Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-12-043

PANEL:	**Ms Yvonne Tavares, Chairperson** **Ms Janet Frohlich** **Ms Sandra Oakley**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Harvey Pollock, Q.C., and Mr. Wayne Forbes;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Steve Scarfone.**
HEARING DATES:	**September 25, 26 and 27, 2013 and October 1, 2, 3, 7, and 8, 2013.**
ISSUE(S):	**Entitlement to Income Replacement Indemnity benefits beyond October 28, 2010.**
RELEVANT SECTIONS:	**Section 110(1)(a) and 110(1)(c) of The Manitoba Public Insurance Corporation Act ('MPIC Act')**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL HEALLTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

Reasons For Decision

On November 4, 2001, [the Appellant] was working full-time as a night watchman in [Manitoba]. That evening, [the Appellant] was scheduled to work at a strip mall. Upon arriving at the work site, [the Appellant] found the doors to the strip mall were locked. His friend, [text deleted], had driven [the Appellant] to work that evening. [The Appellant] returned to the parked vehicle and was waiting in order to determine whether he would get into work. He was seated in the passenger seat and did not have his seat belt fastened.

Subsequently, his co-worker arrived at the location and also checked the door, only to find it locked. [The Appellant] testified that his co-worker became angry and got back into his vehicle. He backed up his car and "rammed" his vehicle into the car in which [the Appellant] was sitting. [The Appellant] testified that he hit his head on the top of the car and he struck his arm against the door. Thereafter, he and [the Appellant's friend] quickly left the work site in their vehicle. [The Appellant's] co-worker followed them in his vehicle but did not catch up to them.

Later that evening, [the Appellant] testified that he went to hospital by medical van but was not admitted. Thereafter, [the Appellant] reported numbness to the fingers in his right hand. Additional injuries were also documented as soft tissue in nature affecting the lumbar spine and symptoms to the right foot. In a letter dated April 2, 2002, [Appellant's Doctor], provided a report to the case manager noting the following:

> He was first seen on 14 November 2001 in my office. He complained of "needles" in the palm of the right hand with numbness in the tips of the fingers. There was full range of motion in the wrist and hand.
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> He also complained of pain in the lower back especially after sitting for too long. There was also numbness in the right foot. Flexion in the back was limited to 15º and he appeared very stiff.
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> He has been seen regularly since that date, usually weekly.
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> His condition generally has improved very slowly with continuing numbness is (sic) the right hand, pain in the lower thoraic (sic) spine area and continuing stiffness. He is also experiencing head-aches.
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> Treatments has (sic) consisted of physiotherapy but progress has been very slow.
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> There are no pre-existing or unrelated conditions delaying recovery.
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> The accident however does seem to have had a psychological impact on the patient who appears anxious and extremely concerned about the effects of his injuries.
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> He is unable to work at present due to stiffness, pain in the arm and his level of anxiety. It appears he is not capable of any duties of his occupation.
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> Progress has been very slow and it is not possible to estimate a return to work date.

As previously noted, at the time of the accident, [the Appellant] was working full-time as a night watchman in [Manitoba]. He began working in this capacity on June 1, 2001. As the Appellant was unable to return to work following the motor vehicle accident, due to the injuries which he sustained in the accident, the Appellant became entitled to income replacement indemnity ("IRI") benefits. For the purpose of calculating his entitlement to IRI, [the Appellant] was classified as a temporary earner. A 180-day determination of employment came into effect on May 4, 2002. [The Appellant] was determined into the employment of a security guard, or the job he held at the time of the accident. There was no change in his Gross Yearly Employment Income.

On December 2, 2002, [Appellant's Doctor] provided a follow-up report regarding [the Appellant]. [Appellant's Doctor] noted [the Appellant's] regular appointments to obtain prescriptions, pain killers, sleeping pills and tranquilizers. [The Appellant] continued to have ongoing problems with numbness and pain in his hand and pain in the back. In [Appellant's Doctor's] opinion, [the Appellant] was at high risk for developing chronic pain and permanent disability. Treatment, anti-depressants and discussion regarding pain coping strategies had not contributed to significant success or reduction in his symptoms. [The Appellant] had recently undergone surgery for his right carpal tunnel syndrome but continued to complain that his right hand symptoms were worse than before the surgery. [Appellant's Doctor] recommended that [the Appellant's] long-term treatment plan was to continue with anti-depressants and his other medications as required along with counselling regarding pain.

On March 28, 2003, MPIC's case manager issued a decision which terminated [the Appellant's] entitlement to IRI benefits and funding for physiotherapy treatments as of March 27, 2003. At that time, it was MPIC's position that there were no physical findings that disabled the Appellant

from returning to a sedentary type of occupation such as his determined employment of a security guard.

On or about July 30, 2003, [Appellant's Doctor] referred the Appellant to [text deleted], Community Mental Health Worker, due to [the Appellant's] ongoing pain since the motor vehicle accident of November 4, 2001 and his anxiety attacks and poor sleep. [The Appellant] met with [Appellant's Mental Health Worker] and [Appellant's Psychiatrist], psychiatric consultant to the Community Mental Health program, on September 23, 2003 in [Manitoba]. In a file note dated September 23, 2003, [Appellant's Psychiatrist] notes as follows:

> Furthermore, [the Appellant] has experienced several other symptoms since the MVA including anxiety, insomnia, nightmares, startle reaction and avoidance reactions. He says these symptoms "started right after the accident". He says, "When I would think about what happened, my heart pounds and I sweat like crazy." He was placed on Wellbutrin which he now takes at the dose of 150 mgm bid. He says, "Wellbutrin helps me relax." His daytime anxiety while awake is less with the help of the medication, but night symptoms continue. He tells us he continues to have bad dreams and nightmares, seemingly on a daily basis, of the accident. Generally, he may sleep for 2 to 3 hours and then is "scared awake" (he wakes with a startle and in a sweat) by nightmares. He says he is not sleepy afterwards, has great difficulty falling asleep again and does not feel rested in the morning.
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> He also tells us that it is hard for him to go near the scene of the accident because he has "bad memories" and his heart pounds. He says, "I don't want to go there." He also describes a startle reaction that wakes him up if he is travelling as a passenger in a car on the highway and if a big truck passes by while he is dozing.
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> [The Appellant] also tells us that he has little ambition and motivation. His appetite is diminished and he has lost 70 lb over the last year. He has had thoughts and dreams of suicide, but says thinking of his children helps keep him alive.
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> He presents in a cooperative fashion, but he is anxious as he talks about some of the experiences he has had regarding his MVA. Mood generally seems somewhat down, but he claims he is not actively suicidal. Orientation appears to be correct.
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> [The Appellant] has experienced a recognizable trauma in the MVA, he re-experiences the trauma (in the form of anxiety, nightmares, bad memories, etc.), he has numbing of responsiveness (depressed mood), and other symptoms including exaggerated startle response, sleep disturbance and avoidance. These are all criteria for the following diagnosis.

Post-traumatic Stress Disorder secondary to MVA.

[Appellant's Psychiatrist's] report was reviewed by [MPIC's Psychologist]. In an interdepartmental memorandum dated December 12, 2003, [MPIC's Psychologist] comments that "Based on the information provided by [Appellant's Psychiatrist] and the claimant's family doctor, it is my opinion that there is a probable causal relationship between the MVA of November 4, 2001 and the claimant's current diagnosis of PTSD." [MPIC's Psychologist] recommended referral of the Appellant to a clinical psychologist for treatment of his PTSD.

[The Appellant] was referred to [Appellant's Psychologist #1], to assess whether [the Appellant's] diagnosis and/or symptoms were related to the motor vehicle accident of November 4, 2001 and whether his condition was treatable. In his report dated May 20, 2004, [Appellant's Psychologist #1] concludes the following:

> Based on the outcome of the present assessment which included review of background information, psychometric testing, and clinical interviews it is the examiner's clinical opinion that [the Appellant] is presenting with a clinical diagnosis of PTSD secondary to his MVA and here (sic) suffers from what he reports to be severe depressive symptomatology and generalized anxiety. It would appear [the Appellant] also meets the diagnostic criteria for Major Depressive Disorder. Based on [the Appellant's] account, his PTSD symptoms arose following his accident. Reportedly, he presents with no previous history of psychiatric illness or trauma. The examiner questions [the Appellant] somewhat in this respect. His reaction to his MVA has been quite severe, and he seems to be somewhat dismissive emotionally regarding his recent failed marriage. It has been the examiner's clinical experience that such severe reactions to trauma, as in [the Appellant's] case, are often rooted in a pre-morbid history of loss and/or unresolved trauma, usually in childhood. If there is pre-existing issues and/or trauma, [the Appellant] is not sharing or fails, psychologically, to have access to such memories. The examiner suspects there is some blocking and/or minimizing here, and likely some sedation of his feelings due to his medication useage.
> . . .
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> Provided what [the Appellant] is describing regarding his history is reliable and valid, he appears to be suffering from PTSD secondary to his MVA 2 ½ years ago, and depression which require active treatment. Due to the length of time [the Appellant] has gone without psychological treatment, he has developed severe depressive and generalized anxiety-like symptoms. Complicating his clinical presentation is the mix of medications he is prescribed, and moreso his potential misuse of T3's and sleeping medications.

On May 20, 2004, [the Appellant] was involved in a second motor vehicle accident. In this accident, the vehicle he was riding in was rear-ended. [The Appellant] denied any additional traumatic experience as a result of this accident.

The Appellant underwent a further psychological assessment with [Appellant's Psychologist #2], on June 12, 16 and 20, 2006. [The Appellant] was referred to [Appellant's Psychologist #2] by his lawyer for the purpose of assessing possible post-traumatic stress disorder symptoms. In her report dated June 26, 2006, [Appellant's Psychologist #2] notes that:

> [The Appellant's] current presentation is a complicated one. The referral question directly asked about the presence of Post-Traumatic Stress Disorder. [The Appellant's] symptoms do meet full criteria for PTSD. Following an incident in which he felt his life was in danger, he began having re-experiencing, avoidance, and hyperarousal symptoms that form the basis of the diagnosis. These symptoms continue to cause him considerable distress.
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> At the same time, [the Appellant] also has chronic pain, which is perhaps more relevant to his current functioning. PTSD and chronic pain are common co-morbidities. Not only do people who are physically injured, as was [the Appellant], sometimes develop PTSD, but the two conditions tend to interact, complicating the individual's recovery. Pain at the site of the original injury can act as a reminder of the traumatic incident, triggering anxiety reactions to the memory. Additionally, anxiety tends to exacerbate the experience of pain. So, one ends up in a continuous cycle of physical pain that triggers more anxiety, that intensifies the experience of pain, and so on.
> . . .
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> [The Appellant's] current level of functioning is low. He is able to take care of basic activities of daily living (bathing, eating, taking medications, etc.), however, his physical activity is severely limited. There are several things likely contributing to this limited physical activity including chronic pain, low energy (possibly from the combination of depression, over medication, and poor sleep secondary to nightmares), and poor concentration. It is difficult to see him immediately returning to work given these circumstances.

The file was subsequently reviewed by [MPIC's Psychologist], again for an opinion regarding whether [the Appellant's] PTSD was connected to the motor vehicle accident and whether he was precluded from his employment as a security guard. In an interdepartmental memorandum dated July 25, 2006, it was [MPIC's Psychologist's] opinion that the diagnosis of post-traumatic

stress disorder was related to the accident in question and that this diagnosis would preclude [the Appellant] from working in his previous employment as a security guard.

On September 19, 2006, MPIC's case manager issued a decision reinstating the Appellant's IRI benefits to March 28, 2003. This decision determined that the Appellant was most likely incapable of performing the duties of a security guard at the time of the termination of his IRI benefits (March 27, 2003) due to his psychological diagnosis of post-traumatic stress disorder. Additionally, MPI referred the Appellant for psychological treatment to address his post-traumatic stress disorder with [Appellant's Psychologist #1].

At this time, based on the psychological assessments received to the claim file, [the Appellant's] clinical diagnosis included post-traumatic stress disorder, as well as severe depression and generalized anxiety. There was concern of the possible misuse of Tylenol #3, as well as misuse of sleeping medication. Psychological intervention was continued in the hope that when [the Appellant] had received adequate therapy, he would be able to return to work. The treatment addressed his chronic pain experience, provided education and training and relaxation skills, as well as cognitive behaviour strategies. The numerous psychological reports on file consistently noted [the Appellant's] nightmares relating to the circumstances of the motor vehicle accident of November 4, 2001. Throughout the years that progressed, [Appellant's Psychologist #1] provided the file with consistent updated reports with respect to his work with [the Appellant].

On January 9, 2007, after several years of psychological intervention, [Appellant's Psychologist #1] advised that [the Appellant] continued to present with significant focus on the 2001 accident. [Appellant's Psychologist #1] wrote:

> Based on my initial assessment of [the Appellant], his clinical presentation remains consistent with my initial assessment findings of almost 3 years ago, and with the outcome of his most recent psychological re-assessment this past June by [Appellant's Psychologist #2]. In brief, [the Appellant] continues to present with significant focus on his 2001 MVA. Here, he continues to have re-experiencing (e.g., intrusive ideation; flashbacks; nightmares), avoidance, hyperarousal (e.g., startle response; hypervigilence; irritability; middle insomnia), and a foreshortened sense of the future. Emotional numbing is also present and seems exacerbated by his prescription medication usage. [The Appellant] continues to meet the criteria for Major Depressive Disorder as well. He presents with a depressed mood, with anhedonia, as well as with a host of the vegetative (e.g., weight loss; poor sleep; inattention; poor concentration; diminished energy), affective (irritability; repressed rage; sadness), and cognitive (i.e., low self esteem; low sense of self efficacy; self deprecatory statements) correlates of the disorder. Continued complaints of arm and back pain are present as is social isolation. Passive suicidal ideation appears chronic with intermittent signs of self-mutilation. Based on my ongoing assessments of [the Appellant] he is not viewed, at the present time, at high risk for a completed suicide. He appears to recognize the emotional and psychological needs of his youngest child who lives with him, and how devastating taking his life would be for his son. To my knowledge [the Appellant] has not, in the recent past, planned a serious attempt on his life.

On June 27, 2008, [Appellant's Psychologist #1] submitted another report in which he advised that [the Appellant] was involved in yet another motor vehicle collision while vacationing in [text deleted]. According to [Appellant's Psychologist #1], [the Appellant] did not sustain any serious injuries; however, he was re-traumatized, resulting in a flare-up of pain symptoms and psychological concerns. [Appellant's Psychologist #1] noted various other stressors in [the Appellant's] life and advised that he was managing his anxiety through medication. He recommended ongoing treatment directed at managing his mood, his pain, and his trauma.

On November 20, 2008, [Appellant's Psychologist #1] provided an updated report to advise that he would be meeting with [the Appellant] for two more sessions. Subsequent sessions would be postponed. This change was coming about due to [the Appellant's] move to [text deleted]. This was caused by the additional travel time to [text deleted] following the move and the reported distress that it would create. This distress would likely outweigh the potential benefit to continuing psychological treatment. The suggestion was that [the Appellant] would continue to

be followed in [text deleted], by [Appellant's Mental Health Worker] and [Appellant's Psychiatrist]. [Appellant's Psychologist #1] noted that:

> Based on his dependence on pain medication, the difficulty he has making the "cognitive shift" necessary to more effectively deal with his chronic pain condition, what appears to be a building dependence on others for many aspects of his personal care, and his unresolved PTSD symptomatology, [the Appellant] requires ongoing medical and clinical support and monitoring. Collaboration and team work amongst those working with [the Appellant] is important to his over care and potential recovery. When faced with acute stressors [the Appellant], in the past, witnesses an increase in pain, in his depression, and in his trauma-based symptoms. Suicidal and homicidal ideation surface at these times, as do psychotic-like thought processes [i.e. hearing voices; cutting and burning his finger]. [The Appellant's] compliance with taking his medications as prescribed, and how these contribute to poor sleep, disruptive thought processes, and depressive symptoms is likely an ongoing management issue.

In a report dated January 20, 2009, [Appellant's Psychologist #1] provided a further update regarding his last scheduled meeting with [the Appellant]. [Appellant's Psychologist #1] summarized his sessions with [the Appellant] and provided his opinion that:

> As I have suggested in past correspondence, it remains my clinical opinion that [the Appellant] would likely best be served, treatment-wise, by an intensive multi-disciplinary pain management program with a strong psychological component. In lieu of the length of time which has passed since his accident, of his response to treatment thus far, and of his choice of lifestyle, I suspect that without a strong external directive [the Appellant] will not choose such treatment. [The Appellant], in my opinion, continues to suffer from unresolved PTSD, depressive symptomatology, Chronic Pain Disorder, and multiple psychosocial stressors associated with family relational challenges, unemployment, and social isolation [secondary to mental health issues].

On April 19, 2010, [Appellant's Doctor] provided a report in which he noted that despite the treatment from various mental healthcare providers, [the Appellant's] condition had not improved. [Appellant's Doctor] wrote that, "[the Appellant] stated that seeing the psychologist was causing more stress and these appointments concluded in January 2009."

Subsequently, an independent psychological evaluation was arranged for [the Appellant] with [Independent Psychologist]. On August 30, 2010, [Independent Psychologist] conducted an

assessment which included a clinical interview and multiple psychological tests. In her report dated September 1, 2010, [Independent Psychologist] documented that [the Appellant] was noted to be a poor historian whose symptom reports were judged to be unreliable due to issues of vague, inconsistent, and non-credible reporting. Based on the various tests performed throughout the evaluation by [Independent Psychologist], [Independent Psychologist] noted that the probability that [the Appellant's] reported functional limitations represented issues of malingering was high. Due to this issue, an accurate assessment of [the Appellant's] actual symptom status and functional ability was not able to be obtained during the evaluation. [Independent Psychologist] further noted that:

> However, [the Appellant] does appear to be exhibiting a pattern of maladaptive coping strategies which is strongly suggestive of an underlying personality disorder. What has been consistent in both [the Appellant's] symptom reports and the observations made of him by other treatment providers is the exhibition of a constellation of Cluster B personality traits. This has included difficulties with tolerating negative emotion, the engagement in a number of maladaptive avoidance behaviours not limited to the avoidance of situational triggers such as would be seen in individuals with PTSD, chronic suicidal ideation, engaging in self-harming behavior under conditions of emotional distress, relationship difficulties, and the exhibition of a number of self-limiting behaviours which appear to have contributed greatly to his current difficulties including the abuse of his prescribed pain medication and the use of medications not prescribed for him. [The Appellant] appears to exhibit some dependent traits as well. These issues would not be causally related to the MVA. This type of issue typically has an etiology stemming in the experience of dysfunction within the family of origin and/or the experience of childhood trauma, and tends to be a stable personality style present from the time of late adolescence or early adulthood. Because of this, these difficulties tend to be chronic, and difficult to treat. It is generally recommended that individuals with this type of personality pathology consider referral to the [text deleted] program at the [Hospital], as they are the most equipped to address these issues via a combination of intensive individual and group psychotherapy. However, as this has not historically seemed to interfere with [the Appellant's] ability to obtain and maintain employment, there is little to suggest that this would preclude him from doing so now.

Finally [Independent Psychologist] concluded that:

> In terms of your inquiry regarding whether there is an obvious point in [the Appellant] provided medical file where, on the balance of probability, he was no longer exhibiting symptoms of an MVA-related psychological condition that would have rendered him incapable of performing the duties of his pre-accident employment, this is difficult to answer. For a number of reasons, making a retrospective diagnosis is extremely difficult.

> Although in my opinion, there have been concerns expressed regarding the validity of [the Appellant's] symptom complaints since [text deleted] report in 2001 through to [Appellant's Psychologist #1's] discharge report in 2009, there is nothing obvious in [the Appellant's] provided record which would allow me to definitively state that no MVA-related psychological difficulties were present at any specific point in time. What I am able to say is that, on the basis of my current assessment, there is no objective, valid data to suggest that [the Appellant] is currently as functionally disabled as he claims to be.

The Appellant's file was resubmitted for review to MPIC's psychological consultant. In his interdepartmental memorandum dated September 24, 2010, [MPIC's Psychologist] reviewed the new medical documentation that had recently been added to the Appellant's file. Most notably, based on a review of [Independent Psychologist's] recent independent psychological examination, [MPIC's Psychologist] was now of the opinion that the Appellant did not have post-traumatic stress disorder nor any other Axis I diagnoses (such as depression) that would be considered MVA-related. [MPIC's Psychologist] agreed with [Independent Psychologist] that it appeared probable that the Appellant had malingered his previously self-reported psychological difficulties and this appeared consistent with his presentation during the assessment with [Independent Psychologist] and previous assessments/treatment with other healthcare providers as well. Finally, [MPIC's Psychologist] concluded that there was no MVA-related psychological condition present that would preclude the Appellant from returning to his pre-accident employment and that there was no further need for pharmacological intervention for the Appellant as he did not have an MVA-related condition.

On October 20, 2010, MPIC's case manager issued a decision letter which terminated the Appellant's IRI benefits pursuant to Section 110(1)(a) and Section 110(1)(c) of the MPIC Act as of October 28, 2010. The case manager's decision was based on the totality of the medical information on the Appellant's file including the independent psychological assessment of [Independent Psychologist] dated September 1, 2010. The case manager determined that the

primary disabling concern for the Appellant was his self-reported psychological state. The case manager found that the Appellant was capable of returning to his pre-accident employment, since neither his psychological, nor his physical condition prevented him from performing his pre-accident employment.

The Appellant sought an Internal Review of that decision. In response to the decision letter of October 20, 2010, the Appellant underwent an independent psychiatric assessment conducted by [Independent Psychiatrist], on May 30, 2011. In his report dated June 8, 2011 [Independent Psychiatrist] reviewed the numerous medical and psychological reports available on the Appellant's file, as well as [the Appellant's] self-reporting during a psychiatric interview. In [Independent Psychiatrist's] opinion "there was no indication of a psychotic disorder nor of any organicity". The report continues:

> In my opinion what would call into question [Independent Psychologist's] conclusions would particularly be [the Appellant's] pre-morbid history. There is no evidence of a pre-existing personality disorder. From all accounts, it would appear that he had and maintained a very healthy life and family adjustment prior to his motor vehicle accident. As well, he has a lengthy history of sustained employment with long periods in the same work situation. He has a history of lengthy relationships and would appear to be a responsible and caring parent. There are no previous periods of disability. Although somewhat naive and unsophisticated I certainly do not believe that he is a malingerer. I would certainly concur with the majority of the examiners in concluding that [the Appellant], as a consequence of his motor vehicle accident, does suffer from a classic case of chronic PTSD with a strong depressive overlay, and his illness prevents him from being able to participate in the workplace without undue suffering. [Appellant's Psychologist #1] who has assessed him over a period of time, [Appellant's Psychologist #2], whose practise focused, almost exclusively on the diagnosis and treatment of PTSD, and his treating Psychiatrist, who knows him best, all support the diagnosis and do not question [the Appellant's] sincerity or the validity of his reported suffering. I share this same opinion. Furthermore, I would suggest that it is essential that his pharmacotherapy be continued and that a treatment program, specific to PTSD, be considered.

[Independent Psychiatrist #2's] report was subsequently provided to [Independent Psychologist] for her review and determination as to whether the new information provided in [Independent Psychiatrist's] report would alter the opinion provided in her report of September 1, 2010.

[Independent Psychologist] provided her second report dated January 13, 2012. [Independent Psychologist] reviewed [Independent Psychiatrist's] report and provided her explanation as to how she arrived at her diagnostic impressions documented in the September 1, 2010 report. In her second report, [Independent Psychologist] notes that:

> Unfortunately, as has already been discussed in detail, careful review of [the Appellant's] reported history in comparison to the available collateral information in regard to his case reveals [the Appellant] to be an unreliable historian. This is not an opinion uniquely expressed by me, but was also an issue described by both [Appellant's Psychologist #2] and [Appellant's Psychologist #1] In combination with objective psychological test data which suggests that [the Appellant] provides invalid self-report information regarding his experienced symptoms (again a finding which was consistent across all three psychological evaluations), this strongly suggests that reliance on [the Appellant's] self-report information (i.e., the information provided by [the Appellant] in interview in relation to his symptoms level of disability) is likely to lead to inaccurate conclusions regarding the nature and severity of his symptoms and to diagnostic inaccuracies.
>
> In addition, none of the other evaluators (including [Independent Psychiatrist]) (sic) made use of formal symptom validity measures in evaluating [the Appellant's] described symptoms. This is now a standard expectation within psychological evaluations due to the recognition that individuals may provide biased reports of their difficulties, and that the base-rates of symptom exaggeration are quite high within evaluations related to personal disability claims or civil litigation (the literature suggest that this may be as high as 35 – 40% in disability evaluation populations).
>
> [Independent Psychiatrist] (sic) also cites [the Appellant's] <u>self-reported</u> history when calling into question my diagnosis of his Personality Disorder NOS (with Cluster B features), saying that from these accounts, [the Appellant] had and maintained a "very healthy family adjustment prior to his motor vehicle accident" including a "history of lengthy relationships," and was a "responsible and caring parent."
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> In contrast, [the Appellant] disclosed in his evaluation with me a history of lengthy periods of separation from his wife, both before and after the accident. This is also what was disclosed to [Appellant's Psychologist #1], as he also noted within his report dated May 20, 2004 that [the Appellant] and his wife had separated prior to the accident. Family reunification also appears to have been on ongoing therapeutic theme in [the Appellant's] work with [Appellant's Psychologist #1], as was noted within his report dated June 27, 2008, and again in his report dated September 25, 2008. [The Appellant's] feelings of ambivalence regarding his marital relationship were also noted by [Appellant's Psychologist #1] across many of his psychotherapy progress reports, with [Appellant's Psychologist #1] being most explicit in his report dated November 2008 where he noted that:
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> > *"When I approached [the Appellant] on my understanding that reunifying with his family was a positive step forward in the healing process, [the Appellant] was not necessarily in agreement. He acknowledged that his return to [text deleted] was*

> *due to a number of factors, but not necessarily about his feelings about [Appellant's wife], or about family reunification."*
>
> As previously noted, [Appellant's Psychologist #1] also repeatedly expressed concern within his reports regarding the enmeshed, dependent, and parentified relationship which [the Appellant] appeared to have with his son. I would suggest that this does not speak of a healthy level of family adjustment.
>
> [Independent Psychiatrist] (sic) also suggests that [the Appellant] is exhibiting a "classic case of Chronic PTSD." However, in my opinion, [the Appellant's] reported symptom severity and chronicity and his lack of response to treatment is not consistent with what would be expected from a single-incident trauma, particularly not one of the magnitude suggested by the objective information available about the nature and severity of the accident he was involved in.

The Internal Review Office rendered its decision respecting [the Appellant's] Application for Review of injury claim decision on February 8, 2012. The Internal Review Officer in her decision dismissed the Appellant's Application for Review and confirmed the case manager's decision. The Internal Review Officer found that based on the totality of information on the claim file, she was unable to conclude that the case manager erred in the decision to terminate [the Appellant's] entitlement to IRI benefits effective October 28, 2010. Furthermore, the Internal Review Officer found that [the Appellant's] ongoing complaints of psychological difficulties could not be related to any of his motor vehicle accidents. Accordingly, [the Appellant] was no longer entitled to benefits including medication, psychological treatment, and associated expenses related to his psychological condition.

The Appellant has appealed that Internal Review decision to this Commission. In preparation for the appeal hearing, a number of additional reports were filed with the Commission, including:

- Report from [Appellant's Psychiatrist], dated June 7, 2013, wherein [Appellant's Psychiatrist] states that:

"As I stated in my previous reports to you, [the Appellant] meets all the criteria for Post-Traumatic Stress Disorder (secondary to MVA). He met these criteria when I first met him in 2003, then again in 2010 and still now in 2013.

The criteria consist of:
1. experiencing a recognizable trauma
2. re-experiencing the trauma
3. avoidance
4. increased arousal
5. duration of one month

. . .

Major Depression, Chronic Pain Syndrome, and Anxiety Disorder are diagnoses that would also fit for [the Appellant], but these also can be seen as part and parcel of PTSD."

- Health Care Services Psychological Consultant Opinion, dated August 20, 2013. The Appellant's medical file was resubmitted to [MPIC's Psychologist] for review due to the recent medical documentation that was added to the file, including [Independent Psychiatrist's] report of June 8, 2011 and [Independent Psychologist's] second report dated January 13, 2012. [MPIC's Psychologist] concluded as follows:

  "Based on the current review of the file documentation, it is the writer's opinion that the reports of [Independent Psychiatrist] and [Independent Psychologist] would not alter the conclusions previously provided by the writer in the report of September 24, 2010. The writer would concur with [Independent Psychologist] that her independent examination of the claimant was based on multiple sources of information including: self report, the medical and disability case file, observations during the assessment and administration of standardized psychological tests and measures of response bias.

  . . .

  Based on the review of [Independent Psychiatrist's] report and [Independent Psychologist's] letter of explanation, it is the writer's opinion that [Independent Psychologist's] discussion continues to be the more compelling description of the claimant's psychological functioning and therefore the writer's opinion as previously provided, would not be altered."

The Commission heard testimony from a number of witnesses on behalf of both the Appellant and MPIC throughout the course of the appeal hearing. Those witnesses included the Appellant, his family members, as well as a number of his care providers. There was also expert medical

evidence provided. The Commission does not intend to recite all of the evidence adduced; however, it was considered in its entirety. A summary of the evidence is set forth below as follows:

The Appellant – [text deleted]:

[The Appellant] testified about his work history before the motor vehicle accident, his family life and his childhood. [The Appellant] testified that on November 4, 2001 he was involved in the motor vehicle accident which is the subject of this appeal. He hurt his back as a result of the accident and his right hand went numb following the accident. [The Appellant] testified that he went back to work the day following the motor vehicle accident, he worked approximately five to six hours and then he had to leave. Since then he has not been able to return to work due to ongoing pain symptoms and psychological issues. [The Appellant] also reported nightmares which he attributes to the motor vehicle accident, panic attacks that occur when he is around crowds of people, anxiety, fear of being in vehicles, self-harming behaviour, insomnia and extreme difficulties with memory.

[The Appellant] described his interaction with [Appellant's Doctor] and the referral to Community Mental Health Services. At this time, he was having sleep difficulties and his hand was getting worse. Originally he didn't know why he was being referred to [Appellant's Mental Health Worker]. He saw him in [Manitoba], told him about his nightmares, how he didn't want to be around people and how his heart would start racing. He also began seeing [Appellant's Psychiatrist] in the fall of 2003 and [Appellant's Mental Health Worker] would be present during those visits. [Appellant's Psychiatrist] diagnosed him with Post-Traumatic Stress Disorder and prescribed medication.

[The Appellant] testified that following the motor vehicle accident his relationship with his wife changed. He didn't talk to his wife and no longer went out with his wife or socialized with friends. He also reported being unable to pay attention to his wife and family. He distanced himself from his wife and kids as he was ashamed of his condition. Generally, he stayed in his bedroom and did not leave the home, except for medical appointments or at the insistence of one of his children. He described himself as being awake, but doing nothing but staring at the walls. He lost interest in watching television and many of the activities which he enjoyed prior to the motor vehicle accident. He testified that he still gets panic attacks when he is in crowded places. Typically his son will drive him to his appointments as he does not drive. He lacks energy to do many of the things he did before the accident and has no motivation or drive for many common tasks. He no longer assists with the household chores, or cooks meals. He also lost a significant amount of weight since the accident.

When questioned regarding the assessment with [Independent Psychologist], [the Appellant] testified that initially he had a hard time finding her office. He testified that he was not able to complete the tests that she gave him. He also did not fully understand the tests and felt rushed doing the tests. He maintains that he answered questions that he didn't understand and he didn't want to bother [Independent Psychologist] to ask for help. [The Appellant] further testified that [Independent Psychologist] did help at or near the end of the testing. She read the questions to him and wrote down the answers. He was happy to get out of the interview with [Independent Psychologist] as he felt intimidated by the process with [Independent Psychologist]. [The Appellant] maintains that he did not exaggerate his answers to [Independent Psychologist] and that he is not a malingerer. [The Appellant] testified that he is devastated that he can no longer work and that he was shocked and distraught when his benefits were terminated.

Community Mental Health Worker – [text deleted]:

[Appellant's Mental Health Worker] has been employed as a Community Mental Health Worker in [text deleted]. He works in [Manitoba]. His role is to act as a counsellor and provide therapy to individuals. He received a referral from [Appellant's Doctor] and met with [the Appellant] on August 7, 2003 in [Manitoba]. [Appellant's Mental Health Worker] referred [the Appellant] to [Appellant's Psychiatrist] who is the consulting psychiatrist for the area. He would meet with the Appellant and [Appellant's Psychiatrist] during their sessions. He recalled that [the Appellant] often had difficulty accessing transportation in order to make his appointments in [Manitoba]. [Appellant's Mental Health Worker] testified that he believed [the Appellant] was being truthful to him and accepted the information that [the Appellant] provided at face value.

[MPIC's Psychologist]:

[MPIC's Psychologist] is one the psychological consultants to MPIC's Health Care Services. His expertise in the field of clinical psychology was acknowledged by counsel's consent. In his testimony, [MPIC's Psychologist] confirmed that he had reviewed the Appellant's file on numerous occasions and prepared several memoranda including his opinions regarding the Appellant's psychological condition and its relation to the motor vehicle accident of November 4, 2001. As noted in his interdepartmental memorandum of December 12, 2003, [MPIC's Psychologist] accepted the information provided by [Appellant's Psychiatrist] and the [Appellant's Doctor] that there was a probable causal relationship between the motor vehicle accident of November 4, 2001 and the Appellant's diagnosis of Post-Traumatic Stress Disorder. In his interdepartmental memorandum of February 17, 2006, [MPIC's Psychologist] again confirmed that, on the balance of probabilities, the Appellant continued to meet the diagnosis of Post-Traumatic Stress Disorder and that it was causally related to the motor vehicle accident in question.

[MPIC's Psychologist] further testified that following review of [Independent Psychologist's] report of September 1, 2010, his opinion changed. [MPIC's Psychologist] felt that [Independent Psychologist] provided a thorough examination along with specific validity testing. On the basis of the thorough assessment of [Independent Psychologist], [MPIC's Psychologist] no longer felt that the diagnosis of PTSD was supported. [MPIC's Psychologist] felt that [Independent Psychiatrist's] opinion was not as persuasive as [Independent Psychologist], as [Independent Psychiatrist] did not address the psychological testing that was performed. Based on his review of [Independent Psychologist's] recent independent psychological examination, he changed his opinion and is now of the opinion that the Appellant does not havePost-Traumatic Stress Disorder, nor any other Axis I diagnoses that would be considered MVA related. [MPIC's Psychologist] expressed his agreement with [Independent Psychologist] that the motor vehicle accident of November 4, 2001 was not a significant traumatic event.

[Appellant's Doctor]:

[Appellant's Doctor] testified that he carried on a family medical practice in [Manitoba]. He first saw the Appellant on November 14, 2001, following the Appellant's motor vehicle accident. At the initial visit, the Appellant complained of numbness to the right hand and advised him that he had been in a motor vehicle accident on November 4, 2001 when his vehicle was rammed by another car. [Appellant's Doctor] testified that from November 2001 until March 2002, the Appellant's symptoms basically stayed the same. He felt that there was an emotional overlay to the Appellant's symptoms at that point due to his slow recovery. Throughout 2002, [Appellant's Doctor] felt that the Appellant was developing a psychological disorder, beyond the physical injuries which he sustained in the motor vehicle accident. The Appellant had ongoing pain in his arm and back with very little improvement from physiotherapy treatment. He testified that he

felt there was a psychological impact on the Appellant due to his anxiety, fear, stress and headaches following his accident.

By July 30, 2003, the Appellant's symptoms were still the same and [Appellant's Doctor] felt that this was a serious condition and referred the Appellant to the Community Mental Health program in order to get him to see a psychiatrist. Following that referral, [Appellant's Doctor] testified that he received regular updates from [Appellant's Psychiatrist] and [Appellant's Mental Health Worker] regarding their sessions with the Appellant. [Appellant's Doctor] also testified about the Appellant's self-mutilation and his opinion that this indicated severe stress or an anxiety disorder.

[Appellant's Doctor] testified that the Appellant's symptoms were consistent and difficult. Initially he expected that the Appellant would get better from his motor vehicle accident injuries. However, the Appellant did not improve and his psychological problems became worse. He also noted that the Appellant lost a significant amount of weight following the accident which could have been due to the stress, anxiety or depression that the Appellant suffered with. It was [Appellant's Doctor's] opinion that the Appellant was unable to work due to his anxiety and psychological problems, principally anxiety. Additionally, [Appellant's Doctor] felt that the Appellant was not capable of working because of his pain levels, stress, anxiety, depression and PTSD symptoms. [Appellant's Doctor] also testified about the Appellant's overuse of pain medication and the Appellant's dependency on pain medication and his efforts to reduce the Appellant's reliance on prescription pain killers.

[Appellant's Psychiatrist]:

[Appellant's Psychiatrist] was qualified as an expert in psychiatry before the Commission. He testified that the Appellant became his patient on September 23, 2003. At that time, he saw people in the community. His role as a consultant in the community was to make a diagnosis and follow-up with patients. When he met with the Appellant, [Appellant's Mental Health Worker] would also be present during their sessions.

He testified that he diagnosed the Appellant with Post-Traumatic Stress Disorder in 2003, due to the symptoms that he reported during their sessions. [Appellant's Psychiatrist] felt that the motor vehicle accident of November 4, 2001 was a traumatic event for the Appellant. He based his diagnosis on the Appellant's experience of nightmares, flashbacks, avoidance and fearfulness. He felt that the Appellant met the diagnostic criteria for PTSD, due to the trauma which he experienced from the motor vehicle accident, his re-experiencing the trauma through his recurring nightmares and his avoidance thereafter. He also discussed the Appellant's dependency on pain medication.

With respect to [Independent Psychologist's] assessment of the Appellant as a malingerer, [Appellant's Psychiatrist] did not agree. He found that the Appellant was genuine, consistent and forthright in his sessions, although not a terribly sophisticated individual. [Appellant's Psychiatrist] indicated that the Appellant also suffered from Major Depression, Chronic Pain Syndrome and Anxiety Disorder, but these were part and parcel of PTSD. Furthermore, [Appellant's Psychiatrist] stated that the Appellant's current condition prevented him from working.

[Independent Psychiatrist]:

[Independent Psychiatrist] was qualified as an expert in psychiatry, with an emphasis on mood and anxiety disorders. [Independent Psychiatrist] testified that PTSD was an anxiety disorder where an individual had to be exposed to significant trauma which they perceived as hazardous and life-threatening. Signs and symptoms of PTSD included:

1. Re-experiencing the traumatic event, including thoughts throughout the day of the event and recurrence of dreams of the event.
2. History of avoidance; avoiding thoughts or feelings of the event.
3. Losing interest in previous activities, or a period isolating themselves from other people.
4. Worrying that their life will be shortened.
5. Symptoms of arousal including not being able to fall or stay asleep, startle reaction and difficulty concentrating.

[Independent Psychiatrist] testified that these symptoms must last at least one month. If they last longer than three months the condition is considered chronic. PTSD is treated with medication and psychotherapy. [Independent Psychiatrist] testified that he met with the Appellant for 2½ hours. Initially the Appellant was quite anxious but became more at ease during the interview. He was quite dysphoric and tearful throughout their interview. The Appellant described the nightmares that he has experienced since the motor vehicle accident. These nightmares have consisted of him reliving the motor vehicle accident. The Appellant told him that he had lost interest in some of the things that he used to do. He feels like he is "living in a cloud" and has become much more isolated since the accident. The Appellant also explained to him that he would not go into crowded spaces as he was worried about panic attacks. He would also just stare at the T.V. and was not interested in any particular television programs.

[Independent Psychiatrist] felt that the Appellant was not a sophisticated individual, cognizant of world events. He did not have a high degree of education and was somewhat naive. He was certainly lacking in psychological insight. He felt that the Appellant may have exaggerated his symptoms somewhat – he was trying to impress [Independent Psychologist]. However, he felt that the Appellant's suffering was genuine. He found him to be a frank individual and tried to respond to him in a forthright manner. [Independent Psychiatrist] found the Appellant's description of his symptoms as truthful. [Independent Psychiatrist] did not believe that the Appellant was a malingerer. He testified that malingering tends to be a pattern, it is not going to all of a sudden show up with a feigned illness. He would have expected a history of illness if this was the case for the Appellant. [Independent Psychiatrist] testified that the Appellant would not likely become a malingerer over time.

[Independent Psychiatrist] testified that he did not agree with [Independent Psychologist] regarding her diagnosis of a Cluster B personality disorder, including borderline and dependent traits. He felt that this would require a particular symptom pattern to have persisted throughout an individual's adult life. Usually these types of individuals are very difficult individuals, erratic, difficult to get along with, problematic, don't succeed in life, constantly changing jobs, experience difficulty with people in their jobs, and family usually cuts them off. [Independent Psychiatrist] testified that the Appellant did not have the characteristics of someone suffering from a personality disorder. The Appellant had maintained a very healthy life and family adjustment prior to his motor vehicle accident. As well, he had a lengthy history of sustained employment with long periods in the same work situation. He had a history of lengthy relationships and appeared to be a responsible and caring parent with no periods of disability (prior to the motor vehicle accident).

With respect to the psychological testing undertaken by [Independent Psychologist], [Independent Psychiatrist] testified that he based his opinion on the Appellant's self-reporting. His opinion is that the Appellant is suffering with PTSD with depression and he believed that it was connected to the motor vehicle accident as the Appellant did not experience those symptoms prior to November 4, 2001. [Independent Psychiatrist] was adamant that the Appellant did not suffer from a borderline personality disorder.

[Independent Psychologist]:

[Independent Psychologist] is a registered psychologist and clinical neuropsychologist in Manitoba. She was qualified as an expert clinical psychologist and clinical neuropsychologist before the Commission.

[Independent Psychologist] testified that she was contacted by MPIC's case manager for the purpose of conducting an independent psychological evaluation of the Appellant. This independent psychological evaluation was scheduled for August 30, 2010 at [Independent Psychologist's] office. [Independent Psychologist] testified that there were difficulties with the assessment from the outset. [The Appellant] arrived at his appointment unaccompanied. Upon arrival, the Appellant immediately began to attempt to negotiate a two hour lunch break in order to fill a prescription. [Independent Psychologist] found this request a very odd start to the day and a very unusual way to begin an evaluation. She testified that she had a difficult time directing him to pay attention to the consent forms. She indicated that the Appellant took several phone calls while attempts were being made to discuss issues relating to informed consent with him. She found that he seemed to pay little attention to the written consent form prior to signing it and immediately began resuming attempts to renegotiate the extended lunch hour that he wanted.

[Independent Psychologist] testified that although [the Appellant] presented as alert and oriented, he was a poor historian who provided vague and often contradictory information regarding his personal and medical history. She found him very difficult to interview, he kept answering phone calls during their interview, he was vague and many statements were contradictory. She found that the Appellant was very confusing and as a result it was difficult to get a history about his marriage, he couldn't remember how old he was, he didn't have a lot of memories of his childhood. Usually the interview process would last approximately 2 to 2½ hours. However, in this case it was a longer interview because she was having such a difficult time eliciting information from [the Appellant].

[Independent Psychologist] testified that following lunch, the psychological testing commenced. This comprised numerous questionnaires to be completed by the Appellant. [Independent Psychologist] testified that she checked on [the Appellant] more than she normally does. Usually he was on the phone and she had to ask him to stop making calls. She found that [the Appellant] did not appear to be motivated to provide accurate information about himself, nor to complete the requested questionnaires. He took phone calls every few minutes throughout the time given him to work on his questionnaires and he was frequently observed not to be working on them. [Independent Psychologist] testified that when she would check on him, [the Appellant] would raise his hand and complain about the pain, saying that he had to take lots of breaks. After several hours, [the Appellant] still had not made significant progress with the questionnaires. By 3:00 p.m., in the interest of having him complete the necessary testing, [Independent Psychologist] offered to read him the questions and mark down the answers for him. [Independent Psychologist] administered four psychological tests to [the Appellant].

[Independent Psychologist] found that [the Appellant's] MMPI-II profile was valid in terms of his consistency of responding, suggesting that he attempted to and understood the content. However, she found that his profile was invalid due to an extreme degree of symptom exaggeration. [Independent Psychologist] testified that the Appellant endorsed every possible symptom of mental illness included on the questionnaire. He also endorsed an unacceptably high number of symptoms which are not typically responded to by those with genuine mental illness, but which tend to be endorsed by those attempting to feign mental illness. In addition, [Independent Psychologist] testified that the Appellant's score for measures to assess malingering was significantly above established cut-offs for the identification of malingering. His score on this measure was elevated to such an extreme degree that this has been shown to approach a 0% risk of being a false positive, even among PTSD and chronic pain populations. [Independent Psychologist] indicated that because of his extreme symptom magnification and indications for malingering, the probability that [the Appellant's] symptom reports represent deliberate attempts to exaggerate or feign symptoms is high.

[Independent Psychologist] concluded that her diagnosis of the Appellant was that of a personality disorder NOS with cluster B personality traits. She found that [the Appellant's] symptoms and presentation were very odd. There was a disconnect between his reported symptoms and what he told her during her interview. She didn't find [the Appellant] to be forthright and was having a very difficult time finding him credible. He was frustrating throughout the assessment process and behaved inappropriately. In her opinion, [Independent Psychiatrist] did not appear to have critically evaluated [the Appellant's] behaviour.

[Independent Psychologist] also testified that she did not think the Appellant was suffering from PTSD. In her experience, for a single incident of limited severity, PTSD should resolve fairly

quickly with treatment (10 sessions), in approximately 10 to 15 weeks. In her experience, chronic PTSD sufferers are people who have significant childhood or adolescent trauma or military personnel. Additionally first responders or RCMP personnel may exhibit symptoms of chronic PTSD. [Independent Psychologist] testified that the Appellant received an extreme amount of therapy from 2006 to 2009 for a single incident trauma. She also noted that there were concerns raised by the Appellant's treating psychologist regarding treatment compliance and failing to follow through on treatment recommendations. Ultimately [Independent Psychologist] provided the opinion that the Appellant was not currently as functionally disabled as he claimed to be.

Appellant's Submission:

Counsel for the Appellant submits that the Appellant suffers from PTSD which was caused by the motor vehicle accident of November 4, 2001. This condition prevents him from holding the employment which he held at the time of the accident and which was determined for him at the 180-day determination. Counsel for the Appellant maintains that the Appellant had an uneventful childhood and throughout his adult life was gainfully employed and happy at work. Counsel contends that the Appellant liked working and there is no evidence that he was trying to get out of working. There were no lengthy illnesses that prevented him from working prior to the motor vehicle accident. Additionally, counsel for the Appellant argues that there is no evidence that the Appellant had a pre-existing mental health issue prior to the motor vehicle accident. Although he may have been prescribed anxiolytic drugs prior to the motor vehicle accident, this alone does not equate to the diagnosis of a mental disorder.

Counsel for the Appellant submits that the Appellant has been consistent about his description of the motor vehicle accident and he has not waivered about the circumstances of the motor vehicle

accident. The Appellant maintains that his car was rammed; he indicated that the wheels left the ground; he hit his head on the roof of the car and hit his arm on the control panels of the door. The Appellant went to the emergency department at [Hospital] that night. The vehicle was sufficiently damaged that it was written off. Counsel submits that the Appellant's evidence was candid, sincere, genuine and unwavering in his description of the motor vehicle accident.

Counsel for the Appellant contends that the events surrounding the car accident are important to the Appellant's perception of the motor vehicle accident. Counsel argues that the Appellant perceived that he could have been killed during that accident and this was the significant event which led to the PTSD. Counsel for the Appellant contends that soon after the motor vehicle accident, the Appellant began to suffer psychological symptoms.

Counsel for the Appellant asserts that, although the Appellant was a poor historian, much of the Appellant's testimony was corroborated by his family. [Appellant's wife] verified the family life and their problems following the motor vehicle accident. She maintained that following the motor vehicle accident she became frustrated with the Appellant as he had changed. His son sees his father every day and is primarily responsible for taking him to his appointments. His son described much of the same changes as the Appellant and the Appellant's wife – his father is weak and tired all of the time and has no energy.

Counsel also referred to the testimony of [Appellant's Doctor], from November 2001 until January 2011. Counsel for the Appellant notes that early on [Appellant's Doctor] began to feel that there was a mental condition arising for the Appellant. He referred him to the Community Mental Health program. The Appellant saw [Appellant's Mental Health Worker] and [Appellant's Psychiatrist]. [Appellant's Psychiatrist] diagnosed the Appellant with PTSD

connected to the motor vehicle accident. [Appellant's Doctor] who is also knowledgeable in the area of PTSD, did not question the Appellant's diagnosis of PTSD. [Appellant's Doctor] never had the impression that the Appellant was trying to deceive anyone.

Counsel for the Appellant maintains that all of the Appellant's care providers came to the conclusion that he was suffering from PTSD. [Appellant's Psychologist #1], diagnosed PTSD connected to the motor vehicle accident of November 4, 2001. Counsel for the Appellant also submits that the Appellant is supported throughout by [Appellant's Psychiatrist] and by [Appellant's Psychologist #2], who both had the opportunity to personally assess the Appellant and diagnosed the Appellant with PTSD. Specifically, counsel referred to the testimony of [Appellant's Psychiatrist], who diagnosed the Appellant's PTSD in 2003 connected to the motor vehicle accident. [Appellant's Psychiatrist] has remained consistent with that diagnosis since September 2003. [Appellant's Psychiatrist] disagreed that the Appellant was a malingerer. He also testified that subsequent events have prevented the Appellant from healing and recovering from his PTSD. [Appellant's Psychiatrist] testified that it was rare, but not impossible that PTSD would arise from a single event trauma. He submits that [Appellant's Psychiatrist] would have analyzed and questioned the Appellant in order to come to his diagnosis.

Counsel for the Appellant also submits that [Independent Psychiatrist] supports the Appellant's diagnosis. [Independent Psychiatrist] is completely independent and comes to the same diagnosis and conclusion as [Appellant's Psychiatrist]. Counsel submits that both [Appellant's Psychiatrist] and [Independent Psychiatrist's] opinions are relevant and consistent and should be given considerable weight. Further, with respect to [Independent Psychiatrist], counsel for the Appellant notes that [Independent Psychiatrist] has diagnosed and treated numerous patients with PTSD over the years. It was also [Independent Psychiatrist's] opinion that it is the patient's

perception of the event that determines whether the individual has PTSD. [Independent Psychiatrist] noted that self-reporting is a reliable method to diagnose and treat patients. He can assess and analyse the information that patients are telling him to determine their diagnosis. It was [Independent Psychiatrist's] opinion that it is not rare for PTSD to arise from a single event. Further [Independent Psychiatrist] maintains that the Appellant did not suffer with borderline personality disorder. [Independent Psychiatrist], in his testimony, maintained his diagnosis for the Appellant of PTSD with co-morbid depression. [Independent Psychiatrist] testified that one cannot arrive at a diagnosis of malingering with an invalid test. Counsel for the Appellant submits that [Independent Psychiatrist] is an experienced and highly trained psychiatrist and his opinion should be given considerable weight.

Counsel for the Appellant submits that [MPIC's Psychologist's] testimony and opinions should be given little or no weight. He maintains that [MPIC's Psychologist's] opinion is biased in favour of MPIC. [MPIC's Psychologist] agreed with the diagnosis of PTSD made by [Appellant's Psychiatrist], consistent with the reporting of symptoms by the Appellant throughout. It was not until August 2010, when MPIC sent the Appellant to see [Independent Psychologist] that the diagnosis of PTSD was questioned. [MPIC's Psychologist] completely changed his opinion when he received [Independent Psychologist's] report. Counsel for the Appellant submits that [MPIC's Psychologist's] opinion is based entirely on [Independent Psychologist's] assessment. There was no independent analysis of her opinion by [MPIC's Psychologist]. As a result, he submits that [MPIC's Psychologist's] opinion should be given little or no weight.

With regards to the assessment conducted by [Independent Psychologist], counsel for the Appellant submits that the Appellant had difficulties taking the psychological tests administered

by [Independent Psychologist]. He maintains that the Appellant did not have an agenda to try and deceive [Independent Psychologist] and does not have the sophistication to design and present answers to get ahead and to deceive MPIC throughout this extended time. Counsel for the Appellant contends that the Appellant felt uncomfortable from the outset with the assessment by [Independent Psychologist]. The Appellant feared that his benefits could be in jeopardy. He did not understand the questions that he was being asked and he felt rushed to complete the tests. The Appellant felt that he was being set up for failure during his assessment with [Independent Psychologist].

With respect to [Independent Psychologist], he submits that [Independent Psychologist's] opinion should not be given any weight. Counsel for the Appellant maintains that [Independent Psychologist's] role was to provide a report favorable to MPIC, and not to provide an independent assessment of the Appellant. Counsel for the Appellant argues that [Independent Psychologist] based her opinion on one meeting with the Appellant. That meeting did not get off to a good start. The Appellant was negotiating an extended lunch hour and there was no attempt by [Independent Psychologist] to put the Appellant at ease. Counsel for the Appellant submits that [Independent Psychologist] was dismissive of the Appellant's symptoms. She did not analyze what he reported to her. [Independent Psychologist] has a very strong disregard for self-reporting. She doesn't trust psychiatry and was dismissive of the opinions of [Independent Psychiatrist] and [Appellant's Psychiatrist]. Counsel for the Appellant claims that [Independent Psychologist] does not have anywhere near the depth of experience of [Independent Psychiatrist] or [Appellant's Psychiatrist]. Counsel for the Appellant submits that the breadth of the questions set out in the testing was not reasonable. He notes that there were 934 questions in the tests being posed to the Appellant. It was not reasonable to require him to do such extensive testing,

in a single afternoon. He maintains that the Appellant would have zoned out after all of those questions.

With respect to the test for malingering, counsel for the Appellant maintains that [Independent Psychologist] should have questioned the Appellant's results and realized that something was wrong with the testing. He submits that the Appellant's results should have alerted [Independent Psychologist] that they couldn't be relied upon. He submits it was not reasonable for [Independent Psychologist] to rely upon the testing for malingering where such a remarkable result was achieved. The high score should have indicated to [Independent Psychologist] that there was a problem with that testing.

Counsel for the Appellant submits that [Independent Psychologist] was completely dismissive of self-reporting, while being unwavering in her reliance upon test scores. He maintains that her conclusions do not make sense in this case. She was very rigid in her opinion and dismissive of other opinions. As a result, counsel for the Appellant submits that [Independent Psychologist's] opinion should not be relied upon.

In conclusion, counsel for the Appellant submits that the Appellant has established that he has PTSD which prevents him from holding the employment which he held at the time of the motor vehicle accident and which was subsequently determined for him. As a result, counsel for the Appellant submits that the Appellant's appeal should be allowed and his benefits should be reinstated.

MPIC's Submission:

Counsel for MPIC submits that the Appellant's accident-related injuries do not prevent him from holding the employment he held at the time of the accident or the employment that was later determined for him. He claims that on the strength of [Independent Psychologist's] evidence, there is nothing that prevents the Appellant from working and he is no longer suffering from PTSD. Counsel for MPIC submits that, probably by 2009 and certainly by 2010, the Appellant's PTSD had resolved.

Counsel for MPIC reviewed the events of the motor vehicle accident. He submits that there was no evidence that the vehicle in which the Appellant was seated actually left the ground when it was hit by the other vehicle. Counsel for MPIC submits that this accident was not a traumatic event which would have given rise to PTSD. At least, he submits not on an objective basis; perhaps subjectively it was a traumatic event for this Appellant. Counsel for MPIC cites examples given by [Independent Psychologist] of chronic trauma which would have lead to a case of chronic PTSD. He insists that this is not one of those instances.

Counsel for MPIC states that from November 2001 to March 2003, benefits were extended to the Appellant for the physical injuries to the Appellant's right hand and his back. His IRI benefits and funding for physiotherapy treatments were terminated as of March 27, 2003. At that time, it was MPIC's position that there were no physical findings that disabled the Appellant from returning to a sedentary type of occupation such as his determined employment of a security guard. Subsequently, on the strength of reports from [Appellant's Psychologist #1], [Appellant's Psychologist #2] and [MPIC's Psychologist's] review, the Appellant's benefits were reinstated retroactive to March 2003. Counsel for MPIC notes that in September 2006 the Appellant began psychotherapy, but by this time he also had a troubling dependency on prescription medication. [Appellant's Doctor] attempted to reduce the Appellant's dosage, unsuccessfully. [Appellant's

Psychologist #1] continued to provide psychological intervention for three years, however, he became frustrated over the Appellant's lack of progress. [Appellant's Psychologist #1] noted that the Appellant was not helping himself get better and not complying with treatment recommendations.

Counsel for MPIC contends that by 2009 the Appellant's PTSD symptoms were gone, replaced by a dependency on prescription medication. Counsel for MPIC claims that at this time, the Appellant would say whatever was required in order to get his medications. He continued to report pain symptoms as he did in 2002, 2003 and 2004, with no improvement whatsoever in any of his symptoms, despite years of psychotherapy treatment.

Counsel for MPIC submits that the Appellant was not a credible individual. He was a poor historian, unable to recall many events of his past. Counsel for MPIC also notes that the Appellant had a selective memory. He remembered some details of his past history, but not all. His self-report was often inconsistent and there are many examples throughout the file of contradictory reports.

This resulted in him withholding significant information from his caregivers regarding past traumatic events in his life. He was also unable to recall previous traumatic events with any detail in his oral testimony before the Commission. Even under cross-examination, counsel argues that the Appellant provided little assistance regarding past trauma. This also extended to details about his personal relationships. Counsel for MPIC argues that the Appellant misled his caregivers about the details of his separation from his wife and his relationship with his children and grandchildren. He notes that the file is replete with references to the Appellant's separation from his wife, [text deleted]. Yet in their testimony before the Commission, the Appellant and

his wife denied ever having separated. Counsel for MPIC maintains that the Appellant's lack of credibility and the inconsistencies in his self-report demonstrate that he was not a reliable historian. Counsel for MPIC concludes that the Appellant provided inconsistent information throughout the history of his claim and his evidence cannot be relied upon.

With respect to the assessment with [Independent Psychologist], counsel for MPIC submits that the results of her testing are quite compelling. Counsel for MPIC insists that the Appellant did not take the assessment with [Independent Psychologist] seriously. He took at least 10 phone calls during his assessment. He did not make a concerted effort to complete the questionnaires. He took phone calls every few minutes throughout the time given to him to work on his questionnaires and he was frequently observed not to be working on them. Despite the complexity of some of the questions, the Appellant exhibited no difficulties with attention, concentration, or item completion when [Independent Psychologist] read him the questions and wrote down his answers. Counsel argues that the Appellant appreciated the significance of the assessment with [Independent Psychologist], yet he purposely completed the testing in a careless, inattentive and lazy way in order to portray his difficulties in an exaggerated manner.

Counsel for MPIC submits that [Independent Psychologist] gave her evidence in a very forthright and professional manner. Counsel for MPIC submits that the Commission should prefer the evidence of [Independent Psychologist] over that of [Independent Psychiatrist] because of the psychological testing. According to [Independent Psychologist], a clinician's judgement is much less accurate than objective psychological testing – 50% of people tested are malingering. As [a] result, he submits that it is very unwise to rely solely on self-reporting in assessing malingering. The tests administered by [Independent Psychologist] guard against pattern testing and symptom exaggeration. Counsel for MPIC maintains that [Independent

Psychiatrist] is not in a position to challenge [Independent Psychologist's] testimony. [Independent Psychologist] believes in psychological testing and she is an expert examiner. He is not an expert in psychological testing.

With respect to the Appellant's test scores, counsel for MPIC argues that the Appellant's counsel has attacked the method of testing because they cannot attack the results of the testing. The Appellant never told [Independent Psychologist] that he couldn't understand the test questions. The test results showed that he did understand the tests and the tests are designed for individuals who are not well educated. Despite the Appellant's reduced effort, the results obtained by [Independent Psychologist] were valid. The Appellant's MMPI-2 profile was valid in terms of his consistency of responding, suggesting that he attended to and understood the item content. Counsel for MPIC maintains that the Appellant's efforts to attack the testing are not sincere since the testing was valid.

Counsel for MPIC submits that there may have been some form of PTSD in 2002, 2003 and 2004. However, by 2010 the Appellant's PTSD had resolved. Based upon [Independent Psychologist's] testimony, the Appellant was not suffering from PTSD by 2010. Counsel for MPIC submits that the Appellant's appeal must be dismissed as he has not established that he was still suffering from PTSD in 2010. If there was any reason the Appellant could not work in 2010, it was not related to the accident of November 4, 2001.

As a result, counsel for MPIC submits that the Appellant's appeal should be dismissed and the Internal Review decision dated February 8, 2012 should be confirmed.

Decision:

Upon a careful review of all of the medical, paramedical and other reports and oral and documentary evidence filed in connection with this appeal, and after hearing the submissions of counsel for the Appellant and of counsel for MPIC, the Commission finds that the Appellant's IRI benefits were incorrectly terminated on October 28, 2010, pursuant to Section 110(1)(a) and 110(1)(c) of the MPIC Act.

Reasons for Decision:

Upon a careful review of all of the information before it, the Commission finds that the Appellant has established, on a balance of probabilities, that the motor vehicle accident of November 4, 2001 has caused the Appellant's psychological condition, which prevents him from holding employment. We find that the medical evidence on the file is consistent with that conclusion.

The Appellant's testimony at the hearing indicated that he continues to experience recurring nightmares "almost every night". He also startles when he hears loud noises, particularly while asleep. He described his symptoms of anxiety (heart starts to race) and stated that his PTSD symptoms are the same in intensity now as they were following the motor vehicle accident. The Appellant also testified that his symptoms are no more manageable now than they were 10 years ago. His typical day involves staring into space and roaming his household. He does not actively participate in any cooking or cleaning of the home and has distanced himself from his family. This lack of interest and lack of involvement with his family were corroborated by the testimony of his wife and his eldest son at the appeal hearing.

The Commission finds that the Appellant's lifestyle establishes that he is not functioning at a level which would allow him to work in a competitive employment environment. Although the

Appellant was a poor historian, his lack of productive engagement with his community, his family or his social circle convince us that he suffers from a psychological condition which has disabled him and prevented him from engaging in a productive lifestyle. This particularly so when compared to his pre-accident history. According to the evidence before the Commission, the Appellant maintained a healthy family life prior to the motor vehicle accident. He had periods of lengthy sustained employment. He had relatively stable familial relationships and he and his wife socialized regularly. He was also a responsible and caring parent and grandparent. The protracted length of the Appellant's disengagement leads us to the conclusion that he continues to suffer with the psychological effects of the PTSD condition.

With respect to the opinions of the many specialists involved with the Appellant's care, the Commission prefers the evidence of the Appellant's care providers, who had the benefit of assessing the Appellant over an extended period of time, to that of the opinion offered by [Independent Psychologist]. The Appellant's healthcare providers are all of the opinion that [the Appellant] is suffering from a chronic post-traumatic stress disorder with depression. They cite as evidence of this diagnosis, his re-experiencing of the accident, his persistent anxiety, his nightmares, his numbed responsiveness to his environment, his startle responses, his sleep disturbance and his avoidance techniques. We find that the Appellant's treating care providers are in the best position to assess the Appellant and provide an opinion as to the Appellant's condition. They are also in agreement as to his diagnosis and its causal relationship to the motor vehicle accident of November 4, 2001.

In that respect, we find that the Appellant continues to suffer from the effects of PTSD which was first diagnosed by [Appellant's Psychiatrist] in September of 2003. Additionally, we prefer the opinion of [Independent Psychiatrist] with respect to the Appellant's functioning to that of

[Independent Psychologist]. [Independent Psychiatrist] was adamant that the Appellant did not possess a borderline personality disorder based upon his level of functioning prior to the motor vehicle accident. The Commission accepts [Independent Psychiatrist's] expertise with respect to this diagnosis.

The Commission finds that the termination of the Appellant's benefits based upon one day of neuropsychological testing was unfair to the Appellant. Clearly, the Appellant was intimidated by the entire process. A task of answering almost 1,000 questions over the course of an afternoon was an overwhelming proposition for this Appellant. Throughout the Appellant's testimony before the Commission, the Commission found that the Appellant did not understand many of the questions which were posed to him. He also has a dysphoric mood, poor concentration and memory. Psychological testing was previously undertaken by [Appellant's Psychologist #2] and [Appellant's Psychologist #1]. Those psychologists were unable to obtain valid results from the Appellant on psychological testing. We are not convinced that the testing conducted by [Independent Psychologist] is any different. Due to the Appellant's poor intelligence, his low energy levels and his depression, we are unable to conclude that the neuropsychological testing conducted by [Independent Psychologist] provided an accurate reflection of the Appellant's abilities.

The Commission found that although the Appellant was a poor historian, unable to recollect accurate details surrounding much of his past history, we do not find that the Appellant is a malingerer. Rather, we find that the Appellant is naive and unsophisticated and lacking in any self-awareness or psychological insight into his condition. This lack of psychological insight was noted by [Appellant's Psychologist #1] in his report of November 20, 2008 where he noted that, "*Based on his dependence on pain medication, the difficulty he has making the "cognitive*

shift" necessary to more effectively deal with his chronic pain condition, what appears to be a building dependence on others for many aspects of his personal care, and his unresolved PTSD symptomatology, [the Appellant] requires ongoing medical and clinical support and monitoring." [Independent Psychiatrist] also noted this in his report of June 8, 2011, where he stated that, "*He [the Appellant] was certainly lacking in psychological insight*." [Independent Psychiatrist] testified that malingering tended to be a pattern and that the Appellant would not likely become a malingerer over time. The Commission accepts [Independent Psychiatrist's] expertise in this regard.

The Commission finds that the Appellant, as a consequence of his motor vehicle accident, does suffer from chronic PTSD with a strong depressive overlay and his illness prevents him from being able to participate in a competitive employment environment. The Commission accepts that this condition prevents him from holding the employment which he held at the time of the accident and which was determined for him at the 180-day determination. The Commission finds that the termination of the Appellant's IRI benefits pursuant to ss. 110(1)(a) and ss. 110(1)(c) was not appropriate.

As a result, the Appellant's appeal is allowed and the Internal Review Decision dated February 8, 2012 is hereby rescinded.

Dated at Winnipeg this 12th day of June, 2014.

YVONNE TAVARES

JANET FROHLICH

SANDRA OAKLEY