IN THE DISTRICT COURT
AT WELLINGTON

[2013] NZACC 385 ACR 25/12

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF AN APPEAL UNDER SECTION 149 OF THE ACT	
BETWEEN	L S Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 5 November 2013

Appearances: M C Bagnall for the appellant
L M Hansen for the respondent

Judgment: 22 November 2013

RESERVED JUDGMENT OF JUDGE L G POWELL

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[1] The issue in this appeal is whether the respondent's decision of 23 February 2011 was correct in declining the appellant's claim for potential earnings entitlements on the grounds that the cause of the appellant's incapacity, schizophrenia, was not linked to the appellant's covered sensitive injury.

[2] It is not in dispute that the appellant had a significant history of sexual abuse between the ages of 5 and 13. It is equally not in dispute that the appellant has schizophrenia. What is in issue in the appeal is whether the sexual abuse is the cause or a significant cause of the appellant's schizophrenia.

Background

[3] On 4 December 2010 following the appellant's application for an independence allowance, the appellant was assessed by Dr Geetha Willamune, psychiatrist. Following the assessment Dr Willamune prepared three reports, all dated 4 December 2010, a psychiatric assessment report and treatment plan ("psychiatric assessment"), a mental injury sensitive issue independence allowance assessment report ("independence allowance assessment") and the third a letter regarding the loss of potential earning entitlement ("potential earning assessment").

[4] The introduction to the psychiatric assessment noted that the assessment had been "requested by ACC to help determine whether the claimant's mental condition is clinically significant and has been caused by sexual abuse". Having reviewed the appellant's history and noted her examination findings, Dr Willamune confirmed the appellant's diagnosis as being "schizophrenia paranoid type currently in remissions". With regard to the purpose of the report Dr Willamune noted:

> Sexual abuse is not likely to be material cause of current mental condition. There is no evidence of sexual abuse as etiological factor in schizophrenia. However in general, sexual abuse may have increased his vulnerability to mental illness. To a small extent his mental condition can be attributed to events in 1988, 1985, and 1986 in increasing his vulnerability.
>
> Other issues that may have contributed are separation of parents at the outset, unknown parenthood of children, erratic work record, failed relationships, losing access to his son, unemployment, financial stresses, and diagnosis of schizophrenia. It is unlikely to be directed attributable to sexual abuse.
>
> To a larger extent his mental condition is due to other issues rather claimed injury.

[51 The independence allowance assessment, after setting out similar background information to the psychiatric assessment, undertook a functional assessment which concluded the appellant had an estimated whole person impairment of 17%, but after deducting 10% for those matters which Dr Willamune did not think were related to the appellant's sensitive claim (including schizophrenia), Dr Willamune concluded that **the** appellant's final whole person impairment was 7%. In her discussion on apportionment Dr Willamune noted:

> Schizophrenic disorder is considered the major cause for his impairments. Long term nature of the condition with multiple relapse is likely to cause significant impairment. Schizophrenia is not directly related to sexual abuse. Childhood issues of separation of parents, uncertain parenthood of siblings and head injury are developmental factor that predisposed to adult mental condition. Erratic work record, failed relationships are further contributions. Ongoing issues of difficulty in access to his son, financial stresses arc considered perpetuating factors. Mental health issues of father may indicate genetic predisposition although cannot be certain.

[6] The potential earnings assessment was a much shorter report, being limited to a single page letter. Under the heading "Cause of incapacity", Dr Willamune noted:

> Client is unable to engage in work attributed to his mental illness that is diagnosed as Schizophrenia. This is not directly related to sexual abuse. His incapacity began at the onset of illness age 18. Subsequent incapacity has also attributed to ongoing illness consists of relapses.

[7] Following receipt of these reports on 23 February 2011 the respondent declined the appellant's application for loss of potential earnings and weekly compensation on the basis that "there is no evidence to show that your incapacity to work is directly related to your sensitive claim". A similar decision declining to approve an independence allowance was made by the respondent on 14 March 2011,

[8] The appellant sought a review of the decisions. Prior to the review being heard the appellant was examined by Dr Gil Newburn, a neuropsychiatrist, on 12 August 2011. After reviewing the appellant's history and symptoms, Dr Newburn reached the following diagnosis in respect of the appellant in terms of the DSM IV TR Axis I as follows:

> 1. ?paranoid schizophrenia, currently in remission. A differential diagnosis of sohizoaffective disorder, or bipolar affective disorder with psychotic manic episodes.
> 2. Adjustment disorder, chronic. He does not meet the criteria for post traumatic stress disorder, but has some symptoms of this.

[9] In reaching these conclusions Dr Newburn noted as follows:

> [The appellant] presents with accepted occurrences of sexual abuse. The question arises as to whether or not this leads to any current impairment, This is particularly significant given a history of recurrent psychotic disorder, with a current diagnosis by his treatment team of paranoid schizophrenia.

> However, I note that with current treatment there is no evidence for psychotic symptoms. He does nevertheless show some issues on assessment with frontal symptom function, and his presentation was facile and digressive. These are likely to reflect negative symptoms of a chronic psychotic disorder. I also note for the record that I agree with Dr Willamune's view that there is no evidence for sexual abuse being aetiological factor in schizophrenic disorders.

[10] The reviews of both decisions proceeded on 17 November 2011, By decisions dated 15 and 22 December 2011 respectively, the reviewer dismissed both applications for review on the basis that the appellant's incapacity resulted from schizophrenia, which was a health issue unrelated to his covered injury.

[11] The appellant appealed against the review decision dated 22 December 2011 regarding the loss of potential earnings and weekly compensation. Prior to the appeal being heard the appellant was examined by Dr David Codyre, psychiatrist, who reported on 3 April 2013. Dr Codyre's DSM IV Axis I psychiatric diagnosis was that the appellant had:

> Schizophrenia, paranoid type, chronic, with good response to Rx Clozapine (differential diagnosis — schizo affective disorder — as when acutely unwell has some symptoms suggesting mania).

[12] Regarding the cause of the appellant's schizophrenia, in Dr Codyre's view:

> OPINION RE QUESTIONS POSED FOR ASSESSMENT:
> 1. DSM IV Diagnosis is as outlined above. There are no current symptoms suggesting any diagnosis other than Schizophrenia.
> 2. Regarding the question of the cause, on balance of probabilities, of the Schizophrenia — like all major psychiatric conditions, aetiology of Schizophrenia has been increasingly viewed in. the psychiatric literature as multifactorial, with a combination of genetic and environmental factors being found to be associated with increased risk of Schizophrenia. With due respect to my colleagues who undertook the prior psychiatric reports referenced above, however, their opinion that sexual abuse is not causally related to Schizophrenia is not evidence-based. Although the opinion they express was widely held up until the 1990s, there is a cumulative body of evidence from the last 2 decades, numbering almost 200 studies, that has clearly and repeatedly demonstrated a strong association between childhood abuse/adversity and risk of psychosis — as summarised in the papers referenced below. In the words of Bebbington (ref 3), and with specific reference to sexual abuse, ".., there is now considerable evidence of an association between childhood sexual abuse and psychosis — the relationship is at least as strong, and may be stronger than, with other mental disorders ...". A 2012 meta-analysis of the 36 most methodologically rigorous of these studies concluded that "childhood adversity is strongly associated with increased risk for psychosis (ref 5). Further, there is also some evidence of an

association between a history of childhood sexual abuse, and related content of subsequently developed psychotic symptoms (see refs below, in particular refs 4 and 5).

Regarding the question of substance abuse as a possible causative factor in this case (given that early onset of cannabis abuse is a recognized factor increasing risk of later psychosis), the one study exploring systematically the link between childhood sexual abuse, cannabis, and psychosis (ref 7) suggests that the cannabis-psychosis link exists only for people abused as children — implying that the use of cannabis is largely to "self-medicate" for the effects of the abuse.

While there remains some confusion in relation to the PTSD and Schizophrenia diagnoses, (due to a certain amount of overlap in symptomatology) there can be no doubt that both sets of symptoms can be trauma-based. Moving to legal precedents, in 2005 a British High Court Judge rule that "... the likelihood as it seems to be is that the terrible abuse to which A was subjected led to both his suffering PTSD, and that disorder of the mind which is symptomatic of Schizophrenia what is important is that his adult psychiatric problems, however they are classified, were caused by his childhood sexual abuse" (ref 6)

With reference then to [the appellant's] case, apart from the query raised at the time of first presentation in 1999 regarding possible substance abuse, there is an absence of any of the other the vulnerability factors typically seen in people with Schizophrenia — there is no family psychiatric history, no clear and verified history of early onset and sustained substance abuse (and certainly no history of substance abuse since 1999 when he first presented, indicating clearly that this has not been a factor in the complicated and initially poorly treatment responsive nature of his illness), and no history of significant interfamilial disruption, loss, or trauma. The only factor in his history that has any proven association with increased risk of continued psychosis, is the multiple incidents of sexual abuse, stretching through childhood into adolescence, 2 of which in particular were severe. The fact that when acutely psychotic he is much more preoccupied with the past sexual abuse, his behaviour is sexually inappropriate, and he has had content of delusions that relate to being sexually molested, also suggests that the sexual abuse has been significant in precipitating the psychotic illness. On this basis, it is my opinion that the sexual abuse has been a significant factor in creating vulnerability to development of the schizophrenia, and as such it thus meets the test of being "on the balance of probabilities", a cause of [the appellant's] condition (Schizophrenia).

Please do not hesitate to contact me if you require further information or clarification.

[13] Dr Codyre subsequently provided the respondents with a number of the reports referred to in his evidence. Dr Codyre's report was then referred to Dr Willamune for comment. In a response dated 30 August 2013 Dr Willamune stated:

Thank you for your request for comments in response to Dr Codyre's report.

I understand the issue is mainly based on etiology of [the appellant's] condition.

> He has a well established diagnosis of Schizophrenia paranoid type, treatment resistant, maintained on Clozapine.
>
> The onset of condition is around age 18 that is the usual age of onset for Schizophrenia. His condition has taken its course with relapses and remissions, proved to be treatment resistant that required Clozapine therapy.
>
> In general well accepted etiological factors for schizophrenia is congenital predisposition and possible prenatal and birth injuries.
>
> Although he has no known family history, Schizophrenia of severe form is accepted to be of higher genetic loading. Family history may have been present but unknown in his ease or new genetic mutations could be the case,
>
> Childhood psychological trauma such as sexual abuse as an etiological factor for schizophrenia has never been established. Increase vulnerability to mental illness by developmental factors are considered, but the extent and the significance of its contribution in emergence of Schizophrenia is doubtful.
>
> The crucial question is whether or not [the appellant] would have developed Schizophrenia if he was not subjected to sexual abuse.
>
> In my view it is very likely he would have developed Schizophrenia regardless of sexual abuse. In other words it is more likely that he would have developed Schizophrenia in absence of sexual abuse and it is unlikely that he would be free of schizophrenia if he was not sexually abused.
>
> My view is supported by the severity of his illness and the natural course the condition had taken.
>
> In milder form of illness the vulnerability factors may be more significant considering perhaps lower genetic loading. In [the appellant's] case where illness is severe vulnerability factors takes less significant.
>
> In balance of probabilities [the appellant] would likely to have developed Schizophrenia regardless of sexual abuse.

Discussion and Analyses

[14] It is accepted by both parties that the central issue in this case is causation — whether the sexual abuse suffered by the appellant was a substantial or material cause of the appellant's schizophrenia. In the course of argument before me it became clear that there were really two issues that needed to be addressed. The first is whether medical science recognises that a causal link can exist as between sexual abuse and schizophrenia, and if that is so, the second is whether on the facts of this case, such a link has been established.

[15] The starting point for analysis of these questions are the principles set out by the Court of Appeal in *Accident Compensation Corporation v Ambros* [2008] 1 NZLR 340. In that case it was noted:

> [66] The legal approach to causation is different from the medical or scientific approach. In *March v Siramare,* Mason CJ at p 509 in the High Court explained that the scientific concept of causation has been developed in the context of explaining phenomena by reference to the relationship between conditions and occurrences, whereas in law problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence. At law the cause is not the sum of the conditions, which are jointly sufficient to produce the occurrence.
>
> [67] The different methodology used under the legal method means that a Court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty ,,. However, a Court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture ,.. Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence ...
>
> [68] Spigelman CJ in *Seltsan* said that the only time that Judge is not able to draw a robust inference of causation is in cases where medical science says that there is no possible connection between the events and the injury or death ... if the facts stand outside an area in which common experience can be the touchstone, then the Judge cannot act as if there were a connection. However, if medical science is prepared to say that there is a possible connection, the Judge may, after examining all the evidence, decide that causation is probable
>
> [69] We agree that the question of causation is one for the courts to decide and that it could in some cases be decided in favour of the plaintiff even where the medical evidence is only prepared to acknowledge a possible connection. .
>
> [70] Finally on this topic, .., the generous and unniggardly approach referred to in *Harrild v Director of Proceedings* may, however, support the drawing of "robust" inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a Court to draw even a robust inference on causation. Risk of causation does not suffice,

Sexual Abuse as an Etiological Factor in Schizophrenia Generally

[16] It is common ground that any acknowledgement of a link between sexual abuse and schizophrenia is a recent phenomena, prior to which causation had been seen in exclusively biological or genetic terms. As psychiatrists John Read and Richard Bentall stated in an invited editorial for the British Journal of Psychiatrists entitled Negative Childhood Experiences **and Mental Health Theoretical Clinic** and Primary Prevention Implications (Brit ,J.Psych,2012; **200:89-91)** (referred to in Dr Codyre' s report) noted:

> Until very recently the hypothesis that child abuse has a causal role in psychosis was regarded by many biologically oriented psychiatrists as heresy. While the public, all over the world (including patients and their families) place more emphasis on adverse life events than on genetics or brain abnormalities when asked about the causes of "schizophrenia", David Kingdon found, in 2004, that for every British psychiatrist who agreed with the public 115 thought psychosis is caused primarily by biological factors. None the less, the evidence on the association between childhood adversity and psychosis has accumulated at a staggering pace. The first large scale general population studies did not appear until 2004. By 2009 a review had identified 11. 10 found that child maltreatment is significantly related to psychosis. The authors of the one exception recently corrected a flaw in the original study and found the same as the other 10. Nine of the 11 tested for, and found, a dose response relationship. For example, a prospective Netherlands study found, after controlling for history of hallucinations or delusions in first degree relatives, that people who had been abused as children were 9 times more likely than none abused people to experience "pathology level psychosis". The odds ratio for mild abuse was 2.0, but 48.4 for severe abuse.

[17] These comments and the other material referred to by Dr Codyre referenced a growing body of material through various research studies that indicated a causal link between childhood trauma (including sexual abuse) and psychosis (including schizophrenia). Included in this material was a further article by John Read, Richard Bentall and Roar Fosse entitled "Time to Abandon the Bio-Bio-Bio Model of Psychosis: Exploring the Epigenetic and Psychological Mechanisms by which Adverse Life Events Lead to Psychotic Symptoms" (Epidemial.Psychiatr.Soc.2009;18:299-310) which analysed a number of the research studies referred to in the editorial, and it also included an English judgment in the case of *A v The Archbishop of Birmingham* [2005] EWHC 1361 (QB) in which Clarke J concluded that the plaintiff in that case was suffering from schizophrenia, and that the only possible cause was the sexual abuse he had suffered.

[18] Ms Hansen for the respondent did not dispute these recent developments and accepted the issue was now a matter for serious study. Ms Hansen did however dispute whether sexual abuse is regarded as a well established etiological cause of schizophrenia. To this end she referred me to an article by Craig Morgan and Helen Fisher entitled "Environmental Factors and Schizophrenia: Childhood Trauma — A Critical Review" (Schizophrenia Bulletin vol 33 no.1 pp 3-10 2007) This article from 2006 critiqued an earlier (2005) article by Read (coauthored with Van Os, Morrison, and Ross) and noted in its conclusion that:

> The evidence that childhood trauma causes psychosis is controversial and contestable, Child abuse certainly causes prolonged suffering, and may increase the distress experienced by those who develop a psychotic mental illness in adulthood and lead to worse outcomes. The implications of this for clinical practice require careful consideration. There is not, in our view, a large body of research supporting a causal connection, contrary to the impression gained from the review of Reed et al. There are a modest number of recent population-based studies that suggest the risk of experiencing psychotic symptoms is increased in those exposed to early trauma. The plausibility of proposed biological mechanisms add some weight to these data. The findings from such studies, however, have not been wholly consistent, and a number of methodological limitations mean we should be cautious of over interpreting these. That said, this issue is one that certainly merits more sustained and systematic research.

[19] Far from disproving any causal link I find the Morgan/ Fisher article although cautious, recognises the importance of the research being undertaken and the significance of what had been identified to that point. Since then as the two recent Read/Bentall articles note there have been further significant population based studies of the type noted as being significant by Morgan/ Fisher.

[20] In any event applying the principles set out in *Ambros* referred to above for the purposes of this case I do not have to determine whether sexual abuse is an accepted etiological factor for schizophrenia. On the contrary the issue is whether generally medical science says there can be "no possible connection" between sexual abuse and schizophrenia, which I understand to be the position taken by Dr Willamune and Dr Newburn. Having considered the material relied on by Dr Codyre and referred to above, as well as the Morgan/Fisher article provided by Ms Hansen, I find that medical science now appears to recognise at the very least a significant possibility of the connection, which is sufficient for me to now consider whether there is sufficient evidence of causal connection in the present case.

Whether Sexual Abuse Caused the Appellant's Schizophrenia?

[21] With regard to the present appeal, Ms Bagnall for the appellant submitted that the specific conclusions of Dr Codyre were to be preferred; that the sexual abuse suffered by the appellant was caused by or at least is one of the causes of schizophrenia in this case and "consequently a sufficiently direct causal link is established".

[22] Ms Hansen on the other hand submitted that the evidence as a whole did not support a finding that the appellant's sexual abuse caused his schizophrenia. In particular Ms Hansen submitted Dr Willamune's conclusion that the appellant's schizophrenia was caused by other factors was correct, and that in any event Dr Codyre did not conclude that the schizophrenia was caused by the sexual abuse but rather submitted:

> At best Dr Codyre identified sexual abuse as being a risk factor for schizophrenia and that it may be "a cause". ... Dr Codyre nowhere in his report says that the sexual abuse materially and substantially caused the schizophrenia.

[23] Turning to the evidence, it is apparent that the issue is whether the analysis of Dr Codyre or Dr Willamune is to be preferred as to the causes of the appellant's schizophrenia. I discount Dr Newburn on the basis that ultimately Dr Newburn did not diagnose the appellant with schizophrenia, while his comments that sexual abuse could not cause schizophrenia appear to have been rooted in the more general issue that I have already addressed above.

[24] Having discounted schizophrenia caused by sexual abuse in largely generic terms, Dr Willamune's view, developed briefly in her 30 August 2013 letter appears to be that when accepted etiological factors for schizophrenia are looked at, namely "congenital predisposition and possible prenatal and birth injuries" she opines:

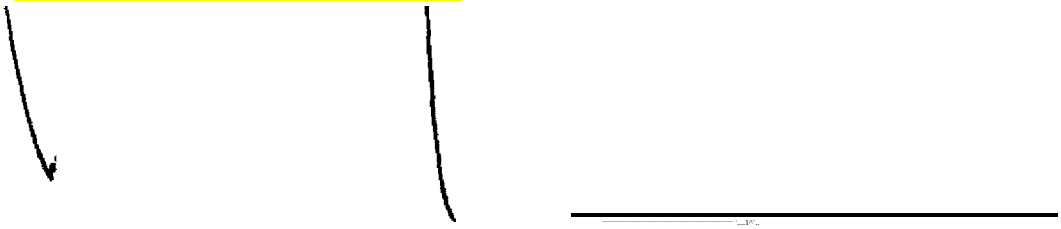
> Although he has no known family history, schizophrenia of severe form is accepted to be of higher genetic loading. Family history may have been present but unknown in his case or new genetic mutations could be the case.

[25] Furthermore based on the severity of the appellant's schizophrenia and the natural course that his condition has taken (including the onset of the condition at age 18, the "relapses and remissions" and the need for Clozapine therapy), Dr Willamune concludes that the appellant would have developed schizophrenia regardless of sexual abuse.

[26] In contrast Dr Codyre, specifically rules out the other "vulnerability factors typically seen in people with schizophrenia including family psychiatric history, sustained substance abuse, history of significant interfamilial disruption, loss or trauma, and turns instead to the appellant's history of sexual abuse as being "the only factor in his history that has any proven association with increased risk of continued psychosis", that "sexual abuse has been significant in precipitating the psychiatric illness", that it has been "a significant factor in creating vulnerability to development of the schizophrenia", and that it is "a cause of [the appellant's] condition (schizophrenia)", While I acknowledge Ms Hansen's arguments that the risk of causation is not causation, and the somewhat equivocal reference made by Dr Codyre to "a cause", I am satisfied that when Dr Codyre's report is read as a whole, and in particular the opinion reproduced in paragraph 12 above, I find that he does indeed conclude that the sexual abuse suffered by the appellant is a material or substantial cause of his schizophrenia.

[27] Ultimately I find Dr Codyre's analysis to provale a more compelling and inherently more credible cause of the appellant's schizophrenia than Dr Willamune's analysis, which is necessarily speculative, relying as it does on unknown family history and unknown genetic mutations, which together would have resulted in the appellant developing schizophrenia regardless of his suffering sexual abuse. I also note that while it is discounted in her final response to Dr Codyre, Dr Willamune does herself recognise that the sexual abuse suffered by the appellant increased his vulnerability to schizophrenia "to a small extent", While Dr Willamune also noted other symptoms that increased his vulnerability (several of which, including losing access to his son, unemployment, and diagnosis of schizophrenia either post dated the diagnosis or were clearly not relevant), the fact that she is prepared to acknowledge even a small link I find casts some doubt on her bald conclusion that the appellant would have "developed schizophrenia regardless of sexual abuse".

[27] The appeal is therefore allowed, The review decision of 22 December 2011 is quashed, The decision of the respondent dated 23 February 2011 is set aside. The appellant is entitled to such entitlements as flow from his schizophrenia coming within the ambit of his covered sensitive claim. The appellant is also entitled to costs on this appeal which if they cannot be agreed by counsel within one month, I will determine on receipt of memoranda.



Judge L G Powell
District Court Judge

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