BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LALETTA L. BENNER, Claimant, v. THE HOME DEPOT, INC., Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	**IC 2005-004849** **IC 2005-006656** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed January 9, 2013**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Industrial Commission assigned the above-entitled matter to Referee Douglas A. Donohue, who conducted a hearing in Boise on October 7, 2011. Claimant was represented by Hugh Mossman. Defendants were represented by W. Scott Wigle. The parties presented oral and documentary evidence. Post-hearing depositions were taken, and the parties submitted post-hearing briefs. The matter came under advisement on March 21, 2012. It is now ready for decision. The undersigned Commissioners[1] have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law, and order.

ISSUES

By agreement of the parties at hearing, the issues to be decided are:

1. Whether the condition for which Claimant seeks benefits was caused by the alleged industrial accident;
2. Whether and to what extent Claimant is entitled to:
    a. Permanent partial impairment (PPI);

[1] Chairman Thomas P. Baskin recused himself from this case, as he represented Defendants prior to becoming a commissioner.

b. Permanent disability in excess of impairment, including total permanent disability,
c. Medical care, and
d. Attorney fees; and

3. Whether apportionment of permanent disability for a preexisting condition pursuant to Idaho Code § 72-406 is appropriate.

CONTENTIONS OF THE PARTIES

It is undisputed that Claimant injured her low back in two industrial accidents that occurred on April 4, 2005 and June 1, 2005. Defendants accepted the claim but now dispute the extent of their liability.

Claimant contends that she suffered psychological as well as physical injuries as a result of the second accident. Her psychological and physical injuries have combined to render her totally and permanently disabled. Even if her psychological injuries are not compensable, she is nevertheless entitled to permanent disability over and above impairment. Apportionment pursuant to Idaho Code § 72-406 would be inappropriate, because there is no evidence that Claimant suffered a preexisting physical impairment.

Defendants contend that they have paid all benefits due to Claimant, including 19% whole person PPI. Claimant's psychological conditions are not compensable pursuant to Idaho Code § 72-451. In the event that Claimant's psychological conditions are compensable, she is not totally and permanently disabled. Claimant has suffered minimal disability in excess of impairment.

EVIDENCE CONSIDERED

The record in this matter consists of:

1. The testimony of Claimant and Claimant's husband, Archie Benner, taken at hearing;

2. Joint exhibits A-K admitted at hearing;

3. The post-hearing depositions of Camille LaCroix, M.D., and Michael McClay, Ph.D., and

4. The Industrial Commission legal file pertaining to this claim.

After having considered the above evidence and the briefs of the parties, the Commissioners issue the following findings of fact and conclusions of law.

FINDINGS OF FACT

Background

1. Claimant was born on April 28, 1964. She was 47 years old at the time of hearing and is now 48. She resides in Pocatello with her husband, Archie Benner. Claimant has two adult children, Tiera and Clifford, from a previous marriage, as well as two adult stepchildren with Mr. Benner. Additionally, Claimant and Mr. Benner are the legal guardians of a ten-year-old girl, Arianna. Arianna is the daughter of a family friend who surrendered custody of Arianna after being sentenced to prison.

2. Claimant grew up in Oregon. Prior to Claimant's birth, Claimant's mother had an affair with a neighbor, Bob B., who is Claimant's biological father. Claimant believed that her mother's husband, Bob W., was her father until she discovered her true parentage at the age of 24.

3. Claimant's childhood and adolescence were turbulent and sometimes traumatic. Her mother and Bob W. were verbally, emotionally, and physically abusive. As a child, Claimant felt "forgotten, different, and unimportant." Ex. D1, p. 48. She struggled with feelings of depression and worthlessness. Around the age of five, Claimant was molested by a neighbor; later, at the age of 12 or 14,[2] she was raped three times by another neighbor.

4. Claimant began to use tobacco, alcohol, and illegal drugs in her early teens. By

[2] Evidence in the record conflicts on Claimant's age when the rapes occurred.

the age of 16, she was drinking daily. Around this time, she met Casey, who would become her first husband. According to Claimant, Casey was abusive in every way — verbally, physically, emotionally, and sexually. Nevertheless, Claimant and Casey moved in together when Claimant was still in high school. For Claimant's seventeenth birthday, Casey gave her cocaine and encouraged her to use it with him. Claimant became addicted to cocaine, as well as to methamphetamine.

5. Claimant's relationship with Casey was volatile, and when he threatened to leave her, she attempted suicide by overdosing on pills. Claimant's sister found her, and Claimant was taken to the emergency room. She spent the night in the hospital to get her stomach pumped. However, Claimant was deemed not to be a threat to herself, and she was released from the hospital the next day. Claimant apparently did not seek psychiatric care after this incident.

6. Claimant is of above-average intelligence, and she did well in school as a child. By high school, her grades slipped to middling or poor, mostly due to truancy. Nevertheless, Claimant was able to graduate high school in 1982. Three years later, she married Casey.

7. For the next nine years, Claimant suffered severe domestic and sometimes sexual violence. She continued to abuse cocaine and methamphetamine, using them almost daily, which Claimant described as her way of escaping reality. She gave birth to her children, Clifford and Tiera, during this time, but she also suffered from multiple miscarriages.

8. The domestic violence escalated until Claimant's thirtieth birthday, when Casey pointed a loaded gun at her in the presence of their children. The police intervened, and Claimant fled to Idaho with Tiera and Clifford. They went into hiding at a domestic violence shelter, but Casey found them and stalked Claimant. The abuse only ended when Casey suffered a severe brain injury in an automobile accident. He was forced to move back in with his parents, and

Claimant divorced him.

9. Claimant quit using drugs, though she continued to abuse alcohol; she drank excessively on weekends and experienced two to three blackouts per month. To support herself and her children, she sought regular employment. (Claimant's work history prior to her divorce was inconsistent.) From 1996 to 2001, Claimant worked as a secretary/bookkeeper for the Silver Valley Economic Development Corporation, secretary for the Wallace Historical Preservation Council, purchasing manager for Environmental Reclamation, secretary/tax processor for H.F. Magnuson & Company, and accounts payable/tax processing secretary for H.F. Magnuson & Company. She would often hold more than one position at a time.

10. During this period, Claimant was briefly married to a man named Chad, but she divorced him when he became abusive.

11. In May 2001, Claimant began to work as a senior buyer for the Morrison Knudsen Corporation, a contractor at the Idaho National Laboratory (INL). She held this position for two years. Claimant met her third husband, Mr. Benner, while working at the INL; he also worked for a contractor at the site. Claimant and Mr. Benner married in 2003. Since meeting Mr. Benner, Claimant has significantly cut back on her drinking and no longer uses alcohol regularly.

12. On March 5, 2003, Claimant presented to Mark Mansfield, M.D., her primary care physician, for a physical exam. She complained of several symptoms, notably breast pain, heart arrhythmia, nausea, and trouble swallowing solid foods. She was concerned about the breast pain due to a family history of breast cancer. She did not complain of back pain or psychological problems at this time. Claimant was screened for cancer, but her results were negative. Dr. Mansfield diagnosed dysphagia (a swallowing disorder). He recommended monitoring and following up on Claimant's other symptoms. Nicole Manning, Dr. Mansfield's

assistant, prescribed Pepcid to Claimant in an effort to alleviate Claimant's symptoms.

13. Around this time, Claimant and Mr. Benner were having problems at home, mostly due to the complications of blending their families. They underwent family counseling. The counselor recognized signs of depression in Claimant and recommended that Claimant seek individual treatment for depression. Claimant contacted Dr. Mansfield's office, and on March 20, 2003, Ms. Manning prescribed Lexapro, an antidepressant, to Claimant. Ms. Manning noted that she or Dr. Mansfield would follow up with Claimant in one month.

14. Claimant presented to Dr. Mansfield on March 26, 2003 for her nausea and swallowing difficulties. Though Claimant's depression was not specifically discussed, Dr. Mansfield noted that Claimant had a "flattened affect." Ex. F3, p. 22. Dr. Mansfield recommended an endoscopy, which Claimant underwent on April 2, 2003. She was diagnosed with gastritis, duodenitis, and gastroesophageal reflux disease (GERD). Dr. Mansfield prescribed Omeprazole 20 and recommended follow-up in six weeks. He also recommended that Claimant avoid using alcohol, tobacco, and NSAIDs (non-steroidal anti-inflammatory drugs), which could aggravate Claimant's conditions.

15. In May 2003, Claimant was laid off after her position was eliminated. She had the opportunity to continue working for Morrison Knudsen at another location, but she remained in Pocatello due to her relationship with Mr. Benner.

16. Claimant's nausea and swallowing problems were not eliminated by Omeprazole, and though other medications were prescribed, they proved equally unhelpful. Claimant returned to using Pepcid, which helped her symptoms somewhat. She also continued to use Lexapro. On June 11, 2003, she met with Dr. Mansfield, who noted:

> [Claimant] has decreased dysphagia, nausea…but it does persist. It is mild four times a week. Also interestingly she was started on

> Lexapro 3/20/03 for depression. She has feelings of guilt, worthlessness, feeling overwhelmed. Much stress around the family. Mood has gone from a one to a 9/10 on the Lexapro 10 mg a day. She attempted suicide age 17 with attempted overdose. She has no current ideations.

Ex. F3, p. 29.

17. Dr. Mansfield diagnosed major depression. He noted that Claimant's depression was possibly exacerbating her nausea and dysphagia. He increased her Lexapro prescription to 20 milligrams a day and scheduled Claimant for follow-up in six weeks.

18. On July 23, 2003, Claimant complained to Dr. Mansfield of ongoing nausea, sinus/allergy symptoms, and low back pain. Dr. Mansfield wrote:

> [Claimant's low back pain] is on the right near the insides. She states that it is sharp. It feels like stabbing. It does not extend into her leg. No numbness or tingling. She gets no left sided symptoms.
>
> …
>
> Regarding her Lexapro 20 mg, [Claimant] states that she is feeling good. She puts her mood at a 9/10. She states that she is bored now that she is out of work and has been laid off but states that the medication is helping and she would have much more severe symptoms without it.

Ex. F3, p. 30. Dr. Mansfield noted that Claimant could use over-the-counter medications for her back pain, but he would recheck her if there was no improvement or if her symptoms worsened. He refilled her Lexapro prescription and scheduled follow-up in three months.

19. On July 28, 2003, Ms. Manning noted that Lexapro was worsening Claimant's nausea and decreasing Claimant's sex drive. Claimant was also worried about gaining weight. Ms. Manning prescribed Zoloft as a replacement.

20. On August 12, 2003, Claimant presented to Dr. D.F. Liljenquist, a chiropractor, for treatment. She cited neck and shoulder pain as her chief complaint, with other complaints

including headaches and low back pain. Claimant's back pain resolved after a few chiropractic therapy sessions.

21. In October 2003, Claimant followed up with Dr. Mansfield on several issues. One new complaint was muscle pain, and Claimant requested a hepatitis panel. Dr. Mansfield agreed to the panel to "alleviate [her] concerns." Ex. F3, p. 33. Additionally, he noted:

> Patient also reports that she needs a refill on her Zoloft. She has increased fatigue, reduced libido, she's taking it nightly. She tried Gingko w/o any improvement. She's doing counseling once a week but just started it today. She's wondering if she needs an increased dose. She's noticed that she does not have good concentration, has significant decreased motivation. She recently was put out of her job. She states she wakes up often over night, she doesn't want to get up in the morning. She has guilt, decreased memory and slight anxiousness off and on.

Id. Dr. Mansfield refilled Claimant's Zoloft prescription and also prescribed Wellbrutin XL in an effort to increase Claimant's energy levels and libido.

22. Claimant tested negative for hepatitis. At her appointment with Dr. Mansfield on November 20, 2003, she complained of new symptoms, specifically shoulder pain, constipation, and an irritable bowel. Claimant's shoulder pain was related to an old injury; Dr. Mansfield referred her to another doctor to treat it. Regarding Claimant's constipation and bowel problems, he scheduled a colonoscopy, based on Claimant's family history of colon cancer. He noted that Claimant's Wellbrutin prescription seemed to be working for her, as she had good energy, better motivation, and better concentration. Claimant reported that her counseling was going well.

23. Claimant's colonoscopy revealed no evidence of cancer. Dr. Mansfield suspected that Claimant might have irritable bowel syndrome. On January 9, 2004, Claimant complained that she was suffering from lower right abdominal pain. She was prescribed medication. She also reported that she had weaned herself off Zoloft due to the negative side effects and asked for a

replacement. Dr. Mansfield prescribed Prozac; however, for reasons not clear in the record, Claimant did not take it.

24. On March 24, 2004, Claimant presented to Dr. Mansfield for follow-up. She had a "flattened delayed affect" and spoke in a "monotone voice." Ex. F3, p. 45. She continued to suffer from abdominal pain. As for her depression, Dr. Mansfield noted:

> Her counselor thinks she needs more than just Wellbrutin. She is on Wellbrutin XL 300 mg a day. She didn't try the Prozac as prescribed to her. She admits to being depressed and feels like crying all of the time. No suicidal ideation.

Ex. F3, p. 45. Dr. Mansfield diagnosed major depression, recurrent, with anxiety disorder. He refilled Claimant's Wellbrutin prescription and re-prescribed Prozac as well.

25. On March 30, 2004, Claimant called Dr. Mansfield's office requesting pain medication for her irritable bowel syndrome. Lorbid was prescribed, but two days later, Claimant complained that Lorbid gave her headaches and asked for something else. A note from Dr. Mansfield indicated there was not another medication available for irritable bowel syndrome.

26. Claimant returned to Dr. Mansfield on May 5, 2004. She reported that she was doing much better, with more energy, improved concentration, and fewer feelings of hopelessness, helplessness, and worthlessness. Her average mood was 8/10. Her irritable bowel syndrome was also better. Dr. Mansfield noted, "She has called for pain meds which have been declined by us to refill." Ex. F3, p. 49. Claimant's only reported new symptom was a rash on her chest related to a recent breast augmentation. Dr. Mansfield prescribed medication for the rash and continued Claimant on her depression medications.

27. Claimant presented at the emergency room on August 4, 2004 for chest discomfort. She followed up with Dr. Mansfield on August 18, 2004 for GERD, dysphagia, and constipation. Her depression was not mentioned in Dr. Mansfield's notes from that day, though

her prescriptions for antidepressants continued and Claimant remained in counseling.

28. It appears that Dr. Mansfield and Ms. Manning became concerned about Claimant's intake of medications, because on August 24, 2004, Ms. Manning filed a request for prescription information with the Idaho State Board of Pharmacy's Abuse Prevention and Diversion Investigation Program. Claimant's patient profile report revealed that in May 2004, she had been prescribed Vicodin, an opiate medication, by Dr. Blaine Andersen, her plastic surgeon.

29. On September 7, 2004, Claimant presented to Dr. Mansfield for follow-up on her irritable bowel symptoms. She requested Vicodin or Percocet for her pain. Dr. Mansfield denied the request for pain pills, noting that he would not "treat IBS with narcotics." Ex. F3, p. 66.

30. On September 21, 2004, Claimant began to work for Employer as a receiving clerk. Her duties included unloading boxes off trucks. The boxes could weigh up to 100 pounds.

31. Claimant's abdominal symptoms worsened, and she again requested pain medication from Dr. Mansfield on September 22, 2004. She presented to him the next day complaining of abdominal pain. Dr. Mansfield ordered an ultrasound, which was negative for any pathology, but Claimant's pain continued to intensify. On September 28, 2004, following a visit to the emergency department, her gallbladder was removed. This resolved Claimant's abdominal symptoms.

32. On December 1, 2004, Claimant complained to Dr. Mansfield of right shoulder pain. She stated that her job at Home Depot, which required a lot of lifting, made her symptoms worse. Claimant was prescribed Arthrotec, an NSAID, and Norflex, a muscle relaxant. Claimant was instructed to follow up if her symptoms did not improve.

33. Claimant's shoulder pain continued, but Dr. Mansfield "declined to prescribe any

[more] narcotics or muscle relaxants." Ex. F3, p. 79. Neither, he wrote, was "ok for long term [pain] management." *Id*. at 81.

34. Dr. Mansfield's notes from late 2004 do not discuss Claimant's depression, but he continued her prescriptions for Wellbrutin and Prozac, and Claimant remained in counseling. She only ceased going to therapy after her counselor died in a boating accident in early 2005.

Claimant's First Accident

35. On April 4, 2005, Claimant was using a forklift to drop a load when the forklift tipped forward and crashed down, jolting Claimant. She felt pain all over her body but did not initially seek medical care. A few weeks later, Claimant was bending over when she felt severe back pain. She reported her pain to Employer, which referred her to the WorkMed Clinic at Portneuf Medical Center (PMC) on May 9, 2005. Claimant was seen by James R. Collet, M.D., who noted:

> She thinks that [her back pain] was due to [the forklift] incident because she has had no other trauma….Her low back pain is in her low back and upper buttocks. It does not radiate into her legs.

Ex. C1, p. 2. Dr. Collet diagnosed a severe lumbosacral strain and prescribed Flexeril, a muscle relaxant, and Vicodin. He placed Claimant on modified duty with no lifting over five pounds and no repetitive bending, twisting or stooping. He also ordered physical therapy.

36. On May 16, 2005, Claimant followed up with Dr. Collet. She reported that she was doing much better, though she continued to have pain. Dr. Collet continued Claimant on Flexeril, physical therapy, and modified duty.

37. Claimant followed up with Dr. Collet again on May 24, 2005. She stated that she was completely better with no residual symptoms. Dr. Collet found Claimant to be at maximum medical improvement and returned her to full duty.

Claimant's Second Accident and Aftermath

38. On June 1, 2005, Claimant was at work, cleaning up the back room, when she lifted a bundle of shingles. The bundle split, and Claimant felt "excruciating pain" in her low back. Hrg. Tr. 23-24; Ex. C9(a), p. 90. Claimant reported to the emergency department at PMC. She was diagnosed with acute lumbosacral strain and instructed to follow up with Dr. Collet at the WorkMed Clinic. Claimant was prescribed Norflex, Naprosyn, and Vicodin.

39. Claimant presented to Dr. Collet on June 2, 2005, complaining of severe back pain and tingling in her feet. Though Claimant was still using Prozac and Wellbrutin, she informed Dr. Collet that she had "no problems at work and no personal problems at home." Ex. C1, p. 13. She also stated that she had a "perfect life." *Id*. Dr. Collet seemed to suspect there was more going on with Claimant, as he wrote, "She seems extraordinarily in quite a bit of pain and very emotionally over-wrought today in the clinic but does not volunteer anything else going on in her life at this time." *Id*. Dr. Collet diagnosed lumbosacral strain. He ordered physical therapy and imposed work restrictions, including no lifting over five pounds, no repetitive bending, twisting, or stooping, and no pushing or pulling over five pounds.

40. On June 6, 2005, Claimant called Dr. Collet to inform him that she could not go to work that day "secondary to tense low back pain [and] inability to drive secondary to taking her pain medicines." Ex. C1, p. 17. Dr. Collet noted:

> I spoke with her and she says that she is taking Vicodin, two every four hours. She sounded perfectly coherent and articulate. She apparently was driven to Physical Therapy this morning by her daughter and there was able to do very little per the Physical Therapist.
>
> I have instructed her to discontinue the Vicodin except before bedtime and I have asked that she try to go to work at the light duty that has been detailed for her starting tomorrow. Also, I have an appointment to recheck with her tomorrow to see how things

are going.

Id.

41. Claimant reported minimal improvement at her appointment with Dr. Collet the next day. A week later, at another appointment, Claimant stated that her pain had improved about 50%, but Dr. Collet noted some "signs suggestive of non-organic back pain." Ex. C1, p. 22. He continued her on physical therapy and modified duty.

42. On June 21, 2005, Claimant reported to Dr. Collet that she was doing better, though she felt that working four hours each day was aggravating her back pain. However, she had ceased taking pain pills and muscle relaxants, and she reported that physical therapy was helping her. Dr. Collet continued Claimant on physical therapy and modified duty but noted that he intended to restore Claimant to full-time work the next week.

43. By June 30, 2005, Claimant reported that she was doing a lot better, rating her pain at only 1 out of 10. She no longer had tingling in her feet or radiating symptoms. She was able to lift fifty pounds in physical therapy. Dr. Collet found that Claimant could return to eight-hour work days, and he altered Claimant's restrictions to no lifting over thirty pounds.

44. Claimant again presented for follow-up on July 7, 2005. She stated that her pain was ranging from a 2/10 to 6/10 and that she was having difficulty sleeping. She said that she felt that she had made a lot of improvement, but that she had "hit a plateau." Ex. C1, p. 32. Dr. Collet continued Claimant on modified duty and physical therapy, and he referred Claimant to Mary Himmler, M.D., for further evaluation and possible SI joint injections. An appointment with Dr. Himmler was scheduled for July 25, 2005.

45. On July 13, 2005, Claimant presented to her primary care physician, Dr. Mansfield, with "several issues." Ex. F3, p. 87. She reported that her Protonix prescription was

working well for her GERD, but that she was suffering from ongoing back pain:

> She is seeing a back specialist on the 25th. She has had several on the job injuries since April which continue to irritate her back. She is doing rehab at PMC and working with WorkMed specialists. She states she has not had an MRI or x-ray. She has only done physical therapy and rehab.
>
> Patient also is currently on Wellbrutin 150 mg and Prozac 40 mg. She states she gets some breakthrough frustration especially with some increased irritability, hopelessness, helplessness. She states things could be better. She states they are okay but could see improvement. She occasionally has difficulty with sleeping, worries about her daughter that just moved out which has increased some of her mood issues.

Id.

46. On July 25, 2005, Claimant presented to Dr. Himmler for evaluation. Claimant reported that her pain was constant and ranged anywhere from 1/10 to 10/10. Dr. Himmler prescribed a trial of Ultram, an opiate agonist. She continued Claimant's work restrictions and physical therapy with a note to follow up in three weeks.

47. Claimant quit her position with Employer on July 29, 2005. She felt like she was being pressured to work outside of her restrictions. Claimant began working as a purchasing agent for SMS Custom Home Builders on August 1, 2005, but the job was short-lived; Claimant was laid off on September 15, 2005, as her new employer was going out of business.

48. On August 15, 2005, Claimant reported to Dr. Himmler that the Ultram prescription was not helpful, but physical therapy was improving her symptoms. A month later, Claimant told Dr. Himmler that physical therapy was "somewhat" helpful, but that she was having to control her pain through Arthrotec and occasionally Norco, an opiate pain reliever. Ex. C2, p. 5. Dr. Himmler ordered an MRI, which was taken on September 26, 2005. The MRI revealed a herniated disc at L4-5.

49. By October, Claimant told Dr. Himmler that physical therapy was no longer helpful. Dr. Himmler recommended an epidural steroid injection at the L4-5 level. She also continued Claimant's Norco prescription to be used as needed.

50. Claimant received an epidural steroid injection, but rather than relieve her symptoms, the injection seemed to exacerbate them. Claimant told Dr. Himmler that the shot was "awful." Ex. C2, p. 11. Dr. Himmler ordered another injection and noted that she was switching Claimant from Norco to Lortab, as Claimant "had been doubling up on the 5mg Norco dosage." *Id*. Lortab is another opiate pain reliever.

51. Claimant experienced no relief from her second injection. Dr. Himmler referred her to Clark Allen, M.D., for further evaluation. Claimant presented to Dr. Allen, a neurosurgeon, on February 1, 2006. She reported back pain with radiation into her hips, buttocks, and right leg. She was experiencing weakness in the leg and numbness at times. After ordering a discogram to confirm Claimant's pain generator, Dr. Clark discussed surgical options with Claimant. He believed that further conservative care would be futile. Claimant agreed to proceed with surgery.

52. On April 28, 2006, Dr. Allen performed an anterior lumbar interbody fusion at L4-5 and L5-S1 on Claimant. Claimant initially reported that she was doing well after surgery, though she was taking "about four pain pills a day." Ex. C4, p. 31. Dr. Allen encouraged her to walk daily and to wean herself off the back brace she was using. He restricted her to lifting ten to fifteen pounds while she was in recovery.

53. On July 20, 2006, Claimant reported to Dr. Allen that she was getting better, though she still had some back pain and right leg symptoms. However, she was "happy with her improvement." Ex. C4, p. 34. Dr. Allen ordered physical therapy and requested that Claimant

walk and exercise daily.

54. At six months post-surgery, Claimant stated that she was having both good and bad days. She was taking pain pills daily but insisted that she felt "better than before surgery." Ex. C4, p. 37. Dr. Allen noted:

> [Claimant] is looking toward going to school for more education in the future. She would also like to start a home business….Laletta is doing well and is on course for a good result. We discussed daily exercise and activity and to avoid lifting heavy objects.
>
> I think it will take a full year to stabilize and reach MMI. She will likely have some residual limitations.

Id.

55. While convalescing, Claimant began to take online classes in criminal justice from Everest University in Florida. She eventually attained her associate's degree in criminal justice in late 2008, graduating with honors.

56. On October 31, 2005, Claimant and Mr. Benner began to care for their ward, Arianna, who was three years old at the time. Claimant and Mr. Benner eventually became Arianna's legal guardians.

57. Claimant was scheduled to follow up with Dr. Allen in early 2007. However, on December 21, 2006, Claimant presented early because of pain:

> She was walking upstairs last Saturday when she experienced severe pain in her back and hips. She was not lifting. The pain has been about the same with mostly core pain and spasm. She is taking pain pill [sic] every 4 hours and spasm medicine daily. She has some shooting leg pain. She has done some modalities in PT but no other exercise.

Ex. C4, p. 39. Dr. Allen prescribed pain and spasm medication and also recommended a special treatment plan to Claimant's physical therapist.

58. Following her surgery, Claimant grew fearful of re-injuring her back. With the

arrival of winter, she became very anxious about going outside and possibly slipping on ice. Claimant's family was concerned about her anxiety. On January 2, 2007, Claimant's daughter Tiera convinced her to go out in public, but Claimant suffered an acute anxiety attack and presented to the emergency department at PMC. Claimant informed emergency department personnel that she feared going outside. A mental health consultation was obtained, but Claimant was found not to be a threat to herself or others. She was treated with medication and released.

59. Three days later, Claimant's husband, Mr. Benner, found her poised to take a handful of pills. Mr. Benner "basically had to wrestle them away from her." Ex. C9(b), p. 41. Mr. Benner took Claimant to see Vicki Watson, a counselor. Ms. Watson noted that Claimant was in an "extremely emotionally devastated condition" and recommended that Claimant be placed in psychiatric care. Ex. D3. Mr. Benner took Claimant to the emergency department at PMC for anxiety and suicidal ideation:

> Patient has been increasingly anxious about injuring her back ever since her surgery. At first she didn't want to leave the house without someone with her…eventually she wouldn't leave the house unless it was really really important. Eventually, she stopped leaving the house at all. Tuesday, her daughter talked her into coming to Pocatello and by the time she got here she was having a "panic attack" and came to the ED. She was [discharged] from the ED and went to Dr. Mansfield's office and was started on some Buspar and Ativan. Patient's anxiety has continued and today, husband found patient ready to take a handful of her medications ….Patient admits to suicidal ideation. Her husband took her to see Vicki Watson today and after evaluating her, Vicki recommended having her come here and be admitted to BHS. I spoke with Vicki who knows patient and says this is out of the ordinary for patient. Vicki is concerned for patient's safety. Patient's husband says when he asks patient if he can get her anything she has joked, "Yeah, a gun," but this is different and he is also concerned that patient might try to kill herself.

Ex. C9(b), p. 41. Claimant was admitted into the Behavioral Health Services Unit at PMC.

60. On January 6, 2007, Claimant underwent a psychiatric evaluation by Ninon

Germain, M.D. Claimant told Dr. Germain that she could not stop crying and that she did not understand why, because she had a "wonderful life." Ex. D8(a), p. 25. She informed him that she had received psychotherapy from a local counselor until the counselor died. She also told him that she had been abusing her opiate medications and that her husband was trying to manage her intake. She reported that she felt "held back" by the fact that she had only a high school diploma. She stated that prior to her suicide gesture, she had been feeling a "smothering fear" for the past five days. *Id*. at 28.

61. Dr. Germain assessed Claimant as follows:

> This is a 42-year-old female who presents with a complicated history of inconsistent parental involvement, some emotional abuse and relative maternal deprivation with educational neglect in childhood and adolescence….
>
> [T]he patient's history is complicated by significant frank sexual and physical abuse as an adult, and significant polysubstance dependence. The patient's genetic loading for depression as well as the paternal rejection and questionable maternal attachment does place the patient at risk statistically for depression and anxiety which she is now experiencing, and the patient also appears to have significant psychological overlay on her somatic symptoms, with significant diagnoses commonly associated with sustained prepubertal maltreatment, namely migraine headaches, irritable bowel syndrome, dysphagia, pelvic pain, palpitations and chronic pain. Overall, this patient's diagnostic profile is consistent with characterological maladaptation in the context of significant depression and anxiety with somatization and a history of polysubstance dependence.

Ex. D8(a), pp. 28-29. Dr. Germain diagnosed Claimant with major depressive disorder, dysthymia, anxiety disorder with agoraphobic features and post-traumatic features, with significant dissociative and somatization components as well; opiate abuse, and personality disorder NOS (not otherwise specified), with passive aggressive and narcissistic traits. He believed her prognosis was fair, provided that Claimant received "aggressive appropriate

outpatient psychopharmacologic and psychotherapeutic intervention, specifically cognitive behavioral therapy." *Id*. at 29.

62. Claimant was discharged from her psychiatric hospitalization on January 12, 2007. Shortly thereafter, she began to treat with Predrag V. Gligorovic, M.D., for her psychiatric conditions. She also saw Vicki Watson for counseling.

63. On January 25, 2007, Claimant followed up with Dr. Allen for her back pain. He noted her recent hospitalization and was concerned that she was taking four Norco pills per day, as well as two Soma pills. Dr. Allen discussed with Claimant the "very real issues with her pain medication" and referred her to Pat Farrell, M.D., for appropriate pain management. Ex. C4, p. 41.

64. On February 22, 2007, Claimant presented to Dr. Farrell for left and right SI joint injections. The injections reduced but did not eliminate Claimant's pain. On March 6, 2007, Claimant returned to Dr. Farrell for additional injections after her pain returned "significantly." Ex. C6, p. 2. This time, the injections did not provide any relief.

65. On March 8, 2007, Claimant had an appointment with Dr. Allen. She informed him that she was feeling "frustrated and concerned" about her back pain. Ex. C4, p. 43. She stated that, while she felt better than she had before surgery, she did not feel like her condition was improving.

66. As Claimant's pain continued to worsen, so did her abuse of opiate medications. Both Claimant and Claimant's husband were concerned about her opiate dependence, especially after Claimant began to experience visual and auditory hallucinations. Mr. Benner researched inpatient treatment facilities, and on August 4, 2007, Claimant checked herself into an addiction treatment facility operated by the Rimrock Foundation.

67. At Rimrock, Claimant underwent a psychiatric evaluation. She admitted to thoughts of suicide, though she did not have any plans for self-harm. She admitted to daily misuse of opiate drugs. Her symptoms of dependence included tolerance for the drugs, inability to control use, withdrawal symptoms upon cessation of use, decrease of important activities due to use, and continued use despite health problems related to use. Claimant told her providers that for the first four months after her surgery, she used her medications as prescribed, but then began to increase her dosage incrementally. The providers at Rimrock weaned Claimant off several medications but believed that she required some medication for her ongoing severe back pain. They placed her on Suboxone, an opiate replacement drug.

68. Claimant was discharged from Rimrock on September 1, 2007. Approximately two weeks later, she presented to Dr. Allen, who found that Claimant was "markedly symptomatic in regards to her low back." Ex. C4, p. 52. Claimant had sustained a fall at the Rimrock facility that aggravated her back pain. Dr. Allen recommended facet blocks to determine if Claimant's facet joints were her pain generator. Claimant underwent facet blocks at L3, L4, and L5. She experienced relief for about twelve hours, and then the pain "returned with a vengeance." Ex. C4, p. 55. On October 11, 2007, Dr. Allen discussed Claimant's options for further treatment with her, and Claimant elected to proceed with a posterior fusion at L4, L5, and S1. Dr. Allen performed surgery on November 12, 2007.

69. At a follow-up appointment on December 20, 2007, Claimant reported that she was doing well. She said that she was feeling much better. Though she was prescribed Norco and Soma after the surgery, she was back on Suboxone by February 7, 2008. On this date, she reported to Dr. Allen that she had a bad fall on the ice ten days before. She believed that she was mostly recovered, though Dr. Allen was concerned about the fall. Films did not reveal any

damage to Claimant's fusion. Dr. Allen ordered that Claimant start some "light progressive" physical therapy and noted that Claimant would probably have "significant limitations" once she attained maximum medical improvement. Ex. C4, p. 64.

70. On May 14, 2008, Claimant followed up with Dr. Allen. She reported that she was continuing to improve, but she was having difficulty with her right leg giving out. She was also having problems sleeping.

71. In early June 2008, Claimant suffered two falls, which increased her back and leg pain. She reported the incidents to Dr. Allen, who believed her symptoms were consistent with nerve compression from a ruptured disc. He ordered a lumbar MRI, which revealed

> good decompression and no evidence of significant changes above the fusion. There is some degeneration at L3-4 but no significant stenosis. No evidence of disc rupture or compression of nerves is seen.

Ex. C4, p. 71. In effect, Dr. Allen could find no evidence of pathology that would explain Claimant's complaints. He recommended that Claimant undergo a bilateral lower extremity EMG to evaluate for a nerve injury. The EMG study was negative, with "no evidence of radiculopathy, deinervation [sic] or neuropathy." Ex. C4, p. 73.

72. On November 19, 2008, Dr. Allen examined Claimant and found that she was at maximum medical improvement. He noted that he could find "no pain generators that could explain her continued symptoms." Ex. C4, p. 75. He believed that Claimant's future medical treatment should consist of management for chronic pain. He opined that no further surgical intervention was warranted.

73. Claimant completed her associate's degree in late 2008, and she began to pursue a bachelor's degree, also through online classes. However, she struggled with the course work, failed a class, and dropped out. On February 5, 2009, she confessed to Dr. Gligorovic that she

felt like she could not "live like this" anymore. Ex. D4, p. 17. She was feeling depressed and anxious about her academic failure, her ongoing back pain, and issues in her personal life, including some difficulties in her relationship with Mr. Benner. Claimant was worried that Mr. Benner wanted to "escape from her" and would seek a divorce. *Id*.

74. On March 31, 2009, Claimant reported to Dr. Gligorovic that her relationship with Mr. Benner was still "not good" and that she felt angry most of the time. Ex. D4, p. 19. She continued to have trouble sleeping. She denied suicidal ideation but stated that she did not feel like she had a "mission on earth anymore." *Id*.

75. On May 13, 2009, Claimant was voluntarily admitted into PMC's Behavioral Health Services Unit for another psychiatric hospitalization. She was suffering from severe depression, with suicidal ideation and plans to cut herself. Admission notes indicate that Claimant was unable to perform the activities of daily living or to function in a way that was safe. She stated that she felt "lost, like in a big black forest." Ex. D4, p. 22. She suffered her emotional breakdown after she told Mr. Benner that she wanted to go to the Oregon coast, and he expressed concerns about leaving, as they had to consider what was best for Arianna. Claimant admitted that she felt like Mr. Benner was "preoccupied" with Arianna and did not care for Claimant as he once did. *Id*. Claimant admitted to excessive sleeping, missing appointments with her counselor, thoughts of self-harm, feelings of hopelessness, and inability to perform basic chores. She was also depressed about her chronic pain. She admitted to a history of cutting herself as a teen that "never remitted completely." *Id*. at 23. She said that recently, she had been cutting her legs. Claimant was hospitalized until May 20, 2009, when she was discharged with a diagnosis of major depressive disorder, somatic disorder, and borderline personality disorder. After her discharge, Claimant continued to treat with Dr. Gligorovic. She also began cognitive

behavioral therapy with Dr. Steve Ater, a psychologist.

76. On May 26, 2009, at Defendants' request, Robert H. Friedman, M.D., and Michael McClay, Ph.D., performed an independent medical examination (IME) of Claimant. They opined that Claimant's sole medical diagnosis relating to her June 1, 2005 accident was a herniated disc. They "strongly recommended" against any additional treatment, except for a "multidisciplinary comprehensive pain management program." Ex. C8, p. 6. They believed that Claimant should be tapered off Suboxone, as there was "no evidence that opiates have been of benefit to her." *Id*. They further opined that "once detoxified, [Claimant] would be able to return to work full time." *Id*. They believed that Claimant was physically stable, but not psychologically stable. They assessed permanent restrictions that included lifting fifty pounds occasionally and twenty-five pounds repetitively, with no twisting or torquing of Claimant's low back. Under the *AMA Guides to Permanent Impairment*, 6th Edition (hereinafter *Guides*), Dr. Friedman rated Claimant's PPI at 19% of the whole person. Despite Claimant's complaints of persistent pain, he found that her grade modifiers were "not valid given her examination as nonphysiologic in nature," and thus declined to give Claimant a higher rating. Ex. C8, p. 7. Dr. McClay opined that Claimant's psychological conditions were preexisting and did not relate to her industrial accident.

77. On October 9, 2009, at Defendants' request, Mary Barros-Bailey, Ph.D., performed a disability evaluation of Claimant. Dr. Barros-Bailey found that Claimant had a history of working in skilled and semi-skilled clerical and warehousing occupations. Dr. Barros-Bailey believed that Claimant had transferable skills in purchasing, clerical tasks, and basic bookkeeping. Within the restrictions assigned by Dr. Friedman, Claimant should be able to engage in most of the "usual and customary" work that Claimant had performed in the past,

though not her time-of-injury job. Thus, Claimant had lost only about 6% of her access to the labor market due to her industrial injury, and had not suffered any appreciable wage loss; she had therefore suffered no disability over and above impairment. However, Dr. Barros-Bailey believed that Claimant was unlikely to return to work "based on her present psychological instability." Ex. I, p. 10.

78. Dr. Friedman, Dr. McClay, and Dr. Barros-Bailey evaluated Claimant at what appears to have been her psychological low point. Soon after the evaluations, Claimant's condition began to stabilize. Her improvement seems to be at least partly due to her cognitive behavioral therapy with Dr. Ater, whose sessions focused on helping Claimant improve her coping skills. Though Claimant suffered some stressful events during this period — the death of Bob W., her assumed father; her mother's diagnosis with breast cancer; her son's deployment to Afghanistan; and various conflicts with her children and stepchildren — Claimant was able to handle these events without being overwhelmed again. Her relationship with Mr. Benner improved, and Claimant assumed primary responsibility for Arianna's care.

79. On April 23, 2011, at Claimant's request, Claimant was evaluated by Camille A. LaCroix, M.D., a forensic psychiatrist. Dr. LaCroix interviewed Claimant, administered psychiatric inventories, and reviewed Claimant's medical and personal history. Claimant told Dr. LaCroix that her mood was "pretty good" lately, though she still struggled with low energy, low motivation, and low self-esteem. Ex. D7, p. 9. However, Claimant no longer felt hopeless and no longer engaged in self-harming behaviors, such as cutting. Claimant continued to exhibit symptoms of anxiety disorder, including insomnia and excessive worry.

80. Dr. LaCroix diagnosed Claimant with 1) borderline personality disorder, 2) anxiety disorder NOS, 3) dysthymic disorder, and 4) opiate dependence. Dr. LaCroix believed

that Claimant has suffered from borderline personality disorder since late adolescence, though the industrial injury "significantly exacerbated" it. Ex. D7, p. 25. Dr. LaCroix described this as Claimant's "primary psychiatric disorder." *Id*. at 20. Claimant's symptoms of borderline personality disorder included fear of abandonment by others, chronic emptiness, a poor sense of self, suicidality and self-harm (including cutting), impulsive self-damaging behaviors (such as drug abuse), trouble regulating emotions, and episodes of dissociation. Borderline individuals "tend to decompensate in the face of extreme stressors" and have trouble coping with stressful events. *Id*. at 21. Dr. LaCroix cited Claimant's cutting, her decreased ability to regulate her emotions, and her decreased ability to engage socially as symptoms of the exacerbation of Claimant's personality disorder.

81. Though Claimant suffered from mild anxiety prior to the accident, Dr. LaCroix opined that Claimant's anxiety disorder was significantly worsened by her industrial accident and injury. Dr. LaCroix stated that Claimant had exhibited some post-traumatic and panic disorder features in the past but did not exhibit generalized anxiety or social phobia symptoms until after the accident.

82. Dysthymic disorder is a "chronic depressive disorder of over two years' duration with associated hopelessness and low self-esteem." *Id*. at 24. Dr. LaCroix opined that this condition was caused by Claimant's accident and injury, because Claimant had "experienced loss of employment and significant situational stressors in the past and had not had significant impairment until onset" of the work-related injury and its consequences. *Id*. at 25.

83. Finally, Dr. LaCroix opined that Claimant's opiate dependence was caused by the industrial injury. Though Claimant had problems with drug dependency in the past, she had "no prior history of opiate dependence." *Id*. at 26.

84. In describing how Claimant's psychological conditions impact her functioning, Dr. LaCroix noted that psychological conditions can worsen chronic pain. Additionally, Dr. LaCroix believed that Claimant's borderline personality disorder causes Claimant to have "extreme difficulty with ambiguity and uncertainty." *Id*. Though Claimant might genuinely want to participate in various activities, she is "emotionally incapable" of it, as she "lacks the emotional coping skills currently to participate on a regular basis in social or vocational activities." *Id*. Furthermore, Claimant's borderline personality disorder, her anxiety disorder, and her dysthymic disorder negatively impact her thinking, concentration and judgment. Likewise, her "interpersonal and communication skills are worsened by all of her disorders as she has had nearly incapacitating anxiety in public, fear of humiliation […], low motivation, some hallucinations and trouble with memory and concentration." *Id*. Finally, "severe anxiety and chronic depression cause distortions in the way [she] processes data from her environment, with a tendency to distort and catastrophize events." *Id*. Though Claimant's activities of daily living — such as grooming herself, taking care of Arianna, and maintaining her household — have been "minimally impaired" by the disorders, Claimant would probably have difficulty functioning in a professional environment.

85. Dr. LaCroix found that Claimant was at maximum medical improvement with regard to her psychological conditions, though she continued to suffer from "moderate symptoms." *Id*. at 27. Dr. LaCroix assigned a whole person PPI rating of 10%, with 75% due to the work-related injury. Dr. LaCroix did not assign individual PPI ratings for each condition.

86. At hearing, Claimant testified that she has constant pain in her back and weakness in her right leg. She also suffers from foot drag. She falls a lot because of her leg problems. She has been approved for Social Security disability benefits. Claimant testified that she had no

physical injuries that limited her ability to work prior to the accident. She disagrees with Dr. Friedman's assessment that she is capable of lifting twenty-five pounds regularly, as "even a gallon of milk is a lot" for her to lift. Hrg. Tr. 47. She believes that, physically, she could work full-time in a very light or sedentary position with certain accommodations.

87. Claimant is more pessimistic about her psychological conditions. She reports that while she continues to improve, she still has "really bad days" when she does not answer the phone and can barely manage to get out of bed. Hrg. Tr. 44. She testified that she cannot function on bad days unless she "absolutely has to." *Id*. She estimates that she has about half good days, half bad days, and she does not believe she could work consistently on a full-time basis with her psychological conditions. She characterized her psychological health prior to her accident as having its "ups and downs," and admitted that she had periods of depression before the accident. Hrg. Tr. 36. Though Claimant would like to work again, she fears suffering a psychological breakdown in the workplace. Hrg. Tr. 48.

88. At hearing, the Referee found that Claimant presented well and made a good impression. He further found that Claimant was overall a credible witness, though with a tendency to exaggerate. The Commissioners see no reason to disturb these findings.

DISCUSSION AND FURTHER FINDINGS

89. Defendants accepted liability for Claimant's back injury and have paid medical benefits and PPI benefits on the claim. At issue before us is whether Defendants are also liable for benefits relating to Claimant's psychological conditions, whether and to what extent Claimant has suffered permanent disability in excess of impairment, and, if so, whether Claimant's disability should be apportioned pursuant to Idaho Code § 72-406.

90. The provisions of the Idaho Workers' Compensation Law are to be liberally

construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes that it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

Causation

91. The claimant has the burden of proving the condition for which compensation is sought is causally related to the industrial accident. *Callantine v. Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be a medical opinion supporting the claim for compensation to a reasonable degree of medical probability. *Priest v. Valley Regional Transit*, 2012 IIC 0033.20 (April 16, 2012). No "magic words" or special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 591 P.2d 143 (1979), *overruled on other grounds by Jones v. Emmett Manor*, 134 Idaho 160, 163, 997 P.2d 621, 624 (2000); *Roberts v. Kit Manufacturing Company, Inc.*, 124 Idaho 946, 866 P.2d 969 (1993).

92. In order for a psychological injury, disorder or condition to be compensable, it must have been caused by an accident and physical injury; i.e., psychological injuries without an accompanying physical injury are not compensable.[3] Idaho Code § 72-451(1). Furthermore, the accident and physical injury must be the predominant cause as compared to all other causes combined of any consequence for which benefits are claimed. Idaho Code § 72-451(3).

[3] Under Section 451, psychological injuries, disorders, and conditions may also be found compensable if they accompany an occupational disease with a resultant physical injury, or if a "psychological mishap or event" is itself an accident causing a physical injury. However, neither of these alternative paths to compensability is alleged by Claimant.

"Predominant" is defined as "something greater or superior in power and influence to others with which it is connected or compared." *Black's Law Dictionary* 1177 (6th ed., West 1990). Thus, under the predominant cause standard, it is not sufficient for Claimant to show that the industrial injury was merely the straw that broke the camel's back. *Smith v. Garland Construction Services*, 2009 IIC 0179.8 (April 27, 2009). Rather, Claimant must show that the work injury was the greater cause of the psychological condition as compared to all other causes combined. *Id*. In determining the predominant cause of a psychological condition, the Commission must weigh the contribution of all of a claimant's pre-accident factors against the contribution of the industrial accident and injury. *Id*. To put it in mathematical terms, if a percentage of contribution were assigned to each and every factor that collectively produced a claimant's psychological condition, the contribution of the accident and injury must be more than 50% of all total causes. *Id*. It is from this high standard that the evidence in the record must be evaluated. *Id*.

93. Any permanent impairment or permanent disability for a psychological injury must be based on a condition sufficient to constitute a diagnosis using the terminology and criteria of the American Psychiatric Association's diagnostic and statistics manual (DSM), third edition revised, or any successor manual promulgated by the association. Idaho Code § 72-451(5). Diagnosis of a psychological injury, disorder or condition must be made by a licensed psychologist or psychiatrist. *Id*.

94. A claimant must establish causation of a psychological injury by clear and convincing evidence. Idaho Code § 72-451(6). "Clear and convincing evidence means a degree of proof greater than a mere preponderance." *Luttrell v. Clearwater County Sheriff's Office*, 140 Idaho 581, 584, 97 P.3d 448, 452 (2004).

95. The parties agree that Claimant's psychological status has declined since her

accident and resultant back injury; however, Defendants dispute that Claimant's psychological conditions were caused by the injury. They rely on the opinion of Dr. Michael McClay, a licensed psychologist, in support of their position. Dr. McClay performed an IME of Claimant at Defendants' request. He diagnosed Claimant with major depressive disorder, schizoid personality disorder, and chronic pain syndrome, a non-psychological condition.[4] He opined that Claimant's accident was not the principal cause of her psychological issues, which largely preexisted her accident.

96. Claimant relies on the opinion of Dr. LaCroix, a licensed psychiatrist, to support her contention that the accident and injury were the primary causes of her psychological conditions. Dr. LaCroix diagnosed Claimant with borderline personality disorder, anxiety disorder NOS, dysthymic disorder, and opiate dependence.

97. As licensed practitioners of psychiatry and psychology, Dr. LaCroix and Dr. McClay are qualified to diagnose psychological conditions under Idaho Code § 72-451. Furthermore, they made their diagnoses pursuant to criteria in DSM-IV-TR, as required by Section 451.

98. **Personality disorder**. Dr. LaCroix diagnosed Claimant with borderline personality disorder. Dr. McClay diagnosed Claimant with schizoid personality disorder. Though the diagnoses are technically different, Dr. McClay testified that borderline personality disorder and schizoid personality disorder are substantially similar: both develop no later than adolescence or early adulthood, and both involve "long-term, chronic, profound maladjustment

[4] Though chronic pain syndrome has psychological features, it is not a purely psychological diagnosis. According to the *Guides*, chronic pain syndrome (CPS) is "pain that continues beyond the normal healing time for the patient's diagnosis and includes significant psychosocial dysfunction." *Guides to the Evaluation of Permanent Impairment* 32 (Robert D. Rondinelli ed, 6th ed., AMA 2008). The condition has biological, psychological, and social components that can "perpetuate and may even worsen the clinical presentation." *Id*. CPS is a "condition that ultimately and adversely affects the patient's well-being, level of function, and quality of life." *Id*. The major characteristics of CPS include abuse of, or dependence on, prescription drugs; withdrawal from social life; and failure to restore pre-injury function after a period of disability. *Id*. Claimant's chronic pain will be discussed later in this decision.

dating back to childhood." McClay Depo. 27. Dr. LaCroix agreed that Claimant's personality disorder was not attributable to the accident. However, Dr. LaCroix argued that the symptoms of Claimant's disorder significantly worsened after the accident, where before, they had been mild. According to Dr. LaCroix, Claimant had not undergone a psychiatric hospitalization prior to the accident, whereas after, she was hospitalized twice; and Claimant had required no long-term psychiatric care prior to the accident.[5] Dr. LaCroix testified that, pre-injury, Claimant needed nothing more than a general practitioner to help her with minor episodes of depression and anxiety, and Claimant did not engage in significant self-injuring or self-damaging behaviors prior to the accident. Thus, Claimant's personality disorder progressed from a mild baseline to a much more severe condition post-accident and injury.

99. While Dr. LaCroix's opinion is thorough and well-explained, it is also problematic. First, her statement that Claimant did not engage in significant self-injuring behaviors, such as cutting, prior to her accident is incorrect; PMC records from Claimant's 2009 psychiatric hospitalization indicate that Claimant has engaged in cutting since her teens and that the problem had not, as of 2009, ever gone away. (In 2011, Claimant informed Dr. LaCroix that she had ceased cutting.) Second, Dr. LaCroix minimized Claimant's pre-accident mental health history, including a suicide attempt at age 17 and use of antidepressants for a period of two years before the industrial injury. Defendants argue that Claimant's failure to seek psychiatric care prior to her accident does not mean that she did not need it, or would not have benefited from it; considering Claimant's early history, we agree. Claimant suffered severe neglect and abuse as a child, adolescent, and young woman. Rather than seek professional help, she sought escape through alcohol and illicit drug use — hardly a healthy coping mechanism, and, as Dr. LaCroix

[5] Claimant's overnight hospital stay after her suicide attempt at age 17 did not qualify as a "psychiatric hospitalization" because she was admitted for a medical procedure, not for psychiatric reasons.

observed, inability to cope is a major feature of borderline personality disorder.

100. In order for borderline personality disorder to be diagnosed, a patient must exhibit a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more" of the following factors:

> a) frantic efforts to avoid real or imagined abandonment by others;
>
> b) a pattern of unstable and intense personal relationships characterized by alternating between extremes of idealizing and devaluing other people;
>
> c) identity disturbance; that is, markedly and persistently unstable self-image or sense of self;
>
> d) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating, etc.);
>
> e) recurrent suicidal behavior, gestures, threats, or self-mutilating behavior;
>
> f) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);
>
> g) chronic feelings of emptiness;
>
> h) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights); and
>
> i) transient, stress-related paranoid ideation or severe dissociative symptoms.

DSM-IV-TR 710; *see also* LaCroix Depo. 26-27.

101. Dr. LaCroix acknowledged that Claimant would have qualified for a diagnosis of borderline personality disorder prior to the accident. This does not necessarily disqualify Claimant from receiving compensation for this condition, provided that she can prove that her

post-accident condition is so much worse than her pre-accident condition that it can be said that the accident/injury is the predominant cause of the severity of the condition from which Claimant suffered post-accident.

102. Claimant has offered insufficient evidence to meet her burden. There is little or no evidence in the record to conclude that, for example, Claimant has engaged in frantic efforts to avoid abandonment, that these efforts are far more numerous or far more impactful than they were pre-injury, and that these efforts were provoked by her injury. This is also true for the factors of identity disturbance, anger, paranoid ideation, and chronic feelings of emptiness: Claimant has simply not offered enough evidence to show to what extent these factors exist, let alone the extent to which they can be attributed to the accident and injury.

103. There is more evidence in the record on the other factors, including recurrent suicidal or self-mutilating behavior, unstable personal relationships, and mood instability. However, the bulk of the evidence establishes that these factors are about the same — and in some cases, perhaps better — than they were pre-accident.

104. Claimant has made only one suicide attempt in her life. This occurred well before the accident, when Claimant was seventeen. It was provoked by her boyfriend's threat to leave her. In early 2007, post-accident, Claimant made a suicide gesture by holding a handful of pills that her husband had to "wrestle" away from her. *See* ¶ 59 above. Claimant's suicide gesture was alarming, but it did not represent a substantial worsening of her borderline personality disorder. Throughout her life, both before and after her injury, Claimant has struggled to cope with stress and pain in a healthy manner. As a teen and young woman, Claimant used illicit drugs and alcohol to cope with neglect and abuse from her parents and her first husband, Casey. Also as a teen, she attempted suicide when Casey threatened to leave her. Well into her adulthood — even

after recovering from her abuse of cocaine and methamphetamine — Claimant continued to abuse alcohol, experiencing blackouts two to three times per month. In the two years leading up to the accident, Claimant, experiencing both family stress and physical pain, made repeated requests for opiate painkillers inappropriate to treat her various maladies, to the point that her primary care physician felt obliged to monitor her intake of medications through the Idaho State Board of Pharmacy. Claimant's accident and injury, with its resultant chronic pain, were certainly stressors, but they did not create Claimant's borderline personality disorder, and they did not cause it to substantially or permanently worsen. Claimant's suicide gesture was unfortunately consistent with a long-established pattern of conduct.

105. Claimant's long history of cutting, a self-mutilating behavior, also supports the conclusion that Claimant's self-destructive tendencies are due to a personality disorder that has been severe since its onset, and not merely since Claimant's industrial injury. Claimant began cutting as a teenager and did not stop until 2010 or 2011, when she engaged in cognitive behavioral therapy with Dr. Ater. Dr. LaCroix's statement that Claimant did not begin cutting until after the industrial injury is contrary to the evidence in the record, and Claimant has not offered sufficient evidence to prove that her cutting became more severe post-injury as compared to pre-injury. Whatever the frequency and severity of Claimant's self-inflicted wounds, we have no way to compare her cutting behavior pre-injury and post-injury. Claimant failed to offer detailed evidence on this matter.

106. Mood instability is another factor establishing the existence of borderline personality disorder, and the evidence in the record shows that Claimant suffered mood problems both before and after the accident. However, Claimant's mood problems are more chronic than episodic in nature and are more appropriately discussed in the context of her anxiety and

depression diagnoses, which are treated below. Claimant has not offered evidence sufficient to prove that she suffers from borderline-specific mood issues and that such issues have become substantially worse as a result of the accident.

107. Finally, with regard to the factors of unstable personal relationships and self-damaging impulsivity, the evidence in the record implies that Claimant has actually improved in these areas, or at least not worsened, since her accident. Before her accident, Claimant had two unstable, failed marriages with abusive men, while her current marriage to Mr. Benner is strong and supportive, according to Claimant's own testimony. Of course, this relationship, like all relationships, has had its ups and downs, but this was true pre-accident, when Claimant and Mr. Benner engaged in family counseling, as well as post-accident. It is also true that Claimant's relationships with her children and stepchildren are complex, as detailed in Dr. Ater's therapy notes; but again, this was true pre-accident as well, and Claimant has offered insufficient evidence that would allow us to compare and contrast the nature of her pre-accident relationships to her post-accident ones. We know that Claimant underwent family counseling pre-accident; we know that she discussed her family relationships quite a bit with her post-accident psychological care providers, but we lack the evidence to judge whether these relationships actually worsened. In the absence of such evidence, we cannot say that her relationships are significantly less stable now than they were pre-accident, let alone that this instability was caused by the accident and injury.

108. Perhaps the most significant feature of Claimant's preexisting borderline personality disorder was her self-damaging impulsivity, as manifested by her abuse of cocaine, methamphetamine, and alcohol. The drug dependencies lasted for more than a decade; the alcohol abuse, even longer. Claimant did develop opiate dependence post-accident, which is

discussed in further detail below. However, Claimant's active abuse of opiate medications was relatively short-lived compared to her past dependencies, and Claimant demonstrated her maturation by voluntarily seeking inpatient treatment for opiate abuse — a step she never took with her cocaine, methamphetamine, and alcohol abuse, which took much longer for her to address. Claimant has failed to show that her self-damaging impulsivity has worsened since her accident.

109. Considering the evidence in the record relating to Claimant's borderline personality disorder and how it manifested pre-injury versus post-injury, we find that Claimant has failed to prove that her current condition was predominantly caused by her accident and injury. Claimant's personality disorder is not a compensable psychological condition.

110. **Depression**. Dr. LaCroix diagnosed Claimant with dysthymic disorder. Dr. McClay diagnosed Claimant with major depressive disorder. Dr. LaCroix explained the difference between the two: dysthymic disorder is a chronic, low-level depression that lasts for at least two years, whereas major depressive disorder is an "acute concentrated episode of depression." LaCroix Depo. 12.

111. To qualify for a diagnosis of major depressive disorder, Claimant must have suffered one or more major depressive episodes, and the episodes must not be better accounted for by another psychological disorder. DSM-IV-TR 375-376. A major depressive episode is marked by at least five of the following symptoms:

a) depressed mood most of the day, nearly every day;

b) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day;

c) significant weight loss or weight gain, or significant changes in appetite;

d) insomnia or hypersomnia nearly every day;

e) psychomotor agitation or retardation nearly every day;

f) fatigue or loss of energy nearly every day;

g) feelings of worthlessness or excessive or inappropriate guilt nearly every day;

h) diminished ability to think or concentrate, or indecisiveness, nearly every day;

i) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

DSM-IV-TR 356.

112. To qualify for a diagnosis of dysthymic disorder, Claimant must meet the following criteria:

a) Depressed mood for most of the day, nearly every day, for at least two years;

b) Presence, while depressed, of two (or more) of the following:
   1) Poor appetite or overeating;
   2) Insomnia or hyperinsomnia;
   3) Low energy or fatigue;
   4) Low self-esteem;
   5) Poor concentration or difficulty making decisions;
   6) Feelings of hopelessness;

c) During the period of the disturbance, the person has never been without the symptoms in Criteria A or B for more than two months at a time;

d) No major depressive episode has been present during the first two years of the disturbance; i.e., the disturbance is not better accounted for by chronic major depressive disorder, or major depressive order in partial remission.

DSM-IV-TR 380.

113. In 2003, Claimant was diagnosed with major depressive disorder by Dr.

Mansfield, her primary care physician. Dr. Mansfield is not a psychologist or psychiatrist, and his diagnosis is not definitive, but his notes are useful in determining the symptoms that Claimant suffered pre-accident. At various times in 2003 and 2004, Claimant complained of feeling overwhelmed, guilty, and worthless, of decreased motivation and concentration, of fatigue and lack of energy, and of a depressed mood. *See e.g.* ¶¶ 16, 21, and 24 above. She denied suicidal ideation but confessed to feeling like "crying all the time." *See* ¶ 24. Claimant was constantly on antidepressants from March 2003 through the dates of her industrial accidents and after. In addition to her family counselor, she began to see a counselor individually in October 2003 and only stopped attending psychotherapy after the counselor passed away in early 2005. Claimant's depressive symptoms slightly, but not significantly, worsened in the immediate aftermath of her second industrial accident; in addition to her general depressed mood, she reported that she was having occasional trouble sleeping. *See* ¶ 45. Interestingly, Claimant blamed her increased psychological issues on "worries about her daughter." Ex. F3, p. 87. Though Claimant discussed her back injury with Dr. Mansfield, she evidently did not connect it to her depression, perhaps because Dr. Mansfield had already been treating her for depression for more than two years prior to the accident.

114. From the evidence in the record, then, it does not appear that Claimant qualified for a diagnosis of major depressive disorder pre-injury. She did not suffer a major depressive episode pre-accident; she complained of four depressive symptoms, rather than the requisite five. Her problem also appears to have been more chronic than concentrated in nature. We therefore find Dr. LaCroix's diagnosis of dysthymic disorder more credible than Dr. McClay's diagnosis of major depressive disorder.

115. However, Dr. LaCroix's opinion that Claimant's accident and injury caused her

dysthymic disorder is less convincing. Dr. LaCroix reasoned that prior to the accident, Claimant suffered from only "minor episodes of depression related to transient life stressors." Ex. D7, p. 24. This opinion conflicts with Claimant's pre-accident medical records, which demonstrate that Claimant's dysthymia developed at least two years prior to the accident, rather than after. It was not a minor, transient problem; it was a chronic one that never went away.

116. The question, then, is whether Claimant's industrial accident and injury caused a worsening of Claimant's depression such that the post-accident severity of her depression was predominantly the result of the accident/injury. As already stated, Claimant's depression did not significantly increase in the immediate aftermath of her accident. Despite her back injury and unsuccessful conservative medical care, Claimant's mood levels appear to have been consistent from June 2005 through October 2006. There is no indication that she complained of severely increased psychological symptoms to Dr. Mansfield or anyone else during this time.

117. Claimant underwent her first surgery in April 2006. She seemed to be recovering well, if slowly, for the first few months after her surgery, but the pain never went away, and in autumn 2006, Claimant began to abuse her opiate medications. By December, she was experiencing a sharp uptake in pain, and by early January 2007, she was suffering from severe anxiety attacks that ultimately contributed to her psychiatric hospitalization on January 5, 2007.

118. The psychiatric hospitalization was a significant event, one that shows that Claimant's psychological condition had, at least temporarily, worsened. During her evaluation with Dr. Germain, Claimant reported feeling a "smothering fear" for five days prior to her hospitalization. *See* ¶ 60 above. She also reported general unhappiness and "crying all the time" as chief complaints. Ex. D8(a), p. 23. Dr. Germain seemed to attribute Claimant's suicide gesture to her "characterological maladapation" (i.e., an inability, consistent with Claimant's personality

disorder, to adapt or cope) in the "context of significant depression and anxiety." *Id*. at 29. That is, Claimant's borderline-related struggle to cope was certainly a factor in her suicide gesture, but the precipitating factors, the ones that overwhelmed Claimant, were her depression and anxiety.

119. Interestingly, Dr. Germain diagnosed Claimant with both major depressive disorder (single episode) and dysthymia. *See* ¶ 61. Though the definition of dysthymia under DSM-IV-TR disallows comorbidity with major depressive disorder during the first two years of dysthymia, once that initial period has passed, it is possible to be diagnosed with both:

> The diagnosis of dysthymic disorder can be made only if the initial 2-year period of dysthymic symptoms is free of major depressive episodes. If the chronic depressive symptoms include a major depressive episode during the initial 2 years, then the diagnosis is major depressive disorder, chronic (if full criteria for a major depressive episode are met), or major depressive disorder, in partial remission (if full criteria for a major depressive episode are not currently met). After the initial 2 years of the dysthymic disorder, major depressive episodes may be superimposed on the dysthymic disorder. In such cases ("double depression"), both major depressive disorder and dysthymic disorder are diagnosed. Once the person returns to a dysthymic baseline (i.e., criteria for a major depressive episode are no longer met but dysthymic symptoms persist), only dysthymic disorder is diagnosed.

DSM-IV-TR 377.

120. Following Claimant's psychiatric hospitalization and subsequent treatment for opiate dependence at the Rimrock facility, Claimant's depression appears to have returned to baseline; there is no indication that she suffered from anything more than her usual depressive symptoms in late 2007 and the first half of 2008. In April 2008, she reported to Dr. Gligorovic that she felt "pretty good"; she rated her energy, stress tolerance, and interest levels as "good," while her sleep and motivation were "fair," and her anger control was fair to good. Ex. D4, p. 9. In June 2008, she was feeling "good," though she did report some struggles with sleep. *Id*. at 11. In July 2008, her condition began to decline again; she reported to Dr. Gligorovic that she had

resumed cutting and that she was having family problems. In September 2008, she confessed to Dr. Gligorovic that she accused Mr. Benner of wanting to return to his ex-wife; she was also stressed that Arianna was having some "behavioral issues." *Id*. at 14. She reported that her back was "hurting a lot." *Id*. In early 2009, she failed a class for her bachelor's program and continued to worry about the health of her marriage; she told Dr. Gligorovic that she saw Mr. Benner "watching some photos of his ex-wife and his kids" and feared that he wanted to "escape" from her. *Id*. at 17. In May 2009, Claimant suffered an emotional breakdown and underwent a second psychiatric hospitalization. *See* ¶ 75 above.

121. According to Dr. Gligorovic, the "precipitating factor" for Claimant's hospitalization was her quarrel with Mr. Benner about vacationing on the Oregon coast. *See again* ¶ 75. Dr. Gligorovic judged that she was suffering from severe depression, with symptoms including excessive sleeping, thoughts of self-harm, increased irritability, increased appetite and weight gain, feelings of hopelessness, and feelings of guilt. She also complained of chronic pain. Claimant reported that she had discontinued her therapy with her counselor, Vicki Watson, after missing several appointments. Dr. Gligorovic diagnosed, among other things, severe recurrent major depressive disorder.

122. After Claimant's discharge, her depression again returned to baseline. In June 2009, she told Dr. Gligorovic that her "life [had] improved dramatically." Ex. D4, p. 35. Her son Clifford had returned from a tour of duty in Iraq, and Claimant was getting along much better with her family, including her husband. In September 2009, she described her mood as "good," though she complained of chronic back pain. Ex. D4, p. 38. Shortly thereafter, she began her cognitive behavioral therapy with Dr. Ater. In May 2010, she reported to Dr. Gligorovic that she was "very satisfied" with her progress under Dr. Ater. Ex. D4, p. 48. Dr. Gligorovic himself

observed that Claimant was "in a much better mood and much calmer" and that this was a "huge improvement" that was "really seeable since she started working with Dr. Ater." *Id*. By the time Claimant was evaluated by Dr. LaCroix in April 2011, she was deemed psychologically stable.

123. After considering the evidence and expert opinions in the record, we find that Dr. Germain's diagnosis of Claimant with "double depression" is the most credible. Claimant suffers from dysthymic disorder, which preexisted the accident; additionally, Claimant suffered two major depressive episodes subsequent to her accident, in January 2007 and May 2009.

124. Claimant has failed to prove that her dysthymic disorder is a compensable psychological condition. It preexisted the accident, and there is no indication in the record that it substantially worsened after the accident. Claimant's psychiatric hospitalizations were both spurred by major depressive episodes, not by the low-level depression Claimant has suffered from for years.

125. Likewise, Claimant has failed to prove that her second major depressive episode, which occurred in May 2009, was a compensable psychological injury. This episode, as detailed in Dr. Gligorovic's notes, was predominantly driven by Claimant's family stress, not by issues related to her industrial accident. It is true that chronic pain was a contributing factor, but the medical records indicate that this was not the most significant factor to either Claimant or to her medical providers.

126. We find, however, that Claimant's first major depressive episode and associated medical care is a compensable psychological injury, for reasons detailed in the anxiety section below.

127. **Anxiety**. Dr. Mansfield diagnosed Claimant with an anxiety disorder prior to the accident. *See* ¶ 24. Dr. LaCroix agrees that Claimant had a preexisting anxiety disorder but

opines that the disorder was significantly worsened by Claimant's accident and injury. According to Dr. LaCroix, Claimant's diagnosis is anxiety disorder, not otherwise specified. "Not otherwise specified" indicates that Claimant has an anxiety condition that does not conform to the symptoms of a specific anxiety disorder, but rather has features of several disorders

128. To qualify for a diagnosis of anxiety disorder NOS, Claimant must have a disorder with prominent anxiety or phobic avoidance that does not meet criteria for a specific anxiety disorder. DSM-IV-TR 484. Dr. LaCroix opined that Claimant's disorder is marked by a mixture of generalized anxiety, social phobia, panic, and post-traumatic stress symptoms. "Generalized anxiety" refers to chronic anxiety and worry that is difficult to control. This leads to physical symptoms, such as muscle tension and fatigue. Generalized anxiety can also cause trouble with concentration and focus, as well as irritability. "Social phobia" refers to a fear of interacting with people. Dr. LaCroix testified that after the injury, Claimant developed a profound fear of embarrassment and worry over what people thought of her. This prevented her from going out in public, even to places like church and the grocery store. Claimant's social phobia was exacerbated by the panic features of her disorder; after her injury, Claimant suffered from severe panic attacks (including the one that caused her emergency department visit on January 2, 2007). Dr. LaCroix testified that Claimant's fear of recurring attacks impacted her functioning, in that it prevented her from going out in public and interacting with people. Claimant herself testified that her greatest fear about returning to work would be the potential of having a breakdown in front of other people.

129. Dr. LaCroix also opined that Claimant's anxiety disorder includes post-traumatic stress features; however, she does not relate these to Claimant's accident and injury, but rather to Claimant's abusive first marriage.

130. Dr. Mansfield's pre-accident records detail Claimant's complaints about her anxiety symptoms, including general anxiety that was "on and off," problems with concentration, and excessive concerns about her health and the possibility of contracting certain diseases, such as hepatitis. *See e.g.* ¶¶ 12, 21, and 24. (Dr. Mansfield's note that he would order a hepatitis panel simply to "alleviate [Claimant's] concerns" suggests that he did not consider the panel necessary or even advisable.)

131. Nevertheless, the tenor of Claimant's anxiety worsened, at least temporarily, post-injury. Claimant did not suffer from crippling anxiety attacks pre-injury, as she did for some time afterward; likewise, Claimant did not suffer from social phobia pre-injury, as she did for some time afterward. Prior to the injury, Claimant married three times and was, for the most part, regularly employed. Claimant and Mr. Benner testified that Claimant used to be a social, active person who enjoyed going out, being with people, and participating in activities such as boating and dancing. Yet after the injury, Claimant had to be coaxed out of the house by her daughter, only to suffer an anxiety attack so severe that she checked into the emergency department.

132. This acute anxiety attack, which occurred on January 2, 2007, was directly related to and caused by Claimant's accident and injury. The attack occurred due to Claimant's injury-related fear of going outside, slipping on ice, and re-injuring her back. A similar fear is not discussed in any of Claimant's pre-accident medical records, and despite Claimant's troubled history, there is nothing in her past to suggest that she would have developed this specific fear had she not suffered the industrial injury. Nor is there anything in the record to indicate that this panic attack was caused by anything other than Claimant's injury-related phobia. Claimant has proven through clear and convincing evidence that her January 2, 2007 panic attack was a compensable consequence of her accident and injury.

133. Whether Claimant's January 5, 2007 suicide gesture and subsequent psychiatric hospitalization are compensable consequences of the accident and injury is a somewhat closer question. Recurrent suicidal or self-mutilating behavior is a feature of borderline personality disorder, and Claimant's personality disorder was not caused by the accident and injury. Claimant, however, did not make her suicide gesture out of the blue. At deposition, Dr. LaCroix was asked by defense counsel to clarify the interplay between Claimant's personality disorder and her other psychological conditions:

> Q. Are there psychiatric or psychological studies that deal with the development of borderline personality disorder or anxiety disorders following back surgery?
>
> A: Borderline personality disorder can't be developed anyplace else than in adolescence. So that would not be possible. You could have the disorder — which I think happened in her case — where it's not significantly impacting your functioning; might come out in times of stress and in the ways you cope with things. But considering her background, I actually feel like she was very functional.
>
> However, what can happen at a time of stress, or when you get taken out of your environment by something like surgery, or significant recuperation, or having to stop working is that some of those traits and those dysfunctional coping skills can become more magnified. As far as anxiety we can certainly —
>
> Q. Well, if that happens, then it's largely due to the underlying problem, correct?
>
> A. Yes and no. If someone is able to have a stable environment, meaning they don't have significant physical or emotional or occupational stressors that derail them, they may or may not display any of those symptoms or need the intense level of care that she has needed since the accident.

LaCroix Depo. 43-44. In other words, while borderline personality disorder might affect the way a person handles stressful situations, it is not necessarily the disorder itself, but rather an outside

stressor, that causes the borderline individual to decompensate.

134. In this sense, Claimant is comparable to an eggshell plaintiff. Just as tortfeasors must take their victims as they find them, so, too, must employers and sureties take claimants as they find them. This does not mean that Surety should be held liable for disability unrelated to Claimant's injury, but Claimant, however frail, is entitled to receive compensation for the consequences of her injury, even if those consequences are more severe than they would have been in an average person. Idaho Code § 72-451 might create a heightened standard of proof, but so long as Claimant can prove through clear and convincing evidence that a psychological consequence for which she is claiming benefits was predominantly caused by the accident and physical injury, she is entitled to benefits for that consequence. *See* Idaho Code § 72-451(c).

135. Throughout her life, Claimant has tended to suffer extreme decompensation in the face of certain stressors. These stressors have typically been personal relationships, whether with her parents, her first husband, or Mr. Benner. In early 2007, however, when Claimant was hospitalized, her primary stressor was not a relationship, but rather her injury-related phobia. Claimant's suicide gesture and subsequent hospitalization were provoked by a "smothering fear" that had built up over a course of five days. *See* ¶¶ 59-61. Though Dr. Germain did discuss Claimant's borderline-related "characterological maladaptation" — i.e., her difficulty with adapting and coping — in his evaluation of her psychiatric status, he also noted that her suicide gesture and hospitalization had occurred "in the context of significant depression and anxiety." Ex. D8(a), p. 29. The anxiety related to Claimant's back injury and her fear of further damage; the depressive episode stemmed from Claimant's distress over her anxiety. These were injury-related stressors that caused a temporary but severe worsening of Claimant's psychological condition.

136. Claimant has proven that her emergency room visits and her psychiatric hospitalization in January 2007 were compensable consequences of her industrial accident and injury.

137. However, as with Claimant's depression, her anxiety returned to a pre-accident baseline by June 2008. At this time, Claimant had not reported anxiety attacks or other unusual anxiety/phobia symptoms to Dr. Gligorovic for several months. In July and August 2008, when she began to report increased psychological symptoms, these symptoms included mood swings, cutting, and anger — symptoms more characteristic of borderline personality disorder than anxiety. Dr. Gligorovic's notes are dominated by discussion of Claimant's difficulties with her personal relationships, while Claimant's injury-related chronic pain is mentioned only occasionally. Anxiety attacks and social phobia are not mentioned at all. Dr. Gligorovic's progress notes from late 2008 through April 2009 do not even mention anxiety as a condition being treated, though they do mention Claimant's major depressive disorder, opiate addiction, and personality disorder.

138. Claimant's anxiety was mentioned in passing in the medical records relating to her 2009 hospitalization, but it was not discussed in detail and was not treated as a substantial contributing factor to her psychological breakdown. Tellingly, anxiety was not included in her discharge diagnoses, and it was not mentioned in post-hospitalization progress notes from Dr. Gligorovic. Nor is anxiety cited in Dr. Ater's therapy notes as a major condition for which Claimant was being treated. Dr. Ater focused mainly on Claimant's borderline symptoms, which he described as "prevalent" in her day-to-day life. Ex. D5, p. 29. Claimant would sometimes discuss her chronic back pain with Dr. Ater but apparently did not mention other symptoms that she now attributes to her accident and injury (such as anxiety attacks). Her difficulty in making

and maintaining friendships was also discussed with Dr. Ater, but it was discussed in the context of Claimant's personality disorder; it was not attributed to social phobia features of an anxiety condition. *See e.g.* Ex. D5, p. 22.

139. From the evidence in the record, then, it is apparent that Claimant had a preexisting anxiety disorder that was temporarily but severely aggravated due to the accident and injury, to the extent that for a period of time, Claimant's accident and injury were the predominant cause of Claimant's anxiety. This temporary aggravation and related consequences are compensable under Idaho Code § 72-451 as discrete psychological injuries, but Claimant's underlying anxiety condition was not caused by the accident and injury and is therefore not compensable.

140. **Opiate dependence**. Finally, Dr. LaCroix diagnosed Claimant with opiate dependence and attributed the dependence to Claimant's industrial injury, explaining that the dependence was "new since the onset" of her injury and was "related to prescribed pain medication" for the injury. Ex. D7, p. 26. At deposition, Dr. LaCroix testified that opiate dependence means that a person cannot "psychologically function" without opiate medication. LaCroix Depo. 12-13. She described the impact of opiate abuse on an individual's functioning:

> Opiates in particular are notorious for causing depressive symptoms, trouble with focus, concentration, motivation, things of that nature….If you become opiate dependent, you're dampening that pleasure center to the point of having significant problems. When you're on replacement medication, such as the Suboxone, there is that — I've seen in my clinical practice a phenomenon, too, that the depression can remain at some low level as long as you're on the opiate medications.
>
> But it's certainly a very significant problem in terms of functioning, in terms of energy, mood, motivation. All those are issues with an opiate dependence, as well as a stigma of opiate dependence. If you've — you know, in terms of future medical care, when someone goes over your records and sees that you're on

> Suboxone and that you've been through residential treatment for opiate dependence, that can cause significant issues navigating things like future procedures, pain medication for things in the future.

Id. at 13-14. Though Claimant has been treated for her dependency, and her condition is considered medically stable, Dr. LaCroix warned that her Suboxone-assisted remission is somewhat artificial, because Claimant has never been weaned off the replacement medication. Claimant's care providers at Rimrock believed that the Suboxone was necessary to assist Claimant with her chronic pain, but Dr. LaCroix and Dr. McClay seem more skeptical; in fact, Dr. McClay also recommended, as part of the IME panel, that Claimant be weaned off Suboxone.[6]

141. Defendants dispute Dr. LaCroix's opinion that Claimant's opiate dependence is attributable to her accident and injury. In their brief, they discuss at length Claimant's pre-accident "fondness for [opiates] that was obviously concerning [to] her primary care physician," leading Ms. Manning to contact the Idaho State Board of Pharmacy to track Claimant's drug prescriptions. *See* Defendants' Responsive Brief, pp. 6-9, 24. Defendants also cite Claimant's history of polysubstance dependence — her abuse of cocaine and methamphetamine — as evidence that Claimant had a preexisting drug dependence problem.

142. Dr. LaCroix acknowledged in her report that a prior history of substance abuse does "place [Claimant] at a higher risk for recurrence of another form of substance abuse or dependence." Ex. D7, p. 26. However, she differentiated Claimant's polysubstance dependence from her opiate dependence, explaining that cocaine and methamphetamine are stimulants, while opiates are depressants, thus rendering the dependencies and their consequences "very different."

[6] Dr. LaCroix's opinion that Claimant's remission is artificial would seem to call into question her opinion that Claimant has reached maximum medical improvement. However, the parties appear to agree with her, as they have requested a determination of permanent impairment and permanent disability; consequently, we will accept that Claimant is medically stable with regard to her opiate dependence.

LaCroix Depo. 37.

143. Claimant's polysubstance dependence was in full remission long before her industrial accident. Furthermore, it is not comparable to opiate dependence: Claimant was not using a depressant medication as a substitute for a cocaine high. We find Dr. LaCroix's distinction between Claimant's polysubstance dependence and her opiate dependence well-reasoned and credible. More concerning to the Commission is Claimant's pre-accident, drug-seeking behavior, as well as an admitted pattern of conduct that includes using substances as a coping mechanism.

144. As detailed earlier, Claimant was prescribed opiate medications on some occasions prior to her industrial accident. While experiencing pain related to her irritable bowel syndrome, she made several requests for pain medication and even asked for Vicodin by name, resulting in Dr. Mansfield's curt note that he would not "treat IBS with narcotics." *See* ¶ 29.

145. Claimant candidly admitted that during her first marriage, she used drugs as a means of escape, and Dr. LaCroix explained that individuals with borderline personality disorder have poor coping skills. It is therefore not surprising that Claimant, both pre-accident and post-accident, sought medication to deal with her pain. Thus, it would certainly seem that Claimant had a preexisting *inclination* to use and perhaps misuse opiate medications. However, an inclination is not the same thing as a dependency. Though Claimant requested opiate medications at times prior to the accident, and though she was prescribed them at times prior to the accident, she did not actually grow dependent on them until after her accident and injury. Dr. Mansfield might have been concerned enough about Claimant's behavior to conscientiously monitor her prescriptions, but there is no mention in his notes of an opinion or even a suspicion that Claimant was drug-dependent.

146. Defendants imply that Claimant's borderline personality is the true cause of Claimant's dependence, but whatever Claimant's inclinations, and whatever the effects of her underlying disorder, there is no evidence that Claimant's dependence would have developed in the absence of her industrial injury and resultant pain. Claimant did not become dependent on pain pills that were prescribed for another condition; she grew dependent on pain pills prescribed to treat her back pain. The pain would not have been there but for her industrial injury. The pills would not have been prescribed but for her industrial injury.

147. Claimant has proven through clear and convincing evidence that her opiate dependence was caused by her accident and injury.

Medical Care

148. Because Claimant has proven that her opiate dependence is causally related to her accident and injury, she is entitled to reasonable medical care for this condition pursuant to Idaho Code § 72-432. We note, however, that Claimant has been found stable, and that neither party disputes this finding. We note, too, that Defendants have already paid for Claimant's inpatient treatment at the Rimrock facility, and it is not clear from the record whether any specific recommendations as to further treatment of Claimant's opiate dependence have been made, with the exception of the IME panel's recommendation that Claimant be weaned off Suboxone.

149. Additionally, Claimant is entitled to medical care benefits relating to her emergency room visits and psychiatric hospitalization in January 2007, and for related care thereafter. There is no opinion evidence in the record on precisely when Claimant returned to baseline — i.e., achieved stability — following her major depressive episode and the temporary aggravation of her anxiety disorder in 2007; however, the records of Dr. Gligorovic indicate that Claimant had ceased complaining about symptoms relating to these events by June 2008.

Thereafter, the bulk of her psychological complaints related to symptoms caused by relationship stress, rather than by Claimant's industrial injury. Claimant is entitled to medical care benefits for her major depressive episode and her temporary anxiety aggravation through June 10, 2008, but not thereafter.

Permanent Impairment

150. Permanent impairment is any anatomic or functional abnormality or loss after maximum medical improvement has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of evaluation. Idaho Code § 72-422. Evaluation (rating) of permanent impairment is a medical appraisal of the nature and extent of the injury as it affects an injured employee's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and nonspecialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only; the Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry*, 115 Idaho 750, 769 P.2d 1122 (1989); *Thom v. Callahan*, 97 Idaho 151, 540 P.2d 1330 (1975).

151. **Back injury**. Dr. Friedman rated Claimant's back-related PPI at 19% of the whole person. Defendants have paid benefits on this rating. Though Claimant believes that her physical limitations are more restrictive than those assigned by Dr. Friedman, and also believes that Dr. Friedman did not appropriately consider her chronic pain when rating her, she does not offer an alternative rating. Claimant is entitled to 19% PPI for her back injury. Her chronic pain will be addressed in the disability section below.

152. **Psychological conditions**. Dr. LaCroix rated Claimant's psychological impairment at 10% of the whole person. She testified that she arrived at this rating pursuant to

the *Guides*. *See* LaCroix Depo. 37. According to the *Guides*, only mood disorders, anxiety disorders, and psychotic disorders are ratable. Conditions that are not ratable include personality disorders and substance use disorders. *See Guides*, *supra* at 349. Thus, Dr. LaCroix's rating only applies to Claimant's anxiety disorder and her dysthymia (a mood disorder).

153. Claimant is not entitled to Dr. LaCroix's 10% PPI rating, as the rating is for non-compensable conditions. We have found that neither Claimant's dysthymia nor her anxiety disorder was predominantly caused by the accident and injury. Claimant did suffer a compensable major depressive episode, as well as a compensable aggravation of her anxiety; however, these temporary injuries did not result in permanent impairment. Though Dr. LaCroix opined that Claimant's overall psychological condition permanently declined as a result of the accident, Claimant's records of psychological treatment show that she in fact returned to baseline for both anxiety and depression by June 2008. Her condition declined again after this, but the decline was due in large part to factors unrelated to Claimant's industrial injury.

154. While Claimant's opiate dependence, as a substance use disorder, is not ratable under the *Guides*, the *Guides* are advisory only; as stated above, the Commission is the ultimate evaluator of impairment. Claimant's opiate dependence could qualify for an impairment rating if she has proven that the dependence is a permanent functional abnormality that affects her efficiency in the activities of daily living.

155. Dr. LaCroix's testimony, cited in ¶ 140 above, details the impact opiate dependence has on a person's functioning, including her ability to focus, concentrate, and regulate her mood. However, a close reading of Dr. LaCroix's testimony on this point reveals that she was referring to *active* opiate dependence. Claimant is in remission. Though Claimant is using a replacement medication, and Dr. LaCroix warned that this could cause depressive

symptoms, the nature of these symptoms — and how they could be distinguished from Claimant's other, non-compensable dysthymic symptoms — was not delineated. Claimant has failed to show how a drug dependency in remission impedes her efficiency in the activities of daily living. As such, she has failed to prove that she is entitled to a permanent impairment rating for her opiate dependence.

156. Claimant is not entitled to any accident-related permanent impairment benefits in addition to the 19% PPI that has already been paid by Defendants for her back condition.

Permanent Disability

157. Permanent disability occurs when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental and marked change in the future can be reasonably expected. Idaho Code § 72-423. Evaluation (rating) of permanent disability is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors. Idaho Code § 72-425. In determining the percentage of permanent disability, consideration should be given to the diminished ability of the afflicted claimant to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee and other factors the Commission may deem relevant. Idaho Code § 72-430. Permanent disability is a question of fact, in which the Commission considers all relevant medical and nonmedical factors and evaluates the purely advisory opinions of vocational experts. *See Eacret v. Clearwater Forest Industries*, 136 Idaho 733, 40 P.3d 91 (2002); *Boley v. State, Industrial Special Indemnity Fund*, 130 Idaho 278, 939 P.2d 854 (1997).

158. Claimant argues that she has suffered disability in excess of impairment due to

her chronic pain and her psychological conditions. Her age, personal circumstances, location, and limited transferable skills, along with her chronic pain and physical limitations, combine to render her totally and permanently disabled, regardless of whether her psychological conditions have been found compensable. Claimant further argues that, even if her psychological conditions are not found to be compensable, they should still be treated as personal circumstances or nonmedical factors that "significantly contribute" to her disability. Claimant's Opening Brief, p. 17.

159. Defendants reply that psychological conditions should only be considered for purposes of disability if they are found to be caused by Claimant's industrial accident and injury; otherwise, Idaho Code § 72-451 would be rendered "meaningless." Defendants' Responsive Brief, p. 27. Even if Claimant's psychological conditions are compensable, they are not totally and permanently disabling. Claimant's condition has improved substantially since 2009, and she was able to complete an associate's degree with honors and to care for her young ward, Arianna, even while she was struggling. Defendants also argue that Claimant's physical disability in excess of impairment is minimal, as her physical limitations do not prevent her from returning to the labor force and performing the type of work she has typically performed in the past.

160. **Medical factors**. Claimant has an accident-related impairment rating of 19% for her back condition. She is restricted from lifting more than fifty pounds occasionally and twenty-five pounds frequently. Claimant believes that her physical capacities are even more limited.

161. **Nonmedical factors**. Claimant suffers from severe chronic pain that was not included in her impairment rating. She was 41 years old at the time of injury and is now 48. She is a high school graduate with an associate's degree obtained online; however, the associate's degree is in a field, criminal justice, in which Claimant has no prior work experience. Claimant

briefly returned to work post-injury but has not held a job since September 2005.

162. **Psychological conditions**. The first question in evaluating Claimant's disability is how her non-compensable psychological conditions should be treated. Claimant asserts that non-compensable psychological conditions should be treated as nonmedical factors or personal circumstances, in the same way that her age and education are. Defendants reply that to treat non-compensable psychological conditions this way would render Idaho Code § 72-451 meaningless.

163. Prior to the enactment of Section 451 in 1994, Claimant's position might have been correct. The Supreme Court held in *Mapusaga v. Red Lion Riverside Inn*, 113 Idaho 842, 849, 748 P.2d 1372, 1379 (1987), that a psychological disorder "can be treated as a nonmedical factor" for purposes of disability evaluation. The landscape changed with the Legislature's adoption of Section 451, which expressly provides that "psychological injuries, disorders, or conditions *shall not be compensated* under this title, *unless*" the injuries, disorders, or conditions were caused by an industrial accident and injury and otherwise meet the requirements outlined by Section 451. Permanent disability benefits are compensation under Title 72. Thus, while we agree with Claimant that her psychological conditions are personal circumstances that might otherwise be appropriately considered under Idaho Code § 72-430, we cannot ignore the express provision of the statute, which states that claimants may receive compensation for psychological conditions *only* if those conditions are caused by industrial accidents and injuries.

164. Claimant's non-compensable psychological conditions are not "personal circumstances" for purposes of Section 430.

165. **Claimant's overall disability rating**. We must next determine Claimant's overall disability. She contends that she is totally and permanently disabled. Defendants dispute this and

argue that Claimant's disability above impairment is minimal.

166. Claimant may prove total and permanent disability under either the 100% method or the odd-lot doctrine. Under the 100% method, a claimant must show that her medical impairment and nonmedical factors combine to equal 100% disability. *Boley*, 130 Idaho at 281, 939 P.2d at 857. If a claimant cannot make that showing, then she must prove that she qualifies as an odd-lot worker. An odd-lot worker is a worker who is so injured that she can perform no services other than those that are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist. *Jarvis v. Rexburg Nursing Center*, 136 Idaho 579, 584, 38 P.3d 617, 622 (2001), *citing Lyons v. Industrial Special Indemnity Fund*, 98 Idaho 403, 565 P.2d 1360 (1977). The worker need not be physically unable to perform any work; she is simply not regularly employable in any well-known branch of the labor market absent a business boom, the sympathy of a particular employer or friends, temporary good luck, or a superhuman effort on her part. *Id.*, 136 Idaho at 584, 38 P.3d at 622. A claimant may prove total disability under the odd-lot doctrine in one of three ways: 1) by showing that she has attempted other types of employment without success; 2) by showing that she has searched for other work and other work is not available; or 3) by showing that any efforts to find suitable employment would be futile. *Hamilton v. Ted Beamis Logging and Construction*, 127 Idaho 221, 224, 899 P.2d 434, 437 (1995).

167. 100% method. Claimant has one accident-related impairment rating, 19% PPI for her back condition. Additionally, she has a 10% PPI rating for her anxiety disorder and dysthymic disorder. While Claimant's anxiety and dysthymia are not compensable, they must be included to assess Claimant's disability from all causes. *Priest* at 0033.24 .

168. Claimant's borderline personality disorder is likewise not a compensable condition, but must be considered to arrive at her overall disability rating. Borderline personality disorder is not ratable under the *Guides*, but Dr. LaCroix appeared to consider it profoundly disabling, at least, post-accident. (She minimized its pre-accident impact on Claimant's functioning.) Though Dr. LaCroix only assessed 10% impairment for Claimant's ratable psychological conditions, she implied that Claimant was totally and permanently disabled in her deposition testimony:

> Q. You identify in your report also certain functional limitations, some of them were coping skills, interpersonal skills, motivation issues, poor judgment, concentration. Are these functional issues or limitations of a sufficient severity to impact her from a vocational standpoint in your view? Would they be limitations that would carry over into a job?
>
> A. I do believe they would. Thinking in combination, especially with chronic pain, you can't predict how your pain is going to be on a given day, and for her, the existing mood and anxiety symptoms that are under control due to the medications that she's on and the work that she has done in therapy, are at a tenuous stability in terms of her environment being controlled, of her ability to rest during the day and not have significant stressors makes [sic] her able to be as functional as she is.
>
> And in a work environment these types of individuals oftentimes can have both their pain and their psychological issues impact even being at work for one or two hours. Interpersonally she has — would have significant difficulty due to pain, irritability, focus, concentration. I think that would make her performance extremely variable to the point of not predictable.
>
> Q. And what is her prognosis at this point from a psychological standpoint, in your opinion?
>
> A. I think that if she continues to work on healthy coping skills, to stay in treatment, continue medications, and to work on living with chronic pain she will have a fairly good prognosis in the sense of being able to enjoy her

> children, her new grandchild, maybe doing some things around the house and hopefully something like volunteering or some low-stress activity to give her some sense of purpose.
>
> Without a sense of purpose folks on disability often do worse. And so, hopefully, if she can do some of those things, that she'll continue to be able to function as she has been for the last few months.

LaCroix Depo. 21-22.

169. Many of the functional limitations identified by Dr. LaCroix in her report, including poor judgment, difficulty with thinking, difficulty regulating emotions, decompensation in the face of stressors, difficulty engaging in personal relationships, and lack of coping skills, are associated with borderline personality disorder. In her report, Dr. LaCroix opined that Claimant, based on her lack of coping skills, was unable to "participate on a regular basis in social or vocational activities." Ex. D7, p. 26. Other limitations, including Claimant's anxiety, low motivation, trouble with memory and concentration, and trouble communicating, are associated both with borderline personality disorder and with Claimant's other disorders. Dr. LaCroix is correct that these would be significant limitations in the workplace, where Claimant would have to exercise good judgment, cope with stress, and engage in professional relationships.

170. Defendants' vocational expert, Dr. Barros-Bailey, considered Claimant totally disabled based on her psychological instability. However, she did not say that Claimant's disability was permanent; she also opined that, should Claimant's psychological problems "ameliorate, [then] based on the permanent restrictions in the record, she should be able to resume most of her past relevant work." Ex. I, p. 10. Dr. Barros-Bailey evaluated Claimant in 2009, and Claimant's overall psychological condition has stabilized since then.

171. Claimant's chronic pain was not included in her PPI rating and so will be treated as a nonmedical factor for purposes of disability evaluation. *See Funes v. Aardema Dairy*, 150 Idaho 7, 11, 244 P.3d 151, 155 (2010) ("Pain may be considered as a medical factor, a nonmedical factor, or both, but it must be considered"). Claimant has been suffering from chronic back and leg pain since her injury in 2005. Her surgeries were not successful in eradicating her pain. There is no indication that she suffered from similar pain prior to her injury, with the exception of an isolated episode of back pain in the summer of 2003, which was treated by a chiropractor and quickly resolved.

172. Defendants have implied that Claimant's chronic pain could be attributable to something other than her accident, specifically her childhood sexual abuse. Defense counsel questioned Dr. LaCroix on this point during her deposition:

> Q. Can sexual abuse lead to psychiatric consequences in adulthood?
>
> A. Absolutely.
>
> Q. In fact, there's been quite a lot of study about that, has there not?
>
> A. Yes.
>
> Q. Would you agree that child[hood] sexual abuse can result in…chronic pain?
>
> A. That can happen. It's a particular type of — there's a certain cluster of chronic pain issues that we typically see in sexual abuse cases. They have a lot to do with the genital/urinary system oftentimes. So interstitial cystitis, frequent urinary problems, dyspareunia, which is a form of pain with sexual intercourse, are usually the most common types of chronic pain that you see with childhood sexual abuse. [Claimant] did not have those.
>
> Q. Well, she has childhood sexual abuse and she has chronic pain. You're just not seeing the link between the two?

A. In her case, no.

LaCroix Depo. 29-30. Essentially, while chronic pain and childhood sexual abuse can be connected, the type of chronic pain associated with sexual abuse is of a different kind than the type of chronic pain experienced by Claimant.

173. Dr. LaCroix went on to testify that chronic pain associated with sexual abuse would have manifested far sooner than Claimant's chronic pain did. Claimant was first abused as a small child, and then raped in her early adolescence. She was in her forties when she began to suffer chronic pain, and only then after her industrial injury. She felt the pain in the same part of her body that she injured. It is far more likely that her chronic pain is connected to her injury than it is to a long-past experience, however traumatic.

174. Though the IME panel doubted Claimant's credibility regarding her pain, we see no reason why it should be dismissed. Over a period of several years, she has consistently complained of pain symptoms to her medical care providers. Her behavior, including her abuse of pain medication, is consistent with being in pain. This pain is a notable factor in calculating Claimant's disability, because constant pain can impede both Claimant's physical ability to engage in even light labor and her mental ability to focus or concentrate on job-related tasks.

175. Claimant's age and education are also relevant nonmedical factors. Due to her physical limitations, Claimant is most suited to work in sedentary occupations. According to Dr. Barros-Bailey, appropriate jobs are mostly confined to the type of work Claimant has performed in the past: bookkeeper, secretary, administrative assistant, and purchasing agent. Dr. Barros-Bailey did not appear to believe that Claimant's associate's degree had appreciably increased her employability. In the labor market, Claimant will likely be competing for sedentary office positions against younger, more highly educated workers without Claimant's history of injury

and long-term unemployment.

176. Taking into account Claimant's medical and nonmedical factors, including her age, education, and chronic pain, as well as her non-compensable psychological conditions, we find that Claimant suffers from significant disability. However, despite the opinions of Dr. Barros-Bailey and Dr. LaCroix, we do not believe Claimant's medical and nonmedical factors add up to 100% disability, for the following reasons.

177. First, Claimant's psychological condition has markedly improved since Dr. Barros-Bailey saw her, and even since Dr. LaCroix saw her. Dr. LaCroix acknowledged that Claimant has been functioning well recently, though she qualified this opinion by stating that Claimant was functioning well in a relatively controlled home environment, as opposed to a more chaotic work environment. However, Dr. Ater, Claimant's cognitive behavioral therapist, believes Claimant has demonstrated both willingness and ability to change her behavior, and that this could lead to "significant improvement in her life." Ex. D5, p. 8. He also believes that her ability to cope with stress has slowly improved, even in the face of several significant stressors. *See* Ex. D5.

178. Second, Claimant is bright and experienced, and has shown herself capable in the past of performing well in positions of responsibility. Even while struggling both physically and psychologically, she was able to complete an associate's degree, graduating with honors. While she also failed a class and dropped out of her bachelor's program, this happened around the time of Claimant's lowest psychological point. Her condition has stabilized since then.

179. Third, Claimant presents well. The Referee found her personable and credible at hearing, and the transcript reflects that Claimant is articulate. She testified that she got along well with her co-workers during her time with Employer. According to Dr. Ater's notes, in March

2010, Claimant was "spontaneously offered a job at a jewelry store." Ex. D5, p. 29. Though the circumstances of the job offer are not detailed in Dr. Ater's notes, it is difficult to believe that anyone, even a close friend, would "spontaneously" offer Claimant a job without believing that Claimant would be pleasant to work with.

180. Dr. Ater's notes are revealing in that they provide insight into Claimant's motivation and mindset outside of a legal proceeding. In his notes about Claimant's job offer, Dr. Ater recorded that Claimant told him she would like to work if it "could be done at a physically appropriate level and if it wouldn't interfere with her [Social Security] disability income." Ex. D5, p. 29. In another note, he wrote that Claimant's "main limiting factor…is that if she doesn't feel like doing something, it's not going to happen." Ex. D5, p. 27. This suggests that, while Claimant's apprehensions about her physical limitations are genuine, she has motives for not working that are unrelated to her injury.

181. Considering Claimant's impairment, her psychological conditions, her chronic pain, and her age, education, and abilities, we find that Claimant's medical factors and nonmedical factors combine for a permanent disability rating of 70%.

182. Claimant is not totally and permanently disabled pursuant to the 100% method.

183. Odd-lot. We also find that Claimant has not met her burden of proving that she is an odd-lot worker. As stated above, in order for Claimant to prove her odd-lot status, she must show: 1) that she has attempted other types of employment without success; 2) that she has searched for other work and found that other work is not available; or 3) that her efforts to find suitable employment would be futile.

184. Claimant has only attempted to work once since her injury; she left Employer to become a purchasing agent at another company. Unfortunately, the company failed soon after

Claimant began to work there. She was laid off, due not to her inability to work, but rather to the company's economic hardship. Claimant has not shown that she has attempted other types of employment without success.

185. There is no evidence in the record that Claimant has conducted an unsuccessful job search. It does not appear that she has sought employment since being laid off from her last position. Claimant has not shown that she has searched for other work and found that other work is unavailable.

186. Finally, Claimant has failed to show that a work search would be futile. No such vocational evidence is in the record. Only one vocational expert, Dr. Barros-Bailey, offered an opinion in this case, and she stated that there was suitable work available in the job market for Claimant as long as Claimant's psychological condition stabilized. In contrast, Dr. LaCroix contended that despite Claimant's current stability, she would probably not be able to participate in vocational activities. But Claimant's most psychologically limiting factor — her borderline personality disorder — has existed throughout Claimant's entire adult life. Though Dr. LaCroix minimized Claimant's pre-accident psychological condition, the record shows that Claimant suffered from many psychological difficulties prior to her injury, including depression, anxiety, drug addiction, alcohol abuse, and attempted suicide. Nevertheless, she was able to hold down jobs — often multiple jobs at once — to support herself and her children. Dr. LaCroix's failure to acknowledge the seriousness of Claimant's pre-accident psychological condition calls into question many aspects of her opinion, including her belief that Claimant's post-accident psychological condition is so severe that Claimant is no longer capable of holding a job of any kind. While is true that Claimant is more limited now than she was before her injury, this does not mean that she is incapable of working. Without even seeking work, Claimant was offered a

job, and apparently turned it down because she was concerned about the effect it would have on her disability payments. To the Commission, Claimant testified that her primary concern about returning to work was her psychological status, but to her own counselor, Dr. Ater, she spoke only of her concern about her physical limitations and her disability benefits.

187. Claimant has failed to prove that she is an odd-lot worker.

Apportionment

188. In cases of permanent disability less than total, if the degree or duration of disability is increased or prolonged because of a preexisting physical impairment, the employer shall be liable only for the additional disability from the industrial injury. Idaho Code § 72-406.

189. Claimant argues that apportionment under Section 72-406 is not appropriate, because Claimant did not have a preexisting physical impairment. This is true; though Claimant had a brief episode of low back pain in 2003, it resolved quickly, without the need for significant medical intervention. None of Claimant's 19% PPI for her back condition was apportioned to a preexisting condition.

190. However, Claimant did have preexisting psychological conditions that have contributed to her permanent disability rating and that are not compensable pursuant to Idaho Code § 72-451. While it is true that Section 72-406 refers only to physical impairments, the edict of Section 72-451 is clear: psychological conditions will not be compensated unless they were caused by the accident. Thus, disability relating to Claimant's borderline personality disorder, anxiety disorder, and dysthymic disorder cannot be assigned to Employer, notwithstanding that these conditions do not constitute "preexisting physical impairments" under Idaho Code § 72-406.

191. Claimant's injury-related impairment is 19%. Her chronic pain and nonmedical

factors must also be taken into account in calculating her total accident-related disability.

192. Claimant has a psychological impairment rating of 10%, which applies to her anxiety and dysthymia. Her borderline personality disorder has not been rated, but it is undisputed that it is Claimant's most limiting psychological condition.

193. Apportioning disability is not an exact science, especially when Claimant's most psychologically limiting condition has not been rated. Claimant's back condition is certainly significant, but so, too, is her borderline personality disorder. However, though Claimant's preexisting psychological conditions did have some impact on her personal life pre-accident, they did not have as much impact on her professional life. Claimant was, by and large, able to maintain steady employment. Thus, we find that a somewhat greater share of Claimant's disability is due to her injury-related impairment and chronic pain than to her non-compensable psychological conditions.

194. Claimant's 70% disability from all causes should be apportioned 40% to Claimant's accident and injury, and 30% to her non-compensable psychological conditions.

Attorney Fees

195. If an employer or surety contests a claim for workers' compensation without reasonable grounds, or unreasonably delays or discontinues paying compensation, then the claimant is entitled to attorney fees. Idaho Code § 72-804.

196. The parties noticed attorney fees as an issue in this case, but the issue was not argued in the parties' briefs. Claimant contends that the issue was reserved at hearing. *See* Claimant's Opening Brief, p. 1. This is incorrect. Some issues were withdrawn, but no issues were specifically reserved. *See* Hrg. Tr. 4-6. However, since it does not appear that Claimant intended to abandon this issue, we will address it here.

197. There is no evidence in the record that Defendants have acted unreasonably in their handling of this claim. They compensated Claimant for the physical consequences of her injury and disputed their liability for her psychological conditions. Considering that Claimant's most significant psychological conditions preexisted her injury, it was not unreasonable for Defendants to deny compensation pursuant to Idaho Code § 72-451. Nor is it evident in the record that Defendants unreasonably delayed paying compensation or unreasonably discontinued payment of compensation.

198. Claimant is not entitled to attorney fees under Idaho Code § 72-804.

CONCLUSIONS OF LAW AND ORDER

Based on the foregoing analysis, the undersigned Commissioners conclude that:

1. Claimant's opiate dependence is causally related to her June 1, 2005 industrial accident and injury, and is thus a compensable psychological condition pursuant to Idaho Code § 72-451. Claimant's major depressive episode in January 2007 is likewise a compensable psychological injury, as is the temporary aggravation of her preexisting anxiety disorder in January 2007. However, Claimant has failed to prove that her anxiety disorder, her borderline personality disorder, and her dysthymic disorder are compensable psychological conditions pursuant to Idaho Code § 72-451.

2. Because Claimant's opiate dependence, major depressive episode, and temporary aggravation of her anxiety disorder are compensable conditions or injuries, Claimant is entitled to reasonable medical care for them as detailed in the discussion above.

3. Claimant has failed to prove that she is entitled to additional permanent impairment.

4. Claimant has failed to prove that she is totally and permanently disabled under

either the 100% method or the odd-lot doctrine.

5. Claimant has proven 70% permanent partial disability from all causes, inclusive of impairment.

6. Defendants are responsible for the payment of a 40% disability rating, inclusive of the impairment previously paid on Claimant's back condition. The remaining 30% disability is apportioned to Claimant's non-compensable psychological conditions.

7. Claimant has failed to prove that she is entitled to attorney fees.

8. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all issues adjudicated.

IT IS SO ORDERED.

DATED this _9th____ day of January, 2013.

INDUSTRIAL COMMISSION

RECUSED
_____
Thomas P. Baskin, Chairman

/s/_____
R.D. Maynard, Commissioner

/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __9th____ day of January, 2013, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

HUGH MOSSMAN
611 W HAYS ST
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W SCOTT WIGLE
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eb /s/_____