CONFIDENTIAL

CLINICAL PSYCHOLOGY REPORT

17th May 2019

Name:	Liz Perlof
Date of Birth:	12/01/1966
Date of assessment:	29th April 2019
Place of assessment:	Cheyham Lodge, Ewell, Epsom
Date of report:	17th May 2019
Assessed by:	Dr Alisdair Radcliffe BSc (Hons) MSc DClinPsych CPsychol PGCert HCPC Registered Clinical Psychologist

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1. Introduction

1.1 The current assessment and subsequent report was prepared at the request of Liz Perlof, regarding her current complaint with health care providers and the input she received following an injury to her foot in 2011. The findings are based upon my meeting with Liz on the 29th of April, 2019, at Cheyham Lodge, Ewell for a roughly one and a half hours. My findings are based on my assessment with Liz and from reading documentation supplied to me by Liz regarding her past medical history.

2. Presenting situation

2.1 Liz reported her experiences, following a physical injury in 2011, as an unrelenting battle with health care professionals from several services, with no perceptible end in sight. Liz continues to experience physical discomfort relating to her injury, with associated loss of functioning. She feels her limited successes in addressing the physical repercussions of her injury have solely come from her continued fight for answers and investigations, with Liz describing relational trauma when interacting with health services.

2.2 Liz explained she experiences significant levels of pain throughout her body, with the pain moving through different areas of her body on different days, believed to be due potential impacts of compensatory gait and weight bearing adjustments, leading to increased pressure on different areas. Liz found it difficult to judge a rating of the pain, as she spends considerable mental energy distracting her away from focussing on the pain. Liz reported that when tired, she finds these distraction techniques less effective, leading to increased pain awareness and experiences.

2.3 Liz is still receiving investigations and treatment for her original and subsequent physical health needs, and also undergoing a complaints investigation, which involves a number of different services in one way or another. This ongoing conflict has left Liz with feelings that the health organisations are engaged in damage limitation practice rather than positively providing her with health care, and a sense that she believes more could be done for her physical health needs.

2.4 Liz described this process in terms of relational trauma experiences, where she experiences repetitive and prolonged stressors due to inter-relational dynamics with health care professionals, damaging her perception of safety and being cared for when engaging with health care services. Due to the ongoing nature of the situation, Liz has also experienced impacts on her emotional well-being, her relationships, and her ability to undertake employment.

2.5 Liz reported she used to enjoy yoga and swimming, in which she is now unable to fully partake as she experiences pain in several areas of her body, with currently constant pain located in her right hip, shoulder, and knee, and sporadic pain in her right foot. She reports she is far less physically active than she used to be, due to pain but also due to the fact she has not been able to work for two years. Additionally, Liz reported difficulties with her sleep, often oversleeping, with a lack of motivation and energy to engage in daily functioning. Liz reported anxiety regarding falling as she has difficulties with her balance. Often when Liz is active for an extended period of time, this leads to increased pain experiences the following day.

3. Background

3.1 Liz reported she fell over a blow up mattress in her house and subsequently fell down a flight of stairs on the 20th of October 2011, injuring her right foot. Although she called the emergency services for an ambulance, one did not attend, and Liz took a taxi to her local hospital. At the hospital, Liz states the attending health care professionals misdiagnosed her injury. Subsequently, Liz feels she has experienced a series of investigations, none of which have produced a significant improvement in her prognosis. Furthermore she feels her experiences of interacting with each subsequent health

service reflects a culture of trying to "cover up" any past errors, leading to frustration and feelings of mistrust for future interventions.

3.2 In 2014, Liz started to experience difficulties beyond her original injury, starting with ankle and hip pain due to an overcompensated gait. Since 2014, Liz has been engaged in ongoing and sustained communication with different health services regarding her feelings of a lack of responsibility from these services for past errors in her diagnosis. Whilst undertaking further medical investigations, Liz also instructed legal representation as she feels significant errors in clinical practice have occurred. However, this did not produce any notable outcomes.

3.3 The prolonged and sustained nature of this engagement with the complaints procedure has coincided with further investigations, testing and scans to continue to attempt to alleviate Liz's physical health issues. Liz feels that the longstanding difficulties with correctly diagnosing her injury and related needs, have led to the development of further complications. Furthermore, Liz also reported that since roughly 2017, she has started to experience emotional impacts of this prolonged situation, on top of the physical impacts. These impacts have been far reaching and include her social and romantic relationships, her employment and her emotional resilience.

4. Assessment scores

4.1 The Hospital Anxiety and Depression Scale (HADS, Zigmond & Snaith, 1983) was used as a standardised measure of Liz's anxiety and low mood. The 14 item self-report scale was developed for use with physical health conditions as a measure of symptoms of anxiety and depression, with higher scores indicating more severe anxiety and depression.

4.2 Liz's assessment indicates she is not experiencing any clinically significant levels of anxiety, scoring nine out of a maximum of 21, with scores 11 or greater indicating clinical 'caseness'. This is congruent with Liz's disclosures during the clinical interview, where she does not have any sustained significant levels of anxiety across different areas, but more time and context specific anxiety related experiences directly linked to the

progression of the current complaint, with peaks of anxiety associated with any contact with health care professionals regarding the complaint.

4.3 Liz's assessment indicates she is not experiencing any clinically significant levels of low mood, scoring 10 out of a maximum of 21, with scores 11 or over indicating clinical 'caseness'. Similarly, this reflects information highlighted in Liz's clinical interview, with a decreased ability to enjoy previously preferred activities and specific worries regarding her current complaint but a maintained ability to laugh, be cheerful and complete activities with enjoyment.

5. Impact of Event Scale

5.1 The Impact of Event Scale (IES, Horowitz, 1979) is a 15 item self-report measure of current subjective distress frequency in response to a specific traumatic event, with higher scores representative of greater distress. Scores exceeding 26 signify an important event that has a significant impact on an individual. However, as Liz is still engaged in the current traumatic event, the current complaints procedure regarding her physical health, the frequency with which Liz experiences distress due to this event would naturally be elevated, given the measure was designed regarding historic events. Therefore, whilst Liz's scores exceeded the 26 cut off for a significant impact, it was felt more prudent to explore the degree of impact of the even in addition to this questionnaire.

5.2 In order to assess the degree of distress experienced, the Impact of Events Scale-Revised (IES-R, Weiss & Marmar, 1997) was also completed. This 22 item self-report scale, a revised version of IES, is comprised of the three subscales representative of the major clusters of post-traumatic stress (Avoidance, Intrusion and Hyperarousal) and measures the degree of impact and not just the frequency of impact. There are no specific cut-off points for the IES-R although higher scores are representative of greater distress.

5.3 Liz's IES-R total score was 51, out of a potential 88, highlighting the significance of the impact the current complaint process has on Liz. What is of interest is that Liz did not

select the accident or injury itself as the event to review but the subsequent health care situation as the significant event in her life. Additionally, moderate scores were highlighted in difficulties for Avoidance, Intrusion and Hyperarousal subscales.

6. Functional analysis and maintenance factors

6.1 Liz reported she tries to avoid strong analgesics due to finding these have a lassitude effect, often leaving her feeling physically unwell. Therefore currently, Liz utilises diclofenac for regular pain relief, although she has recently increased her dosage to help with her current pain levels. This leads to her pain being a constant reminder, not only of the current lack of curative options available, but also of the past relational traumatic experiences of feeling unsafe during the discussions with health care professionals regarding her past treatment.

6.2 The impacts on Liz's social relationships and employment have reduced the positive protective factors in her life, which in turn reduce her resilience to the emotional impacts of the situation. As Liz's life has become ever increasingly focussed on the complaints process, she has struggled to engage in experiences external to this problem, leading to feelings of her life being consumed by the experience.

6.3 Throughout our discussions, I was aware that Liz's narrative was heavily "problem-saturated"; with the problem being her current life revolving around the intertwined experiences of trying to achieve positive progression with her physical health and the perceived battle required to achieve this and hold those accountable for past mistakes. Liz's narrative has become saturated with the problem of having to fight the health care system, to the degree this influences the stories she is able to tell about her life (to herself and others) and it becomes the plot from which she make predictions about where it is possible for her to go from. Her identity is currently defined by the parameters allowed by this complaints battle and her decisions, relationships, feelings, thoughts, and memories are all dominated by the issue. Due to this, Liz struggles to perceive alternative experiences free of the problem, allowing her thinking and emotional space away from the 'battle'. Even during periods of relative calm, Liz is still hypervigilant of

the future arrival of the next expected contact with health services, such as letters regarding her complaints.

6.4 Liz's recurrent experiences of combative discussions with health care services have appeared to reinforce unhelpful patterns of inter-relational interactions and leave Liz with a sense of powerlessness, which may inadvertently re-traumatise her, as someone who has previously experienced feelings of relational trauma (or unsafety), when in discussions with those reviewing her complaint.

6.5 Some of Liz's disclosures about her pre-injury life led me to wonder about the possible impact of her early life experiences and how these developed her experiences of safety and attachment. Furthermore there may be cultural influences, given Liz's significant time spent in South Africa and the differences with how people may expect to experience health services differing between private and publically funded services. However, there was limited scope to explore these in the remit of the assessment and these may be of benefit to explore further in any therapeutic setting.

7. Expressed goals

7.1 Given the fact there is no clear respite or resolution of Liz's current physical health and pain, nor the associated complaint, Liz understandably struggled to identify what could be achievable and realistic goals. The main area Liz identified as a goal, was to understand more about what she is feeling and why, with Liz struggling to explore goals relating to her physical health in the assessment. This may be due to an expectation that physical health services will still be able to identify a curative option.

7.2 Furthermore, Liz wished to explore ways in which she can maintain and maximise hope in the future that her situation will change for the positive. Liz highlighted she was scared her current hope for change won't last. She acknowledged that whilst there is little control over whether or not the situation may change for the better, how having hope can limit the negative impacts of events, and the importance of exploring how to further minimise the impact the current complaint has on different areas of her life, both relating to her physical health and her mental health, social relationships and everyday functioning.

8. Risk assessment

8.1 Liz disclosed historic experiences of thoughts of self-harm and suicidal ideation, occurring roughly one year ago and lasting for approximately five months. Liz described how she felt there was no point to her life and thought about using helium to end her life, as she had researched this as a low pain method with a high probability of success. Liz had purchased the helium, written goodbye letters, started paying off her debts, and started to pack her belongings away. She had completed one suitcase of packing when she received a diagnosis (September 2018) she felt moved her prognosis in a positive direction and lifted her mood. Liz had only informed one person about this experience, as this was linked to her capability to work review. Liz has kept the helium and not unpacked the suitcase; however she reported she did not currently have any intention to take her own life. Given the history of suicidal ideation, intention and planning, Liz is likely to be of significant risk of suicide in the future should she lose hope regarding the potential for a positive outcome of her physical health and complaint. Liz is aware of supportive services but feels in general these do not help. She has undertaken psychotherapy via Skype, which she found helpful at the time but became bored of repetitively talking about her difficulties without progress. She had previously been referred to a Cognitive Behaviour Therapy service, however was discharged prior to being seen.

9. Recommended interventions plan

9.1 As is currently highlighted in good practice, all health care services should aim to be trauma-informed services, and need to be structured and delivered in ways that engender safety and trust and do not re-traumatise individuals who have previously experienced traumatising events. Prioritising safety, trust, mutuality and collaboration, should be cornerstones of current health care provision. However, it is often difficult to adjust the environment with which people are required to engage in order to access different services and therefore lessening the impacts of these interactions is a secondary course of action.

9.2 From the information provided in the assessment session, Liz may benefit from a range of psychotherapeutic approaches. From our discussions, I feel there are three main therapeutic options available that may fit well for Liz.

9.3 Firstly is Cognitive Behavioural Therapy, looking at how early life experiences can create and influence the rules for life and core beliefs of an individual, explore how life events can impact these beliefs and rules, and how our thoughts, feelings, behaviours and physical sensations can interact in different ways to either lead to negative cycles of experiences, or with support to explore new ways to break these patterns, supporting new and more positive experiences.

9.4 Secondly Narrative Therapy may also be suitable for Liz given the inter-relational aspects of her difficulties. As highlighted, the stories we and others tell about us can at times become 'problem saturated', restricting the scope of our potential to see options beyond the parameters of the problem. Narrative Therapy aims to explore how we are recruited into telling the problem-saturated stories, 'externalising' the problems away from being central to ourselves but as something we experience, and thereby looking for other experiences that are exceptions to the problem and exploring how these are possible and their impacts. Through these processes, the therapy aims to 're-author' the dominant stories the individual tells about themselves with and alternative positive focus, often based on hope, strength and resilience.

9.5 Finally, I believe also Compassion Focussed Therapy may also have potential for Liz, given the high level of threat perceived in the current situation, often leading to questions about guilt whether she could have done things differently, and reduced drive for life. Compassion Focussed Therapy is rooted in an evolutionary, neurological and psychological model, through exploring an individual's compassion, drive and threat systems, how these can interact, and how to increase skills in regulating their threat systems through the use of their compassion system. Individuals may have difficulty regulating the threat system using the compassionate system due to limited experience of this from early life. As a consequence, threat based emotions (e.g. fear, anger, disgust, shame) can become too strong. Therefore, safety behaviours (e.g. escape, avoidance, aggression) are used to regulate the threat system. These safety behaviours can have unintended consequences that inflate the threat system. The inflated threat

system is then regulated using safety behaviours, which creates a maintenance cycle. The development of compassion towards oneself can support to regulate the threat system and help break this maintenance cycle.

9.6 Furthermore, Liz has reported benefits of using Skype for psychotherapy and this can also be explored to hopefully increase the potential options for accessing future psychotherapeutic support. Whichever therapy Liz choses, it will be important that consideration of her pain experiences are incorporated into understandings of her current distress. As the exploration of curative and pain reduction options are still underway, Liz would not yet be suitable for assessment by a Pain Management Programme (PMP), which is usually offered once all possible avenues of treatment have been exhausted. However, given the longstanding nature of Liz's pain experiences, Pain Management Programme considerations may be beneficial to explore to support Liz's unresolved pain issues. Potential resources for pain management focus on understanding the interactions of psychological, emotional and physical factors in maintaining the problems associated with pain, and aim to reduce the impact pain has on the individual. This should not replace Liz's current rehabilitation and curative treatment options.

10. Declaration

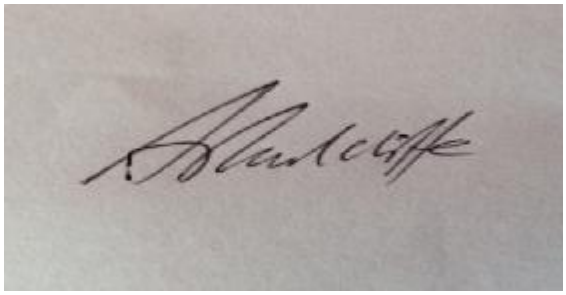
I, Dr Alisdair Radcliffe, HCPC Registered Clinical Psychologist, declare that this report is true to the best of my knowledge.

a. **I am fully aware of the Protocol for the Instruction of Experts.**

b. **I have read Part 35 of the Civil Procedure Rules and the**

c. **I have no conflict of any kind in this case. I will advise the instructing party if there is any change of circumstances which results in a conflict of interest.**

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.



Dr. Alisdair Radcliffe
HCPC Registered, Chartered Clinical Psychologist

Appendix One

Qualifications and Experience

Dr. Alisdair James Radcliffe BSc (Hons) MSc DClinPsych CPsychol PGCert

I am a Chartered Senior Clinical Psychologist, specialising in work with adults with learning disabilities including people with autistic spectrum disorders (ASD), parents with a learning disability and adults with mental health problems. I have experience in neuropsychological and psychometric assessments, in completing assessments and writing Court reports as well as providing therapeutic interventions.

Within my experience as a qualified clinician I have completed detailed cognitive assessments including those to clarify the presence and specific nature of a learning disability. I have also completed psychological assessment of a broad range of mental health problems including depression, anxiety disorders, such as obsessional compulsive disorder (OCD) and post-traumatic stress disorder (PTSD), psychosis, bi-polar and personality disorder. I am skilled in planning and delivering different therapeutic interventions including cognitive behavioural, mindfulness based interventions and psychodynamic and have a specific interest in systemic therapy. I also have extensive experience in completing risk assessments and Mental Capacity Assessments.

I am currently employed within a Community Team for Adults with Learning Disabilities within the NHS. I have a special interest in working with families and clients who have a dual diagnosis and complex needs, as well as providing consultation and support for adult service staff teams.

Professional Qualifications

2017 – 2018	Post Graduate Certificate Postgraduate Certificate systemic approaches to working with individuals, families, and organisations – intermediate level
	Tavistock and Portman NHS Foundation Trust

2011 – 2014	Doctorate in Clinical Psychology (DClinPsych) University of Leicester
2008	Positive Practices in Behavioural Analysis Institute of Applied Behavioural Analysis
2003 – 2004	MSc Health Psychology (Stage 1 accreditation) London Metropolitan University
1999 – 2002	BSc (Hons) Psychology University of Essex