Virtuosa

BLOCK TWO

Now *you* do it

1:01pm

How this works

1. **Get into threes or fours** and give yourselves a name — best one gets read out

2. **I'll tell you the case** out loud, like a handover. Five minutes, no slides.

3. **Then you read the two reports** same case, and both are first drafts. One drafted by a psychologist, one drafted by the AI. drafted by the AI. Neither has been worked over.

4. **Make your own notes first**, before you talk as a group - using Lockwood's own questions. Then begin to answer the answer the questions together.

5. **One form per group** then discuss together

1:04pm

The case

A fabricated workers compensation file. Back to Miyuki

She does not exist. Neither does the clinician who assessed her.

Listen. Don't take notes yet.

1:10pm

Two reports. Same case.

They're in your handout, and they're on the next few pages.

Read Report A. Then read Report B.

Make notes about each one, before you talk to your group.

25 minutes. Nothing to scan, nothing to log in to — everybody has the same pages.

1:38pm

Mr Joe Smith Case Manager Perth Insurance Company joe@PerthIns.com.au 18 September 2026

Opening and Subject

Dear Mr Smith,

Re: Miyuki M. (Female)

Claim No: PE1234 Date of Birth: xx/xx/20xx Date of Accident/Incident: June 2026

Referral and Authorisation

Thank you for your approval dated the 1st of September 2026 for two clinical psychological assessment sessions and one clinical psychological assessment report in relation to Ms M. No treatment sessions were included in this approval.

Reason for Referral

Ms M. was referred by her treating General Practitioner, Dr Brown, of Perth, Perth, Western Australia, by way of a referral letter dated the 20th of August 2026. August 2026. Dr Brown referred Ms M. for clinical psychological assessment, assessment, psychometric testing where indicated, an opinion regarding diagnosis diagnosis and its relationship to the workplace incident, and recommendations recommendations regarding treatment and return to work. The referral indicated indicated that Ms M. was experiencing symptoms of post-traumatic stress disorder stress disorder following an assault at work by a patient with psychosis.

Ms M. attended two clinical psychological assessment sessions on the 10th of September 2026 and the 17th of September 2026. This report summarises the findings from those assessment sessions.

DOCUMENTATION REVIEWED

I note that the following documentation and/or information was on hand at the time of compiling this report:

- Referral letter from Dr Brown, Treating General Practitioner, dated 20th of August 2026
- Medical certificate issued by Dr Brown, dated 20th of August 2026, certifying Ms M. as totally unfit for work
- Approval letter from Perth Insurance Company, dated 1st of September 2026, for two clinical psychological assessment sessions and one clinical psychological assessment report (Claim PE1234)
- Clinical notes from Session 1 (assessment), dated 10th of September 2026

- Clinical notes from Session 2 (assessment continued), dated 17th of September September 2026
- Psychometric test results: Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and Impact of Events Scale (IES), administered 10th of September 2026

BACKGROUND TO THE INCIDENT

Date of Incident: June 2026

The following is an account of events as told by Ms Miyuki M.

Ms M. reported that she is a registered nurse who has worked in the Emergency Department at Perth Hospital for 15 years. She described her role as involving the provision of medical care to patients presenting to the Emergency Department.

Ms M. described that on the date of the incident she was helping a patient with a known history of psychosis with medical care. She reported that the patient's behaviour changed suddenly and unexpectedly. The patient became verbally aggressive, pushed her into a wall, and yelled at her. Ms M. stated that she did not know when he would let her go, describing feeling unable to escape the situation. Security eventually arrived and intervened.

Ms M. reported feeling significant embarrassment and self-blame in the immediate aftermath. She described feeling that she had "let this happen." She minimised what had occurred and continued attending work in the days that followed. Other staff noticed she was quieter than usual. She reported feeling embarrassed when colleagues asked if she was alright.

Over the subsequent week, Ms M. described increasing anxiety about attending attending work. She began arriving late to shifts. A colleague then noticed her noticed her hands shaking during a shift, at which point she burst into tears and tears and went home. Ms M. reported that she has not been able to return to work return to work since that time.

Prior to the psychological assessment, Ms M.'s only treatment had been provided by her general practitioner, Dr Brown, who offered advice and support and commenced her on antidepressant medication. Dr Brown issued a medical certificate on the 20th of August 2026 certifying her as totally unfit for work, with the stated condition being post-traumatic stress disorder following a workplace assault.

Ms M. reported experiencing flashbacks, nightmares, intrusive memories, and sleep disturbance following the incident. She described panic attacks triggered by certain smells that reminded her of the hospital, accompanied by shortness of breath, chest pain, and dizziness. She reported being tearful on a daily basis. She described avoiding leaving her home and no longer going out with friends. She reported avoiding reminders of the incident and trying not to think about it.

Ms M. described a notable change in her functioning at work during the period before she ceased attending. She reported that her level of anxiety or comfort depended on which colleagues she was working with, and she often became tearful at work. She expressed pessimistic thoughts about work and her safety, including thoughts related to not being safe at work. She reported that reminders of the incident brought back feelings about it. She described feeling numb at times and not wanting to talk about the incident with work colleagues.

Since the workplace incident, Ms M. reported becoming aware of using alcohol to numb her anxious symptoms. She estimated her intake at two to four glasses of wine per day. She denied illicit drug use.

PRE-INJURY PERSONALITY AND FUNCTIONING

Ms M. reported that she lives alone. Her mother lives in Japan.

In terms of developmental history, Ms M. is an only child. She described her father as having had a tendency to drink alcohol and as being somewhat verbally abusive towards her mother. Her parents separated when she was 13 years old. Ms M. reported blaming herself for their separation, explaining that her father had hit her and her mother decided to separate after seeing her crying about this incident. She described often trying to do well at school in order to please her parents and in the hope that good grades would stop them arguing.

Ms M. reported being close to her maternal grandparents, who lived near her school. She lived with them for a period following her parents' separation. Her father is deceased; she had been estranged from him at the time of his passing, approximately four years ago.

In terms of employment history, Ms M. is a registered nurse. She reported that she has worked in the Emergency Department at Perth Hospital for 15 years. Her role involved the provision of direct medical care to patients. She is currently certified as totally unfit for work and has not returned to the workplace since the incident.

Ms M. did not report any previous history of psychological problems. No family history of psychiatric problems was reported. Dr Brown's referral letter similarly noted no previous history of psychological problems and no known family history of psychological problems.

In terms of substance use, Ms M.'s use of alcohol to manage anxious symptoms commenced after the workplace incident. She denied use of illicit drugs. No pre-incident pattern of problematic substance use was reported.

Ms M.'s early history is notable for exposure to family conflict, parental separation, paternal verbal abuse towards her mother, and an incident of physical violence by her father directed at her. She reported self-blame in relation to her parents' separation. While these experiences are relevant developmental context, Ms M. reported no previous psychiatric history and was functioning in a demanding clinical role for 15 years prior to the workplace incident.

BEHAVIOURAL OBSERVATIONS DURING ASSESSMENT

Ms M. attended both assessment appointments on time.

Across both sessions, Ms M. presented as politely spoken and quiet throughout. She engaged with the assessment process and provided a clear account of the workplace incident and her subsequent course. Her speech was clear and she was able to express herself in a coherent manner.

There were instances during the sessions where Ms M. appeared to be becoming upset. At these times she would go quiet, stop speaking, and then compose herself before continuing. This pattern was observed across both sessions. Her mood was observed to be somewhat anxious in relation to the trauma, which fitted with my clinical impression of her presenting condition.

Ms M. was fully orientated for time, place and person. She made adequate contact with me during assessment and was fully able to understand questioning throughout. I did not determine any marked perceptual disturbance of a psychotic quality.

Current Psychological Complaints

Ms M reported the following psychological complaints over the course of the two clinical psychological assessment sessions, with respect to how she is currently coping.

Trauma-Related Intrusive Symptoms

Ms M reported experiencing flashbacks, nightmares, and intrusive memories related to the workplace assault. She described panic attacks triggered by certain smells that reminded her of the hospital environment. These panic episodes were accompanied by shortness of breath, chest pain, and dizziness. She indicated that reminders of the incident brought back feelings associated with it, and she reported actively trying not to think about the incident.

Avoidance Behaviours

Ms M reported significant avoidance behaviours across multiple domains. She described avoiding leaving her home, not going out with friends, and avoiding reminders of the incident. She reported that she did not want to talk about the incident with work colleagues. When she had still been attending work, she described her level of anxiety or comfort as depending on which colleagues she was working with. She also reported embarrassment when people asked if she was alright, and she had minimised what had happened in the immediate aftermath.

Anxiety and Hyperarousal

Ms M described living with prominent anxiety symptoms. She reported racing thoughts, pessimistic thoughts about work and her safety, and recurrent thoughts related to not being safe at work. Her anxiety had increased progressively in the week following the incident, during which she began arriving late to work. A colleague noticed her hands shaking during a shift, after which she became tearful and went home. She has not been able to return to work since.

Mood Disturbance

Ms M reported being tearful on a daily basis. She described often becoming tearful at work when she had still been attending. She reported feeling numb at times. Prominent self-blame was noted, with Ms M expressing embarrassment about the incident and a belief that she "let this happen." This self-blame appeared to be a significant feature of her presentation, contributing to her distress and social withdrawal.

Sleep Disturbance

Ms M reported disturbed sleep, including nightmares related to the workplace assault. Specific details regarding sleep duration or quality compared to her pre-incident sleep patterns were not elaborated upon during the assessment sessions.

Social Withdrawal and Functional Impact

Ms M reported reluctance to leave her home and had stopped going out with friends. She described a pattern of social withdrawal and reduced engagement in activities since the incident. Her avoidance of the hospital environment and associated triggers, including smells, had further restricted her daily functioning.

Occupational Impact

Ms M has not returned to work since the shift during which her hands were observed shaking by a colleague and she became tearful. She was certified as totally unfit for work by Dr Brown on the 20th of August 2026. She reported pessimistic thoughts about work and her safety, and recurrent thoughts about not being safe at work. Her anxiety about attending work had escalated over the week following the incident before she ceased attending altogether.

Substance Use

Ms M reported becoming aware of using alcohol to numb anxious symptoms since the workplace incident. She estimated her current intake at two to four glasses of wine per day. She denied the use of illicit drugs.

Risk

Ms M reported experiencing suicidal ideation at times. However, she was sufficiently reassuring that she would not act on her thoughts. No active plan or intent was disclosed.

Psychometric Testing

Psychometric testing was administered on the 10th of September 2026 during the first assessment session. The battery comprised the Beck Anxiety Inventory (BAI), the Beck Depression Inventory (BDI), and the Impact of Events Scale (IES).

Beck Anxiety Inventory (BAI)

The BAI is a 21-item self-report measure designed to assess the severity of anxiety symptoms. Ms M obtained a raw score of 27, which falls within the moderate range. This result indicates a clinically significant level of anxiety symptomatology, consistent with her reports of racing thoughts, physiological anxiety symptoms, panic attacks, and pervasive worry about her safety.

Beck Depression Inventory (BDI)

The BDI is a 21-item self-report measure designed to assess the severity of depressive symptoms. Ms M obtained a raw score of 28, which falls within the moderate range. This result indicates a clinically significant level of depressive symptomatology, consistent with her reports of daily tearfulness, emotional numbness, social withdrawal, self-blame, loss of engagement in activities, and suicidal ideation.

Impact of Events Scale (IES)

The IES is a self-report measure designed to assess subjective distress related to a specific traumatic event, yielding a total score and subscale scores for Avoidance, Intrusion, and Hyperarousal. Ms M obtained a total raw score of 30 out of a possible 88. Scores over 33 are generally considered indicative of post-traumatic stress disorder. Ms M's total score fell below this clinical threshold.

Her subscale scores were as follows

The subscale profile indicates that avoidance symptoms were the most prominently endorsed, followed by intrusion and hyperarousal. The elevation on the Avoidance subscale is consistent with Ms M's reported pattern of avoiding reminders of the incident, withdrawing from social contact, reluctance to leave her home, and efforts to suppress thoughts about the assault. The lower Intrusion and Hyperarousal subscale scores, while still present, were comparatively less elevated. It is noted that Ms M's total IES score fell just below the threshold typically associated with a diagnosis of PTSD. However, the IES score should be considered alongside the broader clinical picture, including the moderate levels of comorbid anxiety and depressive symptoms captured by the BAI and BDI, the range and severity of trauma symptoms reported during the clinical interview, and the significant functional impairment evident across occupational, social, and daily living domains.

Current Medications

Ms M reported that she had been commenced on antidepressant medication by her treating general practitioner, Dr Brown, following the workplace incident. The specific name, dosage, and frequency of the antidepressant were not documented during the assessment sessions. No other current medications were reported.

DISCUSSION OF FINDINGS

I note that this discussion of findings is both derived from and constrained by the available information.

Ms M is a registered nurse who has worked in the Emergency Department at Perth Hospital for 15 years. She was referred by her treating General Practitioner, Dr Brown, for clinical psychological assessment following a workplace assault by a patient with a history of psychosis.

The incident involved a sudden and unexpected change in the patient's behaviour during medical care, escalating to verbal aggression, physical assault including being pushed into a wall, and a period during which Ms M reported feeling unable to escape until security arrived. Following the incident, she initially minimised what had happened and continued attending work. Over the subsequent week, her anxiety about attending work increased, she began arriving late, and after a colleague noticed her hands shaking during a shift, she became tearful and went home. She has not returned to work since.

Psychometric testing administered on the 10th of September 2026 shows clinically significant results across mood, anxiety and trauma domains. Her Beck Depression Inventory score of 28 fell in the moderate range, and her Beck Anxiety Inventory score of 27 also fell in the moderate range. These results indicate comorbid mood and anxiety symptoms of meaningful clinical severity. Her Impact of Events Scale total score of 30 out of 88 fell below the threshold of 33 that is considered indicative of post-traumatic stress disorder. Subscale analysis revealed avoidance symptoms as the most elevated domain (1.88 out of 4), followed by intrusion (1.13) and hyperarousal (1.00). While the total IES score falls below the PTSD threshold, the clinical picture must be considered alongside the broader symptom presentation documented across both assessment sessions, including flashbacks, nightmares, panic attacks triggered by hospital-related smells, prominent avoidance behaviour, daily tearfulness, social withdrawal, and significant self-blame.

Ms M reported no previous history of psychological problems, and no family history of psychological problems was documented. Her presenting psychological symptoms are attributed to the workplace assault. There is a clear temporal relationship between the incident and the onset of her current difficulties, with symptoms developing and escalating in the weeks following the assault.

It is noted that Ms M's developmental history includes exposure to family conflict and domestic violence during childhood, including an episode in which her father hit her, and the subsequent separation of her parents when she was 13 years old. She reported blaming herself for her parents' separation. While these experiences do not constitute a prior psychiatric history, they provide relevant context for understanding certain features of her current presentation, particularly the prominence of self-blame, as she reported feeling she "let this happen" during the workplace assault. These earlier experiences may represent a vulnerability factor that has been activated by the current incident.

It is also noted that Ms M reported using alcohol to manage anxious symptoms since the workplace incident, estimating consumption at two to four glasses of wine per day. This pattern of substance use as a coping strategy warrants clinical attention during treatment, as it may maintain or exacerbate her anxiety and mood symptoms.

DSM-5 Criteria for Post-Traumatic Stress Disorder (PTSD)

Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence: Ms M was directly exposed to a physical assault while providing care to a patient with psychosis, who became unexpectedly violent, pushed her into a wall, and physically restrained her until security arrived. This meets Criterion A through direct experiencing of a traumatic event involving actual physical violence and threatened serious injury.

Criterion B: Intrusion symptoms: Ms M reported flashbacks, nightmares, and intrusive memories related to the assault. She also reported panic attacks triggered by smells that remind her of the hospital, representing intense psychological and physiological distress at exposure to cues resembling an aspect of the traumatic event. This criterion is met.

Criterion C: Persistent avoidance of stimuli associated with the traumatic event: Ms M reported avoiding reminders of the incident, avoiding leaving her home, reluctance to see friends, trying not to think about the incident, and not wanting to discuss the incident with work colleagues. These represent avoidance of both internal reminders (thoughts and feelings) and external reminders (people, places, and conversations). This criterion is met.

Criterion D: Negative alterations in cognitions and mood: Ms M reported prominent self-blame and embarrassment about the incident, pessimistic thoughts about work and her safety, emotional numbness at times, reduced interest in social activities, and daily tearfulness. She also reported suicidal ideation at times. These represent negative alterations in cognitions and mood associated with the traumatic event. This criterion is met.

Criterion E: Marked alterations in arousal and reactivity: Ms M reported sleep disturbance, racing thoughts, hypervigilance regarding her safety at work, and physiological arousal symptoms including shortness of breath, chest pain, and dizziness. Her increased anxiety about attending work and the observed hand tremor at work are consistent with heightened arousal and reactivity. This criterion is met.

Criterion F: Duration: Symptoms have persisted for more than one month since the incident occurred.

Criterion G: Functional significance: Ms M's symptoms have resulted in significant functional impairment, including cessation of work, social withdrawal, and avoidance of leaving her home.

Criterion H: The disturbance is not attributable to the physiological effects of a substance or another medical condition: While Ms M has reported increased alcohol use since the incident, this pattern commenced after symptom onset and represents a coping response to established symptoms rather than a primary cause.

In my opinion, Ms M is presenting with post-traumatic stress disorder (PTSD) following the workplace assault. This diagnosis is supported by the clinical interview across both assessment sessions, the consistency of behavioural observations with her reported symptoms, and the psychometric results indicating moderate depression and anxiety alongside clinically significant trauma symptoms. While her IES total score of 30 fell just below the published PTSD threshold of 33, this does not preclude the diagnosis, as the clinical presentation across all other assessment modalities clearly satisfies DSM-5 criteria. The avoidance subscale was notably the most elevated, consistent with her prominent pattern of behavioural and cognitive avoidance.

The current presentation represents a significant decline from Ms M's pre-incident functioning, marked by an inability to return to work, social withdrawal, reliance on alcohol to manage symptoms, daily tearfulness, and suicidal ideation, in a woman with no prior history of psychological problems who had maintained stable employment in a demanding role for 15 years.

RECOMMENDATIONS

I can confirm receipt of the approval dated the 1st of September 2026 for two clinical psychological assessment sessions and one clinical psychological assessment report. No treatment sessions have been approved to date.

Based on the assessment findings, which indicate that Ms M is presenting with post-traumatic stress disorder following the workplace assault, I am of the opinion that she would benefit from psychological treatment in the short to medium term with the aim of treating her presenting trauma, mood, and anxiety symptoms.

The focus of the psychological treatment will be to:

1. Provide psychological strategies to treat her trauma-related symptoms, including cognitive behavioural therapy (CBT) and psychoeducation regarding PTSD and its management.

2. Provide eye movement desensitisation and reprocessing (EMDR) to reprocess the traumatic memory of the workplace assault and its associated thoughts, feelings, and physical sensations.

3. Address her current pattern of alcohol use as a coping strategy and support the development of alternative strategies for managing anxious symptoms.

4. Support Ms M with regard to her return to work at Perth Hospital, including graded exposure to the workplace environment, when clinically appropriate.

I recommend that approval be sought for an initial six clinical psychological treatment sessions. A review report with recommendations will be forwarded on completion of those sessions.

In the meantime, please do not hesitate to contact me directly should you wish to discuss.

LIMITATIONS

This assessment was based on two clinical psychological assessment sessions conducted on the 10th and 17th of September 2026, a review of the GP referral letter and medical certificate from Dr Brown dated the 20th of August 2026, and administration of three standardised psychometric measures (BDI, BAI, and IES). The findings reflect Ms M's presentation and the information available at the time of assessment and may change as further information becomes available. The history and symptom report rest substantially on Ms M's self-report, which was not independently verified, and no collateral informant was available.

For further discussion, please contact me.

Yours sincerely,

Clinical Psychologist

Mr. Joe Smith.

Perth Insurance Company

E: Joe@PerthIns.com.au

18th September 2026.

Dear Mr. Smith,

RE: Miyuki M.

DOB: xx/xx/20xx

Claim number: PE1234

Thank you for approving two clinical psychological assessment sessions and a clinical psychological assessment report as per your approval dated 1 September 2026.

Reason for referral

Miyuki was referred by Dr. Brown, her treating general practitioner, for post-traumatic stress disorder following an assault at work where a patient with psychosis had hit her multiple times.

She attended two clinical psychological assessment sessions on the 10th of September and the 17th of September 2026.

Collateral information reviewed

GP referral letter dated 20th August 2026

My clinical notes from sessions provided on the 10th of September and the 17th of September 2026

Dr Brown’s medical certificate, dated the 20th of August 2026, stating that she is totally unfit for work.

History of Incident

Miyuki reported that she has been working as a nurse within the Emergency Department at the Perth Hospital for 15 years.

She reported that on the date of the incident she had been helping a patient who had a history of psychosis with their medical care. Described that the patient's behaviour suddenly and unexpectedly changed and he became verbally aggressive and pushed her into the wall, and yelled at her. She didn’t know when he would let her go, and while security eventually arrived, she felt embarrassed that she had let this happen.

Following the assault, she minimised what had happened and continued to attend work on a consistent basis, but other staff noticed that she was quieter than usual. She felt embarrassed when people asked if she was okay, and found that she was becoming more anxious over the subsequent week about going into work.

She began coming into work later, and when a colleague noticed that her hands were shaking during a shift, Miyuki reported that she burst into tears, and went home.

She hasn't been able to return to work since that time.

She has reported problems with flashbacks, nightmares, intrusive memories and sleep problems. She found that certain smells that reminded her of the hospital tend to result in her experiencing panic attacks.

She has attended her General Practitioner for advice and support and has been prescribed antidepressant medication.

Background history

Miyuki lives on her own, and her mother lives in Japan. Her father is deceased, and she was estranged from him at the time of his passing four years ago.

She explained that he was prone to drinking alcohol, and she had uncomfortable memories of him being somewhat verbally abusive to her mother. She tells me that her mother separated from her father when she was 13 years of age, and she blames herself for their separation because she was crying after her father hit her. Her mother decided to separate after that incident.

Miyuki is an only child, she did not have siblings. She explained that she often wanted to do well at school to please her parents, and she hoped that her good grades would stop her parents from arguing.

She described that she was close to her maternal grandparents, who lived close by to her school. When her mother separated from her father they lived with her grandparents for a period of time.

She did not report any history of previous psychological problems or family history of psychological problems.

She was aware of using alcohol to numb her anxious complaints since the workplace incident. She estimated that she drinks 2-4 glasses of wine per day. She did not describe using illicit drugs.

BEHAVIOURAL OBSERVATIONS

Miyuki attended the appointments on time. She was politely spoken, and quiet throughout the assessment sessions.

She was clear with the telling of her story, and her description of the incident as it occurred. There were instances of her appearing as if she was becoming upset. She would become quiet, and stop speaking. Then compose herself.

I have found Miyuki's mood to be somewhat anxious regarding the trauma incident.

Her presentation fitted with my clinical impression of her presenting condition.

I did not determine any marked perceptual disturbance of a psychotic quality. She was fully orientated for time, place and person, and made adequate contact with me during assessment.

CURRENT PSYCHOLOGICAL COMPLAINTS

Miyuki reported the following psychological complaints over the course of the two clinical psychological assessment sessions, with respect to how she is currently coping:

Miyuki reported that she has been teary on a daily basis.

She has avoided leaving her home, or going out with friends.

She reported physiological anxiety symptoms, including shortness of breath, chest pain, dizziness.

She advised that she avoids reminders of the incident.

She stated that when she was still attending work, it depends on who she was working with as to how anxious or comfortable that she felt. She reported that she often becomes teary at work.

She is aware of pessimistic thoughts about work and her safety.

She is aware of racing thoughts.

She is aware of thoughts to do with not being safe at work.

Reminders about it brought back feelings about it.

She is trying not to think about the incident.

She has described being numb at times.

She reported that she had experienced suicidal ideation at times, but was sufficiently reassuring that she would not act on her thoughts.

She was aware of not wanting to talk about the incident with work colleagues.

PSYCHOMETRIC TESTING

Miyuki completed the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI) and the Impact of Events Scale (IES).

Miyuki's results for the BAI showed a raw score of 27, showing results in the "moderate range" for anxiety symptoms.

Miyuki's results for the BDI showed a raw score of 28, showing results in the "moderate range" for depressive symptoms.

Miyuki's results for the Impact of Events Scale, showed a result of 30 out of a possible maximum of 88, where scores over 33 are indicative of having Post-traumatic Stress Disorder (PTSD). Her score suggested that she is presenting with trauma related symptoms.

Her results for the subscales were as follows

avoidance subscale – 1.88 out of a possible 4

intrusive subscale – 1.13 out of a possible 4

hyperarousal subscale – 1.00 out of a possible 4.

Miyuki's psychometry results indicate trauma related symptoms, with comorbid mood and anxiety symptoms.

DISCUSSION OF FINDINGS

I note that this discussion of findings is both derived from and constrained by the available information.

Miyuki is a 27 year old nurse who was assaulted by a patient with psychosis. She was unable to avoid the assault or get away. She feels a great deal of shame that she did not anticipate his behaviour, and blames herself. At the same time, she has reported trauma and anxiety symptoms, associated with the incident, and has become avoidant of leaving her home.

From Miyuki's description, she has suffered trauma related symptoms as well as mood and anxiety symptoms as a result of the trauma incident.

She had returned to work immediately following the incident, and went off work one week later. She has not been able to return to work since June 2026.

I have recommended that she remain off work for the moment, with a view to giving her time to undergo needed psychological treatment.

Psychometric testing shows clinically significant results, showing mood, anxiety and trauma symptoms.

Notwithstanding this, her current presenting psychological symptoms are attributed to the workplace incident.

In my opinion Miyuki is presenting with significant trauma related symptoms with comorbid mood and anxiety symptoms.

She would meet sufficient criteria for Post-traumatic Stress Disorder.

RECOMMENDATIONS

In my opinion, Miyuki would benefit from psychological treatment in the short to medium term with the aim of treating her presenting psychological symptoms associated with the workplace incident.

I have recommended that she delay any increase in her graduated return to work until she has undergone sufficient psychological treatment.

The focus of the psychological treatment will be to:

Provide psychological strategies to treat her mood, anxiety and trauma related symptoms which would include cognitive behavioural therapy (CBT).

Provide a combination of eye movement desensitisation and reprocessing (EMDR) and exposure therapy to reprocess the target memory and its associated thoughts, feelings and physical sensations.

Support her to return to work when she has shown sufficient psychological recovery to do so.

A review report with recommendations will be forwarded on completion of the initial six clinical psychological treatment sessions.

In the meantime, please do not hesitate to contact me directly, should you wish to discuss.

Yours sincerely,

Clinical Psychologist

QR CODE 2 · YOUR VERDICT

One form per group.

Your scores, which one you'd sign, and which one you think was written by AI.

Eight minutes. One person per group fills it in — you'll all still put your own hand up shortly.

Scan to open

1:46pm

HANDS UP · ROUND ONE

Hands up if you scored Report A higher overall.

Now Report B.

Your own verdict — not your group's form. Everybody votes.

1:51pm

HANDS UP · ROUND TWO

Hands up if you would sign Report A.

Now Report B.

Hands up if you wouldn't sign either.

Lockwood's number: 49.6% would sign the human report. 43.1% the AI one.

1:55pm

HANDS UP · ROUND THREE

Which one do you think the AI drafted first?

Hands up for A. Hands up for B.

Then — and only then — I'll tell you.

1:59pm

SO WHAT WERE YOU SEEING?

For those of you who rated the human one lower — and some of you did — what was it doing, or not doing?

Take three or four. Different groups, different specialities.

2:06pm

SECTION SIX

Choosing *your* tool

2:09pm

Four categories, not four brands

Products change every quarter. Categories don't.

1. **Ambient scribes** built around a transcription problem — they listen to the session and give you a note
2. **General-purpose large language models** ChatGPT, Claude, Gemini, Copilot — capable, and the privacy problem the OAIC named
3. **Purpose-built report writers** built around collation, narrative and argument — mine is one of them, and it is a growing field
4. **The stack around all of it** practice management, dictation, storage — where most of the time actually goes

2:12pm

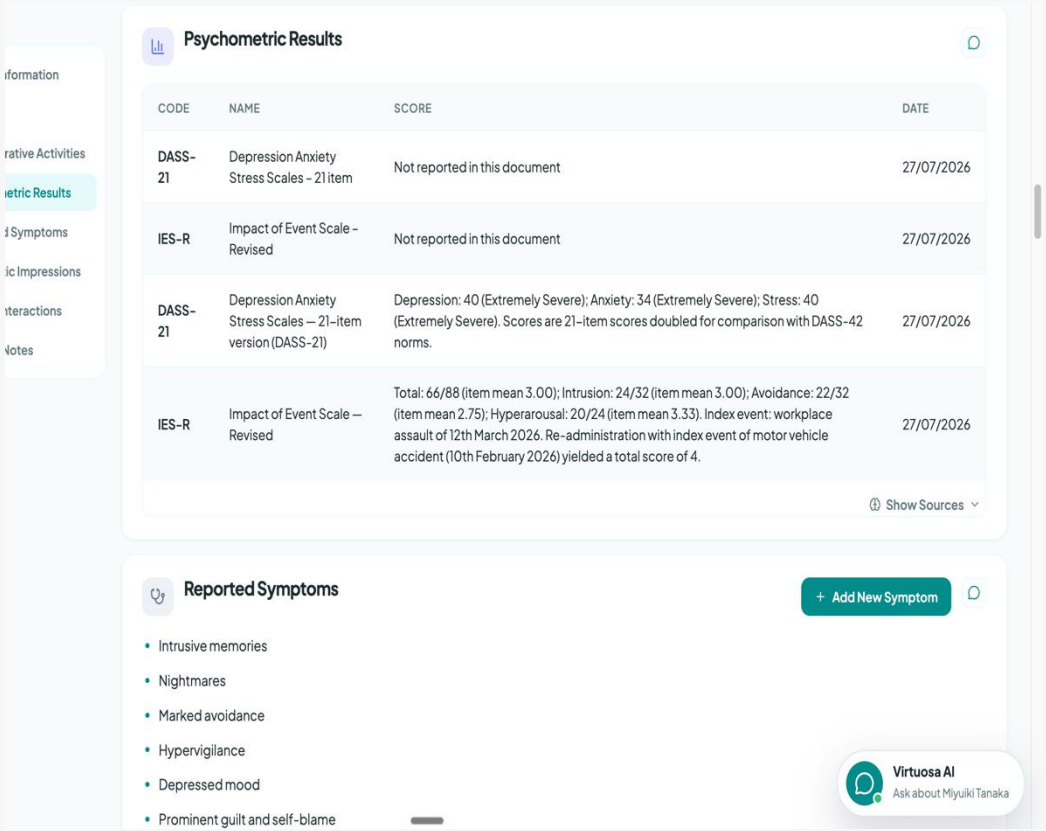
What a purpose-built one is actually doing

Not writing your opinion. Assembling the file underneath it.

The chronology out of a two-hundred-page bundle. The psychometrics with their index events and dates. Each diagnostic impression tied to whose it is.

And — the part that matters — saying “not reported in this document” instead of filling the gap.

That's the assembling layer. The reasoning is still entirely yours.



2:14pm

Is a scribe the same as a report writer?

A scribe

Listens to a session and gives you a note.

Transcript, headings, reallocation.

A transcription problem — and transcription is a solved problem.

A report

COLLATION — notes, collateral, psychometry and referral questions in one place, in the right order.

NARRATIVE — turning that into the client's story.

THE ARGUMENT — reasoning from the material to a defensible opinion.

A reasoning problem. Not solved.

2:17pm

QR CODE 3 · YOUR AI PRACTICE AUDIT

Score whatever tool you already use. Build your stack. Then time one report this week and tell me what you find.

Six minutes, in your own time. I'll send the whole room what we collectively found.

Scan to open

2:19pm

Build your stack — seven layers

Section two of the audit form — fill it in as we go

1. **CONSENT** written, specific, tool-named — what do you say, and where is it recorded?
2. **CAPTURE** how does what happened in the room become text?
3. **STORE** where does client material live?
4. **ASSEMBLE** chronology, collation, evidence extraction
5. **DRAFT** producing structured document text
6. **CHECK** your actual verification step — is it written down?
7. **DISCLOSE** which parts, which tool, which version, what prompts

2:24pm

What you can do

1. **Use something, and give real feedback** not vague feedback — what's on your wishlist?
2. **Measure it** time one report this week. Split assembling from thinking. I promise the ratio will annoy you.
3. **Get involved in the research** if we want tools that hold up medico-legally, the profession has to say what good means
4. **Come and teach her** the next version is learning now — and what she learns now is what she becomes

2:27pm

The future psychologist isn't a machine.

We're curious humans, with better tools,

and a bit more left at the end of the day.

Lisa Irving · lisa@virtuosaai.com · www.virtuosaai.com

2:30pm