**OPINION ENTERED: APRIL 5, 2012**

CLAIM NO. 200977026

VICTOR MORRIS PETITIONER

VS. **APPEAL FROM HON. CAROLINE PITT CLARK, ADMINISTRATIVE LAW JUDGE**

NORTHPOINT TRAINING CENTER
and HON. CAROLINE PITT CLARK,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

**OPINION AFFIRMING**

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BEFORE: ALVEY, Chairman, STIVERS and SMITH, Members.

**SMITH, Member.** Victor Morris ("Morris"), pro se, appeals from the May 23, 2011 Opinion and Order rendered by Hon. Caroline Pitt Clark, Administrative Law Judge ("ALJ") dismissing his claim. Morris also appeals from the ALJ's June 27, 2011 Order denying his petition for reconsideration.

Morris filed an application for resolution of injury claim on August 5, 2010, asserting an injury on September 23, 2009 while working for Northpoint Training Center (“Northpoint”), a facility of the Kentucky Department of Corrections. Thereafter, Morris testified by deposition on October 19, 2010 and at the formal hearing on April 4, 2011.

Morris is a resident of Danville, Kentucky. He achieved a bachelor's degree from Asbury College in Wilmore, Kentucky in 1996. He later earned a Master’s degree in divinity in 1999 and a second Master’s degree in evangelism in 2000, both from Asbury Theological Seminary. Morris pastored several churches over the course of 12 years. In 2006, he began working at Northpoint.

Morris testified that, during the two years prior to the work injury, he had been subjected to continuing harassment by a fellow coworker, Kevin Smith ("Smith"). Smith's continuing harassment included false statements, reports and accusations of mental and emotional instability. Morris filed numerous complaints against Smith and had requested to be reassigned elsewhere. However, it was Morris who was taken off work and required to seek assistance from a mental health professional as a condition for his return. On September 23, 2009, as Morris was performing his duties supervising inmates engaged in

recreational activity, Smith approached Morris from behind and punched him in the back.

Morris testified Smith's punch was so severe it caused extensive bruising and pain, requiring Morris to seek medical attention at a local hospital. Although the bruising and pain subsided, Morris sought treatment from Dr. Shelton, a psychiatrist, who determined he developed post-traumatic stress disorder ("PTSD") solely from the incident with Smith. Morris testified Dr. Shelton continues to treat him with therapy sessions and medications including Alprazolam for anxiety, Lithium, Cymbalta and Temazepam.

Charles Shelton, D.O., a board-certified psychiatrist, filed a letter report to Morris's attorney on June 28, 2010, indicating he had diagnosed Morris with post-traumatic stress disorder due to the assault he sustained from a coworker on September 23, 2009. He noted Morris had been unable to engage in sustained gainful employment of any type as he had been unable to adapt to stressors associated with any workplace environment and was unable to maintain concentration, persistence and pace. Dr. Shelton noted the course of treatment involved therapy and psychotropic medications including Cymbalta, Alprazolam, and Temazepam.

Dr. Shelton testified by deposition on December 21, 2010, acknowledging his diagnosis of post-traumatic stress

disorder was separate and apart from the depression and anxiety problems that had plagued Morris well before the accident of September 23, 2009. He stated:

> Q. Is there some way that you can sort of describe, you know, depression, anxiety and differentiate that from PTSD?
>
> A. Well, PTSD is an anxiety disorder, okay? So you have - so you do have--- then if you look at PTSD in our diagnostic criteria, it's listed as an anxiety disorder. So depression is considered a mood disorder, okay, so depression is going to involve having - feeling down, you're not going to be able to enjoy things when you're depressed. You may have negative thoughts, worry, a lot of pessimism, troubles with sleep, appetite, motivational problems would be present there. May have a propensity to withdrawal, self-isolate, low self-esteem, feelings of guilt, memory problems, difficulty with concentration, you may have fatigue, low energy levels, hopelessness, worthlessness, crying spells, and then people with depression can develop suicidal thoughts and they also can develop suicidal intent and develop a suicidal plan.
>
> Q. Okay.
>
> A. That's depression.
> Q. All right.
>
> A. The PTSD requires having been exposed to an event which is perceived as life-threatening, and so the individual can be exposed to a life-threatening event and subsequent to that event they develop the various symptoms they have

> to -- they have to have a certain reaction to the event, you know, respond with intense fear or horror and then they can develop a whole host of anxiety symptoms and other associated PTSD symptoms.
>
> Q. Such as?
>
> A. Sleep difficulties, nightmares can occur, recurrent distressing recollections regarding the event. You can have avoidance where people will not want to go to certain -- to the location where the event occurred or any area that reminds them of the trauma, they may avoid people associated with the trauma they may also avoid people associated with the trauma or any people that are - that remind them of the trauma. And may have difficulties on viewing things on television or reading anything that even may remotely remind them of their specific trauma.

Morris also presented the independent medical evaluation of Dr. Christopher Allen, a board-certified psychiatrist who examined him on June 23, 2010. Dr. Allen first noted that, as a child, Morris had "quite a problematic relationship with his father who was apparently violently abusive to him." Dr. Allen recorded the following:

> Indeed, the patient apparently sustained two significant concussions secondary to assault on his father's part which occurred at the ages of 13 and 14. Apparently, the patient was struck by his father at age 13 resulting in a 24-hour loss of consciousness with no medical care. The second assault at age

> 14 apparently resulted in a 30 minute loss of consciousness. A third incident in which patient apparently sustained injuries to the head which resulted in post-traumatic amnesia for a few hours occurred secondary to a motorcycle accident at age 21. Mr. Morris also reported that his dominant hand index and middle fingers are partially amputated. The patient indicated, as well, that he manifests a history of transient symptoms of anxiety and depression. In 1993, J. Douglas McCallum diagnosed the patient with "ADD", a diagnosis which was reiterated by Barbie Slevin, LCSW. The first apparently occurred just after he started his ministry in the United Methodist Church. He was apparently treated with BuSpar at the time. He experienced some depressive symptoms one year after leaving the ministry. Work-related stress in his last place of work also apparently led to some negative affect which was treated medically, as well. The patient, however, discontinued use of any psychiatric medication just before he was attacked in 2009.

Dr. Allen concluded Morris could be described as a mildly depressed individual who is socially detached and somewhat hyper-vigilant to threat. Dr. Allen noted evidence of post-traumatic stress but no general signs of significant anxiety were displayed. His evaluation also revealed significant neuropsychological dysfunction and significant impairment in the patient's ability to recall verbal information. Those deviations were not related to the assault Morris encountered in 2009, but could be related to

the assaults Morris endured as a young teen at the hand of his father. Dr. Allen stated:

> The patient deviations are sufficient to interfere with his functioning in everyday life circumstances and may interfere with his functioning in virtually every aspect of his life. These data, further, suggest that the patient manifests problematic personality characteristics which predispose him to emotional distress, and to behavioral inflexibility; to intrapersonal mistrust, and a tendency to be overly competitive, to an extremely conservative and inflexible value system, as well as to be overly conscientiousness and rulebound behavior. In addition, these data clearly suggest that Mr. Morris was the victim of extreme abusive behavior and intimidation on the part of his father which may leave him vulnerable, paradoxically, to such behavior. Indeed, it is very likely that Mr. Morris finds it extremely difficult to deal effectively with any form of intimidation whether it is intended in jest or seriously. The patient's current emotional distress is almost certainly directly related to the assault which he endured in 2009 in his place of work. The intensity and chronicity of his response, however, is likely related in part to his premorbid personality characteristics, developed in large part in response to having been the victim of assault for many years at the hands of his now deceased father. Currently, in fact, the patient reports a significant level of depression, interpersonal isolation, as well as some symptoms of posttraumatic stress. In this examiner's opinion, however, Mr. Morris does not meet diagnostic criteria for a full diagnosis of PTSD. The assault itself

> was not, in this examiner's judgment, sufficient to lead the patient immediately to suspect that he had been seriously harmed or that he had sustained a life-threatening injury. The patient's response to distress, however, was not in any way excessive, but rather was what might be predicted on the basis of such an assault. Nevertheless, these data clearly suggest that the patient manifests significant depression, anxiety and interpersonal sensitivity and self-consciousness due to the attack which he endured in 2009.

Northpoint submitted a medical report by Dr. Thomas Shurling who evaluated Morris on August 19, 2006. The clinical interview conducted by Dr. Shurling indicated Morris suffered from daily dysphoria, loss of interest in pleasurable activities, persistent fatigue, lethargy, pessimism, indecision, anxiety, worry, and poor sleep. Those symptoms were consistent with a depressive syndrome and have persisted for several years according to Morris. Dr. Shurling noted Morris denied symptoms of post-traumatic stress disorder at that time and denied a history of perpetrating verbal or physical violence.

Dr. Shurling administered psychological testing, the results of which he summarized as follows:

> Rev. Morris' objective psychological testing indicates that he responded defensively on two of the three tests. The 16 PF suggests that he is a serious person who is somewhat introverted and is reserved regarding forming

> attachments with other people. There is no data suggestive of psychotic processes or serious mental illness. The caveat here is that he is endorsing symptoms of major depression, which he states have been present for many years. The etiology of these symptoms likely lies in his early childhood experiences living with a violent, alcoholic father.
>
> During the interview and testing there was no evidence of attention deficit hyperactivity disorder or obsessive compulsive disorder. He has a head injury history that needs investigation. No statements can be made about his alleged inappropriate sexual references. It appears that his style of communicating with others both in writing and in person may be the result of early life experiences as noted above.

Based upon his conclusions, Dr. Shurling recommended Morris seek individual psychotherapy to assist him in overcoming depression and help him deal with the influence of early life events in his current functioning. Dr. Shurling recommended psychotropic medications and a neurological and/or neuropsychological evaluation to evaluate a history of head injuries Morris sustained as a child.

Northpoint submitted the medical reports of Joe Bob Pierce, CFBPC, LMFT, who conducted counseling sessions with Morris in 2006 and Dr. Stuart Palmer who conducted counseling with Morris from October 2007 through September

2008. Northpoint also submitted a psychiatric report of Dr. Robert Bunge, who examined Morris in November, 2007. In his report to Dr. Palmer, he stated:

> I feel that he does have a single episode of major depression on top of an underlying dysthymic disorder. He also does have some ADHD symptoms but not meeting full criterion at this time. He also does have some history of panic attacks. I also wonder about the possibility of personality disorder. I did start him on Lexapro and he will take 10-20 mg daily. That had been helpful in the past. I have encouraged his continued psychotherapy with you.

David Shraberg, M.D., a board-certified forensic psychiatrist, examined Morris on November 18, 2010 at Northpoint's request. Dr. Shraberg observed that Morris had been traumatized with post-traumatic stress disorder since childhood. He noted Morris had been "beaten over the head several times by his father and rendered unconscious as a child." Dr. Shraberg concluded Morris had incurred multiple traumatic brain injuries and attention deficit disorder. Morris's problems ultimately culminated in his inability to successfully work in the system with his church. Similar problems affected his employment at Northpoint.

Dr. Shraberg concluded Morris suffered from chronic symptoms of depression and post-traumatic stress disorder existent since childhood. He found no evidence of a *de novo*

or exacerbated post-traumatic stress disorder relating to the September 23, 2009 incident.

In an Opinion rendered May 23, 2011, the Administrative Law Judge reviewed the relevant evidence and issued the following findings of fact and conclusions of law:

> To prevail on his claim, Plaintiff must prove a causal relationship between his employment with Defendant Employer and the alleged injury, and if the injury was brought about by reason of some other cause having no relation to his employment, it cannot be said to have arisen out of employment. *See McCracken Co. Health Spa v. Hanson*, 568 SW2d 240 (Ky. App. 1977). The issue of causation, or proximate cause, is generally a question of fact; however, when the causal relationship between an injury and a medical/psychological condition is not apparent to a lay person, the issue of causation is solely within the province of a medical expert. *Elizabethtown Sportswear v. Stice*, 720 SW2d 732, 733 (Ky. App. 1986); *Mengel v. Hawaiian-Tropic Northwest and Central Distributors, Inc*., 618 SW2d 184 (Ky. 1981).
>
> In this case, Plaintiff relies on his own testimony, as well as the expert medical opinions of Dr. Shelton, his treating psychiatrist, and Dr. Allen, his evaluating psychiatrist, to assert that his current psychological condition is the result of the September 23, 2009 incident at work involving his co-worker, Shane Smith. Dr. Shelton opined that Plaintiff suffers from posttraumatic stress disorder as a result of the work incident, and indicated his belief that Plaintiff's psychological condition is new and separate from his past issues with depression and anxiety. Dr. Allen

disagreed with Dr. Shelton's ultimate diagnosis, opining he does not believe that Plaintiff’s current psychological condition rises to the level of PTSD; however, he found that Plaintiff suffers from depression and anxiety secondary to the September 2009 work accident/assault and assigned Plaintiff a whole person psychological impairment of 15% as a result of the work injury. Dr. Allen did not believe that Plaintiff suffered from a preexisting, active, psychological condition or impairment prior to the work injury of September 23, 2009.

Defendant Employer relies on Plaintiff's prior treatment records from Dr. Springate, Dr. Shurling, Joe Bob Pierce, Dr. Palmer and Dr. Bunge, as well as the medical report prepared by Dr. Shraberg, to assert that Plaintiff suffered from a preexisting, active, psychological condition and to argue that Plaintiffs [sic] current psychological condition is long-standing, chronic, and not the result of the work incident with Shane Smith in September of 2009. Dr. Shraberg opined that Plaintiff suffers from chronic symptoms of depression and posttraumatic stress disorder that stem from his childhood and the significant physical trauma he sustained at the hands of his abusive and alcoholic father. Dr. Shraberg indicated Plaintiff did not suffer a new psychological injury, or the exacerbation of his pre-existing psychological condition, as a result of the events that transpired between himself and Mr. Smith at work on September 23, 2009.

After careful consideration of the evidence presented, including the conflicting medical testimony discussed above, the Administrative Law Judge finds that Dr. Shraberg has rendered the most accurate and authoritative analysis

> concerning the causation of Plaintiff's current psychological condition and symptoms, and adopts his expert medical opinions on this issue. Dr. Shraberg's discussion and opinions seem to best reflect Plaintiffs [sic] significant history of physical abuse and pre-existing psychological problems. The undersigned is convinced that Plaintiff's pre-existing depression and anxiety caused his problems, both real and perceived, with Shane Smith at work, rather than being caused by his work problems with Mr. Smith. This finding is supported by Dr. Shraberg's testimony, as well as by the fact that Plaintiff has a history of difficulty in dealing with his employers and co-workers. Therefore, based on the expert medical opinions of Dr. Shraberg, the Administrative Law Judge finds that Plaintiff's current psychological problems are longstanding, pre-existed the alleged work injury, and are not the result of the September 23, 2009 work incident with his co-worker Shane Smith. Plaintiff's claim for income and medical benefits as a result of his alleged work-related posttraumatic stress disorder is dismissed.
>
> It is noted that the undersigned does believe that Plaintiff was hit by a co-worker, Shane Smith, on September 23, 2009. Although there is no evidence that Plaintiff sustained any permanent physical injuries as a result of the incident, the Administrative Law Judge finds that Defendant Employer is liable for the medical treatment Plaintiff received at the emergency room immediately following the altercation.

Morris filed a petition for reconsideration on June 6, 2011, essentially taking issue with the ALJ's decision to assign greater credibility to the opinions of Dr. Shraberg

over the opinions of Morris’s treating psychiatrist, Dr. Shelton. Morris noted Dr. Shraberg only saw the plaintiff for a total of 1 1/2 hours. Yet, the ALJ extensively detailed Dr. Shraberg's opinions for 2 1/2 pages of the written Opinion and Award. On the other hand, Dr. Shelton's conclusions were summarized in only seven lines of the opinion.

Morris further argued Dr. Shraberg based his opinions on the mistaken belief that Dr. Shelton overlooked Morris's significant history of psychological symptoms when he diagnosed Morris with PTSD secondary to the work injury incident of September 23, 2009. In fact, Dr. Shelton explained why he believes the plaintiff's prior psychological issues were different from the PTSD. Morris stated Dr. Shelton addressed prior psychological issues head on and determined the current problems were not the same as those Morris suffered in the past. Because Dr. Shraberg misinterpreted Dr. Shelton's opinions, Morris argued the ALJ should review the evidence and provide additional findings.

Morris also argued Dr. Shraberg's report could not be read to indicate more than pre-existing personality disorders stemming from Morris's early childhood experiences. Significantly, Dr. Shraberg's report could

not be construed as indicating an active impairment immediately prior to the work injury incident. Morris had been receiving no psychiatric/psychological treatment immediately prior to the work injury and the only medication he was taking was for mild anxiety and not depression or PTSD. Accordingly, any psychological/psychiatric problems Morris suffered would be dormant and non-disabling, not "active".

Morris further argued additional findings of fact should be made explaining the ALJ's reason for rejecting evidence of record which established that, prior to the work injury, Morris had been working full time, performing his job (although with some minor conflicts with a coworker) and after the work injury had been completely unable to work in any capacity.

Finally, Morris noted Dr. Shraberg based his opinion on reports of psychiatrists who saw him in the past. However, the evidence does not show continuing symptoms up to the time of the work injury. Morris noted Dr. Spurling's opinions deal with events in 2006, but nothing from that time until the present incident. The opinions of Dr. Bunge relate to incidents in 2007, but nothing more recent. Morris urged additional findings addressing these issues.

The ALJ, by order rendered June 27, 2011, summarily denied Morris's petition for reconsideration. Morris then filed a notice of appeal on July 27, 2011.

On appeal, Morris argues Dr. Shraberg exhibited bias, was unprofessional in preparing his report, made inappropriate personal criticisms of Morris and Dr. Shelton, and ignored facts in reaching his conclusions. Morris identifies, at great length, alleged errors in Dr. Shraberg's report including, but not limited to, his statement that he spent 90 minutes conducting the evaluation. Morris takes issue with Dr. Shraberg's statements regarding Morris's trouble with authority figures, whether Morris struck Smith, the nature of Morris's relationship with his brothers, the referral to Dr. Bunge, and which doctor first prescribed Lexapro. Morris disagrees with Dr. Shraberg's opinion that he had pre-existing problems. Morris notes he passed all his "psychs" to get into the seminary and ministry and he received awards and commendations for his pastoral work. He further notes he has remained married for 31 years. Morris sums up his argument stating as follows:

> It is my claim that, with seeming partiality owing to content and context ignorance, ALJ Pitt Clark [sic] judged wrongly against me based on the defendant's reports (i.e. from Dr.

> Shraberg) which was patently unprofessional, contains a gross amount of inaccuracies and biased assertions/prevarications, and is not the objective medical analysis and clinical diagnosis it purports to be.

Accordingly, Morris requests that the ALJ's order be overturned and his claim upheld.

As the claimant in a workers' compensation proceeding, Morris had the burden of proving each of the essential elements of his cause of action. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since Morris was unsuccessful in his burden, the question on appeal is whether the evidence compels a different result. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). Compelling evidence is defined as evidence so overwhelming, no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). The function of the Board in reviewing the ALJ's decision is limited to determining whether the ALJ's findings are so unreasonable under the evidence they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000).

As fact-finder, the ALJ has the sole authority to determine the weight, credibility and substance of the evidence. Square D Company v. Tipton, 862 S.W.2d 308 (Ky.

1993). Similarly, the ALJ has the discretion to determine all reasonable inferences to be drawn from the evidence. Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997); Jackson v. General Refractories Co., 581 S.W.2d 10 (Ky. 1979). The ALJ may reject any testimony and believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the same adversary party's total proof. Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000). Although a party may note evidence that would have supported a different outcome than that reached by an ALJ, such proof is not an adequate basis to reverse on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974).

The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to the weight and credibility to be afforded the evidence or by noting reasonable inferences that otherwise could have been drawn from the evidence. Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999). So long as the ALJ's ruling is supported by substantial evidence, it may not be disturbed on appeal. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

Morris's arguments on appeal are essentially an attempt to have the Board re-weigh the evidence and direct a finding

contrary to the ALJ's decision. We may not do so. The ALJ was not persuaded Morris's problems were connected with the September 23, 2009 work incident. The ALJ was most convinced by the opinions of Dr. Shraberg who could not link the incident to Morris's current problems. Dr. Shraberg conducted an interview, reviewed medical records and conducted psychological testing in formulating his opinions.

The ALJ was well within her role as fact-finder in determining Dr. Shraberg's opinion was persuasive regarding Morris's psychological condition. The ALJ was clearly aware of the conflicting evidence. She weighed that evidence and reached her determination based upon the totality of the evidence. As noted by the ALJ, numerous records documented prior treatment for psychological conditions. Those records and Dr. Shraberg's opinion provided a sufficient basis for the ALJ to conclude Morris's pre-existing depression and anxiety caused the problems with his coworker and not the incident of September 23, 2009. There being substantial evidence supporting the ALJ's conclusion, it cannot be said the evidence compels a finding in Morris's favor. Although Morris is able to point to some evidence that could have supported a finding in his favor, the evidence falls far short of compelling such a finding.

Accordingly, the May 23, 2011 Opinion and Order and the June 27, 2011 order ruling on Morris's petition for reconsideration rendered by Hon. Caroline Pitt Clark, Administrative Law Judge, are hereby **AFFIRMED**.

ALL CONCUR.

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