IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Jokhadar v. Dehkhodaei,*
2010 BCSC 1643

Date: 20101122
Docket: M082592
Registry: Vancouver

Between:

Huda Jokhadar

Plaintiff

And

Shahram Dehkhodaei and Shokat Siavosh

Defendants

Before: The Honourable Mr. Justice Willcock

Reasons for Judgment

Counsel for the Plaintiff:	T. Pettit J. V. Marshall
Counsel for Defendants:	L. C. Boulton J. S. Frahm
Place and Date of Trial/Hearing:	Vancouver, B.C. May 31, 2010, June 1-4, June 7-11 and June 14-17, 2010
Place and Date of Judgment:	Vancouver, B.C. November 22, 2010

Introduction

[1] Huda Jokhadar seeks compensation for injuries she suffered in a motor vehicle accident in the interchange at the north end of the Lions Gate Bridge in West Vancouver on October 18, 2006. Since the accident she has experienced back, neck, right shoulder and right arm pain and weakness that is, in part, a result of a soft tissue injury and, in part, a result of irritation of the nerve root caused by protrusion of a disc at the C5-6 level of her spine. In addition, Ms. Jokhadar says a bipolar affective disorder which has affected her for years has been exacerbated by the emotional and physical impact of the accident. That disorder is said to coexist with and contribute to post-traumatic stress disorder, which is also said to arise out of the accident. The assessment of Ms. Jokhadar's claim for loss of enjoyment of the amenities of life and the loss of past and prospective income requires careful consideration of her lengthy and complex psychiatric history.

Evidence

Ms. Jokhadar's Pre-2002 Medical History

[2] Ms. Jokhadar was born in Beirut, Lebanon on January 17, 1972, and raised in Syria. She married Hishram Wattar, a Syrian-born businessman, in 1986 when she was 14 and he was 24. The couple immigrated to Fredericton, New Brunswick in the summer of 1987. Their first child, a daughter, was born in 1988 when Ms. Jokhadar was 16 years of age. After the birth of her daughter she returned to Syria, where she remained with her family for 5 months. While she was in Syria she learned of her husband's intention to divorce her, which he did, according to religious practice, by letter. Surprised by this development, she made arrangements to return to Canada in an attempt to save her marriage.

[3] On her return to Canada she reconciled with her husband and moved with him to Ottawa. She gave birth to a second daughter in 1992 and describes her subsequent life in Ottawa as stable, happy, and stress-free. She missed Syria, however, and made plans to return. Mr. Wattar considered moving to Syria to accommodate her but following her departure, he decided to remain in Ottawa and again divorced her. Neither party to the marriage now attributes the divorce to mental illness or emotional instability.

[4] Ms. Jokhadar remained with her family and children in Syria for approximately nine months before returning to Ottawa at the end of 1994 so that her daughters could be near their father. On her return she lived in an apartment with her girls and trained to become a hairdresser. Although she was on welfare for some period of time in Ottawa she says this was an enjoyable time in her life.

[5] Mr. Wattar moved to Vancouver in 1996, accompanied by his eldest daughter, in search of a more moderate climate. In Vancouver, Mr. Wattar married another woman, with whom he had a third daughter. He occasionally made arrangements to have his eldest daughters visit and speak with Ms. Jokhadar by telephone, but he was not so close to her as to be aware of her psychiatric illness or treatment while she was in Ottawa.

[6] From 1996 to 2002, with the exception of short visits and telephone calls, Ms. Jokhadar was separated from her husband and daughters. During this period she completed her hairdressing training and focused on herself and her career. By 2001, however, she became depressed; in part because she was alienated from her family, and had trouble doing her job. She occasionally drank excessively. On one occasion, while returning from a club in early 2001 she was stopped by the police because she was driving erratically. When asked to

provide a breath sample she felt that if she blew even a small breath into the apparatus the world would explode. Surprisingly, she says she was permitted to go home. The next day she went to the office of her children's paediatrician and created a disturbance. The police arrived; she was taken to the Ottawa General Hospital; and she was admitted to the psychiatric ward, where she remained for three weeks. She says it was at that time her bipolar disorder was first diagnosed. This experience was said to be a turning point in her life. She changed jobs, stopped associating with some friends and altered her lifestyle. She acknowledges, however, that even after moving to a new job, she was suffering from significant depression.

[7] The medical records in evidence contain summary descriptions of Ms. Jokhadar's pre-2002 medical and psychiatric history. Because the sole source of those entries was her memory and because that memory is frail, the pre-2002 history is incomplete and vague. The entries are, however, of some value in appreciating the longstanding nature of Ms. Jokhadar's illness. In addition to documenting the events described above, the records refer to a two week hospital admission in Ottawa in 1996, said to have been a result of a general mental breakdown related to the end of a relationship with another person. Unfortunately there is little evidence of the nature and extent of that breakdown and no medical diagnosis. The records also establish that Ms. Jokhadar periodically suffered from depression after her 1986 marriage, related to, among other things, isolation and loneliness and a history of miscarriages.

[8] It was suggested to Ms. Jokhadar, at trial, that she had suffered from auditory and visual hallucinations since childhood. She acknowledged that as a child she once saw what she believed to be angels. Dr. Termansen, her treating

psychiatrist, cautions that one must not make too much of that because for a young woman in her culture a memory of such a vision is not unusual. This incident was so remote and so poorly described in the evidence that nothing significant can be made of it. The most that can be said on the evidence is that Ms. Jokhadar suffered from depression in the 1990s that culminated in at least one acute manic episode, in 2001, and perhaps another in 1996. From 2001 to the present the medical records reflect periodic significant ongoing symptoms of bipolar disorder.

2002-2006

[9] Ms. Jokhadar moved to Vancouver in early 2002. She had hoped for an immediate reconciliation with her husband but that did not happen. She began working as a hairdresser but soon felt her depression was becoming overwhelming and called the police to her apartment. She was admitted to the psychiatric unit at St. Paul's hospital in early 2002. In the records of that admission Mr. Wattar is recorded to have stated that he had divorced Ms. Jokhadar as a result of her mental instability. At trial he denied that was the case. He said that Ms. Jokhadar had been emotional and demanding but that he had not considered her to be suffering from mental illness until he first learned of her bipolar disease while she was at St. Paul's. That diagnosis caused him to consider her behaviour from a completely different perspective and to become more understanding. Having ended his relationship with the woman who bore his third daughter, Mr. Wattar again reconciled with Ms. Jokhadar in March 2002 and they have lived together since then.

[10] The 2002 hospital admission led to Ms. Jokhadar being referred to a family physician, Dr. Peter Schwarz together with Dr. Carolyn Gilbert, a frequent

locum in his office, he has regularly treated Ms. Jokhadar from 2002 to date. From March 2002 onward there are records of prescriptions for antidepressants and antipsychotics from Drs. Schwarz and Gilbert and references to regular referrals for follow-up psychiatric assessment and treatment. In September 2002 Dr. Gilbert referred Ms. Jokhadar to Dr. Mohamed Abdel-Fattah, a psychiatrist and the director of the acute psychiatric service at the Lions Gate Hospital. Dr. Abdel-Fattah formed the opinion that she was suffering continuing symptoms of bipolar disorder. He has subsequently seen the plaintiff and her husband on many occasions.

[11] Ms. Jokhadar's life became normalized for a period following the 2002 hospital admission. She worked as a hairdresser and made $25,000 in 2002. She remarried Mr. Wattar, lived with her children, and did some gardening and housekeeping. Her medical problems, however, continued. In December 2002 she began to see Dr. Werner Pankratz, a psychiatrist. He thought that Ms. Jokhadar was suffering from a bipolar mood disorder which was only partially in remission and advised her that she would require long-term management which would include medication, a mood stabiliser, and consistent psychiatric follow up. He noted that Mr. Wattar was of the view that there was a much longer history of significant untreated mood swings than Ms. Jokhadar had reported.

[12] On January 16, 2003, Dr. Schwarz saw Ms. Jokhadar for symptoms of De Quervain's syndrome, an inflammatory condition of the wrist that is an occupational hazard among hairdressers. On January 30, 2003, he excised a nodule in a tendon and gave a steroid injection. His testimony was that Ms. Jokhadar was off work for four months from December 2002 to April 2003 for symptoms of De Quervain's. With the exception of that period, Ms. Jokhadar claims to have worked four days per week in 2003. She reported earned income

of $14,400 from employment and $5,202 in Employment Insurance (“EI”) benefits in 2003.

[13] Ms. Jokhadar says she continued to work as a hairdresser four days per week in 2004 until she suffered an ankle injury that required her to wear a cast and take three months off work. She reported income from employment of $14,413 and EI income benefits of $1,668 in 2004.

[14] Dr. Pankratz continued to see Ms. Jokhadar periodically until May 2004. During that period he recorded that she occasionally failed to take her medication as prescribed; she had difficulty accepting the bipolar diagnosis. When he was advised in May 2004 by Ms. Jokhadar and Mr. Wattar of their desire to have another child. Dr. Pankratz cautioned them that Ms. Jokhadar should stop taking mood stabilisers and seek psychiatric care for her mood disorder when off medication.

[15] It is Mr. Wattar’s evidence that if he had any concerns that pregnancy would be problematic he would not have attempted to have another child. He says from 2002 to 2006 Ms. Jokhadar had no difficulty doing physical work. She did housework, was energetic and maintained a clean house. She experienced depression, but not psychotic episodes. The family got together with friends; their business was doing well; they were having fun.

[16] Ms. Jokhadar’s 22 year old daughter, a well-spoken psychology student, testified with respect to her very difficult experiences as the child of a parent suffering from bipolar disorder. Her testimony was honest but clearly affected by her youth at the time she made certain observations and her desire to be supportive of her mother, with whom she is very close. She remembers nothing of her mother’s problems before 2002. She does not recall her mother being

anxious or moody; she seemed normal and happy with her life. Following her mother's move to Vancouver and her 2002 hospitalization she was happy to have her mother return home. She recalls her as an organizing force in the period from 2002 to 2006. The family home was happy during her high school years and she remembers pleasant family trips. She recalls that her mother's work as a stylist was limited by her ankle injury for a while but she loved her work and she had many loyal clients. She was aware of her parents' plans to have another child and thought it was a great idea. Her parents had been stable and close, so far as she could tell, to 2004. She knew pregnancy would mean her mother would have to go off her medication. She did not know what her mother was using, but did not anticipate a problem. She says neither she nor her father would have approved the idea of having another child if they had any concerns about Ms. Jokhadar's emotional stability.

[17] In late 2004 Ms. Jokhadar advised Dr. Schwarz that she and her husband had visited an artificial insemination clinic in Spokane, Washington twice and she had been off her psychiatric medication for six months. He agreed with the decision to go off medication. Mr. Wattar reported that she was manageable but not stable while off medications. She was depressed, anxious and weepy at times.

[18] A letter from Human Resources and Skills Development Canada indicates that between July 11, 2004, and July 9, 2005, Ms. Jokhadar was employed for 633 hours. She therefore worked an average of 12 hours per week, less than two days a week, in that period.

[19] There was a flare-up in her manic symptoms in July 2005. An EI record shows that that she received employment benefits from July 10 to October 30,

2005. That corresponds with the flare-up in manic symptoms documented in the records. Ms. Jokhadar went back on medication. After she returned to work she advised Dr. Schwarz that she was suffering a tremor, a side effect of the use of the antipsychotic used to treat her bipolar disorder, Seroquel. Her reported income from employment in 2005 was $9,582 and her EI benefits were $3,604.

2006 Pre-accident

[20] On April 27, 2006, Ms. Jokhadar advised Dr. Gilbert that she was depressed and lethargic; she had been tearful at work. On May 11, 2006, she was still very tired. Her medications were adjusted and blood tests were ordered to investigate causes of fatigue. On June 30, 2006, she saw Dr. Abdel-Fattah, complaining of reduced concentration and depression. She was weepy. Dr. Abdel-Fattah noted that she was depressed. He was cautious in his treatment because he was concerned that use of antidepressants might trigger a manic episode.

[21] From August 2006 through to the accident that gives rise to this claim Ms. Jokhadar was prescribed, at various times, the antidepressants Cipralex, fluoxetine and Welbutrin. She claims not to have taken many of the prescribed antidepressants because she was still trying to get pregnant. She continued, however, to receive prescriptions for Welbutrin until September 13, 2006. She is uncertain of the date she stopped taking the medications prescribed and dispensed to her, but it would make little sense for her to continue to obtain and pay for medication she was not using. I find that she was using that medication on an ongoing basis until at least the date each was last dispensed.

[22] At her last pre-accident visit on September 13, 2006, Dr. Schwarz noted that Ms. Jokhadar was on Welbutrin, and that her mood was stable with few ups

or downs. She reported that she was sleeping well but irritable and angry at times, especially at work. Dr. Schwarz noted that she advised him that she often felt the need to have a drink for confidence to go to work. She was working about 3 days per week, up to 30 hours a week, in the months before her accident. There is some evidence that her anger at work in 2006 was a symptom of a manic phase of her illness.

[23] We now know that between the office visit and her accident on October 18, 2006, Ms. Jokhadar became pregnant. Before her accident she was therefore destined to go off mood stabilizing medications for at least the duration of her pregnancy to July 2007. When she had previously gone off medication while attempting to become pregnant, in 2004-2005, her depression had become disabling. She required medication on an ongoing basis to control her longstanding bipolar disorder.

[24] Ms. Jokhadar declared income of $26,047 in 2006, and denied income splitting with her husband that year. I place little reliance upon the 2006 declared income for the purpose of assessing her loss of income and income-earning capacity. Ms. Jokhadar did not work at all in November and December 2006. She only claims to have worked 3 days per week when she was working in 2006. Given that she later did engage in income splitting with Mr. Wattar, by declaring some of the income from his restaurant business to be hers for tax purposes, given no other explanation for the 2006 declared income and given the absence of any documentary evidence of income for employment, I conclude that the declared income on the 2006 income tax return is not as indicative of Ms. Jokhadar's pre-accident income or her future income earning capacity as the declared income in 2003-2005.

[25] Mr. Wattar's recollection is that in the summer prior to her accident their family life was normal and happy. Ms. Jokhadar was not unusually depressed. He thought everything was fine at her work and was not aware of her drinking in the morning. He does not think that occurred; it would have been impossible to hide. He knew about disputes at her work but regarded these as normal in the workplace. Mr. Wattar's evidence about this period is inconsistent with the medical records, which I regard as a more reliable indicator of the state of Ms. Jokhadar's pre-accident health. Mr. Wattar minimizes the extent of Ms. Jokhadar's pre-accident depression. For example, he cannot recall the symptoms that led her to take three months off work in 2005. Nor does he remember her becoming increasingly depressed when off medications, although that is well-documented.

[26] Her daughter also testified that Ms. Jokhadar was emotionally stable in 2006. She was getting ready to go to university at that time and her mother was pleasant and helpful to her and her friends. She said she had never seen her mother drinking other than at dinner on special occasions. She does not remember having alcohol in the house.

[27] Ms. Sadik, a family friend who has known Ms. Jokhadar since 2002, saw her regularly at the family home and went on many family trips with her She described Ms. Jokhadar as a very energetic woman who loved life before her accident. She was very clean and organized, "a 1st class housewife". She appeared to have no problems with physical activities. She was not moody and appeared to be happy with her children, her house, and her husband. Ms. Sadik was unaware of any family difficulties prior to 2006; was unaware of Ms. Jokhadar's documented unhappiness at work in September 2006 or her trouble with depression when she stopped taking medication to become pregnant

in early 2005; and was entirely unaware Ms. Jokhadar had a mental illness until 2008. To some extent Ms. Sadik's ignorance of significant functional problems prior to the 2006 motor vehicle accident is a measure of the relative quiescence of Ms. Jokhadar's bipolar illness but it must also be regarded as evidence that Ms. Sadik was not close enough to Ms. Jokhadar at this time to be regarded as a knowledgeable observer of her mental health. There is support for this conclusion in Ms. Jokhadar's own evidence that she only felt comfortable discussing her depression with her treating doctors.

October 18, 2006

[28] On Wednesday, October 18, 2006, Ms. Jokhadar went to her salon at Park Royal in West Vancouver. It was dark when she left Park Royal. As she drove east along Marine Drive through the Lions Gate Bridge interchange she suddenly saw headlights coming toward her. She braked and shut her eyes on impact. She recalls little of the collision, but says that when she got out of the car and walked to the nearby curb she was shaking and felt cold, she was not sure she was alive. She remembers little pain at the accident scene, but says that when she got to the Lions Gate Hospital in North Vancouver she began crying hysterically and felt pain all over.

[29] Mr. Dehkhodaei does not deny responsibility for the accident giving rise to this claim. He testified not to the absence of fault, but to what he regarded as the minor nature of the collision. In the early evening he was driving north on the Lions Gate Bridge at about 60 km/h in heavy rain, intending to turn east on Marine Drive to proceed to Capilano Road. As he began to turn he lost control of his vehicle. The left front wheel of his car hit the concrete median, causing his car to spin. He bounced over the median and travelled into the other eastbound lane of traffic, that coming from West Vancouver, where he collided with

Ms. Jokhadar's vehicle and a second median, separating westbound from eastbound traffic. Although he felt his car sliding and then turning, he does not believe his car ever turned so far as to face eastbound traffic. There was significant damage to the front and front right corner of his car. He noted that the hood of Ms. Jokhadar's car had been crumpled and forced open. Her airbag was activated in the collision.

[30] Mr. Michael Allen, an ICBC estimator, described the damage to Ms. Jokhadar's car. It was not insignificant. Most of the damage was to the front and right front corner. Because the frame rail was bent the car was a constructive total loss.

[31] Mr. Dehkhodaei denied the suggestion that this was a head-on collision, despite his difficulty remembering many of the details of the accident. He insisted that Ms. Jokhadar's vehicle struck his car on the driver's side near the door, despite the absence of any evidence of a significant collision at that point. I conclude that he was mistaken in his recollection at trial, which differed in many respects from his earlier description of the accident. I accept Ms. Jokhadar's recollection of the accident and conclude that the vehicles collided violently while facing each other almost head on.

[32] After the collision, Ms. Jokhadar remained in her car for 5 to 10 seconds before she opened her car door and got out, unassisted, but she soon began crying and trembling. She indicated to Mr. Dehkhodaei that she was OK, but was weeping.

[33] When the emergency health services personnel arrived at the scene of the accident, Ms. Jokhadar was alert and oriented but she complained of neck pain and back pain. She was taken to the Lions Gate Hospital. On admission she

complained of neck pain radiating to her left elbow and discomfort in her mid-abdomen. She was discharged home in a hard collar and advised that she should wear that for two days, then replace it with a soft collar and follow up with her family doctor. She was thought to have suffered a sprain of her cervical spine.

2006 Post-accident

[34] Ms. Sadik went with the family on the day after the accident to see Ms. Jokhadar's vehicle, saw her sit on the floor and heard her say that when the accident occurred she saw the other car's headlights, closed her eyes, and said to herself "I'm dead, I'm finished, I'm done".

[35] Dr. Gilbert saw Ms. Jokhadar on October 20, 2006. She was weepy as she described the accident. She complained of pain in her right arm and tenderness over the 2nd and 3rd cervical vertebrae. Dr. Gilbert did not prescribe an anti-inflammatory, as she otherwise would have done, because it was thought Ms. Jokhadar might be pregnant. By the time Ms. Jokhadar was again seen by Dr. Gilbert on November 3, 2006 she was known to be pregnant. Dr. Gilbert suggested a referral to Dr. Misri, the director of The Reproductive Mental Health Program at St. Paul's Hospital, an expert in the treatment of women with psychiatric illnesses during pregnancy and in the postpartum period. Ms. Jokhadar was afraid of the potential effect of the accident on her pregnancy and was afraid to see Dr. Misri. There is no record of her doing so. When Ms. Jokhadar learned she was pregnant she became fearful of losing the foetus or its features being affected. Ms. Sadik tried to comfort her but to no avail.

[36] On October 24, 2006, she attended at physiotherapy and complained of pain down the right side of her back radiating to her toes. She returned to physiotherapy on four occasions to December 5, 2006.

[37] On November 15, 2006, Ms. Jokhadar complained to Dr. Gilbert of symptoms consistent with injuries in the motor vehicle accident. Dr. Schwarz first saw her after the accident on December 5, 2006. She complained then of right-sided pain in the shoulder and neck. He found muscle spasm and inflammation on palpation. She was very emotional. Normally at this stage a patient might be engaging in gentle range of motion and gentle stretching exercises. Dr. Schwarz felt Ms. Jokhadar was unfit to work due to her injuries.

[38] Her family noted post-accident emotional and behavioural changes. Ms. Jokhadar remained bedridden for a week after the accident and was very emotional. When her daughter tried to reassure her, Ms. Jokhadar said she felt numb. Her emotional state became unstable, she slept in the daytime, didn't take care of herself and was not well dressed. She stopped socializing. A month after the accident she began to complain of constant physical pain. She was, in her daughter's words: "Totally out of whack". Fear seemed to take over her life. She was afraid to walk, to go to the mall or to drive. Her daughter knew she had nightmares, but her mother would not tell her what they were about.

2007

[39] On January 10, 2007, Ms. Jokhadar saw Dr. Schwarz for symptoms of pneumonia. Her next visits were predominantly for those symptoms, but in February 2007, she was referred to Dr. Mark Adrian, a specialist in physical medicine and rehabilitation. Dr. Adrian obtained a history of symptoms of neck pain, predominantly on the right side, radiating into the right shoulder girdle.

Ms. Jokhadar also complained of pain in the lower back region over the right lumbosacral junction travelling into the right buttock. Her symptoms were aggravated with reaching, pushing, pulling, carrying, and prolonged sitting. Dr. Adrian diagnosed mechanical neck, thoracic, and lumbar spinal pain. He anticipated a gradual recovery over three to six months and recommended a low-impact, light exercise program.

[40] In March 2007, Ms. Jokhadar reported continuing significant back and neck pain to Dr. Schwarz, who again referred her to Dr. Misri. Again, she did not attend.

[41] Ms. Jokhadar gave birth to a healthy baby, a son, on July 10, 2007. Her eldest daughter was concerned about her ability to manage at home, didn't want to leave her, and felt obliged to take care of the house. She had been a good and popular student in high school, but because of her obligations at home at this time she made few friends at university and failed a course that fall. She felt her mother became too focused on herself and gave her son little attention. She breastfed him less than a month, complaining of shoulder pain when feeding.

[42] By the fall of 2007 Ms. Jokhadar was still doing little at home. In December 2007 she was again complaining to her doctors about injuries and stress related to the car accident. Dr. Schwarz felt that Ms. Jokhadar was suffering from chronic whiplash symptoms. He referred her to Dr. Paul Termansen for treatment of her bipolar disorder.

2008

[43] Ms. Jokhadar believes she returned to work and worked 8 hours per day for three months, commencing in late February 2008. She was encouraged to do

so by her family who felt work would lift her depression. Constant pain made work intolerable and she soon reduced her hours to part-time. She was tired and guilty because she was not doing her job well. According to her family, she came home from work crying every day and had no energy to do housework. In March 2008, Dr. Schwarz made a note that Ms. Jokhadar appeared to be suffering from hypomania; her mood was rapidly fluctuating. She had been working, going to the gym, and going for walks but she was irritable, self-critical, and retreating from life. Dr. Schwarz prescribed an antidepressant and referred her to Dr. Pankratz.

[44] Dr. Schwarz continued to see Ms. Jokhadar regularly and monitored her antidepressant and antipsychotic medication. On March 28, 2008, he recorded the patient's wish to die. In April he noted that the antipsychotic she was then taking "zombified" her. She felt her psychiatric medications were becoming less effective. They then made her tired, frustrated and bored.

[45] She went to see Dr. Pankratz on April 8, 2008 because, in her words, she felt dead. She reported that since her motor vehicle accident she had felt fearful when outside her home and that she lived with a sense of apprehension and dread. Dr. Pankratz felt she was still obviously depressed and functioning at a poor level.

April 12 to 17, 2008, Lions Gate Admission

[46] From April 12 to 17, 2008, Ms. Jokhadar was an in-patient at the Lions Gate Hospital, having been admitted through the emergency department as a result of bizarre behaviour. While at Lions Gate she was assessed by Dr. Glen Freedman and Dr. Abdel-Fattah. Dr. Freedman noted that on admission her thoughts were tangential, her speech was pressured, her thoughts were racing,

and she was preoccupied with visual and auditory hallucinations. Dr. Abdel-Fattah was advised by Mr. Wattar of a suspicion that Ms. Jokhadar had been taking too many antidepressants and had refused to take mood stabilizers, as they made her feel dull. Dr. Abdel-Fattah believed that antidepressants had precipitated manic episodes in the past. He counselled her to avoid the use of antidepressants as they appeared to trigger delusional manic episodes. The admission was described in the hospital records as having occurred as a result of an adverse reaction to Manerix (a MAO inhibiting antidepressant), which was thought to have precipitated a manic episode. Ms. Jokhadar accepted a recommendation that she commence a trial of Lamictal, an antiepileptic drug used as a mood stabilizer for depressed bipolar patients, as a means of avoiding antidepressants. The defendants say it is noteworthy that on this admission Dr. Abdel-Fattah was not aware of the patient's motor vehicle accident. He agreed that the car accident was not an issue he ever addressed. He did not diagnose post traumatic stress disorder ("PTSD").

[47] During the April 12 to 17, 2008, Lions Gate admission Ms. Jokhadar expressed some dissatisfaction with Dr. Pankratz's care and she was referred to Dr. Pedro Paragas for treatment on her discharge. Dr. Paragas saw her in June 2008. He concluded she was suffering from a mood disorder, in partial remission. He prescribed both Lamictal and the modafinil that had been discontinued by Dr. Abdel-Fattah.

June 23-30, 2008 Lions Gate Admission

[48] In June 2008 Ms. Jokhadar was again hospitalised. Family members again believed she had been non-compliant with her medication. When her behaviour had become increasingly bizarre over a period of approximately two

weeks they called the police, who again took her to Lions Gate Hospital. During the course of the resulting June 23-30 admission, she was assessed by Dr. Avinder Minhas, who concluded that she had been in a manic phase of her bipolar disorder. Ms. Jokhadar denies she told the hospital staff on that admission she had gone off her medication, as was recorded in the chart.

[49] By June 30, 2008, her thought disorder and perceptual disturbances had resolved. She was on appropriate medication and was discharged to see Dr. Allan Burgmann for follow up. She was taken off the modafinil prescribed by Dr. Paragas. On discharge she consulted with Dr. Schwarz; he prescribed medication sufficient to effectively treat her condition during a planned vacation to Syria commencing July 7, 2008.

2008 Post-Discharge

[50] In June 2008 the family moved to a new home. To reduce the stress of the move the family arranged for Ms. Jokhadar to visit Syria with one of her daughters and her son. From July to September 2008 she was in Syria. The family felt she did not improve at all. Ms. Sadik, who was in Syria at that time, met her there and then first learned of Ms. Jokhadar's bipolar illness. On returning to Vancouver Ms. Sadik agreed to live with the Wattars and assist with housework and child care. In late 2008, Ms. Jokhadar continued to complain of pain, was unhappy, and did not engage in activities.

[51] Mr. Wattar says when Ms. Jokhadar went back to work after returning from Syria in 2008 she had not recovered emotionally. She was desperate to work and contacted the salon but they didn't want to hire her. Mr. Wattar made a plea on her behalf that led to a decision to permit her to return to work 2 or 3 days per week. When she did so in October 2008, she tried to hide her pain and limitations

from co-workers. She continued to use antipsychotics and antidepressants. In October and November 2008 she reported to her doctors that she suffered right shoulder pain and right cervical and thoracic back pain after work. Dr. Schwarz's notes indicate that as her mood disorder was increasingly well-managed she made more regular complaints of neck and right shoulder pain. In early 2009, she complained of significant, continuing paravertebral and cervical thoracic pain.

February 21-25, 2009, Richmond General Admission

[52] On February 21, 2009, Ms. Jokhadar suffered another episode of acute manic psychosis leading to hospitalisation. Her family again noticed her behaviour becoming increasingly erratic over a period of five to seven days until she was admitted involuntarily and kept in secure seclusion. She gradually settled over a number of days as her medication was adjusted. There is an uncertain history with respect to whether Ms. Jokhadar had been compliant with her medication prior to admission. Mr. Wattar suspected she was becoming addicted to modafinil and using more than usual. Ms. Jokhadar claims to have been taking medication as recommended by her physicians and she denies her husband's suggestion to the staff that she was addicted to modafinil or that this had acted as a stimulant, triggering manic episodes. She denies that she stopped taking the antipsychotic, Seroquel. She acknowledges, however, that she has given inconsistent histories to health care providers, Seroquel caused her to feel "dead", and once she began using modafinil she suddenly became awake.

[53] Ms. Jokhadar was discharged against medical advice on February 25, 2009. Mr. Wattar says that upon her discharge she seemed to be calmer, but she

had not recovered. She was still manic, was dressing provocatively and acting strangely.

March 2-30, 2009 Lions Gate Admission

[54] Ms. Jokhadar was again involuntarily admitted to hospital shortly thereafter, on March 2, 2009, as a result of manic symptoms. During this hospitalisation she was again seen by Dr. Abdel-Fattah. In his opinion she demonstrated both ends of her bipolarity and had poor insight. She was histrionic, flamboyant and narcissistic. Dr. Abdel-Fattah recorded Mr. Wattar's statement that she was not using the Seroquel that had been prescribed for her and noted that Ms. Jokhadar admitted that she was not using medications as prescribed. Dr. Abdel-Fattah has no recollection or note of any discussion of the motor vehicle accident on this visit.

[55] Ms. Jokhadar was given extended leave from the hospital on March 30, 2009, rather than being discharged, because of the family's continuing concern about non-compliance with medication. It was a term of her leave that she would attend regularly at Community Psychiatric Services and stay on the medications prescribed.

[56] Ms. Jokhadar says her problems in early 2009 were due to stress. She denied non-compliance with prescriptions and attributed her hospitalization to the vagaries of bipolar disease, particularly in the presence of stress. Mr. Wattar says he thought non-compliance with medical advice was a problem until physicians advised him that Ms. Jokhadar could not handle stress. It was a relief to him to learn that Ms. Jokhadar's manic episodes were not intentionally self-induced. He understood that she would attend the outpatient clinic upon her discharge and, on that basis, he was willing to stay with Ms. Jokhadar and

support her. He had considered divorce before the 2009 hospitalization, but says that is not on his mind now.

2009 Post-Discharge

[57] Ms. Jokhadar came into the care of Dr. Termansen, who first saw her in consultation on April 4, 2009 and has since seen her regularly and followed her participation in the Community Psychiatric Services programme.

[58] There is evidence that Ms. Jokhadar's physical injuries have not resolved. Through 2009, Ms. Jokhadar continued to see Dr. Schwarz. She regularly complained to him of shoulder pain and upper thoracic pain. She attended acupuncture and found that this was helpful. On May 22, 2009, she returned to see Dr. Adrian for follow-up assessment. Dr. Adrian noted a mild restriction of neck range of motion and tenderness at the base of the neck and over the mid-back spinal segments. He thought Ms. Jokhadar was continuing to experience clinical features of mechanical neck and mid-back pain.

[59] On June 1 and June 18, 2009, Ms. Jokhadar attended at an assessment by Dr. William Koch, a psychologist retained by her counsel.

[60] On June 19, 2009, she attended an independent medical assessment conducted by Dr. Kevin Solomons, the psychiatrist retained by the defendant.

[61] On July 23, 2009, Dr. Schwarz noted that Ms. Jokhadar required regular physiotherapy for her chronic whiplash injury. When her pain persisted he referred her to the Rapid Access Spinal Clinic at Lions Gate Hospital. On September 11, 2009, she attended for a cervical spine x-ray that revealed moderate disc space narrowing and small osteophytes at the C5-6 level. She underwent a CT scan at Canadian Magnetic Imaging on September 24, 2009.

The CT scan revealed a large disc protrusion at the C5-6 level with cord compression and significant foraminal narrowing described as follows:

> At C5-C6 there is a moderate disc space narrowing and desiccation. There is a right paracentral and foraminal broad-based disc protrusion. This significantly indents and deforms the cord. Significant mass effect on the cord is noted. Cord signal is normal without intracord hemorrhage or obvious edema. There is significant encroachment on the right neural foramen and displacement of the exiting nerve root.

[62] These results are described by the radiologist as demonstrating disc desiccation involving the majority of the mid and lower thoracic spine discs.

[63] On October 8, 2009 Dr. Ramesh Sahjpaul, a neurosurgeon, examined Ms. Jokhadar and reviewed the MRI of September 24, 2009. He concluded that she had a soft tissue injury to her neck and that she might have some right shoulder pathology. He was uncertain whether her right arm symptoms reflected the impingement of the disc on the nerve root, because of the absence of radiated pain in the arm. He was concerned there may be some early spinal cord compression symptoms. He recommended a right C6 nerve root block and follow up assessment.

[64] On October 22, 2009, Ms. Jokhadar underwent a cervical nerve root block.

[65] At the end of 2009, Dr. Termansen was of the view that Ms. Jokhadar was continuing to struggle with emotional instability, chronic PTSD, and chronic pain syndrome. He felt that she was unable to return to work and this had been a serious obstacle to her rehabilitation. Her mood remained unstable and required constant monitoring.

2010 to Present

[66] Ms. Jokhadar saw Dr. Sahjpaul for a follow-up assessment on January 28, 2010. She reported that there had been no improvement of her symptoms following the right C6 nerve block. Dr. Sahjpaul recommended nerve conduction studies to determine whether the symptoms were related to the impingement of the disc on the nerve root at the C5-6 level. Ms. Jokhadar was then assessed by a neurologist, Dr. John Stewart. He could not identify any sensory motor deficit. Following review of Dr. Stewart's report, Dr. Sahjpaul expressed the view on March 5, 2010, that Ms. Jokhadar was suffering from neck pain and right shoulder and arm pain and weakness which were likely a combination of myofascial pain (pain caused by injury to the soft tissues surrounding the spine) and discogenic pain (pain caused by impingement of the disc upon the nerve root).

[67] On February 11, 2010, Ms. Jokhadar was again assessed by Dr. Koch. Ms. Jokhadar has continued to see Dr. Termansen and Dr. Schwarz on a regular basis to the date of trial.

[68] She is now receiving CPP disability benefits. She says she is unable to work because of the combined effect of her physical limitations and bipolar illness. She is working on an exercise program at home. She continues to have pain in the upper shoulder and neck region, occasionally radiating down her arm.

[69] Ms. Jokhadar's relationship with her husband and her daughters has been rocky over the last couple of years, but has improved with better management of her mania. She and her husband have required counselling to understand her illness and that stress relief, rather than a change in her medication, will lead to improvement. She has advised Dr. Termansen that she would like to go back to

school when her concentration improves. Her written English is poor. She has tried to do some upgrading but has had difficulty. She hoped to enter adult education classes at Capilano University. She is now doing housework again but no heavy lifting. She teaches her son Arabic. Her lifestyle is relatively sedentary; she does some light exercise, but her pain has not improved. She habitually massages her neck and shoulder to ease her pain. She says her episodes of depression are not as severe as formerly.

[70] Ms. Jokhadar's daughter described in painful detail the psychotic episodes that resulted in her mother's hospitalization in 2008 and 2009. She testified that between these episodes her mother continued to be emotionally unstable, lost weight, and became depressed. She believes her mother has been working hard on her recovery in the year since the last Lions Gate admission. She thinks her mother cannot work as a hairstylist; she is too slow and unorganized. Her daughter thinks she is now physically better and Dr. Termansen is helping her a lot, however she says her mother does not engage with her son, does minimal housework, and is very inefficient.

[71] Ms. Sadik has regularly visited Ms. Jokhadar from April 2009 to date. She says Ms. Jokhadar regularly complains that she is tired and of pain in the shoulder. She cries a lot and appears to be unable to take care of her family. She has not returned to her former household and social activities.

Expert Opinion

Musculoskeletal Injury

[72] Dr. Schwarz has provided primary care. In his report of June 29, 2008, he summarised the progress of the plaintiff's back and neck injury to that date. He reported that Ms. Jokhadar had "marked cervical thoracic muscle weakness and

wasting". She was tender on palpation on the upper back and upper thoracic and costovertebral joints. After following her progress to early 2010 and reviewing the report from experts and the MRI, Dr. Schwarz concluded:

> I believe that the likely cause of the C5-6 findings is the motor vehicle accident as she does not appear to have had any other significant injury to which it could be attributed. It may be that the accident caused the cord compression to become symptomatic.
>
> The relationship between the accident and the right arm pain is such that I believe that the motor vehicle accident is the cause of the right arm pain. Whether this can be attributed to the C5-6 injury or whether the accident caused some other soft tissue injury, which is not apparent on the MRI, I believe the motor vehicle accident is the cause of her right-sided neck pain and arm pain.

[73] That opinion is consistent with the views expressed by the neurosurgeon, Dr. Sahjpaul, and the physiatrist, Dr. Adrian. Dr. Sahjpaul is concerned that the MRI suggests cord compression, but is not convinced that the plaintiff's symptoms are entirely or even significantly a result of compression. While there is some subtle weakness in the plaintiff's right hand grip strength and a subjective complaint of weakness in the arm, there is no significant neurological component to her injury. Dr. Sahjpaul believes the plaintiff's neck pain and right shoulder and arm pain and weakness is caused by a combination of a soft tissue injury and irritation of the nerve root at the C5-6 level. He says the motor vehicle accident was causative of the plaintiff's symptoms because there is no apparent history of significant neck, back or arm pain prior to the motor vehicle accident; the plaintiff is too young to have primarily degenerative changes; and change at the C5-C6 is focal and pronounced, suggesting that it is a result of trauma at that level, rather than degenerative change. He says there is some prospect that Ms. Jokhadar will require surgical intervention as a result of the obvious and problematic C5-6 herniation seen on the MRI.

[74] In his February 7, 2007, report, Dr. Adrian expressed the opinion that Ms. Jokhadar was suffering from clinical features consistent with a diagnosis of mechanical neck, mid-back, and low-back pain. He felt that it was somewhat unusual for Ms. Jokhadar to have experienced no improvement several months after her accident. He expected there would be gradual recovery from those symptoms over a period of perhaps two years.

[75] Dr. Adrian's opinion became more pessimistic over time. In May 2009 he said:

> Mrs. Jokhadar will probably continue to experience difficulty performing activities that place physical forces on the painful structures involving her neck and back. Specifically, she will probably continue to experience difficulty performing house work, recreational and employment activities that require prolonged static or awkward positioning involving her spinal column, stooping, repetitive twisting, repetitive reaching, heavy or repetitive lifting or carrying.

[76] Dr. Adrian acknowledged Ms. Jokhadar was limited by both physical and psychological symptoms and that he did not evaluate the latter. He did not review the patient's work history to determine whether that history would reflect her limitations, or whether the limitations were consistent or progressive. His poor prognosis was based primarily upon the duration of the persistence of the subjective complaints.

[77] After becoming aware of the results of the CT/MRI in March 2010, Dr. Adrian, in the following words, expressed an opinion very similar to that expressed by Dr. Sahjpaul:

> It is possible that the disc protrusion noted at the C5-C6 level and impingement of the adjacent right C6 spinal nerve root is resulting in atypical spinal nerve symptoms, manifested as scapula (shoulder blade) pain. Other potential sources for Mrs. Jokhadar's right shoulder blade symptoms are referred pain from her neck. Referred pain is pain that is experienced at a site distant to the source of pain, but not due to injured nerves.

Depression, Bipolar Disorder and Post-Traumatic Stress Disorder

[78] As noted above, the plaintiff has been assessed by a psychologist, Dr. Koch, who has interviewed her extensively and reviewed the medical records. Ms. Jokhadar has been treated for some time by Dr. Termansen. He has expressed an opinion on her condition and prognosis. She has regularly seen Dr. Schwarz who has monitored her psychiatric care and she has been seen from time to time by Dr. Abdel-Fattah. She has been assessed at the defendant's request by Dr. Solomons.

[79] There is, of course, a psychiatric diagnosis: Ms. Jokhadar clearly suffers from a bipolar disorder. She is acutely sensitive to changes in her medication. She has had difficulty controlling the disorder over time and has greater difficulty doing so when she is subject to stressors. There is a dispute with respect to the extent to which Ms. Jokhadar's mental illness was aggravated or exacerbated by the 2006 motor vehicle accident as well as the extent to which she should be able to control her mania with appropriate medication over the long term.

[80] Dr. Koch provided the court with reports dated July 9, 2009, and March 16, 2010, in which he says Ms. Jokhadar has been disabled from employment by bipolar disorder with occasional manic episodes, in remission, by PTSD, and by a specific phobia of motor vehicle travel. He says these conditions have been triggered by a variety of psychosocial stressors including marital discord, problems in social support, and the accident. According to Dr. Koch's assessment of her symptoms, Ms. Jokhadar does not meet the stringent test for diagnosis of PTSD. Notwithstanding that fact, Dr. Koch believes that she demonstrates the symptoms of the disorder and that the diagnosis is appropriate. In response to the suggestion the trauma was not such as to generate a

significant psychological disorder, he says the relationship between magnitude of the trauma and PTSD is a modest one. The severity of a patient's physical injury is not highly related to the development of PTSD. This patient related to Dr. Koch that she feared for her life and that upon the occurrence of the collision she felt her spirit leave her.

[81] Her bipolar disorder was considered by Dr. Koch to be a pre-existing condition, primarily biological in nature, symptoms of which were triggered and aggravated by the stress caused by the motor vehicle accident in conjunction with her fears about her foetus. Bipolar disorder is recognized as a constitutional condition - one that is contributed to by genetic and personality factors - that causes patients to be affected by cyclical periods of clinical depression and mania. It is recognized that psychosocial stressors increase the risk of relapse of periods of depression.

[82] During Dr. Koch's assessment of Ms. Jokhadar on June 1 and June 18, 2009, she was very distractible and severely depressed. She had some difficulty with self-assessment, but she did not endorse unusual symptoms. This led him to accept as accurate her description of her then-current symptoms. Dr. Koch felt that sedatives had contributed to her fatigue and low mood. He concluded that her fatigue and distractibility were the greatest impediment to returning to work.

[83] At the time of his most recent report in March 2010 Dr. Koch was of the view that Ms. Jokhadar was primarily disabled by depression, a problem which has been difficult to treat pharmaceutically because of her underlying bipolar disorder. She appeared to be more depressed than previously and related some marital strain. Pending litigation was also recognized by Dr. Koch as a psychosocial stressor. He recommends that an allowance be made to permit

Ms. Jokhadar to attend 50 hours of psychological therapy, but is of the view that even with that therapy there is a poor prognosis for the long term.

[84] Dr. Termansen, who is the expert most familiar with Ms. Jokhadar's condition and treatment, says she is suffering from a rapidly cycling disorder which will require long term monitoring and intense treatment and supervision. Chronic neck and shoulder pain limits her ability to work. Inability to work worsens her depression because work gives her social opportunity and self confidence. Her prognosis for recovery is therefore guarded. The prognosis worsens with the number and severity of episodes of depression, as episodes beget each other. He describes Ms. Jokhadar as being very determined to stay out of hospital because she has had very difficult mental experiences when psychotic. He has agreed to see her regularly to prevent such episodes. He is of the view that Ms. Jokhadar would have been hospitalized twice since 2009 if she had not been actively participating in the outpatient programme.

[85] Dr. Termansen believes she is suffering from PTSD that is aggravating her pre-existing bipolar condition:

> Comorbid PTSD is associated with two of the four indices of bipolar severity, namely inter-episodic depression and quality of life. It is believed that the re-experiencing of the trauma in the form of intrusive images and nightmares is stressful and increases the vulnerability to relapse. In summary, there is indeed a correlation between post-traumatic stress disorder and aggravation of a pre-existing bipolar condition. The understanding of this correlation is based on the acute stress of the trauma as well as the ongoing stress of persisting post-traumatic symptoms precipitating more frequent episodes.

[86] Dr. Termansen cautions, however, that Ms. Jokhadar's fairly severe psychotic problems make chronic pain and PTSD difficult to assess. His prognosis is expressed in the following terms:

> Given how her illness has affected her since her accident, my prognosis for the future is very guarded indeed. It is always difficult to predict what the future may hold but it is my opinion that her prospect for emotional stability has declined significantly since the accident. In addition, a significant impairment in emotional, social and occupational functioning has seriously impaired her role within and outside the family. It is in [*sic*] my opinion that the marital and family situation has become increasingly destabilised and stressful because of Mrs. Jokhadar's instability.

[87] From his initial examination of Ms. Jokhadar's records it was clear to Dr. Termansen that she had a long history of regular mood disturbances that were symptomatic of bipolar disorder, a spectrum neuropsychological disorder with its usual age of onset in the late teens. It is difficult for him to say how severe those disturbances were. While she appears to have been minimally impaired; he is unaware of any psychiatric disturbance prior to the 2001 hospital admission in Ottawa. He believes her level of functioning at the time of his involvement to be significantly lower than that prior to the motor vehicle accident. Dr. Termansen therefore concludes Ms. Jokhadar could have looked forward to significant stability and that the prognosis for her mental illness would have been much improved had the accident not occurred.

[88] This opinion is, at least in part, based upon Dr. Termansen's opinion that if she was significantly impaired Ms. Jokhadar would have been hospitalized prior to 2006. He was aware in general terms of the 2001 Ottawa admission and says that Ms. Jokhadar described her 2002 manic episode to him but he knew little of the St. Paul's admission in 2002. He was not aware of Ms. Jokhadar's pre-accident problems at work. He acknowledged that if she reported anger at work that could have been a symptom of mania. He acknowledged her pre-accident condition may have been more fragile than he appreciated.

[89] Dr. Termansen was not particularly familiar with Ms. Jokhadar's work or her attempts to return to her job. Given that he did not specifically address the

limitations in her physical capacity and knew little of the physical demands of her job, little weight can be placed on his view that she is physically incapable of work. He did not know how many hours she had worked since her 2006-07 pregnancy. It was only on cross-examination that Dr. Termansen noted that Ms. Jokhadar complained she could not concentrate and her mental impairment alone would preclude a return to work. In my view that question was not closely addressed by Dr. Termansen and cannot be regarded as a considered opinion on her capacity to work.

[90] Dr. Schwarz testified with respect to the medications prescribed for Ms. Jokhadar over the years. He knew that she occasionally refused to take Seroquel, an antipsychotic prescribed as a mood stabilizer, because it made her feel lethargic and depressed. He believes that he probably counselled her on the importance of using her medication as prescribed. Psychotropic drug use is, however, a hard sell. Antipsychotics make patients feel depressed, lethargic and hypersomnolent.

[91] Dr. Abdel-Fattah, as noted above, considered the symptoms resulting in the April 2008 and March 2009 hospital admissions to be a result of non-compliance with drug therapy. He had closely reviewed the medication record and, on that review, established that for a period in 2008 Ms. Jokhadar was prescribed gabapentin as a result of a medical error. She appears to have been prescribed Noroxin (an antibiotic) by a Dr. Heyward on May 5, 2008, and to have received Neurontin (also known as gabapentin, a drug prescribed for nerve pain) by mistake. That error was perpetuated when she renewed her prescriptions.

[92] Dr. Solomons, a psychiatrist with significant experience treating patients with mood disorders, including bipolar affective disorders and PTSD, examined

the plaintiff on June 19, 2009, and then prepared a report on July 3, 2009, summarizing his observations and his review of the records. He prepared a supplemental report on August 19, 2009, in response to the reports of Dr. Koch and Dr. Termansen. In his first report, Dr. Solomons expresses the view that Ms. Jokhadar did not develop any emotional, psychological, or psychiatric sequelae as a result of the accident. He says:

> This view is reinforced by the fact that in the first reference in her medical records to emotional symptoms, which occurred seven weeks after the accident, there were no details of her emotional state, nor was any cause given for her symptoms or state. When details of her emotional state were first provided, 18 months after the accident, no cause for her condition was given and no reference to the accident was made. No attribution to any cause for her emotional state was offered at all, whether to the accident or to other more compelling factors such as the nature of her long-standing, unstable psychiatric illness or the ongoing stresses in her relationships, particularly with members of her family.
>
> Her detailed account at this assessment of emotional symptoms following the accident is not replicated in any of her medical records, and this further reinforces my view that she did not, in fact, develop any psychiatric complications as a result of the accident.

[93] In his report of August 18, 2009, Dr. Solomons disagrees with the diagnosis of PTSD for the following reasons:

> Dr. Koch arrives at the diagnosis of a post-traumatic stress disorder (PTSD) and an associated motor vehicle phobia without considering the preconditions for the diagnosis of PTSD which includes a traumatic event that is severe enough to be life or limb threatening and response at the time that includes intense fear, helplessness or horror. Neither of the preconditions was met in the accident. Dr. Koch also appears to ignore the absence of documentation of any emotional symptoms following the accident as well as the absence of any exacerbation of her pre-existing bipolar disorder in the immediate aftermath of the accident.
>
> My reading of Dr. Termansen's report reveals a similar ignoring of the nature of the accident that does not meet the diagnostic criteria for a PTSD diagnosis, as well as a ignoring [*sic*] of the absence of the reports of psychiatric symptoms following the accident. He records in her report that she constantly relives the accident, although no mention of this is made in her family doctor's records.

[94] Dr. Solomons does not take issue with the diagnosis of bipolar disorder or its disabling effects on Ms. Jokhadar, but disputes the diagnosis of PTSD and attributes all of the plaintiff's bipolar disorder to biologic as opposed to traumatic factors. His conclusion that Ms. Jokhadar does not suffer from PTSD is based in part on his characterization of the accident as a "minor incident" and in part on his understanding that there were no emotional symptoms following the accident. When he met the plaintiff she demonstrated composure and showed no signs of psychiatric illness. She was very engaging and appropriately reactive. He says discussion of the accident is usually a trigger for emotional reaction in patients with PTSD. Seeing none in this case was significant to his assessment. He says Ms. Jokhadar didn't volunteer any flashbacks and only claimed to be troubled by them when prompted.

[95] In cross-examination he acknowledged that the leading diagnostic text, the DSM-IV, does not describe the nature of the event that must precipitate PTSD.

[96] On the question of the emotional impact of the accident, Dr. Solomons agreed that when he interviewed Ms. Jokhadar she said she thought she was going to die in the accident and cried recounting it. She told him she was depressed following the accident and was thinking of death all of the time. He believed such an emotional response had not been recorded in the post-accident medical records. For that reason, he concluded that the emotional response is recent and cannot be regarded as a cause of her depression or a symptom of bipolar disorder or PTSD. In cross-examination Dr. Solomons was referred to the October 20, 2006 note that the patient thought she would die at impact and that she was weeping when recalling the incident. Upon reviewing that record Dr. Solomons acknowledged the obvious error on his part. He agreed he had

been wrong to reject Ms. Jokhadar's description of her emotional reaction to the accident.

[97] Further, in coming to his opinion Dr. Solomons ignored or gave no weight to the fact that the patient's mood fluctuated after the accident or that in December 2006 and March 2007 she was referred to Dr. Misri, a psychologist, for bipolar symptoms.

[98] Dr. Solomons says that although there is reference in the GP's records to emotional symptoms on March 4, 2008, there is no cause for those emotional symptoms identified. Dr. Solomons acknowledged on cross examination that was also incorrect, insofar as the return to work is identified in the records of Dr. Schwarz as a possible cause. Dr. Solomons also acknowledged that he was wrong to say that Dr. Pankratz made no reference to the motor vehicle accident in his records and did not identify the accident as a contributing cause of emotional problems.

Functional Capacity

[99] Ms. Jokhadar has been assessed by Mr. Tim Winter and Ms. Jodi Fischer; both are occupational therapists and work capacity evaluators. Mr. Winter saw Ms. Jokhadar at the request of her counsel, on June 9, 2009. Ms. Fischer saw her on February 2, 2010, for assessment at the request of the defendants. Both experts prepared detailed and helpful reports and testified at trial.

[100] When Mr. Winter examined Ms. Jokhadar she had recently been released from the hospital and had only recently begun to work with Dr. Termansen. Mr. Winter noted numerous and significant indicators of inconsistent effort on Ms. Jokhadar. Despite those indicators of poor performance, he concluded that

his evaluation provided a reasonable functional baseline for assessing Ms. Jokhadar's physical capacity. I reject that conclusion. Mr. Winters noted that Ms. Jokhadar appeared to be relatively fit and there were no indications of deconditioning. In work-like simulations, however, she demonstrated pain mannerisms, she cried as she worked and she demonstrated inconsistent and inexplicable limitations. Questioning demonstrated that Ms. Jokhadar perceived herself as very functionally disabled, to an extent not borne out on testing.

[101] Despite the fact Ms. Jokhadar reported no significant improvement in her physical condition between June 2009 and February 2010, her performance on testing by Ms. Fischer was substantially improved. In the interval Ms. Jokhadar had reported some lightening of her mood. She had remained out of the hospital and on consistent medication. I regard Mr. Winter's assessment as having been conducted at or near a low point in her bipolar disorder, and conclude that it was affected by poor effort on her part. Mr. Winter's conclusions stem from testing limited by subjective complaints of pain, and the patient's own unreliable description of the emotional difficulty a return to work would entail.

[102] Ms. Jokhadar saw Ms. Fischer eight months after the Winter assessment. She observed behaviour on the part of Ms. Jokhadar suggestive of significant effort on her part. She was consistent and competitive, starting tests early and using enough effort to raise her heart rate. There was no evidence of an attempt to mislead the examiner by intentional underperformance. To the contrary, performance on testing was good. Through a series of tests of her tolerance for work related and household tasks, Ms. Fischer found Ms. Jokhadar to demonstrate greater tolerance for such tasks than she reported. While Ms. Jokhadar reported increasing levels of pain as the testing progressed, her

performance levels were maintained. She performed many tests of her physical capacity within the norms for women of her age.

[103] Ms. Fischer concluded:

> During testing she demonstrated sufficient grip strength, reaching, dexterity, handling and strength tolerance to attempt to resume part time work as a hairdresser. She was able to perform repetitive and sustained reaching postures associated with the demands of her job as a hairdresser. Her neck/right upper back region also responded well under load...There are no difficulties observed during testing with functional cognition...She was pleasant, sociable and her behaviour was appropriate throughout testing. There was no emotional response to testing... when engaged in functional tasks or when reporting increased pain.

[104] Ms. Fischer noted that Ms. Jokhadar's performance on testing had improved dramatically since the testing by Mr. Winter. Referring to Ms. Jokhadar's emotional response to testing by Mr. Winter - the testing was abandoned after she started crying and performing poorly - she noted that her mental health status might have affected testing. She observed:

> From a physical perspective, work capacity findings indicate that Ms. Jokhadar demonstrated sufficient function to manage the physical demands of work as a hairdresser; however whether she can psychologically manage the demands of this occupation (or other forms of work) is out of my area of expertise to comment. If psychological experts determine that she is psychologically fit to return to work, given that she described fear of failing again and a loss of self esteem, I would recommend that she receive the support of an occupational therapist with return to work. Given also low confidence in her physical function and findings of deconditioning, I am supportive of Mr. Winter's recommendation for an active interdisciplinary rehabilitation program to maximize her chances at a successful and durable return to work.

[105] The strength requirement for working as a hairdresser is light. Ms. Fischer says Ms. Jokhadar has that capacity. She increasingly complained of pain during the day but that was not accompanied by a significant deterioration in her performance. Ms. Fischer says Ms. Jokhadar is less disabled than she considers herself to be.

[106] Ms. Fischer does not disagree with the opinions of Dr. Adrian and Dr. Koch that Ms. Jokhadar's pain can bring on emotional symptoms that could make her manic and cause her to be sent to hospital again. She could not dispute that there is a relationship between returning to work, suffering stress, experiencing pain, and relapsing into a manic state. She is not qualified to address the extent to which a psychiatric condition precludes Ms. Jokhadar from returning to work. That is a psychiatric issue.

Applicable Law

Causation

[107] The plaintiff bears the burden of establishing a causal link between the defendant's negligence and the onset or worsening of her pain and suffering, loss of enjoyment of life, and the reduction in her income or income earning capacity. She must establish, first, that the negligent act caused or materially contributed to the damage she has sustained and, if she can do so, prove the measure of damages. The causation case is met by establishing that but for the negligent act or omission the plaintiff's injury would not have occurred. The parties jointly refer the court to the principles enunciated and restated by the Supreme Court of Canada in *Snell v. Farrell*, [1990] 2 S.C.R. 311; *Athey v. Leonati*, [1996] 3 S.C.R. 458; and *Resurfice Corp. v. Hanke*, 2007 SCC 7.

[108] Causation issues may be difficult in cases where the plaintiff suffers psychiatric symptoms or chronic pain contributed to by multiple causes. In *Maslen v. Rubenstein* (1993), 83 B.C.L.R. (2d) 131 (C.A.), Taylor J.A., considering a claim for damages arising out of chronic benign pain syndrome, in a frequently cited passage wrote, at para. 15:

> ... there may be cases where a chronic benign pain syndrome will attract damages. That will happen where the plaintiff's condition is

> caused by the defendant and is not something within her control to prevent. If it is true of a chronic benign pain syndrome, then it will be true also of other psychologically-caused suffering where the psychological mechanism, whatever it is, is beyond the plaintiff's power to control and was set in motion by the defendant's fault.
>
> ... With respect to the evidence required in order to meet the onus lying on a plaintiff in such cases, Chief Justice McEachern (then sitting as a trial judge) in *Price v. Kostryba* (1982), 70 B.C.L.R. 397 (S.C.), repeating his observations in *Butler v. Blaylock* [1981] B.C.J. No. 31 (October 7, 1981, Vancouver B781505 (B.C.S.C.)), put it thus:
>
> > I am not stating any new principle when I say that the court should be exceedingly careful when there is little or no objective evidence of continuing injury and when complaints of pain persist for long periods extending beyond the normal or usual recovery.
> >
> > An injured person is entitled to be fully and properly compensated for any injury or disability caused by a wrongdoer. But no one can expect his fellow citizen or citizens to compensate him in the absence of convincing evidence − which could be just his own evidence if the surrounding circumstances are consistent − that his complaints of pain are true reflections of a continuing injury.

These principles were recently affirmed by the Court of Appeal in *Mariano v. Campbell*, 2010 BCCA 410.

The Crumbling Skull

[109] In *Zacharias v. Leys*, 2005 BCCA 560, a judgment pronounced in the interval between *Athey* and *Resurfice*, our Court of Appeal addressed the distinction between weighing evidence of causation and considering evidence going to the measure of damages. The distinction is important, particularly in cases where the plaintiff is alleged to have had a “crumbling skull”:

> 16 The crumbling skull rule is difficult to apply when there is a chance, but not a certainty, that the plaintiff would have suffered the harm but for the defendants' conduct. Major J. addressed this issue in *Athey* when he wrote, at paragraph 35, that damages should be adjusted only when there is a "measurable risk that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence." Such a risk of harm need not

> be proved on a balance of probabilities, which is the appropriate standard for determining past events but not future ones. Future or hypothetical events should simply be given weight according to the probability of their occurrence. At paragraph 27, Major J. wrote that "if there is a 30 percent chance that the plaintiff's injuries will worsen, then the damage award may be increased by 30 percent of the anticipated extra damages to reflect that risk." In the same paragraph, he went on to say that a future event should be taken into account as long as it is a "real and substantial possibility and not mere speculation."

[110] The defendants must, therefore, if they seek to establish that the plaintiff's bipolar illness would have in any event disabled her or reduced her income from employment, show there was a measurable risk that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence. Contingencies must be taken into account, as the court noted in *Zacharias*:

> 17 Because in *Athey* the Supreme Court found that there was no basis for finding a "measurable risk", it is of limited assistance when applied to cases in which there is not clearly an absence of a measurable risk. A number of decisions in this Court have struggled with that issue. In *York v. Johnston* (1997), 37 B.C.L.R. (3d) 235 (C.A.), the plaintiff suffered a relapse of her multiple sclerosis after a car accident. Newbury J.A., for the Court, held that it was a "thin skull" case, but that, nonetheless, it was appropriate to reduce the plaintiff's damages in recognition that she might have relapsed anyway. At paragraph 6, Newbury J.A. contrasted the standards used to assess liability and damages:
>
> > Of course, the judgment as to the measure of damages is a much more subtle one than that as to causation, not only because it involves a consideration of mere contingencies as well as probabilities, but because of the range of results available in the discounting of the award, as opposed to the "all or nothing" choice that must be made with respect to causation.
>
> The trial judge reduced the damages to reflect the risk of relapse that pre-existed the accident. Newbury J.A. held that the trial judge was entitled to make such a reduction, even though there was only a weak evidentiary foundation on which to conclude that the plaintiff would have remained symptom-free for just five years.

[111] In the case at bar the plaintiff clearly suffered from a manifest pre-existing condition that was likely to have affected her whether or not the motor vehicle

accident had occurred. That condition must be taken into account in measuring damages. Any measurable risk established by the evidence that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence must be considered: see *Pryor v. Bains* (1986), 69 B.C.L.R. 395 (C.A.); *T.W.N.A. v. Clarke*, 2003 BCCA 670;*McKelvie v. Ng*, 2001 BCCA 384.

Non-Pecuniary Damages

[112] As Russell J. noted in *Smusz v. Wolfe Chevrolet Ltd*., 2010 BCSC 82:

> [85] The purpose of non-pecuniary damage awards is to compensate the plaintiff for "pain, suffering, loss of enjoyment of life and loss of amenities": *Jackson v. Lai*, 2007 BCSC 1023 at para. 134; see also *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229, 83 D.L.R. (3d) 452; and *Kuskis v. Tin,* 2008 BCSC 862 [*Kuskis*]. While each award must be made with reference to the particular circumstances and facts of the case, other cases may serve as a guide to assist the court in arriving at an award that is just and fair to both parties: *Kuskis*, at para. 136.
>
> [86] There are a number of factors that courts must take into account when assessing this type of claim. Madam Justice Kirkpatrick, writing for the majority, in *Stapley v. Hejslet*, 2006 BCCA 34, 263 D.L.R. (4th) 19, outlines the factors to consider, at para. 46:
>
> > [46] The inexhaustive list of common factors cited in *Boyd* [*Boyd v. Harris*, 2004 BCCA 146] that influence an award of non-pecuniary damages includes:
> >
> > (a) age of the plaintiff;
> >
> > (b) nature of the injury;
> >
> > (c) severity and duration of pain;
> >
> > (d) disability;
> >
> > (e) emotional suffering; and
> >
> > (f) loss or impairment of life;
> >
> > I would add the following factors, although they may arguably be subsumed in the above list:
> >
> > (g) impairment of family, marital and social relationships;
> >
> > (h) impairment of physical and mental abilities;
> >
> > (i) loss of lifestyle; and

> (j) the plaintiff's stoicism (as a factor that should not, generally speaking, penalize the plaintiff: *Giang v. Clayton, Liang and Zheng*, 2005 BCCA 54).

[113] The parties have referred to numerous helpful authorities on the quantum on non-pecuniary damages. I will describe them briefly. In *Ashcroft v. Dhaliwal*, 2007 BCSC 533, the plaintiff, a 57 year old office administrator/supervisor suffered soft tissue/musculoskeletal injuries to her low back and neck, with secondary headache, soft tissue injuries to the left forearm, and a nerve entrapment of the lateral femoral cutaneous nerve of the thigh. The nerve entrapment resulted in numbness and pain over the thigh. The medical evidence was that she had a pre-existing spinal condition that might have become symptomatic (to an uncertain extent) in 10 to 15 years' time, but she was otherwise in excellent health prior to the first of two accidents. As a result of both accidents, the plaintiff's life had changed drastically. She was in constant pain and suffered from clinical depression and from PTSD. Mr. Justice Shaw held that her essential identity had been taken from her. Her prospects of improvement were uncertain. Non-pecuniary damages were assessed at $120,000. The case is a helpful benchmark in assessing moderate injuries with longstanding and life-changing psychiatric consequences. Mrs. Ashcroft, however, was not suffering from evident and significant pre-accident psychiatric problems. The functional impact of her injuries was more significant than the impact of the injuries suffered by Ms. Jokhadar.

[114] In *Maillet v. Rosenau*, 2006 BCSC 10, a 38 year old trailer park manager suffered a significant concussion and depression, affecting her concentration and attention, as well as a musculoligamentous strain of the neck and shoulder region which caused tightening of the shoulder girdle and thoracic outlet, and paresthetia in the right arm. Mr. Justice Powers found that the weight of the

evidence supported the plaintiff's position that her injuries were caused by the motor vehicle accident, and that she continued to suffer from them and would do so in the future. Non-pecuniary damages were assessed at $110,000.00. Again, this was a case of a person not otherwise affected by mental illness and unlikely to have been disabled but for the accident.

[115] In *Marois v. Pelech*, 2007 BCSC 1969, the plaintiff suffered from musculo-ligamentous strain to the neck, mid-back, and low back. She went on to develop a chronic myofascial pain condition involving the upper neck musculature, mid back and low back. This, in turn, contributed to depression. Her treating psychiatrist expressed the following opinion, quoted at para. 62:

> Ms. Marois has had significant anxiety and depressive symptoms for over five and a half years. Despite further treatment and the passage of time, Ms. Marois will likely continue to have anxiety and depressive symptoms and not return to her premorbid level of emotional functioning. Ms. Marois will likely continue to be emotionally vulnerable and at risk of developing PTSD in future if she is exposed to further trauma.
>
> In general, patients who have a chronic pain disorder for more than two years in duration continue to be symptomatic. Ms. Marois, however, has had a lessening of her pain during the past year since she started seeing Dr. Foran and I will defer the prognosis regarding her physical symptoms to physical medicine specialists. As long as Ms. Marois has significant pain, anxiety, depression, insomnia, tinnitus and fatigue she will likely continue to have cognitive difficulties. Given Ms. Marois' age and the nature and extent of her physical, cognitive and emotional difficulties, it is unlikely that she will be able to return to competitive employment in future.

[116] Mr. Justice Smart held that the plaintiff had lived a full and busy life but that had been lost over the six years following the accident and that her life would continue to be impacted in the future. After considering the decision of Shaw J. in *Ashcroft* he assessed general damages at $130,000.

[117] In *Shapiro v. Dailey*, 2010 BCSC 770, Grauer J. assessed the claim of a 23 year old student who suffered soft tissue type injuries that developed into

persisting chronic pain syndrome, fibromyalgia, myofascial pain, anxiety/panic disorder, depressive symptoms, PTSD, thoracic outlet syndrome, and associated physical, emotional and cognitive difficulties as follows:

> [60] I have considered the authorities to which counsel referred me, including *Dikey v. Samieian*, 2008 BCSC 604; *Alden v. Spooner*, 2002 BCCA 592, 6 B.C.L.R. (4th) 308;*Prince-Wright v. Copeman*, 2005 BCSC 1306; *La France v. Natt*, 2009 BCSC 1147; *Pelkinen v. Unrau*, 2008 BCSC 375; *Whyte v. Morin*, 2007 BCSC 1329; *Niloufari v. Coumont*, 2008 BCSC 816, varied 2009 BCCA 517; and *Unger v. Singh*, 2000 BCCA 94.
>
> [61] Each case must, of course, be assessed on its own facts. Considering all of the circumstances, including her age at the time of the accident (23), the toll her injuries have taken on her, and her prospects for the future, I consider Ms. Shapiro's plight to be considerably worse than that of, for instance, the older plaintiff in the recent decision of *La France* ($80,000) and worse than the older plaintiff in *Prince-Wright* ($100,000). I have considered as well the very recent decision of the Court of Appeal in *Poirier v. Aubrey*, 2010 BCCA 266, where the 38-year-old plaintiff's non-pecuniary damages were increased to $100,000. I assess Ms. Shapiro's non-pecuniary damages at $110,000.

[118] In *Smusz*, Russell J. described the damages suffered by a 43 year old woman injured in a motor vehicle accident as follows:

> [87] ... She suffered injuries which, although not requiring more than a brief visit to the hospital, were nonetheless significant. The medical evidence was mostly consistent: her physical injuries include moderate right paracentral disc herniation at C3-4 on the right side and moderate paracentral disc protrusion at C6-7 on the left causing irritation of the left C7 root; and a bulging lumbar disc irritating the lumbar roots, all of which result in chronic left-sided neck, arm and low back pain, dizziness and headaches. She suffered from PTSD, now substantially resolved, but still suffers from insomnia, occasional nightmares, depression and chronic pain some three years after the accident.
>
> [88] The chronic pain caused by the injuries received in the accident has resulted in depression, no doubt complicated by her difficult financial situation, but the plaintiff was happy and energetic before the accident notwithstanding the fact that she had very little money.
>
> [89] She was able to work in a job which did not require great skill and which did not pay well but in which she could have continued for the indefinite future. It gave her some income and gave her the sense of participating in her family's finances.

[119] General damages were assessed at $100,000.

Loss of Income Earning Capacity

[120] The leading British Columbia cases on the assessment of loss of income earning capacity were recently reviewed by the Court of Appeal in *Perren v. Lalari*, 2010 BCCA 140. Garson J.A., for the court referring to the decision of the trial judge, wrote:

> [7] Despite his conclusion that the plaintiff had not demonstrated a real possibility she would suffer a loss of income, he awarded the plaintiff damages for loss of earning capacity, in reliance on this Court's judgment in *Pallos v. Insurance Corp. of British Columbia* (1995), 100 B.C.L.R. (2d) 260, 53 B.C.A.C. 310, in which Finch J.A. [...] found [...] that the loss of future earning capacity was suffered, even though the plaintiff continued to earn the same wage from the same employer, as he had before the accident.
>
> [8] The trial judge carefully reviewed the jurisprudence on this point in not only *Pallos*, but also *Steenblok v. Funk* (1990), 46 B.C.L.R. (2d) 133 (C.A.); *Steward v. Berezan*, 2007 BCCA 150, 64 B.C.L.R. (4th) 152; *Parypa v. Wickware*, 1999 BCCA 88, 169 D.L.R. (4th) 661; *Chang v. Feng*, 2008 BCSC 49, 55 C.C.L.T. (3d) 203; and *Djukic v. Hahn*, 2007 BCCA 203, 66 B.C.L.R. (4th) 314, and held that he could not reconcile the judgments in *Steward* and *Pallos* on this question of whether an award for loss of future earning capacity should be made in the absence of proof of a substantial possibility of future pecuniary loss.

[121] The debate was addressed in the following terms:

> [30] Having reviewed all of these cases, I conclude that none of them are inconsistent with the basic principles articulated in *Athey v. Leonati*, [1996] 3 S.C.R. 458, and*Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229. These principles are:
>
> 1. A future or hypothetical possibility will be taken into consideration as long as it is a real and substantial possibility and not mere speculation [*Athey* at para. 27], and
> 2. It is not loss of earnings but, rather, loss of earning capacity for which compensation must be made [*Andrews* at 251].
>
> [31] Furthermore, I conclude that there is no conflict between *Steward* and the earlier judgment in *Pallos*. As mentioned earlier, *Pallos* is not authority for the proposition that mere speculation of future loss of earning capacity is sufficient to justify an award for damages for loss of future earning capacity.

> [32] A plaintiff must always prove, as was noted by Donald J.A. in *Steward*, by Bauman J. in *Chang*, and by Tysoe J.A. in *Romanchych*, that there is a real and substantial possibility of a future event leading to an income loss. If the plaintiff discharges that burden of proof, then depending upon the facts of the case, the plaintiff may prove the quantification of that loss of earning capacity, either on an earnings approach, as in *Steenblok,* or a capital asset approach, as in *Brown*. The former approach will be more useful when the loss is more easily measurable, as it was in *Steenblok*. The latter approach will be more useful when the loss is not as easily measurable, as in *Pallos* and*Romanchych*. A plaintiff may indeed be able to prove that there is a substantial possibility of a future loss of income despite having returned to his or her usual employment. That was the case in both *Pallos* and *Parypa.* But, as Donald J.A. said in *Steward*, an inability to perform an occupation that is not a realistic alternative occupation is not proof of a future loss.

[122] For the purposes of this case that is sufficient elucidation of the guiding principles.

Analysis

The Physical Injury

[123] Liability for the accident giving rise to this claim has been admitted. The description of the accident is significant only to the extent that it assists in weighing the emotional and psychiatric impact of the accident. Having accepted Ms. Jokhadar's evidence with respect to what she saw and experienced I conclude the impact occurred with enough force to cause her physical injuries and produced sufficient fear to cause her emotional reaction.

[124] The defendants say the plaintiff is entitled to non-pecuniary damages to compensate for a mild to moderate soft tissue injury and special damages relating to pecuniary losses in the months after the accident but argue that the plaintiff has not proven any more significant loss.

[125] The plaintiff says there is uncontroverted evidence that Ms. Jokhadar has suffered a soft tissue injury causing back, neck, and arm pain and a disk

protrusion resulting in the prospect that she will develop further neurological symptoms, as a result of nerve root impingement, and may require neurosurgery.

[126] I accept the evidence of Ms. Jokhadar's treating physicians that she sustained injury to the musculoligamentous structures of her right neck and shoulder area and that she now suffers from a disk protrusion at the C5-C6 level that may become increasingly symptomatic. Dr. Sahjpaul, the witness most qualified to address the cause and effect of the disc protrusion believes the MRI suggests some cord compression but is not convinced that the plaintiff's symptoms are entirely, or even significantly a result of that cord compression. I accept his conclusion that the plaintiff has neck pain and right shoulder and arm pain and weakness which is a combination of a soft tissue injury and some irritation of the nerve root at the C5-6 level. I further accept his conclusion that the motor vehicle accident was causative of the plaintiff's symptoms.

[127] I find that since the accident she has suffered mechanical neck, shoulder, mid-back, and low back pain, weakness, and tenderness. Despite that pain and weakness, she has demonstrated on examination by her physicians that she has relatively normal range of motion. Only minimal back muscle wasting has been noted.

[128] Ms. Jokhadar perceives that her persistent back pain limits her ability to engage in tasks that require prolonged static or awkward positioning, including twisting, reaching, or stooping. It is noted, however, that Ms. Jokhadar has difficulty with self-assessment and is prone to overestimate the extent of her disability.

[129] I accept the opinion of Dr. Adrian that Ms. Jokhadar will probably continue to experience difficulty performing activities that place physical forces on the

structures involving her neck and back, but find that Ms. Jokhadar is limited as much by psychological as by physical symptoms. While her pain has been chronic there is some indication that with therapy the psychological component of her symptoms is at least temporarily improving.

[130] I accept the evidence of Dr. Adrian and Dr. Sahjpaul that there is a risk that the C5-6 disc will cause increasing pain over time. Ms. Jokhadar may require surgical intervention as a result of the obvious and problematic C5-6 herniation seen on the MRI.

Psychiatric Illness

[131] Ms. Jokhadar suffers from a bipolar disorder with occasional manic episodes. She is primarily disabled by depression, which has been difficult to treat pharmaceutically because she is acutely sensitive to changes in her medication. I accept Dr. Termansen's opinion that her emotional, social, and occupational functioning has been seriously impaired and her marital and family situation has become increasingly destabilised and stressful because of her symptoms. She now suffers from a rapidly cycling disorder which will require long term monitoring and intense treatment and supervision.

[132] Ms. Jokhadar has now made some partial recovery from the severe depression and cyclical mania that affected her in 2008 and 2009. Ms. Jokhadar says that Dr. Termansen's counselling resulted in some lifting of her depression. Dr. Termansen describes her as being very determined to stay out of hospital and has agreed to see her regularly to prevent recurrent psychotic episodes.

[133] While Ms. Jokhadar had a long history of regular mood disturbances prior to the accident she was clearly less impaired in the period from 2002 to 2006

than she has been in the years subsequent. From 2006 to date she has been subject to significant stress due to the motor vehicle accident and the injuries sustained in that accident, her pregnancy, problems at work and at home arising from pronounced symptoms of her bipolar disorder, and this litigation. Bipolar patients are sensitive to stress, and may decompensate easily. Stressful events often precede an episode of depression or mania. I accept Dr. Termansen's evidence that Ms. Jokhadar's reaction to pregnancy would not have been the same, her bipolar illness would not have been as pronounced, and the prognosis for her mental illness would have been much improved had the accident not occurred.

[134] The defendants do not dispute the opinion that manic or depressive episodes may be triggered by a variety of psychosocial stressors. Nor does there appear to be any question that as individuals have more episodes of depression they become less emotionally resilient. However the defendants say, relying upon the opinion of Dr. Solomons, chronic family stresses, non-compliance with treatment, and a pregnancy all represent more compelling influences on the course of her chronic psychiatric illness. In doing so the defendants address the wrong causation question: "which causes are more compelling?" rather than "but for the accident would the plaintiff have been as ill?"

[135] Further, there is no reason, in my view, to regard stressors other than the car accident as more compelling or predominant. Dr. Solomons, in reaching that conclusion, ignored clear evidence of the significance of the accident. He erroneously concluded that Ms. Jokhadar had not described the traumatic effect of the accident and its emotional consequences to her physicians, or sought psychiatric help. In cross-examination Dr. Solomons acknowledged deficiencies in his review of the records and misunderstanding of Ms. Jokhadar's history and

treatment. While he expressly describes pregnancy as a factor contributing to the increase in symptoms of bipolar illness he does not consider the fact that Ms. Jokhadar's one specific worry during the pregnancy was the possibility of a miscarriage or birth defect due to the motor vehicle accident.

[136] It is not helpful in the causation analysis to attribute the exacerbation of the plaintiff's bipolar disorder to non-compliance with treatment. Although Dr. Abdel-Fattah and Dr. Schwarz concluded that Ms. Jokhadar had occasionally refused to take Seroquel, despite counselling on the importance of using her medication as prescribed, the evidence was that non-compliance occurred because antipsychotics made her feel depressed, lethargic and hypersomnolent. Ms. Jokhadar's reluctance to take antipsychotic medication is not blameworthy conduct but, rather, an aspect of her pre-existing condition, a factor contributing to her susceptibility to events destabilizing her bipolar illness.

[137] I accept the evidence of Dr. Termansen that the motor vehicle accident precipitated a prolonged depressive episode which eventually transformed into a manic episode. I conclude that episodes of mania and depression between 2006-2008 were in part triggered by the motor vehicle accident and in part triggered by her concern about her foetus, her increased anxiety, her physical injuries, and difficulty she had returning to work. I accept the evidence of Dr. Koch and Dr. Termansen that the accident was a significant cause of the worsening of that illness.

[138] In the result, I must turn to a consideration of the contingencies referred to in *York v. Johnston* so as to describe the probable course of Ms. Jokhadar's bipolar disorder had an accident not occurred and compare that with the position she now occupies and the future she faces. In doing so I bear in mind the

injunction of Newbury J.A. that “the judgment as to the measure of damages is a much more subtle one than that as to causation, not only because it involves a consideration of mere contingencies as well as probabilities, but because of the range of results available in the discounting of the award”.

[139] There is evidence of significant pre-accident symptoms. As Dr. Koch noted, there is a medical record of complaints of depressive symptoms (particularly low energy and hypersomnia) throughout the 2001-2006 period and a long history of intermittent impairment from bipolar episodes. Dr. Termansen acknowledged on cross-examination that Ms. Jokhadar’s pre-accident condition may have been more fragile than he appreciated when he drafted his opinion. Speaking of Ms. Jokhadar’s post-accident course both he and Dr. Koch noted that stressors are cumulative and that episodes of depression beget each other. The inability to work worsens Ms. Jokhadar’s depression because work gives her social opportunity and self confidence. The prognosis worsens with the number and severity of episodes of depression.

[140] Ms. Jokhadar’s symptoms became so pronounced that she required hospitalization in 2001 and 2002. She required close supervision thereafter. When she went off medications in 2005 she suffered symptoms that disabled her from work. In 2006 she was complaining of significant continuing symptoms at work, even while on medications. Ms. Jokhadar learned she was pregnant days after the accident. She soon began suffering from nausea and vomiting. She stopped taking antidepressant medication. Given her history, pregnancy certainly contributed to the difficulty she experienced controlling her bipolar illness. She would, in any event, have been subject to the stressors associated with that pregnancy and caring for a newborn. She is likely to have suffered depression off medication during her pregnancy. According to the psychiatric evidence, that

would have had an impact upon her long-term prognosis. For this reason I find that even in the absence of the accident Ms. Jokhadar would still have suffered from increasing symptoms of bipolar disorder after October 2006.

[141] The plaintiff claims to have suffered PTSD as a distinct and compensable condition. The defendant says that the plaintiff does not suffer from PTSD. There is no question the plaintiff had some complaints of emotional issues after she became pregnant and leading up to and after the birth of her son. She was shaken up by the accident, according to the defendant, but there is no mention of her having flashbacks or of disabling mood fluctuation arising from memories of the accident. The defendant says PTSD did not become an issue until the plaintiff engaged Dr. Koch to produce a medical legal report assisting the plaintiff with her litigation.

[142] I accept Dr. Koch's opinion that the accident, as described to him, was an event capable of causing post-traumatic stress, particularly in a person affected by bipolar disorder. The evidence of Drs. Koch and Termansen to the effect that this incident might have a more pronounced effect upon a person with a mood disorder stands to reason. Given that Ms. Jokhadar's own description of her symptoms does not meet the diagnostic criteria for diagnosis of PTSD, and given the absence of reported symptoms, for example when she was treated by Dr. Abdel-Fattah, I cannot find a sufficient basis for Dr. Koch's opinion that "overall" her symptoms are consistent with such a diagnosis. There is certainly evidence of longstanding depression and mood swings, but from these it is difficult to isolate specific symptoms of PTSD. As Dr. Termansen noted, her fairly severe psychotic problems make chronic pain and PTSD difficult to assess. Despite the fact I reject most of Dr. Solomons' opinion, I share his conclusion that Ms. Jokhadar's description of her "flashbacks" is not a description

of that symptom as commonly understood but, rather, a description of an unhappy recollection, more consistent with depression than PTSD.

Non-Pecuniary Damages

[143] I turn then to the functional impact of Ms. Jokhadar's physical injuries and the worsening of her bipolar disorder in order to assess damages for pain and suffering and the loss of enjoyment of life. Although she was working part-time and her bipolar disorder was less disabling prior to October 2006, Ms. Jokhadar was complaining of stress at work and was about to learn that she would have to go off her medication due to her pregnancy. She was suffering from significant illness that required constant monitoring and medication. She had regularly missed work in the years between 2002 and 2006. Ms. Jokhadar told Dr. Adrian that she was working as a hairstylist 4 days per week before her injury and that she had been employed as a hairstylist since 1996. She claimed to have had no physical limitations and to have gone swimming and to the gym regularly. She claimed to have been immediately unable to work due to pain following the accident. All of these claims overstate the level of her pre-accident activity and the impact of the accident.

[144] The plaintiff says the catastrophic effect of these injuries on her ability to enjoy the amenities of life exceeds that described in all of the cases referred to above and seeks an assessment of general damages at $140,000. The defendant submits that the claim should be qualified as a mild to moderate soft tissue injury with some special damages awarded for the time the plaintiff would have needed medical care which was not otherwise paid for by other entities but does not attempt to quantify the claim.

[145] The accident in this case has had a significant effect on Ms. Jokhadar's life. I am satisfied on the evidence that she suffered from a significant bipolar affective disorder that required monitoring and medication prior to the motor vehicle accident but that that disorder was significantly exacerbated to the point that she became significantly disabled by her illness from 2006 to 2009. While she is under reasonable control at the moment, her significant depressive and manic episodes have made her more prone to relapse. In addition, she has a physical injury that continues to trouble her and a disk protrusion that may become more symptomatic in the future. Taking into account the likelihood that she would to some extent have suffered from increasing symptoms of bipolar disorder, I am of the view that non-pecuniary damages should be set at $90,000.

Loss of Income and Income Earning Capacity

[146] Dr. Termansen says Ms. Jokhadar is no longer working because of her physical and emotional state. He believes that her current level of functioning is below her pre-accident state but his view that she is now incapable of working as a hairdresser appears to be based primarily upon his understanding of her physical limitations. Although he said, on cross-examination, that Ms. Jokhadar's limited ability to concentrate would preclude a return to work, his considered, written opinion described physical restrictions as the cause of disability, when he says: "Given her persistent neck and shoulder pain her returning to work as a hairdresser does not appear likely in the near or distant future."

[147] While Dr. Koch also says that the symptoms of depression he has noted, particularly fatigue and difficulty concentrating, disable Ms. Jokhadar, he believes return to work may be possible with some modification of her medication. I

accept that view and regard the potential to return to work as a question that will be determined primarily by the state of Ms. Jokhadar's bipolar illness.

[148] This view is consistent with the reports and opinions of the occupational therapists, specifically Ms. Fischer's conclusion that Ms. Jokhadar demonstrated sufficient function to manage the physical demands of work as a hairdresser. The strength requirement for working as a hairdresser is light and I find Ms. Jokhadar to have that capacity. I accept Ms. Fischer's conclusion that the critical question in relation to loss of income-earning capacity is whether Ms. Jokhadar can psychologically manage the demands of any occupation. Returning to work will be stressful. If the return is not well managed and gradual she may experience some increase in her pain and there is a risk of a relapse into a manic state.

[149] The plaintiff says Ms. Jokhadar's average reported earnings while working as a hairdresser were $20,452 per annum. The plaintiff says that adding unreported tips to this income would bring her average earnings to approximately $32,000 per annum. The plaintiff says if she had not been injured, she would have worked for the entire period between her accident and the date of trial, but for six months maternity leave following the birth of her son in June 2007. On this basis she advances a claim for past income loss of $66,875.

[150] This claim does not take into account the fact that the plaintiff's work was inconsistent in the years leading up to the motor vehicle accident, even when she did not have a young child at home. It does not take into account Ms. Jokhadar's own evidence that she regards hairdressing as an enjoyable pastime rather than as full time employment. It does not take into account the 2005 flare-up in her manic symptoms resulting in income in that year being reduced to $9,582, less than $1,000 per month (excluding tips and EI benefits). Nor does it take into

account the fact that after she returned to work in 2006 she advised Dr. Schwarz that she was suffering a tremor, a side effect of an antipsychotic.

[151] Taking these facts into account and making allowance for the contingency that Ms. Jokhadar would not have worked while pregnant and off medication, would have taken maternity leave following the birth of her son, and would, in any event, have suffered from some periods of depression or mania that would have prevented her from working in the years since, I assess the plaintiff's loss of past income over the period from January 2008 (six months after the birth of her son) to trial, a period of 30 months, at $30,000.

[152] The plaintiff is entitled to interest on that award in 6 month increments assuming the loss to have been evenly distributed over the period commencing six months after the birth of her son.

[153] The plaintiff's claim for loss of income earning capacity is based upon the argument that physical and psychiatric problems now disable her from work as a hairstylist. The plaintiff says she had 27 years of fruitful income ahead of her and that her capacity to earn income has been significantly impaired. She submits that she has lost a greater part of her potential income earning capacity. That total capacity has been estimated by Mr. Gosling, an economist called on her behalf at trial, as a claim with a net present value of $623,803. The plaintiff seeks a loss of earning capacity in the sum $350,000.

[154] The plaintiff says it is not clear whether she will ever be fit to return to work again. Mr. Gosling's projection of net present value of the loss of income earning capacity is based on an estimate of lifetime earnings as a hairstylist to age 65. The claim has been discounted to take into account the factors that limited the plaintiff's income earning in the years prior to trial but appears to include some

unearned income in 2006. It has not been discounted to take into account real and significant prospect that the plaintiff would in any event been disabled by her bipolar illness. Nor has it been discounted to take into account the fact that Ms. Jokhadar might be able to return to work either as a hairstylist or in some other capacity for some or most of the remainder of her working years. The functional capacity evaluations demonstrate that Ms. Jokhadar is capable of light work. She should be capable of working in some capacity.

[155] I accept Dr. Termansen's evidence that the prognosis for the future is very guarded and that Ms. Jokhadar's chances of enjoying emotional stability have declined significantly since the accident. I also accept that the effects of the accident are still reverberating within her life and the total effects are not yet known. I must also find, however, that Ms. Jokhadar had a poor prognosis for continuous long-term employment before the accident. The depression and mania leading to her hospitalization in Ottawa in 2001 and in Vancouver in 2002, had already led her physicians to conclude she was likely to require long term medication and close supervision.

[156] As with the claim for past income loss, I am of the view that the plaintiff has overestimated pre-accident income earning capacity. Using multipliers determined by the plaintiff's expert economist, Mr. Gosling, assuming she would have remained employed, despite her illness to age 55 (13,512) and using her 2005 income ($14,517, including EI) as representative of her income earning potential, the net present value of the whole lifetime stream of earnings before the accident may fairly have been assessed at approximately $195,000.

[157] Bearing in mind the principles referred to above and considering that the motor vehicle accident has resulted in worsening of the prognosis, but is not the

sole factor leading to the plaintiff's relatively pessimistic prognosis for long term future employment, and also taking into account residual income earning capacity, I am of the view that the claim for loss of future income earning capacity should be assessed at approximately one third of that estimate of net present value of the plaintiff's income earning capacity. After adding an allowance for lost tips (said to increase income by 50%) I award $95,000 as compensation under that head of damages.

Special Damages

[158] Dr. Koch recommends 50 hours of psychological therapy. I accept that recommendation. An allowance should be made for ongoing psychological therapy and I award $9,600 in respect of that claim.

[159] The occupational therapists recommend that Ms. Jokhadar receive the support of an occupational therapist to assist her in returning to work. Given her low confidence in her physical abilities and the findings of deconditioning, the experts are supportive of an active interdisciplinary rehabilitation program. Mr. Winters also recommends continuing vocational consulting and estimates the cost of both the occupational and vocational consulting at an amount in the range of $10,000. I award that amount in respect of that head of damages.

[160] In addition the parties have agreed to other special damages in the amount of $500.

[161] The plaintiff has certainly received considerable support from her family in attending to household chores. I find that she is physically able to contribute to the maintenance of the household but that there has been a reduction in her capacity to do housework and that the resulting loss is a pecuniary one, for which

damages should be awarded, in accordance with the principles recently canvassed in *Lakhani v. Elliott,* 2009 BCSC 1058 at paras. 161-66. For reasons set out in the assessment of the loss of income earning capacity, however, I am of the view that the claim under this head must be reduced to take into account the prospect that the plaintiff would periodically have been disabled by symptoms of her bipolar disorder in any event and to reflect the possibility of continuing recovery. I award $15,000 (approximately one third of the plaintiff's estimate of the net present value of additional cleaning costs) under this head of damages.

Judgment

[162] There will be judgment for the plaintiff in the following amounts:

Non-pecuniary damages for pain and suffering and loss of enjoyment of life	$90,000
Past Income loss	$30,000
Loss of Income Earning Capacity	$95,000
Special Damages	$35,100
Interest	Pre-judgment interest in an amount to be determined by counsel

"Willcock