition was simply following a common pattern of waxing and waning alcohol consumption. In particular, he failed to take into consideration his own office note from July 2015, in which he noted that Claimant's alcohol intake had been escalating for the past year. Finding of Fact No. 25 *supra*. Dr. Gieg's failure to take these factors into consideration significantly weakens his opinion.

64. Dr. Gieg acknowledged that if Claimant had been drinking alcohol excessively prior to the May 2016 assault, then that would affect his opinion that her increased alcohol consumption was causally related to the assault. *Dr. Gieg's testimony*, September 14, 2017, at 105. However, his own records document periods of excessive alcohol consumption prior to the assault, and Claimant's therapist testified that she reported drinking excessively immediately prior to the assault. These facts further undermine his opinion that her increased alcohol consumption was causally related to the May 2016 assault.

(b) Kerry Stout, LICSW, LADC

65. Therapist Kerry Stout has a master's degree in social work from Fordham University. She is a licensed independent clinical social worker and licensed alcohol and drug counselor employed by the Howard Center. She provides individual and group psychotherapy for adults with mental health and substance abuse issues.

66. Ms. Stout has been providing weekly individual counseling to Claimant for severe alcohol abuse disorder and post-traumatic stress disorder since September 2016. She did not diagnose Claimant with either of those conditions, but she agrees with the Howard Center's diagnoses. Ms. Stout has not reviewed any medical records from Dr. Gieg or any other providers outside of the Howard Center.

67. Claimant reported to Ms. Stout that she was assaulted at work, but they have not talked about that event "to any great deal," despite a year's worth of weekly therapy sessions. *Ms. Stout's deposition*, August 31, 2017, at 50. Accordingly, Ms. Stout has no knowledge of the date, nature or duration of the workplace assault; she does not know if Claimant was alone with the assailant or whether the assault took place during the day or at nighttime.[22] *Id.*, at 50-51.

68. Claimant has discussed with Ms. Stout in depth the past traumas in her life, including childhood sexual abuse by two relatives, her first husband's emotional, physical and verbal abuse, and at least one motor vehicle accident in which she sustained serious injuries. When Claimant disclosed her history of childhood sexual abuse, Ms. Stout was not surprised. She testified:

> My hunch was that, that there was a history here, that this was not the result of one assault at work or two assaults. Could be, I mean, you never

[22] Ms. Stout knew no details about the December 2014 workplace incident either.

> can say; there's no clear, you know, this number of minutes of assault results in this, there's no way that I could ever say that. But I do recall looking at her and going – something else is going on here. *Id.*, at 52-53.

69. Ms. Stout attributed Claimant's psychological symptoms to these past traumatic events. For example, she testified that Claimant experiences stress and hypervigilance caused by winter driving. She has nightmares and other strong emotional responses related to her first husband's domestic abuse. She has also had sleep disturbances throughout her life; in Ms. Stout's opinion, sleep disturbances are not unusual in persons with a history of childhood sexual abuse. I find her testimony on these issues credible.

70. In Ms. Stout's opinion, Claimant meets the criteria for post-traumatic stress disorder set forth in the fourth and fifth editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*;[23] she based her testimony on the fourth edition (*DSM-IV*).[24] Ms. Stout read the first criterion for post-traumatic stress disorder from the *DSM-IV* as follows:

> The person has been exposed to [a] traumatic event [in] which both of the following are 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, and (2), the person's response involved intense fear, helplessness or horror. *Ms. Stout's deposition*, August 31, 2017, at 21-22.

71. Although Claimant may meet the first diagnostic criterion for post-traumatic stress disorder, Ms. Stout did not specifically apply that criterion to her situation, nor did she identify or apply any of the remaining criteria. Accordingly, it is difficult to evaluate her opinion that Claimant has post-traumatic stress disorder.

72. In any event, Ms. Stout did not testify that the May 2016 assault caused Claimant's post-traumatic stress disorder. Instead, she opined that the assault rekindled her prior traumatic experiences, based on Claimant's subjective reports of sleep disturbance, mood disturbance, flashbacks and anxiety. However, Ms. Stout did not take into account that Claimant was experiencing many of these symptoms before the assault; moreover, she had no information whatsoever about the assault itself. Finding of Fact No. 67 *supra*. Accordingly, her opinion that the May 2016 assault rekindled Claimant's post-traumatic stress disorder is not convincing.

73. Finally, Ms. Stout acknowledged Claimant's diagnosis of severe alcohol use disorder, but she did not consider whether this condition might be the cause of her anxiety, depression, sleep disturbances or other psychological symptoms. This omission further weakens her causation opinion.

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[23] The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) was published in 1994, and the fifth edition (*DSM-5*) was published in 2013. American Psychiatric Association, *DSM* History, https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

[24] Ms. Stout testified that the *DSM-IV* criteria are not "hugely different" from the *DSM-5* criteria for diagnosing post-traumatic stress disorder. *Ms. Stout's deposition*, August 31, 2017, at 21.

(c) Steven Mann, Ph.D.

74. Dr. Mann obtained his doctorate degree in psychology from Saybrook University in 1980. He is a licensed psychologist and the executive director of the Occupational Disability Management Center in Manchester Center, a multi-specialty treatment center for occupational injuries. Dr. Mann's clinical practice and research areas include the psychological and behavioral aspects of illness, chronic pain management and substance abuse. He has developed protocols to screen for addiction and, from 2008 to the present, has been consulting at various Vermont regional health care centers, where he conducts substance abuse evaluations.

75. At Defendant's request, Dr. Mann performed an independent psychological examination of Claimant in September 2016. The examination consisted of an interview, a review of her medical and psychological records, and a battery of standardized psychological tests that have been rigorously constructed and peer-reviewed and that include validity measures.

76. Based on his independent psychological examination, Dr. Mann concluded that the primary diagnosis for Claimant's psychological condition is severe alcohol use disorder. In his opinion, Claimant's alcohol abuse disorder caused or contributed to her personality changes, anxiety, depression, fatigue, problems with work, and difficulty with her commute. In his opinion, her level of alcohol use would affect her brain, personality, mood and behavior; it could also affect her sleep patterns and cause nightmares.

77. Dr. Mann noted the history of alcoholism in Claimant's family of origin and her own history of having been assaulted as a child or young adult as pre-existing conditions or events in her life that might have affected her drinking behavior. In his opinion, Claimant's periods of exacerbation and remission are typical of alcohol use disorder, and the minor assault that took place on May 10, 2016 did not cause, accelerate or exacerbate her alcohol use.

78. Based on his analysis of the psychometric test results and her medical records, Dr. Mann also diagnosed Claimant with persistent depressive disorder and unspecified anxiety disorder. In his opinion, these conditions were of longstanding duration, unrelated to the May 2016 workplace assault. He explained:

> [N]one of the stated psychological diagnoses, including alcohol use disorder, persistent depressive disorder, and unspecified anxiety disorder, have been exacerbated by, accelerated by, or caused by [Claimant's] interaction with an agitated mental health patient on May 10, 2016.
>
> The cause of alcohol use disorder is not fully understood. There is significant evidence of genetic predisposition for underlying addiction disorders, including alcohol use disorder. In [her] case, there is a very strong genetic component. . . .

> In a similar vein, the cause of persistent depressive disorder and unspecified anxiety disorder is not fully understood psychologically or psychiatrically. As in alcohol use disorder, there is evidence in the literature of a genetic component to the development of these forms of emotional illness. Other factors can also play a role including childhood and young adult traumas, as well as the organic emotional impact on the emotions secondary to chronic alcohol overuse. In [her] case, there is a reported history of sexual assault and physical abuse, timeframe unknown. There is a documented history of alcohol use disorder, severe. These factors have more than likely played a role in the development of [her] well-established mood dysregulation and intermittent problems with functioning. *Joint Medical Exhibit,* at BH317-18.

79. In Dr. Mann's opinion, Claimant does not have post-traumatic stress disorder related to the May 2016 assault. He supported his opinion by relying on the *DSM-5*'s criteria for diagnosing post-traumatic stress disorder. The first criterion requires exposure to a life-threatening event, or the threat of a serious injury or serious sexual assault. If a person does not meet the first criterion, then post-traumatic stress disorder is not the appropriate diagnosis. In his opinion, the minor transient attack of May 2016 does not meet the first criterion and therefore the diagnosis is not applicable. Dr. Mann explained:

> [Soon after the assault, Claimant] was described as calm and comfortable and in no distress by the treating doctor for the abrasion. Someone who has experienced an actual PTSD-triggering event, which would entail a threat to their life, serious injury or a serious sexual assault, would be agitated, upset and show the symptoms of significant PTSD, which is a heightened startle response and very obvious signs of agitation and distress so close to the incident; and that was absent by, in fact she was described by the provider as having none of those symptoms and being calm. And the abrasion, itself, according to [her], healed, in her words, real quick, which it did.
>
> *Dr. Mann's testimony,* September 15, 2017, at 196-97.

80. Dr. Mann further explained that post-traumatic stress is most severe at the time of the causal event. In Claimant's case, she reported no post-traumatic stress symptoms at the time of the May 2016 assault and in fact worked the entire day and the following two days without incident. *See* Finding of Fact Nos. 32-35 *supra*.

81. Dr. Mann supported his opinion further by reference to an additional criterion in the *DSM-5* for the diagnosis of post-traumatic stress disorder.[25] Criterion H provides that substance abuse should be ruled out as the cause of the patient's symptoms before a diagnosis of post-traumatic stress disorder can be made. Having attributed Claimant's symptoms to a substance abuse disorder, Dr. Mann thus ruled out post-traumatic stress disorder under Criterion H as well.

[25] The *DSM-IV* did not include criterion H. That criterion was added when the manual was revised in 2013.

82. Dr. Mann also noted Claimant's history of spousal abuse and childhood sexual abuse. In his opinion, it is more likely than not that any residual post-traumatic stress symptoms she is experiencing are attributable to those historical, non-work-related events. He concluded: "The incident in question here just does not have, in its actual component parts, a serious emotional-physical impact to create longstanding anxiety, depression and substance-abuse behavior." *Dr. Mann's testimony*, September 15, 2017, at 186.

83. Finally, Dr. Mann considered Dr. Gieg's opinion that the May 2016 assault caused post-traumatic stress. In his opinion, Dr. Gieg's attempt to causally link his diagnoses to the May 2016 assault was a misattribution of Claimant's "chronic problems with depression, anxiety and alcohol abuse" and had "no basis in fact and [was] not supported by either the context of the incident in question or the reality of [her] chronic deeply ingrained personality traits and chronic issues of depression, anxiety and addiction." *Joint Medical Exhibit*, at BH283. In his opinion, "Dr. Gieg is just not experienced in understanding the underpinnings of these diagnoses." *Dr. Mann's testimony*, September 15, 2017, at 198.

84. I find Dr. Mann's opinions to be clear, persuasive and well-supported by Claimant's medical records, his independent psychological examination results and the diagnostic criteria set forth in the *DSM-5*.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury, *see, e.g.*, *Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17 (1941), as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367 (1984). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

Causal Relationship Between Claimant's Psychological Condition and her Employment

2. Claimant alleges that she sustained a psychological injury as a result of the May 2016 work-related physical assault. Where the causation of a medical condition is obscure, and a lay person could have no well-grounded opinion on the issue, then expert medical testimony is needed to establish the claim. *Lapan v. Berno's Inc.*, 137 Vt. 393, 395-96 (1979).

3. The parties presented conflicting expert medical testimony on Claimant's psychological condition. In such cases, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the

qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

4. Applying the *Geiger* factors, I conclude that Dr. Mann's opinions are the most persuasive. He had no patient-provider relationship with Claimant, but he reviewed her pertinent medical and psychological records. He also administered a series of well-founded, standardized psychological tests and applied his expertise as a clinical psychologist to interpret the results. His opinions were clear, thorough and objectively supported by her medical and personal history, the applicable criteria of the *DSM-5* and the results of his psychometric testing. He credibly explained how Claimant's psychological symptoms were related to her severe alcohol use disorder and how the minor transient assault at work was not a sufficiently serious event to cause either her post-traumatic stress disorder or her psychological symptoms.

5. In contrast, Dr. Gieg's opinion was based largely on Claimant's subjective and incomplete reports of her alcohol consumption, personal history and psychological symptoms. Although he has the longest patient-provider relationship, he did not provide significant treatment for her psychological conditions. By training and experience he is a family medicine doctor, with no expertise in psychological conditions or alcohol abuse. Further, he failed either to define any criteria for diagnosing post-traumatic stress disorder or to reference any medical literature to support his opinion. For these reasons, Dr. Gieg's opinion was neither clear, thorough, nor objectively supported, and I find him the least persuasive. *See, e.g., S.H. v. State of Vermont*, Opinion No. 19-06WC (April 21, 2006) (medical opinion based on subjective reports and temporal coincidence not persuasive); *Rivers v. University of Vermont*, Opinion No. 05-09WC (February 10, 2009) (physician performing a medical records review more persuasive than treating physician who relied on claimant's assertion of a causal relationship).

6. Therapist Kerry Stout had a year-long patient-provider relationship with Claimant as of the hearing date, providing treatment specifically for her psychological condition. Although she is not a doctor, her testimony was more helpful than Dr. Gieg's. In particular, Ms. Stout's support for the diagnosis of post-traumatic stress disorder relied upon the *DSM-IV* criteria and was clear and objective, although incomplete. However, she did not review any records outside the Howard Center's, and she had no information about the May 2016 workplace assault. Thus, she could not credibly explain how Claimant's symptoms were related to that incident. Moreover, she did not take into account the pervasive effects of Claimant's severe alcohol use disorder as a cause of her symptoms. Accordingly, her opinion as to whether Claimant's psychological symptoms were related to the workplace assault was not as thorough or persuasive as Dr. Mann's.

7. Dr. Mann's opinion is not entirely in conflict with Ms. Stout's. In Ms. Stout's opinion, various traumatic events in Claimant's personal history, including childhood sexual abuse and spousal abuse, were sufficiently serious to meet the first criterion for a post-traumatic stress disorder diagnosis. Dr. Mann noted that Claimant may have some lingering stress from these early life traumas as well. Considering their opinions together, I conclude that Claimant may have some ongoing stress related to her early life traumas, but her psychological condition is unrelated to the minor work assault.

8. In the final analysis, for the purposes of her workers' compensation claim, the particular diagnosis, whether post-traumatic stress disorder or severe alcohol abuse disorder, does not matter. What matters is whether Claimant has sustained her burden of proving the necessary causal relationship between her psychological symptoms and her May 10, 2016 workplace assault. Based largely on Dr. Mann's opinion and the medical records, I conclude that she has not.

Standards of Proof for Psychological Injuries

9. Vermont workers' compensation law recognizes two types of psychological injuries: those that are related to a physical injury ("physical-mental") and those that are purely psychological ("mental-mental"). Claimant alleges that the May 2016 physical assault caused her psychological condition. By relating her condition to the assault, Claimant is asserting a physical-mental claim, one in which a work-related physical stimulus causes a psychological injury. *Blais v. Church of Latter Day Saints*, Opinion No. 30-99WC (August 5, 1999); *Lydy v. Trustaff, Inc*., Opinion No. 05-12WC (February 8, 2012). The Commissioner in *Lydy* wrote:

> The key component of any workers' compensation claim is the causal nexus between a work-related accident and a resulting injury. 21 V.S.A. §618. Most compensable claims originate with a physical stimulus, a slip and fall, for example, and result in a physical injury, such as a disc herniation or a ligament tear. The same causal nexus is required in a physical-mental claim, the only difference being that the work-related physical stimulus gives rise to a psychological injury rather than a physical one.
>
> *Lydy v. Trustaff, Inc.*, Conclusions of Law, ¶ 3, citing *Blais, supra*, and 3 Lex K. Larson, *Larson's Workers' Compensation* § 56.03 (Matthew Bender, Rev. Ed.).

10. Dr. Mann's persuasive testimony established that Claimant's psychological symptoms were not only pre-existing, but also were neither aggravated nor accelerated by the workplace physical assault. I therefore conclude that Claimant has failed to establish that her psychological condition bears a causal relationship to the May 2016 physical assault.

11. Defendant provides an alternate analysis of this claim under the standard for mental-mental claims. Such claims require a higher standard of proof, due to the high degree of uncertainty involved in diagnosing the cause of psychological conditions and the fact that providers often rely on their patients' subjective impressions that work-related stress caused their psychological conditions. *See Bedini v. Frost*, 165 Vt. 167, 169-70 (1996). Consequently, the claimant in a mental-mental claim must prove not only that work stress caused his or her psychological condition, but also that the stress is of significantly greater dimension than the daily stress encountered by similarly situated employees performing the same or similar work. *Crosby v. City of Burlington*, 2003 VT 107, ¶ 24.

12. The evidence here does not establish a causal relationship between Claimant's work stress and her psychological condition. Accordingly, whether analyzed as a physical-

mental claim or a mental-mental claim, her claim fails in either event. Moreover, even if she had established a causal relationship, she has also failed to prove that her work stress was extraordinary when compared to similarly situated employees performing the same or similar work.[26] *See* Finding of Fact Nos. 52-55 *supra*. I therefore conclude that her claim does not meet the standard for a compensable mental-mental claim.

Summary and Conclusions

13. Claimant has asserted a physical-mental claim, the legal standard for which requires a causal connection between the work-related physical stimulus and the psychological injury. *Blais v. Church of Jesus Christ of Latter Day Saints*, Opinion No. 30-99WC (1999). Defendant provides an analysis of the claim under both the physical-mental standard and the higher standard for mental-mental claims set forth in *Crosby v. City of Burlington*, 2003 VT 107. Under either standard, Claimant has failed to establish by sufficient credible evidence a causal connection between her psychological condition and her employment. *Egbert v. The Book Press*, 144 Vt. 367 (1984).

14. As Claimant has failed to prevail on her claim, she is not entitled to an award of costs and attorney fees.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, Claimant's claim for workers' compensation benefits referable to her psychological condition is hereby **DENIED**.

DATED at Montpelier, Vermont this ____ day of December, 2017.

_____
Lindsay H. Kurrle
Commissioner

Appeal:
Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§670, 672.

[26] Effective July 1, 2017, the Vermont legislature amended the Workers' Compensation Act to change the standard of proof for mental-mental claims. The amendment requires comparison of an injured worker's stress to the pressures and tensions experienced by the average employee across all occupations, rather than to the stress experienced by similarly situated employees. Because this amendment imposed substantive changes, it does not apply retroactively to claims that were acquired, accrued or incurred prior to its effective date. 1 V.S.A. § 214(b)(2); *see, e.g., Jalbert v. Springfield School District*, Opinion No. 04-17WC (February 16, 2017) (legislative amendments that affect substantive rights and responsibilities not to be applied retroactively).