DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

Introduction

[1] In October 2008, the worker, then working as a part-time care aide, injured her low back while pushing a patient in a wheelchair. This incident formed the basis for an accepted claim with the Workers' Compensation Board (Board), operating as WorkSafeBC.

[2] The worker's claim was initially accepted for a low back strain. Later, other compensable physical conditions were accepted under the worker's claim: a permanent aggravation of degenerative disc disease at L4-5, a right-sided L4-5 disc herniation, and chronic pain. Subsequently, the Board also accepted a psychological injury under the worker's claim: Depressive Disorder, Not Otherwise Specified.

[3] The Board provided the worker with temporary disability benefits in respect of her physical injuries until October 31, 2009. The Board also provided temporary disability benefits in respect of the worker's psychological injury from November 1, 2009 to February 27, 2011. As of February 28, 2011, the worker was left with three permanent conditions: a permanent aggravation of degenerative disc disease at L4-5, a right-sided L4-5 disc herniation, and chronic pain. The Board provided the worker with a permanent disability award equal to 2.5% of total disability in respect of her compensable permanent impairment.[1]

[4] In February 2013, the worker sought a reopening of her entitlements under this claim based on a recurrence or significant change in her psychological injury. The Board denied her request in a decision dated June 3, 2013. That decision was not the subject of a review or an appeal.

[5] The worker later requested a reopening of her entitlements under her claim, alleging a recurrence of or significant change in her physical injuries in April 2013. That request was denied by the Board. That decision was ultimately varied upon appeal to the Workers' Compensation Appeal Tribunal (WCAT). Following an implementation lengthened by another process of review, the Board provided the worker temporary disability benefits in respect to her chronic pain condition from April 25 to September 29, 2013.

[6] While the worker was involved in the review process described above, on May 30, 2014, her representative requested a reopening of the worker's entitlements under this claim due to a recurrence of her psychological injury. This request referenced psychological evidence from January 2014 stating the worker had suffered from a major depressive episode and Generalized Anxiety Disorder. On May 28, 2015, the Board denied the worker's request. The worker

[1] The worker's permanent award was granted in respect of her chronic pain condition. No permanent award was granted in respect of her aggravated degenerative disc disease at L4-5 or her L4-5 disc herniation.

requested a review of that decision, which was confirmed in *Review Reference #R0194551*. The worker appealed the Review Division decision to WCAT and provided additional evidence that the worker suffered from Major Depressive Disorder but not Generalized Anxiety Disorder.

Preliminary Issue(s)

[7] Upon review of the worker's claim file, I decided that there was a matter that had not been determined by the Board which should have been. Pursuant to section 246(3) of the *Workers Compensation Act* (Act), I asked the Board to consider whether the worker's diagnosed Major Depressive Disorder was a compensable consequence of the injuries previously accepted under the worker's claim. As the worker did not argue for the acceptance of Generalized Anxiety Disorder under her claim, I did not refer that condition to the Board for consideration in the referral I made pursuant to section 246(3) of the Act.

[8] The Board responded to my request on August 18, 2016 and concluded that the worker did not suffer from Major Depressive Disorder in January 2014 and, as such, the condition was not a compensable consequence of the injuries previously accepted under the worker's claim.

Issue(s)

[9] Is the worker's diagnosed Major Depressive Disorder a compensable consequence of the injuries previously accepted under this claim? Is the worker entitled to a reopening of her entitlements under this claim due to a recurrence of or significant change in her previously accepted Depressive Disorder, Not Otherwise Specified?

Jurisdiction and Procedure

[10] Section 239(1) of the Act permits appeals from Review Division decisions to the WCAT, subject to the exceptions set out in section 239(2) of the Act.

[11] WCAT reviews the record from previous proceedings and can hear new evidence. WCAT has inquiry power and the discretion to seek further evidence, although it is not obliged to do so. WCAT may reweigh the evidence and substitute its decision for the appealed decision or order. WCAT may confirm, vary, or cancel the appealed decision or order.

[12] The worker is represented. The employer was invited to participate in the appeal but did not respond to that invitation. The worker's appeal proceeded by way of an oral hearing.

Background and Evidence

[13] The worker testified that, before her accepted injury in October 2008, she worked as a care aide for roughly 17 years. As stated previously, following the worker's compensable injury in October 2008, she was temporarily disabled by her physical injury until October 31, 2009.

[14] As I have previously indicated, the worker developed a Depressive Disorder, Not Otherwise Specified as a compensable consequence of her physical injuries, including chronic low back pain. The worker's psychological injury was temporarily disabling from November 1, 2009 to

February 27, 2011. The Board has determined, in a decision letter subsequently confirmed by the Board's Review Division and by WCAT, that the worker's Depressive Disorder ceased by February 28, 2011.

[15] On February 28, 2011, the worker was assessed by a registered psychologist, Dr. Cheung, who stated the symptoms related to the worker's Depressive Disorder, Not Otherwise Specified were mostly in remission. Those residual symptoms were not considered to present restrictions or limitations with respect to work.

[16] Dr. Cheung stated there was an injury-related component to the worker's depressive symptoms, but there were other factors as well: the worker's disputes with the Board, serious health concerns that her husband had at the time, and the death of her mother.[2] Dr. Cheung noted the worker may relapse into depression if an attempted return to work did not go well. Dr. Cheung also expected that the worker's psychological functioning may deteriorate if her husband's health continued to deteriorate, which it was expected to do.

[17] Dr. Cheung stated the worker's global assessment of functioning was 81 to 90 pre-injury and was then currently 70 to 73.

[18] In the oral hearing, I asked the worker about her assessment by Dr. Cheung. She stated it was difficult to remember but she knew she was trying hard to come out of her depression. She was working to keep her routine at the time.

[19] The worker did not return to work right away after the termination of her temporary disability benefits. According to the worker's representative, the worker's return to work was delayed by her husband's deteriorating health status.[3] On March 28, 2011, the worker saw her regular family physician, Dr. Bitonti, who documented the worker was experiencing clinical depression. The worker was noted to be taking Cipralex following a referral to a psychiatrist.

[20] Dr. Bitoni administered the Patient Health Questionnaire-9 (PHQ-9). The worker scored 22 on that visit, a result indicative of severe depression. The worker described experiencing, nearly every day, little interest or pleasure in doing things; feeling down, depressed, or hopeless; having sleep-related difficulties; and feeling tired or having little energy. She reported experiencing, on most days, having a poor appetite or overeating; feeling bad about herself; having trouble concentrating; and moving or speaking slowly or restlessly. She also reportedly thought of hurting herself or that she would be better off dead on several days.

[21] I asked the worker about her assessment by Dr. Bitonti. She stated she did not remember that meeting specifically but she recalled some days being better than others at the time. She stated she was not very good at answering questionnaires, though she tried her best. When I asked about differences between Dr. Cheung's assessment and the results of the PHQ-9, the worker stated this may have reflected a week-to-week fluctuation in her symptoms.

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[2] Documentation supplied in support of the worker's appeal indicates that the worker's mother died in 2009.

[3] This information is found in page 2 of the worker's representative's submissions to WCAT under a previous appeal, published as *WCAT-2015-00178*.

[22] The worker's husband died in July 2011. The worker began a graduated return to work in October 2011 and resumed her pre-injury job duties in November or December 2011. The worker found her increased physical activity due to work to increase her back pain, however, and she managed by taking sick leave and vacation when her symptoms were particularly bad.

[23] On April 25, 2012, Dr. Bitonti administered the PHQ-9 again. This time, the worker's scores were in keeping with moderately severe depression. All evaluation items reportedly occurred on most days, with the exception of three items: feeling tired or having little energy (which occurred nearly every day), feeling bad about herself (which occurred nearly every day), and thinking of harming herself or that she would be better off dead (which had not occurred at all).

[24] On September 27, 2012, Dr. Bitonti completed a form supplied by the worker's representative. Dr. Bitonti indicated the worker was taking ten-milligram tablets of Cipralex for depression in February 2012. As the worker's depressive symptoms worsened in March 2012, Dr. Bitonti increased the dosage to 20 milligrams.

[25] Where the form queried if the worker had ongoing psychological impairment, Dr. Bitonti stated the worker had poor sleep, decreased energy, low motivation, sadness, minimal social interaction, and difficulties with housework and her job demands due to her physical symptoms. The worker's back pain aggravated her depression, according to Dr. Bitonti, who considered that the worker's psychological condition would persist.

[26] On October 22, 2012, Dr. Bitonti administered the PHQ-9 to the worker, who scored a 19, indicative of moderately severe depression. The worker reported, nearly every day, experiencing little interest or pleasure in doing things; feeling down, depressed, or hopeless; having sleep difficulties; and feeling tired or having little energy. She described experiencing, most days, poor appetite or overeating, trouble concentrating, and movement or speech that was so slow that others noticed or speech or movement in a fidgety or restless way. She described feeling bad about herself on several days. She reported not having thought of harming herself or that she would be better off dead.

[27] According to the worker's representative, by November 2012, the worker described being sadder and suffering from worse self-esteem and a reduced capacity to handle everyday situations, compared with her state in February 2011. The worker described ruminating on interactions that caused her to feel distress, sadness, and feelings of low self-worth. She reportedly found it difficult to sleep at night and had less motivation for and interest in socializing, housework, and other activities.

[28] Dr. Bitonti's chart notes from February 28, 2013 indicate that the worker's mood was better at times although she sometimes missed her medication. Dr. Bitonti administered the PHQ-9. The worker scored a 12, which was indicative of moderate depression.

[29] The worker reported experiencing, nearly every day, sleep difficulties and feeling tired or having little energy. She reported that, on most days, she had little interest or pleasure in doing things and feeling down, depressed, or hopeless. She experienced poor appetite or overeating and having trouble concentrating on several days. She endorsed no other evaluation items on the PHQ-9.

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[30] On March 23, 2013, Dr. Cheung completed a psychological assessment report for the worker.[4] The worker reported that she had been well-prepared for the death of her husband and, while it had been a difficult experience, it did not contribute to any ongoing depression.

[31] The worker stated she experienced times when she stayed in bed, did not eat, and thought too much. Dr. Cheung stated the worker did not provide further details, other than to say these episodes lasted less than one week and first started before she returned to work. The worker denied missing any work due to depression and stated she was taking bupropion and Cipralex to treat her depression, although she could not recall when she started taking bupropion.

[32] The worker stated her mood was "pretty good", without persistent feelings of sadness or depression.[5] She had some diminished interest in previously enjoyed activities, such as socializing. She remained engaged with her children and family. She reported a lack of libido which she related to not having a husband. She denied problems with irritability or anger. The worker described having difficulties with her employer, such as when the worker stated she was having trouble with her workload.

[33] Dr. Cheung diagnosed the worker with Depressive Disorder, Not Otherwise Specified, in remission. Dr. Cheung stated that the worker did not have significant depressive symptoms or any psychological restrictions or limitations. Dr. Cheung expected the worker's medication seemed to be keeping her depression in remission, adding that the worker did not meet the diagnostic criteria for a Depressive Disorder. Further stress and non-clinical levels of depression were expected in response to management issues at work.

[34] Dr. Cheung assessed the worker's global assessment of functioning as "65 to 61".

[35] On or around April 25, 2013, the worker stopped working due to her back pain. The worker filed a new claim for compensation in respect of her symptoms. The worker's claim was ultimately denied; however, information from that claim file has been imported into this claim by the Board and by a previous WCAT panel and that information formed part of the claim file throughout the life of the worker's appeal, including when it was disclosed to the worker and her representative.[6] The previous WCAT panel concluded that the worker experienced a significant change in her chronic pain condition as of April 25, 2013 and was entitled to a reopening of her compensation benefits.

[36] Subsequent to the previous WCAT decision, the Board determined that the worker's increased chronic pain in April 2013 was permanent and precluded the worker from returning to her pre-injury job. The Board has accepted physical limitations related to the worker's pain complaints, including a walking tolerance of ten to 20 minutes, a standing tolerance of 15 to 20 minutes, a static sitting tolerance of ten to 15 minutes, difficulty bending, difficulty crouching, difficulty lifting more than five to six pounds, and difficulty managing stairs.

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[4] Dr. Cheung's report states that the worker was seen on March 16, 2012; however, given the date of the report and the fact that the worker was re-referred to Dr. Cheung on March 1, 2013, the assessment date provided in Dr. Cheung's report seems to be in error.

[5] All quotes are reproduced verbatim, except where otherwise indicated.

[6] See *WCAT-2015-00178*.

[37] In the oral hearing, the worker testified that she last worked in April 2013. She explained that her pain increased at that time and her condition worsened to the point that her ability to manage her activities of daily living and take care of her housework was affected. The worker contrasted her condition before her injury to her condition afterward. The worker stated that, before her injury, she could manage cooking, her housework, a busy social life, and her job demands. As of the time of the oral hearing, she had could manage little of any of that.

[38] The worker testified that working helped her mood, which worsened slowly as it became clearer that she would not be able to persist at work. She stated she was looking for a goal to achieve but had lost a big part of her life, including the progress she had made in her career, her relationships, and her ability to distract herself from her pain.

[39] Dr. Bitonti's chart notes from June 10, 2013 indicate the worker was very stressed about her increased inability to do things. A report Dr. Bitonti submitted to the Board on that date indicated the worker was very distressed by the pain and her inability to do anything. Dr. Bitonti stated the pain was affecting the worker's mood and increasing her stress.

[40] On August 22, 2013, Dr. Bitonti completed a Statement of Disability for a private disability insurer, stating the worker suffered from depression, contributing slightly to her disability. Dr. Bitonti described the worker's prognosis with respect to her depression as good. Dr. Bitonti stated the worker had been suffering from back pain with symptoms radiating into her right leg for months, affecting her personal and social life.

[41] On October 21, 2013, Dr. Bitonti completed a medical report stating the worker suffered from depression secondary to stress and chronic pain. Dr. Bitonti stated the worker was very frustrated by her inability to get better despite taking medications regularly and doing exercises daily. The worker's inability to work also was making her more depressed, according to Dr. Bitonti.

[42] Dr. Bitonti's chart notes from October 30, 2013 indicate the worker was feeling very stressed about her financial situation. The chart notes also refer to depression.

[43] Dr. Bitonti's chart notes from November 27, 2013 indicate the worker was feeling more depressed and frustrated. The worker's pain-related limitations were described, as was her dire financial situation. The worker described feeling down and being unable to sleep at night. Dr. Bitonti stated the worker's depression was aggravated by her financial stress and her pain.

[44] Dr. Bitonti's chart notes from December 17, 2013 state that the worker was having problems with sleep. She lacked energy and had no motivation to push herself to do things. Again, Dr. Bitonti noted the worker's depression was aggravated by her financial situation and her pain.

[45] Dr. Bitonti referred the worker to a psychologist, Dr. Thakur, stating the worker's severe back and leg problems dating back months had greatly impacted her mood. Dr. Bitonti stated the worker's antidepressant regimen of Cipralex and bupropion provided some benefit.

[46] On January 7, 2014, Dr. Thakur assessed the worker and stated she seemed to be quite depressed. She reported having difficulty sleeping and constantly worrying about her future and her finances. The worker stated she felt worse when alone and was preoccupied with her financial concerns and pain. She was withdrawing and isolating herself.

[47] Dr. Thakur stated the worker was unable to work at all and increased the worker's dosage of bupropion but discontinued her Cipralex. Dr. Thakur diagnosed the worker with a major depressive episode, Generalized Anxiety Disorder, and chronic pain. Dr. Thakur stated the worker's "General adaptation functioning [was] 40/50".

[48] On February 4, 2014, Dr. Thakur wrote a letter stating the worker still had crying spells thinking about her late husband.

[49] On February 17, 2014, Dr. Bitonti wrote a letter, stating that the worker had been suffering from depression for some time and this depression was aggravated by her ongoing financial stresses and her pain, which prevented her from doing activities of daily living and left her socially isolated. This isolation further compounded the aggravation of her depression, according to Dr. Bitonti, who also stated the worker was taking medication to treat her depression and was seeing Dr. Thakur.

[50] According to Dr. Bitonti's chart notes from March 21, 2014, the worker was very upset about being refused disability benefits from the Canada Pension Plan. Stress was reportedly making her depression worse as she thought about this constantly. This also aggravated her pain, which further aggravated her depression, according to Dr. Bitonti.

[51] On May 22, 2014, a Claims Review Committee for a private disability insurer met provided a report after meeting with the worker in April 2014. The committee was comprised of three physicians: Dr. Bitonti, Dr. McIlrath, and an orthopaedic surgeon, Dr. Locht.

[52] According to Dr. Locht, who authored the committee's report, the worker reported that her depression started in 2009 and this led to a psychiatric referral and a prescription for Cipralex. Dr. Locht stated that Dr. Bitonti described depressive symptoms in chart notes, starting in March 2012.

[53] Dr. Locht documented that the worker had stated that her depression subsequently improved and her depression did not prevent her from working in 2013.

[54] Nonetheless, Dr. Locht stated the Committee unanimously decided the worker had been totally disabled from her work as a care aide between April 30, 2013 and September 29, 2013 by her clinical depression, which decreased her chronic pain coping abilities and amplified her pain sensitization.

[55] According to Dr. Bitonti's chart notes from June 6, 2014, the worker's depression was aggravated by her financial situation and pain. Dr. Bitonti indicated she was referring the worker to a psychiatrist.

[56] On June 10, 2014, Dr. Bitonti wrote a letter stating that the worker had to stop working as a care aide in April 2013 due to her back and leg pain and due to her depression. Dr. Bitonti noted that

the worker's mental health declined when her pain symptoms became more severe. The worker's worsened mental state led to the increase of her dosage of Cipralex and her referral to Dr. Thakur, who was treating the worker regularly. According to Dr. Bitonti, the worker's worsening depression made her progressively less able to work as a care aide.

[57] On December 15, 2014, a psychologist consultant, Dr. Dorward, reviewed Dr. Cheung's assessments from 2011 and 2013, as well as Dr. Thakur's report from January 7, 2014, and stated there seemed to have been a change in the worker's mental health. Dr. Dorward stated if those pain complaints were accepted as part of her claim, it would be advisable to arrange for psychological assessment to determine the etiology of the worker's psychological condition.

[58] On March 13, 2015, the worker was assessed by a registered psychologist, Dr. Saper. According to Dr. Saper's review of the worker's claim file, the worker developed Major Depressive Disorder, which went into remission by February 27, 2011. Dr. Saper also stated that Dr. Bitonti wrote on February 28, 2013 that the worker's mood was good and her depression was improving and summarized further information from Dr. Bitonti.

[59] Dr. Saper interviewed the worker, who described her history of pain symptoms and her ongoing physical limitations. She described not engaging in social activities and having low energy, a poor appetite, and difficulties with memory and concentration. The worker described being dysphoric for 90 percent of the day and having trouble sleeping due to incessant thoughts. She stated she had no interest in doing things.

[60] The worker also described experiencing episodes of anxiety, featuring an elevated heart rate, sweating, shortness of breath, choking, chills, and hot flashes. She described having those episodes multiple times per day. The worker stated these episodes started years previously and came on gradually, but she could not remember specifically when they started.

[61] With respect to her depressive symptoms, the worker stated they started after her claim was initially denied in 2009, but she could not say when her symptoms worsened and when they improved. She thought her symptoms were better while she was back at work. The worker stated that her pain caused her depression and was adamant that her husband's death did not contribute to her depression.

[62] Dr. Saper administered psychological testing which indicated concentration performance in the low average range. This was likely the lower limit of the worker's concentration ability, Dr. Saper stated. Further testing also suggested the worker was not performing as well as she could and was likely malingering. The validity of the worker's test results generally was suspect. Dr. Saper stated it was virtually impossible to arrive at a clinical diagnosis based on the results of the psychological testing suggestive of likely malingering.

[63] Dr. Saper decided to not administer several psychological tests that might otherwise be indicated because of the linguistic and cultural background of the worker.

[64] Dr. Saper stated that, based on inconsistent responses in the interview and invalid responses on testing, as well as her memory difficulties, it was difficult to establish any recurrence or exacerbation of her psychological injury. Dr. Saper stated that the worker's self-report was

significantly distorted and unreliable. Dr. Saper added that the flat denial that her husband's death had any influence on her mood did not seem to be genuine. Dr. Saper stated no diagnosis could be made.

[65] In the oral hearing, the worker described in detail her emotional state as it related to her husband's death. She stated that her husband suffered for one and a half years after his diagnosis. The worker stated she had time to accept the inevitability of his death before it happened and to be thankful for the time that she was able to spend with him, given the aggressiveness of the condition with which he was afflicted. She stated she came to terms with her husband's death after it happened.

[66] The worker stated she was off work when her husband died. She decided to go back to work in October 2011 because she thought it would be good to regain some normalcy in her life and get back to work. She stated that, although she experienced physical and emotional pain while working, she enjoyed the social aspects of work and this helped her manage.

[67] While the worker stated that she was naturally sad about the passing of her husband, but it did not affect her depression in the same way as the loss of her job did. She stated that, when she lost her job, she lost any semblance at her routine. She pointed out she had used her job to cope with the death of her husband.

[68] The worker added that, as part of her job, she had dealt with death repeatedly. She had come to think of residents as family after spending a lot of time with them. I asked if the worker thought of sadness and depression differently. She said she did not, adding that her sadness about losing her job was much greater than her sadness about losing her husband because she had the chance to come to terms with the latter as her husband's illness progressed.

[69] The worker also testified that she was honest in her assessment with Dr. Saper. She stated she tried to put forth as good an effort as she could with testing, although she described the testing as taking place over a long day. She stated she tried her best but could not even complete the tests administered.

[70] On May 25, 2016, the worker was assessed by a registered psychologist, Dr. Nader.

[71] During the assessment, the worker described her then current stressors as including her late husband's illness and death, her treatment by the Board, her inability to work since 2013 and her associated vocational uncertainty, her financial difficulties, and her ongoing pain.

[72] The worker reported her primary concerns from a psychological/emotional standpoint were low capacity to handle stress, avoidance of problems, forgetfulness, tendency to over-react, and her frustration about her physical limitations. She reported feeling depressed, sad, and empty much of the time. She acknowledged a loss of interest in almost all of her usual activities. She described having trouble sleeping and having little appetite. She stated she had low levels of energy and felt tired all the time. She described having difficulties with concentration and memory. She also stated her thinking was slower and she sought help with decision-making. The worker stated she suffered from reduced self-esteem.

[73] The worker stated that her depressive symptoms first occurred after her claim was terminated by the Board. She acknowledged grieving her husband's death but stated her mood improved when she returned to work. Her mood worsened again after she went off work again, but she could not say when this started. The worker was medicating with bupropion and was not in therapy.

[74] The worker described her physical limitations and stated she had difficulties with interaction due to irritability, low energy, and low motivation. She stated she had difficulty with focus and she lost track of what she was doing. She took frequent breaks from activities due to low energy and fatigue.

[75] Dr. Nader administered psychological testing and stated that results indicated that the worker may have presented herself in an unduly negative light in some areas, resulting in possibly inaccurate test results.

[76] In testing, the worker endorsed high levels of worry, average levels of anger, and depression ranging from mild to high. She endorsed normal levels of anxiety and moderate stress. The worker's responses were indicative of high levels of pain and catastrophizing, as well as high levels of pain-related disability. Her reports of disability were generally at mild to moderate levels. Dr. Nader stated that test results indicated the worker was withdrawn and introverted, with a fixed, negative self-evaluation with associated self-doubt and self-criticism.

[77] According to Dr. Nader, the death of the worker's mother in 2009 added to her depression and sadness, which were already existent following her workplace injury.

[78] Even recognizing the idiosyncrasies in the worker's test results, Dr. Nader diagnosed the worker with Major Depressive Disorder. Dr. Nader noted that the worker had poor recall that made establishment of a timeline difficult; however, given her report and the clinical records he reviewed, he thought this condition onset shortly after the worker stopped working in April 2013. Dr. Nader specified that the only documents he reviewed were from the worker's claim file.

[79] Addressing the etiology of the worker's diagnosed Major Depressive Disorder, Dr. Nader stated that the worker's worsening pain and her associated perceived inability to work were significant factors in maintaining that condition. Dr. Nader acknowledged that other factors, including frustration from dealing with the Board, stress with management at work, and grieving from the loss of her husband, were also contributory.

[80] Dr. Nader addressed the worker's prognosis, offering a guarded one, and described the worker's difficulties with the activities of daily living, sleep, socialization, concentration, persistence, pacing, and stress management. Dr. Nader described several limitations, including an inability to work full-time hours, related to the worker's Major Depressive Disorder. Dr. Nader considered these limitations to be permanent. Dr. Nader also addressed whether the worker could work as a receptionist.

[81] Dr. Nader also addressed Dr. Saper's opinion, pointing out that the symptoms reported by the worker were similar in both cases. Dr. Nader stated it was curious that Dr. Saper did not administer particular psychological tests given that the worker had previously completed the same tests and given her demonstrated reading ability, which exceeded the requirements of useful tests that could have been administered. Furthermore, Dr. Nader found the test Dr. Saper

used to be curious given that there was no indication the worker was exaggerating or misrepresenting her symptoms. Dr. Nader could not comment on the test results Dr. Saper obtained as Dr. Nader did not administer the same test to the worker.

[82] Dr. Nader contrasted his approach with Dr. Saper's. Dr. Nader stated he recognized that there were some concerns with the worker's reporting but he kept those in mind and tried to interpret the results regardless. He stated he was able to do so. By contrast, Dr. Nader stated Dr. Saper rejected the worker's account in total because of test results from the one test he administered, without seeming to attempt to address any inconsistencies.

[83] In the oral hearing, the worker testified that she was honest in her assessment by Dr. Nader and put forward her best effort in testing.

[84] The worker's representative provided to WCAT, in support of the worker's appeal, financial information showing that Dr. Saper received, through his consulting company, PsyCorps, significant payments from the Board between 2009 and 2015. The Board also directly paid Dr. Saper significant amounts between 2011 and 2015. The representative also provided statistical earnings information indicating that psychologists typically earned significantly less than the amount the Board paid to Dr. Saper.

[85] The worker's representative also provided what seemed to be source code from a website attributed to Dr. Saper's consulting company, with some underlining in the document provided to WCAT.[7] The text of the source code reads as follows:

> …Thanks for taking a few minutes of your time to read over this material. I think it will change the way you manage psychological claims. Currently, it may seem to you that disability claims with psychological aspects are difficult to deal with. Psycorps.com Inc. can help make these claims easier to deal with….
>
> First, the assessment service provided by psycorps.com will meet your requirements <I>without need for revisions or clarification. </I> Clarity of these reports is the first and most important benefit we can offer. The psychologists associated with the company are specifically trained to make their reports relevant and clear, and they have an understanding of the specific medicolegal questions that are critically important. This will save you time and energy because it will minimize callbacks for clarification….
>
> Second, the treatment services available through psycorps.com are state-of-the-art, targeted interventions that resolve the problems quickly and efficiently. The course of treatment and expectations will be set out in advance, so that you know what to expect and when. The psychologists associated with psycorps.com have been trained and have experience dealing with the most common disabling psychological conditions. The goal of treatment is to restore function and you can

[7] It is not clear whether the underlining was added by the worker's representative or not.

> count on the psychologists to work with you rather than against you in returning people to productive work….
>
> Third, the referral process is simplified….

[86] On August 7, 2016, a Board psychology advisor, Dr. Louth, reviewed the worker's claim file and stated the worker was not likely experiencing Major Depressive Disorder in March 2015. Dr. Louth stated the worker's symptoms never reached the severity required of that condition following her compensable injury, although the worker likely experienced some mood disorder.

[87] Dr. Louth stated that Dr. Cheung's reports followed standard procedures, were complete and comprehensive, and were persuasive. Dr. Louth stated it was difficult to reconstruct information on the worker's condition after the latter of Dr. Cheung's assessments. Dr. Louth also noted it was more difficult to establish an injury-related etiology for the worker's psychological complaints given that her husband died, she suffered financial hardship, and that she reportedly became depressed when her compensation benefits were terminated.

[88] Dr. Louth noted that the worker's self-reporting to Dr. Bitonti was considerably different than her self-reporting to Dr. Cheung at similar times in her post-injury chronology. Dr. Louth also noted the worker reported inconsistent information about the impact her husband's death had on her mental state at various points. Dr. Louth added that Dr. Saper's assessment was the best measure of the validity of the worker's complaints on the claim file and this assessment, along with the other concerns summarized by Dr. Louth, indicated that the worker's self-reports cannot be considered reliable. Dr. Louth was critical of Dr. Thakur's report because it did not contain validity measures and because it did not contain much detail about the onset and maintenance of symptoms or much depth of analysis in terms of causation.

[89] On December 6, 2016, the worker's son wrote a letter in support of another appeal that was ongoing at that time at WCAT. The letter indicates that the worker faced a very hard time after her workplace injury, suffering an inability to attend to even activities of daily living such as cooking and grocery shopping. The letter goes on to describe the difficulty the worker faced in respect of her pain complaints.

[90] On January 7, 2017, Dr. Nader wrote an opinion after reviewing the psychological opinion of Dr. Louth. Dr. Nader confirmed that he assessed the worker and diagnosed her with Major Depressive Disorder. He stated that Dr. Louth's opinion to the contrary could be explained on the basis that she did not actually assess the worker. Dr. Nader also stated that Dr. Louth seemed to have ignored relevant information supporting a diagnosis of Major Depressive Disorder, including the report of Dr. Thakur and the possibility that the worker's cessation of work in April 2013 could have worsened her psychological condition and resulted in her developing Major Depressive Disorder after Dr. Cheung's assessment in March 2013.

[91] Dr. Nader stated that Dr. Louth's opinion also seemed arbitrary, insofar as she did not find Dr. Thakur's opinion persuasive because of the lack of validity measures, but found Dr. Cheung's opinion to be persuasive despite the lack of validity measures. Dr. Nader also stated that Dr. Thakur's report was not lacking in detail or analysis given its stated intention—to provide diagnostic information and outline a treatment plan for the worker.

[92] Dr. Nader added that, while Dr. Louth relied on Dr. Saper's opinion because of, in part, the validity measures from that report, Dr. Saper's decision to administer the test he did was curious. Dr. Nader stated the test administered by Dr. Saper was designed to assess for feigning cognitive (specifically memory) symptoms. Dr. Nader stated the worker was not complaining of such problems and the test administered by Dr. Saper did not provide a valid measure of global malingering symptoms or of malingering with respect to mood-based symptoms. Dr. Nader noted that neither Dr. Saper nor Dr. Louth seemed to have considered limitations in the validity measure used by Dr. Saper.

[93] Dr. Nader also described it as curious that Dr. Louth would not question why Dr. Saper did not administer other psychological tests to the worker, to measure her depression and emotional difficulties. Dr. Nader noted these tests contained validity measures, as discussed in his earlier report.

[94] Dr. Nader concluded that his approach was different from that of Dr. Saper and Dr. Louth. They rejected the whole of the worker's self report based on the cognitive malingering test administered by Dr. Saper, leaving them with no data from which to arrive at a conclusion from a psychological perspective. Dr. Nader, by contrast, attempted to acknowledge the limits in the data with which he was presented, before trying to use other sources of information, such as the interview, psychometric testing, behavioural observations, clinical records, and psychological research, to arrive at a conclusion.

Submissions

[95] Previously, the worker's representative argued to the Review Division that the worker's depression related to her recurrent disability in 2013. The representative emphasized the worker's treatment records, stating Dr. Saper's report should not be accepted because, despite the fact that much of what the worker reported in her interview with him was truthful, he stated nothing reported during the interview was accurate. The representative stated that Dr. Saper's level of suspicion was inappropriate, particularly given that the worker's self-report of physical symptoms had been accepted as reliable by the Board and WCAT previously. The representative criticized Dr. Saper for not addressing those factors in his report.

[96] Previously, the employer's representative argued that the worker's depressive disorder resolved. The representative referenced Dr. Saper's evidence was then-uncontested expert evidence and should be relied upon in denying the worker's request for a reopening of her entitlement to compensation benefits.

[97] On appeal, the worker's representative argued that the Board's recognition that the worker's chronic pain was permanently worse suggested that her worsened psychological condition was compensable.

[98] The worker's representative argued that the worker's Major Depressive Disorder should be accepted as a result of the worker's increased back pain, which the Board had already found to be permanent. The representative added that the worker did not have the ability to return to work, or even to return to an alternate job that the Board had identified, based on a recent decision of another panel of WCAT.

[99] The worker's representative stated the worker provided good evidence, acknowledging her imperfect recall. The representative argued that work was a major part of the worker's life, based on her testimony, when comparing her pre-2013 and post-2013 life. The representative added that the worker was honest in describing the impact her husband's death had on her. The representative argued that Dr. Saper's interpretation depended on the phrasing of questions he put to her, though that information was unfortunately unavailable. The representative suggested possibilities of what the worker may have said to Dr. Saper and characterized the worker's reaction as typical for one grieving.

[100] The worker's representative argued that I should not consider Dr. Saper's evidence on its merits at all. He stated that there was a reasonable apprehension that Dr. Saper was biased against the worker, given the financial information provided to WCAT. The representative also criticized Dr. Saper for not being independent. The representative referenced comments made by a previous WCAT panel on this point in *WCAT-2016-00651*.

[101] Additionally, the worker's representative pointed me to *WCAT-2016-00563*, an appeal where the psychological opinion of Dr. Saper was considered by an independent health professional commissioned by WCAT. The representative summarized that, in that case, the lack of scoring information provided by Dr. Saper meant that the independent health professional could not assess how he had scored the test results or interpreted the data he obtained. The representative was critical of Dr. Saper for not providing the raw test information in this case.

[102] I pointed out to the worker that some test authors insist that test protocols, including completed tests, not be included with reports. This is, as I understand it, to safeguard the intellectual property of the company that developed the test and to safeguard the test from becoming invalid by having questions and/or solutions publicly-known. I advised the worker that, as I understood it, psychologists and psychiatrists agreed to such requirements and committed to only provide raw test scores and such information to other psychologists and psychiatrists who would be similarly bound by professional ethics to safeguard the test protocols. As such, it was not clear to me that, even if criticism was appropriate where there was a reviewing psychologist or psychiatrist, the same criticism would apply in this case. Here, no one had requested the raw data from Dr. Saper for the purposes of review by another psychologist or psychiatrist. I asked the worker's representative for further submissions on this point and the representative simply acknowledged that I had made a fair point.

[103] The worker's representative argued that, if I decided to consider Dr. Saper's evidence on its merits, Dr. Nader's evidence was preferable to that of Dr. Saper. The representative stated that Dr. Nader's opinion had a strong depth of analysis and also discussed the impact of the worker's return to work and measure of normalcy. The representative also referenced the criticisms Dr. Nader had of Dr. Saper's evidence and noted Dr. Nader carried out multiple relevant tests. The representative summarized that Dr. Nader was able to administer testing without concerns about the worker's English proficiency or cultural factors. The representative queried why Dr. Saper would be concerned over the worker's English proficiency but would not seek an interpreter. The representative also questioned why Dr. Saper administered tests that did not deal with depression, chronic pain, or anxiety. The representative described Dr. Saper's conclusion as advocacy and argued I should not be persuaded by it.

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[104] The worker's representative submitted that I should accept Dr. Nader's evidence, noting that he completed relevant testing without any concern that the worker was malingering. The representative noted that Dr. Nader diagnosed the worker with Major Depressive Disorder and stated the worker's pain was the most significant factor involved in its development.

[105] Insofar as the inconsistencies between the observations of Dr. Cheung and Dr. Bitonti were concerned, the worker's representative argued that the descriptions of the worker's condition offered by herself directly and Dr. Cheung could not be compared directly. The representative noted that Dr. Nader had indicated the worker responded in idiosyncratic ways to test questions, which may have coloured the results of one assessment or the other. The representative suggested that differences in the questions posed of the worker could explain the different interpretations offered by Dr. Cheung and Dr. Bitonti.

[106] The worker's representative argued that Dr. Louth's evidence was based on Dr. Saper's and suffered from the same shortfalls. Furthermore, the representative argued, Dr. Nader addressed the shortcomings in Dr. Louth's report and provided a clear, compelling opinion on the causative significance of the worker's Major Depressive Disorder.

[107] I asked the worker's representative if he wished to raise any argument with respect to the worker's entitlement to a reopening of her entitlements under this claim due to a recurrence of or significant change in her previously accepted Depressive Disorder, Not Otherwise Specified. He stated he did not.

Reasons and Findings

[108] Subject to section 250(4) of the Act, the standard of proof in an appeal is the balance of probabilities. Section 250(4) provides that in a matter involving the compensation of a worker, if the evidence supporting different findings on an issue is evenly weighted, the issue must be resolved in a manner that favours the worker.

[109] Section 250(2) of the Act requires WCAT to apply published policy of the board of directors of the Board, subject to the provisions of section 251 of the Act. The *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) contains the published policy applicable to this appeal. Although the applicable policy in this instance was amended subsequent to the acceptance of the worker's claim, the version of the RSCM II in existence at the time of the worker's injury is applicable in the circumstances of this case.

Is the worker's diagnosed Major Depressive Disorder a compensable consequence of the injuries previously accepted under this claim?

[110] Section 5 of the Act provides that a worker will be eligible for compensation in respect of any injury arising out of and in the course of his or her employment.

[111] Policy item #22.00 of the RSCM II deals with compensable consequences of work injuries. It states that the work injury must be a significant cause of the later injury for it to be accepted under a claim as an injury under section 5 of the Act.

[112] The facts surrounding the progression of the worker's medical condition for several years are not contentious and have been determined by previous decisions of the Board and WCAT. Following the worker's injury in October 2008, she was temporarily disabled by her low back injury until October 2009. After this, the worker was temporarily disabled by her Depressive Disorder, Not Otherwise Specified until February 27, 2011. After that date, her temporary disability resolved.

[113] The worker remained off work despite not being disabled by any compensable condition from February 2011 to October 2011. In the first two months of this period, the worker displayed variable levels of psychological symptoms. According to Dr. Cheung, the worker experienced non-limiting depression symptoms, mostly in remission. These symptoms were partly related to her compensable back injury and partly to other factors; however, it was significant that Dr. Cheung noted the worker's continuing well-being would be expected to deteriorate with worsening of her husband's health condition and/or if her return to work did not go well. The worker's condition at the time was indicated by the decrease in her global assessment of functioning, from 81 to 90 before her injury to 70 to 73 when her Depressive Disorder, Not Otherwise Specified resolved in February 2011.

[114] Following Dr. Cheung's assessment, the health of the worker's husband continued to deteriorate and the worker's psychological condition worsened. By the end of March 2011, Dr. Bitonti had administered psychological testing that indicated the worker was suffering from severe depression.

[115] I am cautious in relying much on Dr. Bitonti's opinion, insofar as it is based on the administration of the PHQ-9. The use of a questionnaire on mental health issues is no substitute for a detailed assessment by a trained psychologist or psychiatrist. In the case of assessment by a psychologist or psychiatrist, there is a greater level of detail, more time spent with the patient, the possibility of psychological tests that include validity measures being administered, and a greater degree of experience dealing with mental health concerns. Additionally, the worker stated she had difficulties completing questionnaires like the PHQ-9. As she pointed out, they were not clear in describing the time period to be considered in answering test questions.

[116] Even considering Dr. Bitonti's evidence from March 2011 cautiously, however, I am satisfied that the worker experienced some worsening of her psychological condition. It is unclear whether this could be related to any compensable factors, but the results of the PHQ-9 described symptoms that exceeded those described by Dr. Cheung in February 2011.

[117] According to the worker, following the death of her husband in July 2011, her symptoms did not significantly worsen. She described this in detail during the oral hearing, stating that she was accustomed to death as a result of her vocational history and had time during her husband's illness to come to terms with his impending death. She also stated that she returned to work within two months and found that to be helpful by providing her with social contact, routine, and normalcy.

[118] While Dr. Saper thought this was an implausible reaction to the death of the worker's husband, I disagree. Dr. Saper did not provide a detailed basis for that conclusion. As such, I am uncertain if this conclusion as to the worker's credibility hinged on any psychological expertise on the part of Dr. Saper or on an assessment of the worker's credibility in the context of her discussion of

the impact her husband's death had on her. I am unwilling to infer that Dr. Saper's opinion on this point was based on psychological expertise but, in any case, I do not consider a blanket proposition that anyone would suffer a particular degree of impact from the death of his or her spouse to be established in the evidence or in Dr. Saper's opinion.

[119] In this case, the worker provided a persuasive explanation for why the impact of her husband's death was significantly less than the impact of her loss of work. In the case of the former, she had her work routine and the supportive interactions there to mitigate her loss. In the case of the later, she had already lost her spouse and had fewer supportive relationships with which to manage the loss of her ability to work. I found her explanation on this point to be credible.

[120] The test for credibility is laid out well in *Faryna v. Chorny*, [1952] 2 D.L.R. 354 (B.C.C.A.). In that decision, the court states that the test of the truth of a witness's statement is its "…harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions." All that is required to establish the worker's credibility is that what she described is likely to be reasonable in all the circumstances of her case, when viewed from an informed and practical perspective. It does not require that I consider her reaction to be the most likely reaction or even a reaction I would consider typical of the population or some segment thereof. One must be vigilant against imposing the values or expectations of one's own experience unduly on another when assessing their credibility. It is based on this measure that I found the worker's testimony to be credible and Dr. Saper's assessment of the plausibility of the worker's reaction to the death of her husband to be explained insufficiently and so be non-persuasive.

[121] While the worker continued to work, she repeatedly saw Dr. Bitonti due to her depression. Dr. Bitonti prescribed the worker anti-depressant medication in February 2012 and increased the dosage in March 2012. Dr. Bitonti administered the PHQ-9 several times and, while I am cautious in relying on the PHQ-9, the results indicated some level of depressive symptoms in April and October 2012. According to the worker's representative, the worker had described worsened depressive symptoms relative to her condition as it was when her temporary disability ceased in February 2011. This evidence points to the worker's depressive symptoms worsening to some extent in the months following her return to work but stabilizing at a non-disabling intensity for nearly one year.

[122] While Dr. Bitonti administered the PHQ-9 again in February 2013, obtaining results suggestive of moderate depression, I do not put a great deal of weight on that conclusion for the reasons I have already identified. While I accept the value of the PHQ-9 as a screener tool for depression, I do not consider the results it produces to be sufficiently reliable to distinguish between moderate and moderately severe symptoms. I find it sufficient to conclude that the worker continued to experience some level of depressive symptomology in February 2013.

[123] I place more weight on Dr. Cheung's report from March 2013, which provided a summary of the worker's circumstances that is consistent with the facts of the case as I have accepted them thus far. Dr. Cheung provided a detailed, expert analysis of the worker's circumstances, concluding that the worker continued to experience depressive symptoms that were present at a level too mild to warrant a psychological diagnosis of depression. I find Dr. Cheung's analysis to be compelling and I accept that conclusion. Dr. Cheung's assessment of the worker's global assessment of functioning at 61 to 65 supports that the worker's condition was slightly worse

than it was when Dr. Cheung assessed the worker previously, even if her depressive symptomology remained under the threshold required to give rise to a diagnosable and active psychological condition.

[124] The worker's medical condition changed significantly in April 2013, as has already been decided by a previous WCAT panel and as implemented by the Board. The worker's chronic pain condition became permanently more severe in that month and imposed additional limitations on the worker's ability to function, such that she could not continue in the job she had been doing.

[125] The worker testified that this negatively impacted her mood. She explained this convincingly in the oral hearing and, given that her previous psychological depression had been caused by, among other factors, her chronic pain, it is not altogether unexpected that worsened chronic pain would precipitate a worsened state of depression. I also note that Dr. Cheung expected the worker's psychological state would worsen with the failure of her return to work.

[126] Dr. Bitonti's treatment of the worker changed, consistent with a change in the worker's presentation. Whereas, while the worker was working, Dr. Bitonti prescribed medications and administered questionnaires from time to time, after the worker ceased working, Dr. Bitonti advised the Board that the worker was in increasing distress. By August 2013, Dr. Bitonti stated that the worker's depression was contributing to her inability to work and referenced the worker's underlying back pain. In October 2013, Dr. Bitonti indicated that both the worker's chronic pain and her inability to work were contributing to her depression. Dr. Bitonti stated that the worker's depression continued to worsen in November 2013, noting again that her depression was aggravated by her financial stress—a result of her disability—and her pain. Finally, Dr. Bitonti referred the worker to Dr. Thakur due to the impact the worker's back and leg problems had on her mood.

[127] While I am cautious in inferring a great deal from Dr. Bitonti's treatment of the worker, I am satisfied that Dr. Bitonti observed steadily declining psychological function on the part of the worker. Following the worker's cessation of work in April 2013, Dr. Bitonti observed the worker's depressive symptoms increasing until they started to contribute to her disability and then to the point where a psychological referral was indicated. Dr. Bitonti's records establish to my satisfaction that the worker consistently reported some underlying contribution of back pain and back pain-related disability to her worsening condition over that time.

[128] Dr. Thakur's assessment of the worker was likewise consistent with the worker's worsened condition, when compared to her psychological state when Dr. Cheung assessed her in March 2013. I agree with the worker's representative that it is important to bear in mind the purpose(s) behind Dr. Thakur's assessment. His narrative described significant depression with roots in the worker's pain and her financial condition, which itself was a result of her disabling chronic pain. Dr. Thakur described the worker as totally psychologically disabled and adjusted her medications. He made some psychological diagnoses without the benefit of psychological testing and described the worker's "general adaptation functioning" as between 40 and 50.

[129] I have several concerns with Dr. Thakur's report. He did not seem to have had much clinical experience with the worker and, as I have said, he did not administer psychological testing. As has been noted, there is some question about the conclusions he reached without the benefit of any validity measures in his assessment of the worker's condition. Furthermore, Dr. Thakur's

diagnoses were made under a multi-axial system, suggesting the use of the then-outdated *Diagnostic and Statistical Manual-IV* (DSM IV) of the American Psychological Association, rather than the then-current *Diagnostic and Statistical Manual-5* (DSM-5). The DSM IV incorporated, as its fifth axis, the global assessment of function; however, Dr. Thakur described the fifth axis of his diagnosis as being a "general adaptation functioning" between 40 and 50.

[130] Overall, I give Dr. Thakur's evidence little weight; however, it supports my impressions of the worker's declining psychological condition over 2013 both due to the qualitative account provided by Dr. Thakur and what seems to be a global assessment of function score of 40 to 50, further reduced from the score Dr. Cheung recorded before the worker's chronic pain condition significantly worsened in April 2013.

[131] That Dr. Thakur documented the worker was still having crying spells about the death of her husband is not, in my view, inconsistent with the worker's testimony that her husband's death did not significantly worsen her depressive symptoms. I am mindful that correlated symptoms do not speak to the question of causation. As such, I am uncertain whether the worker's crying spells about her husband's death were a reflection of her worsening depression following the aggravation of her chronic pain condition or indicative of her husband's death contributing to her psychological state. I am unwilling to speculate on this point and leave the question of the impact of the death of the worker's husband to be discussed by the psychologists who assessed the worker.

[132] In the months that followed Dr. Thakur's assessment, Dr. Bitonti's treatment records continued to indicate that the worker's depression was worsening. By May 2014, three physicians, admittedly without any apparent expertise in psychology or psychiatry, considered the worker to be totally disabled by her depressive symptoms. While I am cautious in accepting evidence from medical physicians without expertise in mental health on this point, I nonetheless consider this evidence to be consistent with the documentation present throughout 2013 and 2014 that indicates the worker's depression was worsening and that she was reporting this stemmed from her aggravated chronic back pain and her associated disability, at least in part.

[133] My findings with respect to the worker's condition up to and including 2014 are important to stipulate before addressing the psychological evidence that is central to the disposition of this appeal. My impressions from a lay perspective, that the worker's depression seemed to be worsen following the worker's cessation of work in April 2013 and throughout 2013 and 2014, are consistent with the opinion offered by Dr. Dorward on December 15, 2014. Given that the worker's aggravated pain complaints have been accepted as part of the worker's claim, a more detailed assessment of the worker's psychological condition is warranted.

[134] This leads me first to Dr. Saper's evidence. The worker's representative argued that I should not even consider that evidence on its merits, advancing two arguments on that point.

[135] The easier argument to respond to was that Dr. Saper was not independent. It is true that, in some cases, WCAT retains independent health professionals to assist in the disposition of appeals. This process is set out in section 249 of the Act. Subsection (2) stipulates that any health professionals retained for this purpose must be independent.

[136] It follows that WCAT has selection criteria for the health professionals, including psychologists, whose services are secured under section 249 of the Act. These selection criteria include determining whether the health professionals are sufficiently financially independent from the Board to satisfy the requirement of section 249(2) of the Act.

[137] Outside of the process described in section 249 of the Act, there is no requirement for experts to be independent in order to have their evidence considered. Routinely, WCAT relies on evidence from health professionals either in the employ of the Board or who have treated the worker. Neither is independent, yet both can provide valuable expert evidence of assistance to panels in deciding appeals. As such, a lack of independence is, on its own, no reason to exclude expert evidence.

[138] The second argument made by the worker's representative is that I should not consider Dr. Saper's evidence because there is a reasonable apprehension that he is biased against the worker. The representative did not refer to any previous dealings between the worker and Dr. Saper or any individual concerns. Rather, the representative referenced Dr. Saper's earnings from the Board, suggesting some perception of a systemic bias, and excerpts from a website advertising Dr. Saper's services.

[139] The comments made by the previous panel, to which the worker's representative referred me were these, found at paragraphs 74, 75, and 77 of *WCAT-2016-00651*:

> Dr. Saper clearly took issue with the worker's credibility. Dr. Saper used words such as:
>
> - "...did not enhance his credibility"
> - "..did not reassure the writer that his verbal report of symptoms could be trusted"
> - "...as there is no credible evidence on which to base a diagnosis"
> - "...there was objective evidence of significant distortion in the worker's self report"
> - "...[w]hen challenged, he did not offer any satisfactory explanation as to why his self-report was at variance with the written record..."
>
> The use of these words suggest, in my opinion, that Dr. Saper was acting more as an advocate despite his acknowledgment that he had a duty to be impartial and not act as an advocate.
>
> …
>
> These issues and the fact that Dr. Saper did not administer testing for the mental conditions in question is the basis for my conclusion to place little weight on his opinion. While it may be that Dr. Saper is biased against the worker in his opinion, I find the main fault in his opinion lies in the fact he did not perform a thorough assessment and his opinion is unreliable as a result.

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[140] I do not read the previous panel's comments as making any finding that Dr. Saper was biased against the worker in that case. To my view, the panel explained that she would not address the argument raised in that case that Dr. Saper was biased due to other deficiencies in Dr. Saper's opinion before her. I am aware that the worker's representative has expressed similar concerns about Dr. Saper's assessment of the worker's credibility, arguing the testing he administered was inadequate; however, those are arguments that go to the weight of Dr. Saper's evidence. I will consider them if I proceed to consider Dr. Saper's opinion on its merits.

[141] I do not consider the earnings Dr. Saper received from the Board to be indicative of bias. As I discussed with the worker's representative in the oral hearing, to establish that there was systemic bias related to the earnings Dr. Saper realized from the Board, Dr. Saper would have to think that his earnings would be reduced or eliminated if he produced opinions in favour of workers.

[142] I asked the worker's representative where his evidence was that the Board had any interest in denying claims or denying coverage for particular conditions. The representative pointed out that he did not need to establish the Board was so inclined, merely that Dr. Saper thought it was. I asked the worker where his evidence was of such a belief on the part of Dr. Saper and the representative responded that he had none.

[143] Given that I have noticed similar arguments being advanced in multiple appeals by the law firm of which the worker's representative is a part, I consider it important to discuss this allegation of bias in more detail. The worker's representative walked a fine line just short of accusing the Board of being interested in the denial of conditions that might be compensable, at least in the context of cases referred to Dr. Saper. This not only impugns Dr. Saper's professional ethics but casts doubt on the Board's administration of one of its core functions, which is to provide compensation for workers that have suffered injuries, occupational diseases, and other work-related conditions.

[144] The representative's allegation of a reasonable apprehension of bias against Dr. Saper based on the website advertising his services is likewise insufficient. The representative did not reference any portions of the source code provided to me in specific, leaving me to guess what portions were illustrative of the bias he alleged to be present in this case.

[145] In the whole of the source code provided to me, I did not see sufficient reason to be concerned that there was a reasonable apprehension of bias on the part of Dr. Saper. The website advertised that reports would be clearly-written, without the need for clarification or revisions. This does not suggest that the substance of the report was determined by the party who retained Dr. Saper.

[146] The website also advertised that state-of-the-art services would provide maximally effective treatment with an aim of restoring function and returning psychologically injured workers to work. This speaks to the efficacy of treatment, not to the provision of expert reports. I find it hard to understand how someone could consider that advertising treatment as effective to return people to useful work gives rise to a reasonable apprehension of bias against workers with psychological injuries. This should be, where possible, the goal of treatment for psychologically disabled worker.

[147] I likewise do not understand how a simplified referral process to other providers could have caused the worker's representative any reasonable concern about Dr. Saper's impartiality. In all, I found the evidence presented to support a finding that there was a reasonable apprehension that Dr. Saper was biased against the worker to fall markedly short of its intended effect.

[148] I consider it would be advisable for the worker's representative and others thinking of making similar arguments to reflect on the seriousness of the accusations they are making before making them with such scant evidence in support of their arguments. I am reminded of the comments of the British Columbia Court of Appeal in *Lorna Adams v. Workers' Compensation Board*, [1989] 42 B.C.L.R. (2d) 228, where the court stated ably:

> This case is an exemplification of what appears to have become general and common practice; that of accusing persons vested with the authority to decide rights of parties of bias or reasonable apprehension of it without any extrinsic evidence to support the allegation. It is a practice which, in my opinion, is to be discouraged. An accusation of that nature is an adverse imputation on the integrity of the person against whom it is made. The sting and the doubt about integrity lingers even when the allegation is rejected. It is the kind of allegation easily made but impossible to refute except by a general denial. It ought not to be made unless supported by sufficient evidence to demonstrate that, to a reasonable person, there is a sound basis for apprehending that the person against whom it is made will not bring an impartial mind to bear upon the cause. As I have said earlier, and on other occasions, suspicion is not enough.

[149] I also recognize that the worker's representative argued that Dr. Saper acted improperly by not providing raw data along with his report, referencing *WCAT-2016-00563*. I have already outlined my response to that argument: that I understood Dr. Saper may be precluded from providing such raw data with his report, other than for the purposes of review by another psychologist or a psychiatrist, where confidentiality of test materials could be safeguarded. The worker's representative seemed to have abandoned this element of his argument in light of my response. Regardless, I am not persuaded by this argument for the reasons I have already provided—namely that insufficient evidence has been provided to establish that Dr. Saper did anything wrong in not including raw test scores with his report in the circumstances of this case, as distinct from the situation in *WCAT-2016-00563*.

[150] Having concluded that I should weigh Dr. Saper's evidence on its merits, I turn to consider that evidence. I have several concerns where Dr. Saper's evidence is concerned, each of which impacts the weight I give to his evidence.

[151] First, Dr. Saper misidentified the psychological condition previously accepted under this claim as Major Depressive Disorder, when it was Depressive Disorder, Not Otherwise Specified. This may seem like a minor concern but it goes beyond semantics—the two conditions have different requirements insofar as the degree of depressive symptoms is concerned. Dr. Saper's misunderstanding of the worker's previously-accepted condition signals a misunderstanding about the degree to which she was symptomatic before that condition went into remission in February 2011.

[152] Second, as I have already said, Dr. Saper seems to have made credibility findings insofar as the worker's response to the death of her husband was concerned and those findings are different from those I have made. This signals that Dr. Saper may have based his assessment on facts other than those I have accepted. As Dr. Saper did not provide a very detailed assessment of the worker's credibility, I am uncertain to what degree this would have tainted his conclusion.

[153] Third, Dr. Saper elected not to administer several psychological tests that otherwise would have been indicated, referencing concerns over the worker's linguistic and cultural background. Dr. Nader stated the worker's English fluency was sufficient and provided a detailed discussion on the point, referencing the worker's reading ability and demonstrated ability to complete psychological testing previously. Dr. Nader's explanation was much more detailed and convincing than was Dr. Saper's explanation. This leads me to conclude that Dr. Saper incorrectly considered the worker's linguistic background to prohibit the use of psychological tests that may have otherwise been relevant.

[154] Additionally, I am left to wonder why the worker's cultural background would have rendered a variety of tests unsuitable, according to Dr. Saper. It may be that this related to the lack of normative data for scoring purposes from specific cultural group, but I am left to wonder. Without further detail, I am uncertain if Dr. Saper appropriately declined to do tests based on the worker's cultural background. I note that Dr. Nader administered other relevant tests, however, and Dr. Cheung did not seem to consider the worker's cultural background to preclude the administration of relevant psychological tests.

[155] Given these circumstances and the lack of detail Dr. Saper provided with respect to his decision to not administer further psychological testing, I am concerned that he incorrectly decided to not administer testing that he could have provided. This affects the weight I give to his report.

[156] While Dr. Nader criticized Dr. Saper's selection of the psychological test he did administer, I do not share that concern. Dr. Nader asserted that the worker did not report any impairment of her memory to Dr. Saper, yet his summary of his interview with the worker establishes that she did. Additionally, while Dr. Nader stated there was no indication that the worker was exaggerating her symptoms, Dr. Saper documented that he thought she did so in the interview. I therefore do not consider it inappropriate for Dr. Saper to have used the psychological test that he did to assess the veracity of the worker's complaints.

[157] I agree with Dr. Nader that it is important to bear in mind the limitations in the validity measures incorporated into the tests administered. In the case of Dr. Saper's assessment, his test results suggest that the worker exaggerated her symptoms of impaired memory. I am willing to accept that she did so. As Dr. Nader explained so clearly, however, this is an insufficient basis to discard all the information she provided, particularly given that Dr. Saper was critical of areas of credibility that I consider the worker to have provided truthful information on and the fact that Dr. Saper may have ignored relevant tests with additional validity measures without good reason. As a result, I give Dr. Saper's evidence little weight.

[158] I turn to consider the evidence of Dr. Nader, which I found to be much more convincing. Dr. Nader administered a variety of psychological tests with their own validity measures. These tests assessed the worker's presentation in a variety of ways and captured that the worker may have presented herself in an unduly negative light.

[159] This does not mean that the worker did not have a diagnosable psychological condition; rather, the worker's potentially inaccurate presentation is one factor Dr. Nader needed to keep in mind when applying his expertise to determine whether the worker had a diagnosable psychological condition related to her compensable physical injuries, and in particular her chronic pain condition.

[160] Dr. Nader addressed the concerns he identified with respect to the worker's presentation, particularly insofar as her possible magnification of symptoms and her inability to recall a specific timeline was concerned; however, there was a lengthy and fairly detailed documentary record to assist. I have already summarized that documentary record, which Dr. Nader used to supplement his reasoning. I found Dr. Nader's methodology to be convincing and I consider the assumptions underlying his opinion to be consistent with my factual findings in this case.

[161] I am satisfied that Dr. Nader adequately addressed my concerns with respect to the worker's presentation. I recognize Dr. Nader's expertise as a psychologist as well as the significant depth of analysis in his well-reasoned and detailed opinion. I give Dr. Nader's expert evidence significant weight and conclude that the worker developed Major Depressive Disorder shortly after she stopped working in April 2013 due to a variety of factors, including the significant worsening in her compensable chronic pain and the increase in her associated impairment.

[162] I recognize that Dr. Louth provided a contrary opinion. This opinion suffers from a significant limitation, however, insofar as Dr. Louth did not assess the worker directly and has addressed the issue of diagnosis.

[163] Insofar as Dr. Louth's criticism of Dr. Nader's evidence is concerned, I appreciate that it was relatively difficult to reconstruct information on the worker's condition after the latter of Dr. Cheung's assessments. Despite this, however, I am satisfied that the documents in the worker's claim file provide sufficient information to do so, even with the worker's limited recall.

[164] I also recognize that there were several non-claim related factors involved in the worker's psychological condition in 2013 and beyond, including the death or her husband and mother and the financial implications of her claim initially being denied. After reviewing Dr. Nader's report, however, I am satisfied that he was aware of those complications and addressed them in his reasoning.

[165] I have already addressed the distinctions between what the worker described to Dr. Cheung and to Dr. Bitonti. I have said that I give the assessments of Dr. Bitonti relatively little weight and note that the worker's situation at the time was dynamic, particularly insofar as the deteriorating health of her husband was concerned, a circumstance Dr. Cheung predicted would exacerbate the worker's depression. As the worker explained in the oral hearing and at several points during the life of her claim, she dealt with her grief surrounding the impending loss of her husband in advance, during the time he struggled with his terminal illness, yet she made clear in the oral hearing that she still grieved after his death.

[166] I agree with Dr. Nader that Dr. Louth did not adequately address the permanent worsening of the worker's chronic pain condition in April 2013 and did not adequately explain why the lack of

validity measures was a concern insofar as Dr. Thakur's evidence was concerned but not insofar as Dr. Cheung's evidence was concerned. For these reasons, I give Dr. Louth's evidence little weight.

[167] I disagree with Dr. Louth that Dr. Saper's assessment is the best measure of the validity of the worker's complaints for the reasons I have already provided. I agree with Dr. Louth that Dr. Thakur's report does not warrant significant weight for the purposes of deciding the issue under appeal; however, unlike Dr. Louth, I considered Dr. Nader's evidence to be the most persuasive.

[168] I have concluded that the worker's diagnosed Major Depressive Disorder is a compensable consequence of her accepted chronic pain condition, which worsened in April 2013. I allow the worker's appeal on this issue.

Is the worker entitled to a reopening of her entitlements under this claim due to a recurrence of or significant change in her previously accepted Depressive Disorder, Not Otherwise Specified?

[169] Section 96(2) of the Act permits the Board to reopen a matter that has been previously decided by the Board where there has been a significant change in a worker's medical condition that the Board has previously decided was compensable, or a recurrence of the worker's injury.

[170] Policy item #C14-102.01 of the RSCM II echoes the requirements of section 96(2) of the Act, adding that a significant change "...means a change in the worker's physical or psychological condition. It does not mean a change in the Board's knowledge about the worker's medical condition." The policy adds that a change is considered significant where it would, on its face, warrant consideration of a change in compensation or rehabilitation benefits or services for the worker.

[171] Policy item #C14-102.01 also explains what is meant by a recurrence, under section 96(2) of the Act. The policy states that a recurrence refers to the original injury appearing again without any intervening incident.

[172] The first indication that the worker suffered recurrent disability after February 2011 came in April 2013, when the worker ceased working, at least in part due to her chronic pain condition. From then onward, the worker was not diagnosed with Depressive Disorder, Not Otherwise Specified. I have accepted Dr. Nader's opinion that the worker developed Major Depressive Disorder soon after she ceased work in April 2013.

[173] As a result, any change in the worker's psychological condition after April 2013 was not attributable to a recurrence of or significant change in her previously accepted Depressive Disorder, Not Otherwise Specified, but rather to the Major Depressive Disorder I have accepted under this claim as a compensable consequence of the worker's chronic pain condition, worsened in April 2013.

[174] I deny the worker's appeal on this issue.

Expenses

[175] The worker requested reimbursement of the expenses she incurred to obtain Dr. Nader's evidence. In considering the worker's request, I find guidance from the WCAT *Manual of Rules of Practice and Procedure* (MRPP) to be helpful.

[176] Dr. Nader's evidence from June 2016 had an associated invoice amount of $3,281.25. Dr. Nader's evidence from January 2017 had an associated invoice amount of $556.50.

[177] Item #16.1.3 of the MRPP states that expenses for evidence will generally be reimbursed where the evidence is useful or helpful to the panel, or where it was reasonable for the party to have sought such evidence in connection with the appeal. Dr. Nader's evidence provided evidence with respect to issue under appeal. I therefore consider that it was reasonable for the worker to have obtained this evidence.

[178] Item #16.1.3.1 of the MRPP provides that reimbursement of a worker's expenses incurred in obtaining expert documentary evidence will be normally limited to the amount paid by the Board in respect of that evidence, as set out in fee schedules.

[179] The standard rate fee schedule the Board has for psychologists addresses the creation of psychology assessments and reports. The schedule calls for payment of $180 per hour, to a maximum of 12 hours. This corresponds with a maximum of $2,160.00. The standard rate fee schedule the Board has for psychologists also addresses supplemental reports, with a corresponding maximum of $325.00.

[180] The worker's representative argued that I should order the reimbursement of Dr. Nader's evidence from June 2016 in full, stating that Dr. Nader's hourly rate was appropriate given his expertise. The representative argued that the worker, as a privately-contracting party, did not have access to the preferential rate secured by the Board in its fee agreement. The representative also stated that Dr. Nader spent a reasonable amount of time on a complex file with a lengthy history and that, accordingly, the invoiced amount associated with his evidence should be reimbursed.

[181] I pointed out to the worker's representative that I had two major concerns with reimbursing above the Board's fee agreement with respect to Dr. Nader's evidence from June 2016.

[182] The first issue I identified was that Dr. Nader's report extended beyond the issued under appeal and seemed to reflect an attempt to cover other issues that the Board would need to consider in implementing a previous decision by WCAT in the worker's favour. The worker's representative agreed that there was a forward-looking component to obtaining Dr. Nader's evidence, but argued that it was most efficient to obtain one larger report, rather than two smaller reports. The representative added that obtaining this information early in the adjudication process may obviate the need for further appeals.

[183] The second issue I identified was that, in the letter soliciting Dr. Nader's opinions, the worker's former representative indicated that he would pay for the invoiced amount without referencing

the applicable Board fee schedule or the fact that WCAT tried to hold to it.[8] I advised the representative at the oral hearing that I was not inclined to exercise my discretion in favour of exceeding the tariff where it seemed no effort was made to adhere to the tariff.

[184] The worker's representative asked for one week to see if there were any other communications between the previous representative and Dr. Nader. I agreed to provide the representative with this time and he committed to send anything relevant to my attention within one week of the oral hearing. The representative did not provide anything further after the oral hearing.

[185] I do not consider it appropriate to order reimbursement in excess of the relevant fee codes. Section 7 of the Act's *Appeal Regulation* permits WCAT to order reimbursement for appeal expenses, not for expenditures that aid in the adjudication of other matters or in the efficient conduct of a worker's claim. Additionally, the representative who solicited Dr. Nader's opinions did not make any apparent effort to inform Dr. Nader about WCAT's usual practice of limiting reimbursement to the typical amount of the Board's fee codes. The representative did not seem to make any effort to conform expenses to that usual practice. For those reasons, I do not consider it appropriate to exercise my discretion in favour of reimbursement above the fee code amount. Either reason would be dispositive of the issue of quantum of reimbursement.

Conclusion

[186] I allow the worker's appeal.

[187] I vary the Board's determination letter of August 18, 2016 and find that the worker's diagnosed Major Depressive Disorder is a compensable consequence of the injuries previously accepted under this claim.

[188] I confirm *Review Reference #R0194553* and find that the worker is not entitled to a reopening of her entitlement to compensation benefits due to a recurrence of her accepted psychological injury as of January 2014.

[189] I order the Board to reimburse the worker $2,485.00 for the reasons provided above.

Darrell LeHouillier
Vice Chair

[8] The worker's representative at the oral hearing was from the same organization as her former representative, who wrote the letter soliciting Dr. Nader's opinion. Although the two worked in the same organization, the two were, in fact, different individuals.

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