2001 ONWSIAT 1838

WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1949/99

[1] This appeal was completed in Toronto on June 5, 2001, by a Tribunal Panel consisting of :

F.W. McIntosh-Janis: Vice-Chair,
P.A. Barbeau : Member representative of employers,
M. Tzaferis : Member representative of workers.

THE APPEAL PROCEEDINGS

[2] The worker appeals the decision of the Appeals Officer, dated June 5, 1997. That decision concluded that the worker was not entitled to further benefits for a chronic pain disability (CPD), a psychotraumatic disability, or an organic disability.

[3] The worker was represented by L. Rochester, barrister and solicitor. The employer was advised of the worker's appeal but chose not to participate.

[4] In *Decision No. 1949/99I* (January 12, 2000), we outlined our findings of fact based on the evidence on file and the oral evidence which we received, summarized the medical evidence on file, set out our instructions to Tribunal counsel to arrange an assessment of the worker, and set out our questions for the assessors.

[5] On June 5, 2001, we received the worker representative's final submissions.

THE EVIDENCE

[6] In addition to the materials outlined in our Interim Decision, we had before us Post-Hearing Addendum #1, Post-Hearing Addendum #2 which included the assessors' responses to the Panel's requests for clarifications of their initial reports and a complete copy of Dr. Margulies' report (which was found in Post-Hearing Addendum #1 but with missing pages), Post-Hearing Addendum #3, Tribunal counsel's letter dated June 4, 2001, acknowledging receipt of the worker representative's letter of May 31, 2001, and 12-page summary of the assessors' reports, the worker representative's Revised Legal Brief and a DSM-IV Guidebook prepared by the worker's representative.

THE ISSUES

[7] The worker was hit on the left side of her head on November 5, 1990. The Board has granted the worker benefits related to an aggravation of a pre-existing condition involving migraine headaches and a cervical condition until April 7, 1992, at which time the Board terminated the worker's benefits.

The worker claims continuing entitlement to benefits related to a CPD, a psychiatric disability and/or an organic disability.

THE REASONS

(i) The accident

[8] In our Interim Decision, we outlined in detail the worker's original injury. It can be summarized as follows:

- On November 5, 1990, a side-supporting rod from a partially-assembled wardrobe rack (a wheeled upright rack 5' tall, weighing 5-7 lb. in total) fell and hit the worker on the left side of her skull. The worker did not lose consciousness, but testified that she did feel an immediate headache and, soon after the accident, pain going down into her shoulders. She completed the balance of her shift on alternate duties.

- The worker attended the hospital the next day. The ER reports indicate that there was an abrasion and contusion on the crown of her scalp and her cervical spine was tender.

- The worker attended her then family physician, Dr. Tenore, whose diagnosis was head injury with concussion.

(ii) The worker's pre-accident history

[9] We outlined the worker's pre-accident history in detail in our Interim Decision. We summarize the most important parts of that history as follows:

- The worker was 38 at the time of her accident. Her work after college was mostly as a wardrobe assistant for television, theatre, film and ballet productions, as well as commercials for television. She worked freelance, taking jobs when she could.

- In the two years prior to her 1990 accident, the worker had fairly consistent employment, often involving long hours well beyond a "normal" 40-hour workweek. We accepted the worker's testimony that any gaps in her work history prior to her November 1990 accident related to the nature of the work she did in the film and television industry, and not to any "instability" in the worker herself.

- Immediately prior to the November 1990 accident, the worker had been receiving psychological treatment and was taking Prozac because her relationship with a long-standing partner had ended. However, the effect of the worker's break-up with her boyfriend in 1990 did not appear to affect the worker's abilities to work in 1990.

- Prior to the November 1990 accident, the worker had abused drugs. For approximately one to one-and-a-half years prior to and during 1990, she had used cocaine on a regular basis one to two times per week. We accepted the worker's

testimony that she stopped using drugs in the late summer of 1990 and was not using drugs (apart from those prescribed by Dr. Tenore) at the time of her accident.

- The worker did have headaches prior to her November 1990 accident. We accepted the worker's evidence that her headaches after the November 1990 accident, as compared with her pre-accident headaches, were different in frequency, duration and severity.

(iii) Testing of the worker's cervical spine

[10] Because the worker has had continuing complaints of pain in her neck area, the doctors have ordered various tests of the worker's cervical spine. The results of those tests are outlined in our Interim Decision and are summarized below.

[11] Most of the x-rays were reported as negative, apart from those done in November 1991 which showed minimal narrowing of the disc space between C4 and C5, minimal anterior inferior marginal lipping of the vertebral body of C4-5, mild degenerative changes with marginal lipping of the lateral mass of facet joints, particularly between C3-4, C4-5 bilaterally, joint spaces between C2-3 also slightly narrowed; the findings were considered to be compatible with early and/or mild osteoarthritic changes.

[12] A myelogram and EMG were reported as negative.

[13] A cervical spine MRI in December 1994 showed a small lateral disc herniation at C3-4 on the right. The radiologist noted that the significance of this finding was uncertain, however, as similar changes may be seen in normal asymptomatic volunteers.

(iv) Testing of the worker's brain

[14] Because of the worker's continuing complaints of headaches, the treating specialists ordered various tests to ascertain whether there was an organic explanation for the worker's complaints.

[15] A skull x-ray in April 1991 was negative. Brain scans done in November 1991, January 1992 and January 1993 were all normal. A spect scan done by Dr. Gawel also was normal, suggesting no permanent functional damage to the brain.

(v) Treatment of the worker's complaints of pain and headaches

[16] The Board referred the worker to the Toronto Hospital Regional Evaluation Centre (REC) in mid-June 1991. The diagnosis was "cervical strain, which will recover, and reactive depression, the prognosis of which is guarded".

[17] Because of continuing complaints of headaches and neck pain, Dr. Tenore referred the worker for assessment and treatment by Dr. Jacobs at the Pain and Headache Clinic. The worker has continued to attend for treatment at this Clinic, more recently from Dr. Fainman. As the findings of the doctors at this Clinic and those of the assessors to whom the Clinic referred the worker were the focus

of many of our questions of the assessors, we consider it appropriate to summarize the most important findings from that Clinic:

- September 1991: Dr. Gawel, a consultant neurologist, diagnosed the worker as suffering from "post-traumatic headaches and also confusion".

- November 1991: Dr. Jacobs reported the worker's x-rays as indicating "very severe extensive disease of her cervical spines and also lumbar pathology present as well".

- December 1991: Dr. Jacobs referred to "significant facet joint injury along the C2-4 level" which "could probably be contributing to her headaches as we see quite a lot of this at the clinic: cervicogenic pain with facet problems is a strong etiology of head pain and neck pain in post-traumatic patients".

- January 1992: Dr. Jacobs referred to a "cervical injury" causing some of the problems which the worker had been having. He considered the worker's degenerative changes as compatible with her headaches, which he considered to have been brought on by the accident.

- May 1995: Dr. Fainman referred to the worker's cervical myelogram revealing thecal indentation at the levels C3-4 and the subsequent MRI revealing a small lateral disc herniation at the C3-4 level of the right side. He referred to "possible sympathetically maintained pain secondary to the injury she sustained at her work place in November 1990".

- August 1995: Dr. Ford, an orthopaedic surgeon, reported that the MRI findings did not correlate with the worker's clinical presentation. He found non-organic signs with much in the way of pain behaviour and no objective evidence of any neurological conduction deficit or long track signs.

- November 1995: Dr. Fainman did not agree with a reference by a Board adjudicator to the worker's disc herniation "having arisen gradually as a result of natural degenerative change". He considered that the disc herniation "occurred as a direct result of the trauma in which [the worker] was involved". He concluded that the worker "suffered a traumatic incident to her head and neck region which has resulted in a chronic pain syndrome". He also referred to "disruption of sympathetic nerves resulting in reflex sympathetic dystrophy as well as cervicogenic headaches".

- April 1997: Dr. Fainman stated that his diagnosis of the worker was complex regional pain syndrome, Type I (reflex sympathetic dystrophy), manifest by cervicogenic headaches and myofacial pain involving predominantly upper back and neck muscles.

- July 1997: Dr. Picard, a specialist in psychiatry and neurology, stated that the degenerative changes "are not unusual in the patient's age range".

(vi) Treatment of the worker's psychiatric complaints

[18] As our questions to the assessors also requested their opinions concerning previous opinions on file concerning the worker's psychiatric complaints, it is worth summarizing that evidence here:

- Prior to the accident, the worker had been treated with medication for depression by her family doctor, Dr. Tenore.
- Reference is also made in the early reports to problems with drug addiction.
- July 1991: Dr. Tenore questioned whether there was an underlying borderline personality disorder, likely a borderline or dependent personality disorder. Dr. Tenore referred to the worker's prior work history in the past three to four years as having been erratic and to the likelihood that it would remain as such. Dr. Tenore arranged for assessment at the Clarke Institute of Psychiatry.
- August 1991: Dr. Faris at the Clarke Institute considered that the worker had "developed a reactive depression secondary to the termination of a long-standing romantic relationship. Underlying this are probable personality dysfunction issues." The worker's pre-accident personality condition was referred to as "mixed personality with avoidant passive aggressive, histrionic, labile and impulsive features".
- May 1993: Dr. Jacobs reported that the worker had memory problems, concentration difficulties, balance problems, a sleep disturbance, a loss of appetite and loss of 20 lbs. since the accident. He referred to the worker's development of "an adjustment disorder with mixed emotional features, as a result of a work-related accident in November 1990".
- August 1993: Dr. Miller, psychologist, did psychological testing of the worker at the Whiplash and Headache Clinic which showed that the worker was exhibiting a mixed neurotic picture involving higher levels of depression and somatic pre-occupation, with a high level of anxiety and significant withdrawal and social isolation.
- October 1993: Dr. Jacobs reported that the worker was having "quite a lot of panic attacks" which medication was not relieving.
- The worker attends the Headache Clinic in Toronto about every two to three weeks. If she delays, the pain builds up, she loses all movement, and she becomes depressed because of the pain and lack of mobility.

(vii) Reports from Board doctors

[19] In March 1992, Dr. Mitchell was asked to comment on the worker's entitlement to benefits under the Board's psychotraumatic policy. He stated as follows:

> Agree the accident was not particularly psychotraumatic. Also she has a multitude of other problems including substance abuse causing her present mental status. I think this was perhaps mildly influenced by her accident. However it was not a really significant head injury in that there was no unconsciousness and no amnesia. She already had headaches I believe.

With respect to Dr. Mitchell's reference to the worker's problems with substance abuse, as noted above we accepted the worker's testimony that, although this had been a problem in the past, she was not abusing drugs immediately prior to her compensable accident in November 1990. With respect to Dr. Mitchell's reference to the fact that the worker had had headaches prior to her injury, we accepted that, although the worker had had headaches in the past, her headaches were different in frequency, duration and severity after her November 1990 accident.

[20] In February 1993, Dr. Baichwal was asked to comment on the worker's entitlement to benefits under the Board's CPD policy. He stated as follows:

> Psychiatric problems in this I/W [injured worker] predate the work related injury and hence are not medically compatible as work related. Migraine headaches also predate the D.O.A. [date of accident] and hence are not acceptable on an ongoing basis once M.M.R. [maximum medical rehabilitation] has occurred. Therefore Imitrex [drug] therapy for migraine on a long term basis is not allowable. The headaches that I/W is complaining of are not the migrainous type and more likely related to cervical D.D.D. [degenerative disc disease] and whiplash type of injury that she had. *This injury aggravated a pre-existing cervical spine problems* and recovery with nerve blocks has resulted. P.I. [permanent impairment] therefore is not recognised as *pre-accident status has been restored.* This therapy is therefore acceptable as due to work related injury. This has never been a head injury and should not be considered as such as ruled by Dr. Mitchell before. All pertinent investigations and consultations have also ruled this out. *C.P.D. is not an issue here as organic features are recognisable in the history*. No restrictions are needed for R.T.W. [return to work]. As a prophylactic measure to protect her from her neck pathology overhead work is to be minimised.
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> Therapy for migraine during the recovery phase after injury is allowable as they were more troublesome during this stage of recovery process. *The injury has not made them more frequent or more severe as these headaches seem to have the same intensity once they commence.*
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> (emphasis added)

With respect to Dr. Baichwal's reference to a "pre-existing cervical spine problem", the worker denied any pre-1990 neck problems and there also does not appear to be any clear evidence of the existence of any pre-1990 neck condition. With respect to Dr. Baichwal's comment that the worker's post-1990 headaches were of "the same intensity" as her pre-1990 accident, we did not consider that the evidence indicated this to be the case.

[21] In August 1995, Dr. Shneidman was asked to comment on the worker's entitlement to benefits related to an organic disability, in particular, the findings of disc herniation. He stated as follows:

> The diagnosis of disc herniation at C3-4 is not compatible with her accident history and it was diagnosed four years after accident. The results of MRI scan is not compatible with cervical myelogram, which was normal.

(viii) The Appeals Officer's conclusions

[22] The Appeals Officer denied the worker entitlement to benefits for a psychiatric disability. He referred to the worker's pre-accident treatment for depression for non-work-related causes and to the psychiatric assessment at the Clarke Institute which confirmed the family physician's suspicions of an underlying personality disorder.

[23] The Appeals Officer also denied the worker entitlement to benefits under the Board's CPD policy. He referred to the worker's nerve block treatment as relieving the worker's pain for periods of time, thereby not meeting the Board CPD policy's criterion of continuous pain. He also referred to the medical evidence that the worker's pain was consistent with organic findings.

[24] Finally, the Appeals Officer denied the worker entitlement to benefits for an organic disability. He referred to the medical evidence that the disc herniation was not noted in the early reports, the fact that the worker's symptoms did not correlate with the findings, and the presence of other post-accident incidents that could have caused the disc herniation.

(ix) Post-accident incidents

[25] As noted above, the Appeals Officer referred to other post-accident incidents which could have affected the worker's symptoms.

[26] The worker's post-accident incidents can be summarized as follows:

1. The worker fell down stairs in March 1991, when she caught her foot on the top step of a stairway on her way to physiotherapy. The worker dislocated her left shoulder.
2. The worker had a whiplash injury as a passenger in a car in December 1992 which increased her headaches and neck discomfort for a short period of time.
3. Snow fell on the worker's head in early 1993, causing her more severe pain for a few days, but there was no change in treatment.
4. The worker hit her head in late September 1993, causing a small laceration and a severe headache with pain radiating into the neck

(x) Recent medical information from Dr. Perlin

[27] Dr. Perlin, a rheumatologist who first saw the worker in April 1999, did not think that her symptoms represented recurrent rheumatic-fever-related arthritis. In a later note, he confirmed that the worker did not have rheumatoid arthritis.

(xi) Our request for an assessment

[28] After the first day of hearing, we directed Tribunal counsel to arrange for an examination and assessment of the worker, after which time the assessors were asked to prepare a report to answer our questions. Given the different diagnoses on file and the various views of the worker's continuing

problems, we strongly suggested that Tribunal counsel consider arranging an assessment by a multi-disciplinary team of specialists.

[29] The worker was examined by the following assessors:

(i) Dr. Malcolm, an orthopaedic surgical consultant,

(ii) Dr. Watson, a neurologist with a particular interest in chronic pain problems, and

(iii) Dr. Margulies, a psychiatrist.

[30] All three assessors submitted extensive reports outlining the results of their examinations and their answers to the questions we posed to them. After our receipt of their initial reports, we directed Tribunal counsel to seek clarification from all three assessors on their reports. All three responded with detailed responses to our follow-up questions. We thank all three assessors for their thoughtful and thorough reports.

(xii) Our general questions of the assessors and their answers

[31] The general questions we asked were as follows:

1. What do the assessors consider to be the more probable explanation(s) for the worker's continuing problems – especially her neck pain, headaches and recurrent depression – after April 1992 (when the Board terminated the worker's benefits)?
2. Do the assessors consider that the worker's continuing problems are medically compatible with her November 1990 injury as described in this decision?

(a) Dr. Malcolm, the orthopaedic surgeon

[32] Dr. Malcolm considered that the worker had developed "a chronic pain condition".

[33] As to the etiology of this condition and the role of the 1990 accident in the development of the worker's post-1990 condition, in his September 2000 follow-up report Dr. Malcolm pointed out that Dr. Margulies had offered an explanation "as to how the non-physical (psychosocial) may have become a major contributor to [the worker's] ongoing disability, which as stated by her, is self-imposed on the basis of her ongoing pain experience".

(b) Dr. Watson, the neurologist

[34] Dr. Watson considered that the worker's pain was "largely of muscular origin and not driven by any physical factors related to the accident". In his follow-up report in October 2000, he stated that the worker "has an enigmatic, chronic pain problem" but he could not find any physical injury or physical disorder as a cause for this. He considered that "there may be a psychological or psychiatric origin for the pain which appears to be predominantly muscular to me".

(c) Dr. Margulies, the psychiatrist

[35] Dr. Margulies diagnosed the worker as having "a pain disorder with psychological factors".

[36] As to the etiology of this condition and the role of the 1990 accident in the development of the worker's post-1990 condition, Dr. Margulies saw the worker, prior to her accident, as "a personality disordered individual, needy of affection and neurotically prone to look for the love and caring which always eluded her in fundamentally unsatisfactory relationships". He considered that, although her actual depressive illness eventually resolved, her pattern of pain persisted and was repeatedly reinforced and perpetuated by factors which fulfilled her needs "which long antedated the subject accident" and that these factors "have played the major role in the perpetuation of her complaints of pain in sites initially traumatized in it".

(xiii) Our specific questions of the assessors and their answers

[37] We also requested that the assessors address the following specific questions.

(a) The worker's complaints of continuing neck pain – an organic disability?

[38] **A "cervical injury"?** We requested assistance in understanding whether the worker had injured her neck in her November 1990 accident and, if so, to what extent she had injured her neck.

[39] Dr. Malcolm considered it "possible" that "a mild cervical soft tissue injury or strain" had occurred in November 1990, which would have had a customary healing time of three to four months.

[40] **"Pre-existing problem"?** We requested comments on Dr. Baichwal's reference to a "pre-existing cervical spine problem".

[41] Dr. Malcolm confirmed our impression that there was no evidence of pre-1990 complaints. He also stated that any changes in the x-rays since the accident were not the result of the compensable accident.

[42] **The November 1991 x-ray findings:** We requested assistance in understanding the x-ray findings in November 1991. As noted above, these appeared to be the *only* tests which indicated anything (apart from the December 1994 MR which will be discussed in more detail below).

[43] Dr. Malcolm considered that Dr. Ming Chiu noted these findings because he always focused to the greatest detail on describing any changes in cervical or lumbar spine radiographs. Dr. Malcolm considered the findings which Dr. Ming Chiu had noted as normal for the worker's age.

[44] **How severe is the worker's degenerative condition?** We requested assistance in understanding the seriousness of the November 1991 x-ray findings. As noted above, Dr. Jacobs stated in late 1991 that they indicated "*very severe* extensive disease of her cervical spine" and "*significant* facet joint injury", but in January 1992 referred only to "*mild* degenerative changes" (emphasis added). Dr. Fainman referred to the November 1990 accident having aggravated or accelerated the worker's degenerative changes, whereas Dr. Picard considered that the changes noted in the x-rays were consistent with the worker's age.

[45] Dr. Malcolm considered that the findings were consistent with the worker's age and were "mild".

[46] **The December 1994 finding of a disc herniation:** We requested the assessors' comments on the following:

> (i) Dr. Schneidman's opinion that the finding in December 1994 of a possible disc herniation was *not* compatible with the November 1990 accident;
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> (ii) the radiologist's comment that the finding was perhaps not clinically significant; and
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> (iii) Dr. Fainman's opinion that the finding *could* be as a result of the November 1990 accident.

[47] Dr. Malcolm concluded that the 1994 finding of the possible disc herniation was not compatible with the 1990 compensable accident, given the widespread distribution of symptomatology as reported by the worker.

[48] Dr. Watson also considered that the worker's clinical picture was not compatible with a disc herniation. He agreed with the radiologist that the finding was not clinically significant.

[49] **The post-accident incidents:** Given the worker's comments concerning the four post-accident incidents described earlier in this decision, we requested the assessors' comments on the significance, if any, of these incidents in the progression of the worker's complaints of neck pain.

[50] Dr. Malcolm noted that repeated physical insults to an area may affect recovery from the previous injury in both the physical sense and the psychosocial sense.

[51] Dr. Watson considered that, if we accepted the worker's statement about pain not being worsened by any of the episodes, this would not be unreasonable, given their minor nature (except for the dislocated shoulder).

[52] **Complaints consistent with an organic condition?** We asked whether, if there was evidence of an organic neck condition, the worker's continuing complaints of neck pain were consistent with that organic condition.

[53] Dr. Malcolm stated as follows:

> It is clear from the documentation that her soft tissue neck injury was superimposed upon an apparently asymptomatic but pre-existing, age-related degenerative changes. *It is also clear that this injury occurred in a person who had pre-existing psychosocial comorbidities.*
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> The evolution of this woman's symptom complex (duration, distribution) is not in keeping with the anticipated recovery from a minor soft tissue cervical injury yet shortly following
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> he accident in question, [the worker] recovered full range of motion in her cervical spine with a normal neurological examination, which is consistent with physiological recovery of structural integrity. *Therefore, other factors (nonphysical) are suggested to explain the apparent severity/disabling nature of her ongoing symptomatology.*
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> …

> It is my medical opinion that the ongoing constellation of symptomatology expressed by [the worker] is not medically compatible with the musculoskeletal injuries to her head and cervical spine, which I would envisage might have occurred with the November 1990 [accident] as described. *Other nonphysical explanations seem more medically appropriate.*
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> …
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> It is my opinion, based on this review, that an organic cause for the distribution of symptomatology described by this woman has not been identified and in my opinion cannot be identified. I believe, however, that patients presenting with neck and/or back pain do have an organic cause for their pain.
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> (emphasis added)

We asked Dr. Malcolm to expand on the last sentence of the above-quoted passage, given the reference to an "organic cause" for pain in the face of all his previous references to no apparent organic cause for this worker's pain. In his September 2000 report, he stated that individuals complaining of pain, whether traumatic or spontaneous in onset, initially have an organic cause for their symptoms despite the fact that we cannot identify it in 95% of patients. As to the recovery from these injuries, he stated as follows:

> A process of physiological healing of the injury is genetically predetermined and inevitably occurs in all injuries, unless there are intercurrent medical conditions compromising the process. The majority of patients recover from their injury. In those who have continuing symptoms, their success in returning to function depends on their real or perceived severity and the patient's ability and motivation to normalize activity in their presence. This is the very significant "non physical" side of managing the disability associated with pain, where intercurrent psychological comorbidities have their greatest effect.

Dr. Malcolm pointed out that the distribution of the worker's symptom complex was *not* consistent with any specific organic diagnosis, condition or lesion and noted that Dr. Watson supported this conclusion.

[54] Dr. Watson stated that he did not find any evidence of a significant organic neurological condition related to the worker's neck pain.

(b) The worker's complaints of headaches – a "head injury"?

[55] **Was there a "head injury"?** With respect to the worker's complaints of headaches since the November 1990 accident, we requested assistance concerning the apparent dispute between the doctors as to whether the worker had had a "head injury".

[56] Dr. Watson considered that there had been a head injury but, because the worker had not been unconscious and had had no amnesia, it was not a "significant" head injury.

[57] Dr. Margulies also considered that the worker had sustained a head injury, but that there was no convincing evidence that this was associated with any underlying brain dysfunction or damage.

[58] **Medical compatibility?** We asked the assessors whether they considered that the worker's headaches after April 1992 were medically compatible with the worker's November 1990 accident as described in our Interim Decision.

[59] Dr. Watson considered that it was "hard to imagine" that the worker's current headaches were consistent with her work injury nearly 10 years ago. He considered that the headaches were "not driven by physical factors from the accident at this time". In his October 2000 report, Dr. Watson stated that, in his view, the worker's accident "did not cause any physical injury, disorder or disease which would give rise to this physical condition" which he had diagnosed as an enigmatic, chronic pain problem. He stated that we were then left with the possibility that the worker was misrepresenting her situation or that the current muscular pain and headaches were driven primarily by psychological factors. He was convinced that there was no misrepresentation. As to whether psychological factors could have arisen related to the accident that would be generating her pain at this time, he deferred to the opinion of Dr. Margulies, as the answer to this question required "a determination of the role of premorbid psychological factors in making her more vulnerable in the sense of a 'thin skull' or in a 'crumbling skull' situation". Dr. Watson concluded as follows:

> *Supposing no premorbid relevant psychological factors were determined*, then it is common in injuries for a process of medicalization to occur which can lead to potentiation of symptoms and that is that the patient is not reassured by the physicians that she sees, that the process is long and drawn out, and repeated visits to various consultants occur, there is no settling of the case, and this to some individuals produces a chronic psychologically generated pain condition. Whether this has occurred in this case I think is for you to determine.
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> (emphasis added)

(c) The worker's psychiatric disability

[60] **The effect of the pre-accident history:** We asked what was the significance, if any, in the development of the worker's post-November 1990 depression of her pre-accident substance abuse and her pre-accident treatment for depression because her long-standing relationship with her boyfriend had ended. We asked the assessors to keep in mind our findings that the worker had ceased her substance abuse some months prior to her accident, that the worker had been working on a fairly regular basis while she was being treated by Dr. Tenore for her reaction to her personal problems, and that her pre-1990 work history reflected the industry in which she worked, not any particular personal instability.

[61] After receiving Dr. Margulies' initial report, we were concerned that he might have been overly impressed by the references on file to the worker's "erratic" work history and also suspected that the worker had been taking cocaine after the accident to help reduce her pain symptoms. We were also concerned that Dr. Margulies appeared to have considered the worker "readily distraught and depressed" when her work accident occurred, but we did not understand the evidential basis for this finding. We therefore asked for clarification.

[62] In his December 2000 response, Dr. Margulies stated that he was aware of the fact that it was the worker's boyfriend who had described the worker's work history as "erratic". What he found significant, however, was that the worker had professed unawareness of her boyfriend's complaints. He saw this as reflecting "what amounted to her wishful thinking that the relationship was a good one and her inability to recognize any problem therein and contributed, following the break-up of her relationship

with her boyfriend in December, 1989, to the development of a depressive illness". He considered that, whether the boyfriend had been accurate or not with respect to the worker's work history or cocaine use, the worker's reported ignorance of her boyfriend's dissatisfaction in the relationship reflected her need to deny just how troubled the relationship had been in order to fulfil her needs for affection and caring. "It is when she could no longer deny the frustration of her needs and was forced to face reality that [the worker] developed a depressive illness."

[63] With respect to his concern that the worker might have reverted to cocaine use after her accident, Dr. Margulies noted the well-known difficulties for an individual to overcome cocaine addiction, particularly without professional assistance. He therefore considered it not unreasonable to question whether the worker had been successful in this regard. He pointed out, however, that "whether she was or was not [successful in ceasing cocaine use] had no bearing upon my diagnostic opinion". He also stated that "whether she did or did not played no major role in her subsequent emotional difficulties".

[64] With respect to the Panel's questions as to Dr. Margulies' understanding of the worker's mental state at the time of the accident, he reported as follows:

> [R]eference to my clinical records note the following comments made by [the worker]: "no self worth"; "complete horribleness"; "cried a lot"; "a terrible numbness … like when someone dies". [The worker's] self description clearly is one in keeping with symptoms of a depressive episode.

[65] **An underlying personality dysfunction?** We requested the assessors' comments on Dr. Faris' consideration that the worker had a "probable personality dysfunction". We asked whether the assessors considered that Dr. Faris had sufficient evidence to make such a comment.

[66] Dr. Margulies commented on the worker's affect or mood as varying between histrionic and controlled. He stated that the worker displayed little psychological awareness of insight, remained highly impressionistic in her portrayal of her emotional difficulties and completely focused on her pain as the primary cause of all her problems. Dr. Margulies concluded his first report as follows on this point:

> [T]here are sufficient data, in terms of a repetitive pattern of faulty and impaired heterosexual relationships, episodes of emotional decompensation and multi-substance abuse, to indicate that *[the worker] has been a personality disordered individual*. Initially idealizing a relationship in which she hoped to obtain stability, acceptance of love from essentially faulty men who were incapable of fulfilling her needs, when rejected she was prone to react with the development of a depressive episode. In retrospect, this occurred on at least two occasions, in 1978 following the breakup of her marriage and again in 1989 after again she was rejected by her on-again off-again companion of many years. *While there is insufficient information to determine whether [the worker's] pattern of personality disturbance was in keeping with a borderline personality disorder, her repeatedly unsatisfactory heterosexual relationships, emotional decompensations into depression, and drug abuse clearly indicate a characterologically disordered individual.* In the year prior to the work-related accident in question, following the break-up of her tumultuous common-law relationship, [the worker], much as she had following the breakdown of her marriage, developed a depressive illness and sought counselling with Dr. Tenore.
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> (emphasis added)

(With respect to the possible "borderline personality disorder", the worker's representative supplied the Panel with a more detailed description of this diagnosis from the DSM-IV.)

[67] **The diagnosis and cause of the worker's depression:** We asked whether the assessors agreed with the initial diagnosis of the worker's psychiatric condition after the accident as "reactive depression". We asked the assessors whether the worker still has a psychiatric condition and, if so, what the diagnosis of this condition was. We also asked whether the worker's continuing psychiatric symptoms were compatible with her November 1990 injury.

[68] Dr. Margulies did not respond directly to these questions in his initial report, but did offer the following comments:

> *It is evident that long prior to the accident, [the worker] had been an emotionally disturbed individual and at the time of it was still undergoing treatment for a depressive episode in reaction to the loss of her boyfriend* whom she had idealized and vainly hoped would fulfill her needs. Furthermore, for at least four years prior to the subject accident, she had abused cocaine and while she indicated that she had ceased usage prior to the accident, her described profound drowsiness and sleepiness on the day following the accident is highly suggestive that she had again turned to cocaine as a means of symptomatic relief. Such behaviour would be entirely consistent with her characterological disturbance and propensity to seek "comfort" in drugs.
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> …
>
> [The worker] was likely always an inwardly very needy individual who, in what amounted to a repetitively neurotic and vain manner, looked to unsatisfactory relationships or drugs to assuage the emptiness and neediness within her. *Still experiencing a depressive episode when injured, howsoever slightly, she quickly focused upon her painful symptoms as a further means of expressing the psychic pain within her: the pain of depression and of her profound neediness.* Consequently, these pre-existing psychological factors came to be focused upon her ongoing expression of pain, seemingly in excess of demonstrable physical pathology, and became a manifestation of what can be considered a pain disorder with psychological factors (and, possible, an underlying medical condition). With little alteration, this state of regression, mediated through a pain disorder, has persisted into the present and, over the course of time, has been repeatedly reinforced by her receipt of disability benefits, the attention and consideration obtained through her various health care providers, medical investigations and consultation, and the support, attention and therefore love that she has been able to obtain from her parents since she moved to [her current address].
>
> (emphasis added)

[69] In his follow-up report, Dr. Margulies addressed our questions as follows:

> It has been requested that I consider what factors may have contributed to [the worker's] current state. This, I believe, has been addressed in my report in which it was indicated that *at the time of the subject accident, November 5, 1990, [the worker] was experiencing what was at least a second depressive episode* in reaction to the break-up of her relationship with her "boyfriend who she had idealized and vainly hoped would fulfil her needs" [citing his earlier report]. At the same time, she was described as a personality disordered individual, needy of affection and neurotically prone to look for the love and caring which always eluded her in fundamentally unsatisfactory relationships. Always needy and depressed, [the worker], at an unconscious level, quickly focused

> upon sites initially traumatized in the accident as a means of further expressing her pre-accident emotional distress at the time. While the actual depressive illness eventually resolved, her ungratified neediness persisted and her pattern of pain (i.e., via a pain disorder with psychological factors) also persisted and was repeatedly reinforced and perpetuated by her receipt of disability benefits, the attention she has obtained through medical investigations, consultations and treatment from various health care providers and the support and attention she has received from her parents since moving to [where her parents live]. In other words, these factors, which fulfilled her needs which long antedated the subject accident, have played the major role in the perpetuation of her complaints of pain in sites initially traumatized in it.
>
> (emphasis added)

(d) Additional matters

[70] **The summer of 1991:** Our reading of the medical reports on file indicated that the doctors who initially treated the worker had expected that she would recover from her November 1990 accident with conservative treatment. In some of the early progress reports on file, the worker herself anticipated that she would be able to return to work. However, sometime in the summer or early fall of 1991, the worker's condition appeared to have worsened considerably and the doctors ceased expecting that the worker would recover. We asked the assessors whether they could offer any explanation for this apparent change in the course of the worker's recovery.

[71] Dr. Malcolm noted that the objective evidence and testing soon after the accident indicated a full recovery from the possible soft tissue injury which the worker had suffered in her November 1990 accident. He considered that, by the summer of 1991, the "nonphysical realm of the situation" had become more prominent; he also suggested that the treatment interventions which began around that time (nerve block and trigger point injections) might have had an effect on the deterioration.

[72] Dr. Watson could offer no clear explanation for this deterioration, but wondered whether perhaps the worker's accident in March 1991 (when she dislocated her shoulder) might have aggravated her situation.

[73] Dr. Margulies could offer no explanation for the deterioration.

[74] **The treatment since 1991:** As noted in the reports on file, since August 1991 the worker has been receiving nerve blocks on a very regular basis (with such nerve blocks being done under general anaesthetic for approximately the first year of treatment). The worker's treating doctors do not appear to anticipate any change in the worker's continued future need for such treatment for pain relief. As we were unfamiliar with this type of treatment, we requested the assessors' comments on the course of the worker's treatment since the accident.

[75] Dr. Malcolm considered that there would be "absolutely no physiologic benefit" to this treatment and raised a concern that the worker could become "passively dependent on others for management of [her] symptomatology" because of the short-term relief of symptoms from the treatment. His experience with the treatment was only through many patients who had been through the treatment regimen without success, although he noted that this could have been a reflection of the spectrum of his practice.

[76] Dr. Watson was "rather shocked" to see the number of nerve blocks which had been carried out without any evidence of any ongoing permanent benefits. He considered them to be "invasive procedures" and, like Dr. Malcolm, appeared to consider that they might have played a role in "potentiating her chronic pain situation", although he did not know the exact role in this regard.

[77] Dr. Margulies offered no response to this question.

[78] **The prognosis:** Finally, whatever the more probable diagnosis or diagnoses of the worker's current condition, we asked whether the assessors considered that the worker's condition was permanent and whether there was any treatment which might assist the worker in returning to some form of gainful employment (including modified work).

[79] Dr. Malcolm considered that the worker's chronic complaints of pain were going to be permanent. As for possible future treatment, he stated as follows:

> As I have stated before, given this situation [the absence of any organic disease] it will be her ability and motivation to normalize function and activity in the presence of ongoing pain, which will be the major determinant of her successful return to that function.
>
> Obviously, if chronic pain is the stumbling block, the only kind of treatment that I could visualize would be a milieu which addresses her pre-existing and post-accident psychosocial situation and dovetails that with a program of knowledge building in self-directed pain control and strengthening initiatives.

[80] Dr. Watson appeared to consider the worker's condition permanent and could not suggest any treatment that would be helpful at this point.

[81] Dr. Margulies did not address these questions specifically in his initial report. In his follow-up report, he advised that, in his view, "it is extremely unlikely whether any program of rehabilitation and treatment" could change the worker's pattern "in which she has assumed the sick and disabled role".

[82] We encouraged the assessors reviewing this file to offer any further comments concerning these issues which were not covered by the questions listed above but which the assessors considered would assist us in determining this appeal. Dr. Watson added the following final comment:

> … I do not gain any information that would clearly corroborate the various diagnoses that have been considered which include cervicogenic headaches, complex regional pain syndrome, myofascial pain, disc herniation, reflex sympathetic dystrophy, sympathetically

> maintained pain, et cetera. The situation at present seems to support more widespread muscular pain and that there are no significant relevant neurological findings that I can determine.

(xiv) A summary of the worker's claim and the Board's findings

[83] Given the magnitude and complexity of the medical evidence which we have reviewed, we think it worthwhile to outline again the worker's claim before us and the reasons for the Board's denial of that claim.

[84] The worker claims continuing entitlement to benefits related to a CPD, a psychiatric disability and/or an organic disability.

[85] The Appeals Officer denied the worker entitlement to benefits for a psychiatric disability because of her pre-accident treatment for depression for non-work-related causes and the medical references to an underlying personality disorder.

[86] The Appeals Officer also denied the worker entitlement to benefits under the Board's CPD policy because the worker's nerve block treatment relieved the worker's pain for periods of time, thereby not meeting the Board CPD policy's criterion of continuous pain, and because the medical evidence indicated that the worker's pain was consistent with organic findings.

[87] Finally, the Appeals Officer denied the worker entitlement to benefits for an organic disability because of the disc herniation not noted in the early reports, the fact that the worker's symptoms did not correlate with the findings, and the presence of other post-accident incidents that could have caused the disc herniation.

(xv) Is there an organic cause of the worker's condition?

[88] The preponderance of medical evidence satisfies us that there is no organic condition, either compensable or non-compensable, which explains the worker's continuing pain.

[89] We accept the opinions of the assessors - which confirm the earlier views of Drs. Ford, Picard and Shneidman - that the worker's pre-existing asymptomatic degenerative disc disease and the minor changes in that condition since the accident do not explain the worker's pain, that the worker's pain is not related to any findings of a disc herniation, and that there is no organic brain injury to explain the worker's continuing pain. In our view, the opinions of Drs. Ford, Picard, Shneidman, Malcolm, Watson and Margulies far outweigh the opinions of Drs. Jacobs and Fainman, who both put forth organic explanations for the worker's pain which they considered to be related to the worker's 1990 compensable accident.

[90] We therefore agree with the Board's denial of continuing benefits for an organic condition, but for different reasons.

(xvi) Is there an inorganic cause of the worker's condition?

[91] The assessors to whom the worker was recently referred all appear to be in agreement that the worker's condition is best described as a psychological condition manifesting in chronic pain or, as Dr. Margulies stated, "pain disorder with psychological factors". The preponderance of medical evidence on file - especially the evidence from the assessors - satisfies us that the most appropriate way to consider the worker's claim is under the Board's CPD policy.

(a) The Board's CPD policy

[92] In Board Operational Policy Document #03-03-05, "Chronic Pain Disability", it states that the Board will accept entitlement for CPD when it results from a work-related injury and there is sufficient credible subjective and objective evidence establishing the disability. The policy goes on to state that the following conditions must exist:

- A work-related injury occurred.
- Chronic pain was caused by that injury.
- The pain persists for 6 or more months beyond the usual healing time for the injury.
- The degree of pain is inconsistent with organic findings.
- The chronic pain impairs earning capacity

[93] We accept that the worker has met the criteria set out in the Board policy concerning a work-related injury, pain beyond the usual healing time and pain impairing her earning capacity. The evidence of marked life disruption is clear to us.

[94] With respect to the requirement that the degree of pain be inconsistent with organic findings, because of our findings outlined above that there is no organic explanation for the worker's pain we cannot agree with the Board's denial of the worker's claim for CPD benefits on the basis that the worker's pain was consistent with organic findings.

(b) Is the worker's CPD "caused by" the 1990 injury?

[95] The remaining question is whether, in the words of the policy, the pain is "caused by the injury".

[96] Board policy refers to the need to establish "subjective or objective medical evidence of the worker's continuous, consistent and genuine pain since the time of the injury" and the need to establish that "the pain resulted from the injury". On this last point, Tribunal decisions have interpreted this as requiring us to ask whether the worker's 1990 compensable accident played a significant contributing role in the development of the worker's chronic pain condition.

[97] The Appeals Officer considered that the worker's pain was not sufficiently "consistent, continuous and genuine" to meet the Board policy requirements because the Clinic treatments had offered the worker periods of relief. The medical evidence indicates to us that the Clinic's treatments of the worker over the years have resulted in, at the most, temporary and very transitory relief - sometimes for only minutes. In addition, we note that both Dr. Malcolm and Dr. Watson have raised concerns that this

treatment has, in fact, *enhanced* the worker's pain condition by prolonging the worker's dependence on outside sources for relief. In the circumstances, we do not consider that the Clinic's treatment, by itself, should disentitle the worker to benefits under the Board's CPD policy.

[98] The Board denied the worker psychiatric or CPD entitlement because of what it viewed as a pre-existing psychiatric condition, including an underlying personality disorder, which was requiring treatment at the time of the worker's compensable accident. This conclusion was based upon the opinions of Dr. Tenore, the worker's treating physician who was giving the worker psychotherapeutic support and counselling prior to her compensable accident, and Dr. Faris, the psychiatrist at the Clarke Institute to whom Dr. Tenore referred the worker after her compensable accident.

[99] Dr. Margulies' opinion after his more recent examination of the worker agrees with the previous opinions that the worker had an underlying personality disorder which has contributed to the development of her current condition. We must therefore consider the significance of the role of the worker's pre-accident psychological profile when compared with the role of the worker's compensable accident.

(c) The test we have applied when considering the worker's pre-accident psychological profile

[100] We have found helpful the discussion in the Tribunal's *Decision No. 915*, 7 W.C.A.T.R. 1, at pages 141-142, regarding the "role of psychological or emotional pre-disposition", in particular the following excerpt:

> As we have said, the thin-skull doctrine applies in workers' compensation systems as it does in the courts. Accordingly, the fact the condition may be attributable to some pre-existing "weakness" or special inherent vulnerability in the pre-accident psychological make-up or emotional state of the individual cannot in law affect the result.
>
> The Panel does not think there can be much doubt about this. There is no difference in principle it can see between pre-existing psychological or emotional deficiencies and pre-existing physical weakness such as weak backs, or disc disease or frail bones.
>
> *There does seem to the Panel, however, to be a point at which a pre-disposition may be so large a factor in causing the subsequent disability that it reduces the role of the industrial injury to insignificance in the overall scheme of things.* Dr. Tunks spoke in this regard of a "career invalid" - a person who was committed - unconsciously to be sure, to always being an invalid. For such a person an industrial accident (if it were relatively minor) might be just the current, most convenient "hook" on which to hang that commitment. If this incident had not occurred he or she could be counted on to "find" other reasons for continuing to be an invalid....
>
> In the Panel's view a predisposition of that quality would render the ensuing disability non-compensable on the grounds that the accidental injury's contribution to the disability could be seen from an overall perspective not to have been significant.
>
> (emphasis added)

(xvii) Our detailed analysis of the medical evidence on this issue

(a) Summary of Dr. Margulies' opinion

[101] As outlined in detail above, Dr. Margulies considers that the worker had significant pre-accident emotional problems and was in the midst of a serious depressive episode (her second) at the time of her compensable accident. In his two reports, he sets out his reasons for considering that the worker's pain disorder with psychological factors is related to her underlying personality disorders and the various supports she has received since her compensable accident, rather than to a reaction to the accident itself. We have quoted from his reports in detail above and need not repeat those reasons again here. We note that his opinion was based on not only his review of the previous medical file but also his examination of the worker.

(b) The worker representative's concerns with Dr. Margulies' opinion

[102] The worker's representative raised concerns with our placing any weight upon Dr. Margulies' opinion. He raised several specific concerns with the psychiatric assessor's report which we consider must be addressed here.

[103] **Ignoring the Panel's findings?** The worker's representative was concerned that Dr. Margulies had ignored the specific findings of fact which the Panel had made concerning the worker having ceased cocaine use prior to her accident, the worker having been able to work despite having broken up with her boyfriend and the worker's pre-1990 work history reflecting the industry in which she worked rather than any particular personal instability.

[104] When we received Dr. Margulies' first opinion, we were also concerned that the assessor might not have paid sufficient attention to the findings of fact to which the worker's representative referred. As we have noted above, we directed Tribunal counsel to request clarification from Dr. Margulies concerning several specific points. Our supplementary questions to the psychiatric assessor were extensive and are found in the last two pages of our memorandum to Tribunal counsel dated August 21, 2000.

[105] In the portion of our decision above concerning the effect of the worker's pre-accident history on the worker's psychiatric disability, we outlined Dr. Margulies' responses to our concerns. We are satisfied that Dr. Margulies did *not* ignore our findings of fact.

[106] As his responses indicated, Dr. Margulies noted our findings but added his own opinions concerning what, for example, the boyfriend's concerns about his relationship with the worker indicated to him about the worker's ability to assess their relationship. With respect to the effect the worker's break-up with her boyfriend had had on her prior to her accident and Dr. Margulies' opinion that she was in a "depressive episode" prior to her accident, in his first report he noted the worker's report of "a depressed mood, frequent crying, insomnia, anorexia with a 40-pound weight loss, low self-esteem and a general sense of numbed hopelessness".

[107] As for the worker's possible cocaine use at the time of the accident, we see nothing in Dr. Margulies' report to indicate clearly that he did not accept our finding in that regard. With respect to Dr. Margulies’ concern that the worker had perhaps reverted to her prior drug abuse *after* the accident, he explained his comments in this respect and noted that, even if the worker *had* begun to use cocaine again after the accident, this did not affect his diagnostic opinion concerning the worker's condition and its etiology and also, in his view, did not play a major role in the development of the worker's post-accident emotional difficulties.

[108] We read Dr. Margulies’ reports as indicating that the worker’s dependence on drugs (even if only prior to the accident) was a part of her psychological make-up and her need for emotional comfort. (In his first report, Dr. Margulies had noted reports on file that the worker had also used amphetamines and alcohol when under stress, which he viewed as evidence of the worker’s “propensity to seek ‘comfort’ in drugs”.)

[109] **An insufficient examination of the worker?** The worker's representative also raised concerns with the fact that Dr. Margulies had based his opinions on a meeting with the worker which had taken less than two hours. (The worker had advised her representative that Dr. Margulies' examination took approximately 1 3/4 hours. Dr. Margulies confirmed this in his first report.) He raised concerns that this assessment had not given Dr. Margulies sufficient time to fully understand the worker's condition.

[110] We do not share the worker representative's concerns that Dr. Margulies did not have adequate time with the worker to develop an informed opinion concerning the questions which we posed. In addition to having spent what we consider to be a more than reasonable time with the worker, Dr. Margulies had access to the worker's full medical file. Unlike any of the other psychiatric consultants who have examined the worker, Dr. Margulies had copies of *all* the medical reports from *all* the doctors who have examined the worker since the accident. Dr. Margulies also had the benefit of a detailed summary of that evidence in the 15-page Interim Decision which was forwarded to him for review.

(c) What does the other evidence tell us?

[111] We emphasize to the worker and her representative that, even if we were to *totally* disregard Dr. Margulies' opinion concerning the probable source of the worker's post-accident psychological problems and pain disorder, we would still not consider that the medical evidence supported the worker's claim that her accident was a significant contributing factor to the development and progression of her pain disorder.

[112] For the reasons discussed in more detail below, we do not agree with the worker's representative that the other medical evidence on file supports the worker's claim. We refer, in particular, to the worker representative's reliance upon the reports of Dr. Tenore and Dr. Faris.

[113] **Dr. Tenore's report:** The worker's representative submitted that Dr. Tenore's report indicated that the worker's psychiatric problems were related to her accident and its sequelae. He noted that the

first reference by Dr. Tenore to a possible underlying borderline personality disorder was in July 1991, *after* the worker's compensable accident. While it is true that Dr. Tenore did not refer to such a diagnosis of the worker's condition until after her compensable accident, our reading of her report indicates that she considered the worker's *pre*-accident problems to be the main cause of the worker's condition. In her July 1991 report, she referred to the worker's prior work history and the worker's recent break-up with her boyfriend, which had clearly been the reason the worker had begun to see Dr. Tenore.

[114] The worker's representative also appears to submit that it was not completely clear from Dr. Tenore's reports that the worker did indeed have any pre-accident psychiatric condition. We do not read Dr. Tenore's reports so restrictively. In our view, if the worker had not had any pre-accident psychiatric condition, there would be no clear explanation for either Dr. Tenore's psychotherapy or the prescription of Prozac prior to the accident.

[115] **Dr. Faris:** The worker's representative also relied upon Dr. Faris' report in August 1991 as supporting the worker's claim that her psychological condition was work-related. He relied, in particular, upon Dr. Faris' reference to the worker's closed head injury in November 1990 at Axis III of his diagnosis. Dr. Faris' diagnosis in full was as follows:

> <u>IMPRESSION</u>
>
> This lady has developed severe intractable headaches and sleep dysfunction secondary to a closed head injury. These are severe enough to impair her functioning and have prevented her return to the work of her choice. She enjoys working and feels frustrated and depressed at this restriction to her primary outlet for creativity.
>
> She has developed a reactive depression secondary to the termination of a long-standing romantic relationship. Underlying this are probable personality dysfunction issues.
>
> DIAGNOSIS
>
> Axis I Dysthymia
>
> Axis II Mixed personality with avoidant passive aggressive, histrionic, labile and impulsive features
>
> *Axis II Closed head injury and secondary migrainous type headaches*
>
> Axis IV Psychosocial stressors – moderate
>
> Axis V Moderate impairment in functioning
>
> (emphasis added)

[116] In support of his submission, the worker's representative provided us with excerpts from a DSM-IV Guidebook which explains the multiaxial system for classification of psychiatric disorders. (DSM-IV is an acronym for the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. This Manual has undergone several revisions; "IV" indicates that the Guidebook is referring to the 1994 revisions. We understand that the Manual underwent additional revisions in 2000, referred to as DSM-IV-TR.)

[117] This Guidebook indicates the following:

> <u>Axis I</u> outlines clinical disorders and other conditions that may be a focus of attention. All psychiatric disorders in DSM-IV are listed in Axis I, with the exception of the Personality Disorders and Mental Retardation which are noted on Axis II.
>
> <u>Axis II</u> outlines Personality Disorders and Mental Retardation. The Guidebook indicates that the clinician can also indicate the presence of maladaptive personality features on Axis II. "Personality features" refer to those presentations that are below the threshold necessary to quality for a diagnosis of Personality Disorder but are still worth noting. The recognition of personality features reflects the fact that problematic personality functioning occurs on a continuum so that the thresholds dividing a diagnosis of Personality Disorder from less severe personality traits are necessarily arbitrary.

> Axis III is provided for noting the presence of general medical conditions. The Guidebook indicates that a general medical condition can be related to the Axis I or II conditions in one of four ways:
>
> > (i) It can be the physiological cause of the Axis I or II disorder (e.g., Mood Disorder as a direct consequence of hypothyroidism).
> >
> > (ii) It can precipitate the Axis I or II disorder by acting as a psychological stressor (Mood Disorder after an amputation).
> >
> > (iii) It can be unrelated causally but nonetheless be important to consider in the management of the Axis I or II disorder (e.g., choice of antidepresssant therapy in an individual with a cardiac arrhythmia).
> >
> > (iv) It may be an incidental finding (e.g., acne).
>
> Axis IV recognizes the importance of environmental and psychosocial problems in the pathogenesis, course and treatment of many, if not all, mental disorders.
>
> Axis V allows the clinician to outline a global assessment of the level of the patient's psychological, social and occupational functioning.

[118] Our reading of this Guidebook indicates that Dr. Faris' inclusion of a reference to the worker's November 1990 compensable accident in Axis III does not necessarily indicate that he considered it to be the cause of the worker's psychological problems. As noted above, the inclusion of this reference in Axis III could also indicate merely an incidental finding or it could be "unrelated causally but nonetheless … important to consider in the management" of the Axis I or II disorders.

[119] Our reading of Dr. Faris' report in full indicates to us that Dr. Faris considered that the worker's 1990 accident could not be ignored but that it was *not* causally related to the worker's Axis I disorder of dysthymia (i.e., mental depression). Dr. Faris' opinion makes it clear to us that, while he attributed the worker's headaches and sleep problems to her work accident, he considered that her Axis I and II disorders related to something else: "She has developed a reactive depression secondary to the termination of a long-standing romantic relationship. Underlying this are probable personality dysfunction issues." There is no reference to this reactive depression being related in any way to the worker's 1990 work accident. Under "Treatment Recommendations", Dr. Faris referred to the need for psychotherapy "for issues of personality dysfunction, particularly as evidenced by her denial of her cocaine abuse and her limited insight into her functioning in personal relationships". There was no reference here to that psychotherapy being needed to address anything stemming from the worker's 1990 accident. In short, we see nothing in Dr. Faris' report to support the submission that he considered the worker's depression to be related to her 1990 work accident.

[120] We consider that our reading of Dr. Faris' report is further supported by the description of "dysthymic disorder" in the DSM-IV Guidebook which the worker's representative provided.

[121] The diagnostic criteria for "dysthymic disorder" indicate that it is a depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, "for at least two years". The diagnostic criteria also require that, during the two-year period, the person has never been without the symptoms for more than two months at a time.

[122] Dr. Faris was commenting on the worker's condition in August 1991. The DSM-IV was not complete until 1994. However, our review of the DSM-III-R diagnostic criteria for dysthymia (which is what Dr. Faris was presumably using) indicate that the diagnosis of “dysthymia” in the DSM-III-R also required a depressed mood for two years, during which period the person is never without depressive symptoms for more than two months. We therefore read Dr. Faris’ diagnosis of "dysthymia" as indicating a condition which he clearly considered to have been in existence *prior* to the worker's November 1990 accident.

[123] In summary, we do not accept the submission that Dr. Faris’ reference to the 1990 work accident in Axis III indicates his opinion that the worker's depression at the time was causally related to that work accident.

(d) The temporal connection between the accident and the worker's inability to work

[124] Finally, the worker's representative referred to the temporal connection between the worker's 1990 accident and her inability to work. He noted the worker's ability to work prior to her November 1990 accident, notwithstanding her break-up with her boyfriend, her prior cocaine use and her need for psychological counselling from Dr. Tenore. He noted our previous finding that gaps in the worker's work history prior to November 1990 related to the nature of the work she did and not to any "instability" in the worker herself. He submitted that it was not until *after* the worker's compensable accident that she found that she could not return to work.

[125] We appreciate that there is a temporal connection between the worker's inability to work and her work accident in 1990. Clearly that is something we cannot ignore and have not ignored.

[126] However, we also cannot ignore the evidence from the worker's family doctor who provided psychotherapy prior to her 1990 accident (Dr. Tenore), the psychiatrist who saw the worker in August 1991, less than a year after her accident (Dr. Faris), and the assessor who examined the worker and reviewed the extensive medical evidence concerning the worker's condition (Dr. Margulies).

[127] In our view, to accept the worker's claim on the basis of the existence of a temporal connection between the worker's inability to work and her work accident in 1990 would ignore all that medical evidence. As we have noted above, that evidence indicates to us that the worker's pre-disposition was so large a factor in causing her subsequent disability that it reduced the role of her work injury to insignificance in the overall scheme of things.

(xiii) Summary of our conclusions on the worker's CPD

[128] In summary, for the reasons discussed in more detail above, the preponderance of medical evidence leads us to conclude that the worker's 1990 compensable accident was *not* a significant contributing factor in the development of her chronic pain disorder.

[129] We interpret the medical evidence from both the worker's treating physician at the time of her accident and the two psychiatric consultants who have examined the worker (one in 1991 and one in 2000) as indicating that the worker's pre-existing psychological condition was so large a factor in the development of her subsequent disability that it reduced the role of her work accident to insignificance. This evidence far outweighs the opinion of Dr. Jacobs in 1993 that the worker had an adjustment disorder as a result of her work-related accident in 1990.

[130] Accordingly, the worker is not entitled to benefits for her CPD.

THE DECISION

[131] The appeal is dismissed.

DATED: This 12th day of June 2001.

SIGNED: F.W. McIntosh-Janis, P. A. Barbeau, M. Tzaferis.