ACC6429

Supported Assessment - adults

Mental injury assessors carrying out the Supported Assessment service should complete this form after a client's mental injury assessment. If you are new to providing these assessments, please make sure you obtain supervision or peer consultation from an experienced ACC mental injury assessor. This form is for adults, if the client is a child or young person use the *ACC6424 Supported Assessment – child and young person* form.

Please refer to the guidelines at the end of this form before you complete it. We also have more supporting information at 'Supported Assessments and Mental Injury'.

When you've finished, please return this form to sensitiveclaimsproviderreports@acc.co.nz

1. Client details		
Client name: x		Claim number: x
Date of birth: x		Address: x
☒ Female	☐ Male	☐ Non-binary Preferred pronouns and/or other information:
Ethnicity: x		
Client's existing covered injuries: Covered claim no diagnosis		
Contact details / Safe contact where appropriate: x		
Are there any reasons why ACC should not contact the client? No		
Oranga Tamariki status, if applicable: N/A		

2. Assessor and supplier details	
Supplier name: South Coast Psychology	Supplier ID: G09884
Assessor name: x	Assessor ID: x
Assessor email address: x	Assessor phone number: x
☐ Psychiatrist	☒ Psychologist
☐ Psychotherapist	☐ Counsellor

3. Introductions	
Dates of consultations: x	Duration of consultations: 8 x 1hour; 1 x2 hours
Sources of information (list all documents, including dates and authors): 1. x Clinical interview sessions with x 2. x Psychometric testing data 3. x General practitioner medical notes x Request ACC - SCR to Support a Claim	

4. x ACC6426 Early planning report psychologist x
5. x ACC referral file – various authors
6. x Psychiatric review psychiatrist x, x. Child and Adolescent Mental Health Service (CAMHS)
7. x Referral to Psychiatrist clinical psychologist x, x. Child and Adolescent Mental Health Service (CAMHS)
8. x Return to Counselling report clinical psychologist x
9. x ACC Cover report psychologist x

It would have been useful to have full DHB mental health assessments and reviews, however these were not available at the time of this assessment. Should these assessments and notes become available I would like the opportunity to review them and make any required adjustments, if necessary, to my formulation, diagnoses and treatment recommendations.

Client capability: This refers to the client's ability to understand the purpose of the assessment and also their ability to provide the information needed by the assessor.

X gave every indication of understanding my role as an ACC assessor and psychologist, the purpose of the supported assessment being to assist ACC in their task of making a decision on cover. She appeared to have unimpeded capacity to provide valid information throughout the assessment process.

4. About the event(s)

Briefly describe the event or events, the date range of the event(s), frequency of the event(s), and the age of the client at the time of the event(s) identified as the basis of this mental injury claim. Please outline the meaning and emotional impact of the event(s) for the client at the time of the event and after.

1. In x, when X was x years old her x took her to a rugby game. A group of little kids were playing together. A girl who was older, about x years old, who was x's neighbour, got all of the little kids together and made them undress and perform sexual acts on one another. The acts included oral sex, sexual touching, and penetrative sex. The older girl directed all the acts. At the time, x was scared and wanted to be accepted by the other children, but felt that the acts were wrong. Her x came down to the children, however, x did nothing about the situation. "Straight after" this event, x described feelings of hypersexuality that lead to her to seeking out porn which was in her household. She reported that she had and continued to have lots of anxiety in relation to other children particularly girls, withdrew from female friendships, and could not tolerate confrontation. X believes her x's own history of engaging in inappropriate sexual behaviour as a child, is why x didn't intervene, along with a pattern of disregard for the safety and wellbeing of them as children. At the time she blocked the sexual event out of her mind. This event led her to mistrust her x and x inability to keep her safe. She learned to depend on herself.

2. When x was x years old, at an after-hours speech and drama lesson in x, two boys grabbed at her vulva, pinching at it. This incident was instigated by the older of the 2 boys. She was shocked and confused. She froze and then after about a minute, or two she reacted swearing at them. She has little other memory of this time and also blocked this event from her mind.

3. A little later in her late primary school years, an older girl touched her backside and she reacted, screamed at her and told the teacher. From that point she began having flashbacks and intrusive memories and the 4 year old incident came flooding back to her. She disclosed the events to her x. Her x was told and x got angry and did not believe her that the incident at 4 years old had happened. She felt unprotected once again, hurt and invalidated. She became angry and distant. Her x had pornography in the house and x's sexually acting out with it increased. Then began flashbacks, nightmares, dreams and spacing out. She would isolate herself away on her x. She became much more reckless when her parents did not believe her or doing anything that reminded her of the events. She was rebellious, particularly reaching puberty. At x years old she attempted suicide.

Since becoming an adult, x's x told her that her x sexually assaulted his x when he was x, whilst his x year old sister was

watching, and the girl was a virgin and she screamed and my x has had a hang up about women enjoying sex ever since. Her x telling this and intimate details about her parents sex life was also traumatising for x.

"*X believes that she would have taken a different path in life and would have followed her dream of x much earlier in life had it not been for the effects of the sexual abuse in her life. She believes she would have had more tolerance, and perseverance earlier in life - she would have been a x earlier and would have become a x. Instead, she has always given up rather than fail. The abuse and her parents' inability to keep her safe has left her with no self-belief. X loses it when people are dishonest, lack loyalty, and keep secrets*" x,).

5. Background information

A) Summary of relevant background information. Please refer to relevant medical history (illnesses, operations, hospitalisations), developmental history, education or employment history, alcohol and drug history (if relevant), family history, cultural and spiritual background, and forensic history (if relevant):

X was born in x by forceps delivery at x am on the x. She reports that her mum was healthy and x until 2 days before her birth. X was brought up in x, born into an established x family who had x in the area for generations. Both her x and x had x the local primary school. X is the x of her siblings with a x who is x years younger. As far as she knows xmet the developmental milestones. She reports that she was "raised in the x and on the back of the x and so forth". She was left on her own with x frequently. She didn't like being on her own but was happy if she had x around her. She would often play with groups of x creating a fantasy play world. X remembers being "farmed out a lot to family", which she didn't mind as she was "fascinated by people". X always had a deep sense of what was right and wrong "but my x used me when x needed a support in fighting in that love hate relationship with my x, she was not insightful or aware of her behaviours".

X had a lot of contact with both sets of grandparents. Also her paternal Aunty x, a x. X's maternal grandfather she describes as a "gentle wonderful man", and she had a great relationship with her maternal grandmother, "until x cut her out of our lives because she was abusive to x, which x is repeating - intergenerational emotional abuse". X describes a less friendly relationship with paternal grandparents, "grandad hated me cos I wasn't a boy as first born, grandma had a successful x career and was very stoic".

X describes an ambivalent "love-hate" relationship with her x. She felt her x love has always been conditional. As a small child, x's x wanted a boy and she looked up to x and wanted x to love her. She learned to hunt, fish and followed him around as a young child. X enjoyed this time with her x, but also feels a sense of unsafety and recklessness when she remembers her early childhood. According to mental health notes received x has a maternal family history of anxiety and a paternal family history of depression (x, x).

When she was x years old x was sexually abused by an older child forcing her to engage in sexual acts with other children whilst in her x care at x (see event 1 above). She felt unprotected by her x and as she got older she reports that her x was "immature, would tease she and her sister until they were in tears, x frightened x, and did not take her safety seriously. X buried these memories and memories only came back when event 3 occurred (see above). Looking back she also recognises her x inappropriate behaviour with sexualised talk and pornography around she and her x. From a very early age x would masturbate with her x pornography.

X attended a x unit which she enjoyed. She loved learning, loved reading books and was a veracious reader, forming a movie in her head and a vivid fantasy world, where she would "loose myself", and "become the characters". X suffered from secondary nocturnal enuresis from the time of the abuse until she was x years old and going to x. Then at x, she didn't wash her vulva, not realising there was any problem until her roommate complained about the smell of her underwear.

At 5 x began school, insisting that she went alone on the bus for the 20 min ride to school, from the first day. X remembers being fiercely independent at this age which has continued throughout her life. The school was a x school with about x children. X excelled at school, and enjoyed school academically and activities. She always loved x mythology and the strong sense of belonging that was evident in her school. Peer relationships were difficult for x, she struggled with friendships and was often the target of bullies. She remains sensitive to bullying and tended to just comply with the bullies. She remembers being attracted to kids with parents who showed unconditional love. She reports that she "always took things to heart and personally". Now she understands that many of the children had little and were jealous of her having x and x.

At x years old x was sexually abused by 2 boys on her way home from an after x lesson. She froze initially and then

experienced overwhelming anger and swore and yelled at the boys, behaviour that was not usual for her at this age. When she told her parents, her x ambivalent and x reported to the incident to x teacher and safety practices were put in place (x recently asked her x about this).

At about x or x x was patted on the bum by a girl at school. She had "a massive reaction, jumped out of my skin, was shaking", and flashed back to the earlier memory of the girl forcing her and other children to perform sexual acts.

Around this time, x described being very miserable at home, having a suicide attempt at x, She began experiencing anxiety and depression and was prescribed Aropax by her GP. Despite being at the top of her class academically, she was struggling emotionally. Her parents were unaware of the suicide attempt she made. Her x was angry and denied the event at x years old, and x became very defensive around her and her x deferred to her x. Her x was concerned however and discussed the incident with the principal and the principal made the girl apologise. X was feeling terrified, retraumatised, and numb, "going back to being a x year old".

In x's final year of primary school, there was a x for a 3rd time. Because she was bright her x suggested that she should move to a school with an excellent teacher and school. So she attended school at x, a 25 minute drive for her parents. She excelled with an amazing teacher and principal who commanded the children's attention, and was a great male role model for her. She excelled academically and despite being a new place and feeling like an outsider she made friends.

For 2 years x attended secondary school at x. She took the bus from x to x and came home in the weekends. She hated being around so many girls. She felt on edge, anxious, jumpy, had nightmares of being attacked, and she didn't wash her vulva at boarding school until her roommate complained about her underwear.

At x x was at x school with girls from x, some of whom were naughty and sent there. In her first year x began rebelling (e.g found people and copied them, emulated them, started smoking, finding weed and alcohol, etc). She became Goth like a friend, played Marilyn Manson, all black clothes and wanted to fight her upper middle class, white-privileged, x background.

At x x went private boarding with a woman who had x children and x other boarders. X reports, "she worked until 5 or 6 at night and "had no time for me" . X's depression worsened. She moved to another private boarding situation with a solo mum with x teens. This is when x began "getting into trouble". She got on well with x, and sought her out. Her x did not get on with her x. Her x and her x partner, would provide x with alcohol. X drank heavily, didn't go to school, and was "feeling really crap, but pulled myself through it each day". She thinks the fact that she x a lot helped her mental health.

In x, at x, x finally disclosed the sexual abuse events to the guidance counsellor who "drove me in her x to Rape Crisis". X says the benefit of this was "my parents had to acknowledge the abuse". She undertook counselling sessions with a counsellor, who, her parents believed, attempted to entrap her into saying her x sexually abused her, and was driving the family apart. Her parents sought advice from the GP who told them to remove her from the rape crisis centre. X reports that she "had a breakdown" and attended x mental health service when she was x attracting diagnoses of anxiety and depression. X reports, "I went home to x and went wild".

According to the ACC referral file, at x x saw a psychologist who filed an ACC claim and worked with her for 6 months. The referral file suggests x's parents complained via an advocate about this psychologist and her GP made a referral to a clinical psychologist at the local Child and Adolescent Mental Health Services, and during this time was referred for a psychiatric review, where she was diagnosed with anxiety and depression. She saw this same psychologist in private practice under ACC for 6 months. There was never any closure notice to ACC and after 6 months the file was closed.

At x, x was also badly burned. She used petrol to light a fire outside x, as she had seen her x do many times before. The fire blew up and burned her badly. She was taken to hospital by ambulance, and was in x hospital for a week, had skin grafts at x burns unit and then went home. X worked for x years with an occupational therapist on her burns. X's psychologist queried the family thinking it was a deliberate attempt to harm herself – X disputes this. She, in fact, sees this incident as a turning point in her life, that she was lucky to be alive and felt reborn after the fire. She felt like a different person and had an appreciation for her parents and her life "seeing the care at those times". X said from this time she "matured rapidly".

At x x attended a public co-ed school – x. She lived in private board with an x immigrant family. She did well, "aced school", She described this time as really good and enjoyable, with "good school, good teachers and good kids". Her mood improved, she came off Aropax. At x, x also did well, she got on with life and tried to leave the past behind. At x,

she became x, achieved university entrance, and at the end of the year describes as a, “golden summer with lifelong friends”.

When she was nearly x, x enrolled x, undertaking a double degree in x “to make x proud”. She “found the pressure too much”, she reports “I did O week and kept on drinking”, dropping out of university. With the growing importance of relationships, her developing sexuality, feeling like a failure and not good enough, x became anxious and depressed again, and went back on Aropax. She went home to x to pay off student loan. At x she had a job x for a year in x moving out of home into a flat. Then x’s x needed her to come and do x with x, “working just x and I, it was OK’

X met her son’s father and began a relationship. At the end of x, she went to x to live with him. X report, “x didn’t like him so withheld my wages”.

X enjoyed him as he and his family were so different from her own. He was from a very poor background, with x siblings and x siblings. His parents were the happiest couple that she’d ever met, so in love and so happy, despite having nothing. He was a little bit older than x, “part of the in crowd”, and “very good looking, sold drugs, and had a bad boy persona with a heart of gold”. The experience was the complete opposite to the status money and wealth that she had been brought up to need. They had a x year relationship. She states, “he was my protector, didn’t buy into the x wealth culture, great family love but unable to give it to me quite the same”. She reports, “I clung to him and castigated him for not being good enough”. He cheated a lot, which x reports, ”didn’t concern me much”. However, he had no ambition and x had a lot of ambition. When he was angry he would lash out verbally and sometimes physically. Even though she knew it wasn’t a match, she would not/could not leave him. During this relationship in x, x studied and gained her x. Her x gave her a weekly allowance whilst studying, but stopped paying her when she became pregnant with her son. It eventuated that the x had defrauded the student loan scheme and is still paying off the student loan. X attempted to convince her parents to fight it legally, but they wouldn’t, so she did not get her accreditation. X felt like a child and violated again with no-one to help.

In x their son was born. X loved him and enjoyed being a mum. She began spending time away from her partner. In x x, her son, and her sons father moved to x, and went to stay with to stay with his x. They “were kicked out and lived in a caravan park. Then the x hit” The relationship ended in x, after increased verbal violence which her son began repeating. X and her son went home to x, her partner was unaware and thought it was on holiday

From the time her son was x years old, x was a sole mum. X was a young mum doing it on her own. She was a very determined to give him as much as she could, and made sure he had plenty of interactions with his grandparents and a positive role model. She began studying x towards her degree. She studied and engaged with her son. She took him onto x, to x and so forth, They moved to x to be closer to the x, her x paid for the transfer. Shortly after moving up, she quit x and worked for x as a x with people with x. The job and her study challenged x to assess her own life. Socially she played x, great social team and began a new club – played 3 nights a week and in the weekends. She had good friends at work and did fun things and outdoor activities with her son.

In her work she encountered an abusive female manager and this interaction “triggered my past stuff”, and I began spiralling. In x x began a relationship, “ignoring all the red flags” that it was not healthy for her. When her son was x years old, x moved in with this man. Soon after he became violent towards both x and her son. Her son went to live with his father and his father’s partner who were in a positive relationship. X knew that this was best for him. He has remained living with his father and stepmother. They now live in x and x sees him x or x times a year. X stayed in the violent relationship going back and forwards. X reports, “I just lost myself, my identity, I was so victimised”. X engaged with the local counselling service and realised she was in a “classic abusive relationship”. X was back and forward in that relationship, too terrified of him to turn him away when he’d turn up on her doorstep

In x x went home to x and then found a job in x and trained in her x. She then went x for 6-8 weeks in x. From x to x she travelled around jobs in x and x, and undertaking x work. Her ex continued to come back and she would resume the relationship with him.

In x, x gained a full-time x role at x, she was very proud of herself. She also completed another x, and was well thought of throughout the x. She remains as x.

In x, x settled into her work, and “did lots of work on myself physically and mentally”. It helped having a good friend in the second in charge x. She attended to her health and self-care and her whole system seemed to “clear”. She decided to try dating again

X met her current partner through on line dating, they met each family and got engaged before she moved down to be with him. In x she moved to x with new her partner. X found a job next to him whilst continuing her x. She reports, “He really wanted children and time was ticking by” so they began planning to have children. In x their first son together was born, and their second son last year, x. They are now working together, x.

X wants to engage in therapy to resolve her history of abuse.

B) Past psychiatric or psychological history including treatment for the presenting problems:

X has both maternal and paternal family history of mental health problems. Her x suffering from anxiety and panic and there being anxiety disorders in her family, and her x having a familial history of depression.

In childhood x experienced fantasy dissociation, emotional numbing and blocking memories of her early childhood abuse experiences. From the age of x x has experienced suicidal thoughts and a suicide attempt. She experienced since that time: anxiety, feeling defective, helpless and unworthy of good things, relational discord with her family and feeling unsafe and unprotected.

At x ,she entered into counselling with a school counsellor, then ACC therapy with psychologist, x at the rape crisis centre. After about 6 months of treatment, her parents were dissatisfied with x progress, citing x’s anger at her parents as divisive. As a result, her GP referred her to CAMHS at her parents request where she saw clinical psychologist x who referred to psychiatrist x, attracting diagnoses of anxiety and depression. x opined that the sexual abuse was not the cause of x’s problems referring to x’s familial history of mental health problems. X admits however that she never disclosed nor was she asked about the full extent of the sexual abuse events or her previous suicidality, at age x. She did assume this would have been in her GPs notes. She then saw x as an ACC funded therapy provider for less than 6 months. Her GP managed meds which she began at x and finished them at x. In x x re-entered into ACC therapy with x, wanting to resolve her abuse history and improve her mental health.

C) Current situation and presenting problems:

X lives with her partner and their x children aged x. They (work) x. They live in x and x is only able to do telehealth due to the demands of x and parenting. X receives support from her partner and his family and feels blessed by their support. Her family “retraumatises” her, and has since x, when she decided to stop all contact bar a little with her x. X has decided to stop “fighting to be part of that family”. Her parents use money, she says, to attempt to control X.

At engagement x described dissociative periods, has difficulty managing emotions and tolerating distress. She has bodily aches and pains which get worse with stress, she has dreams and nightmares and a very restless sleep. She reports, “daily, swinging between bursts of anger and then detachment when dealing with my very healthy x year olds toddler behaviour” -hyper/hypo arousal and a very small window of tolerance; “everyday incessant negative thoughts and ruminating on past behaviours of my parents towards me”, constant anxiety, insomnia occurring daily, “panic attacks - When any graphic sexual content is on TV or any articles relating to child abuse are within my awareness”, continuous extreme self-loathing/terrible body image; “getting stuck/ fixations on irrelevant people/issues”.

Clinical interview suggests x presents with:

Posttraumatic stress symptoms (intrusive thoughts, body sensations, memories, dreams and nightmares; dissociation, avoidance of people places, conversations and situations reminiscent or triggering of the abuse events, anxiety and panic; hyperarousal, hypervigilence, and an exaggerated startle response oscillating with hypoarousal and emotional numbing and zoning out; trauma related somatisation; sexual disturbance, attachment problems)

Depressive symptoms (feeling sad much of the time most days, continuous feeling of guilt, feeling like she is being punished, memory and concentration problems, angry outbursts, irritability, suicidal thinking and the negative cognitive triad characteristic of depression)

Anxiety symptoms (racing heart when not exerting, dry mouth, sweaty, difficulty staying still, feeling uptight, tense and on edge most of the time, nervousness, worry and fear most of the time, fears of criticism and disapproval, a sense of impending doom, pounding heart, tight chest, and gastric distress)

Sexual dysfunction that distresses her – absent reduced interest in sex, lack of erotic thoughts, reduced sexual excitement, reduced genital sensations, for an extended period (months), then hyposexuality and urges to masturbate

and high sexual need.

D) Summary of previous clinical and psychometric assessments:

There are currently no psychological, psychiatric or psychometric assessments or tests made available to me for the current assessment. See history of treatment below.

E) Current medications and dosages, including the name(s) of prescriber(s):

Low dose of Amtritylene for chronic pain syndrome. She has been diagnosed with pain modulation syndrome by x Musculoskeletal Specialist, and prescribed Gabapentin, and Tramadol

If this client has received any treatment from another health provider(s) for this condition(s), please provide a contact name and address for each provider.

Contact name: x	Contact email: unknown
Contact name: Past GP	Contact email: unknown
Contact name: x	Contact email: unknown
Contact name: x	Contact email: unknown
Contact name: x	Contact email: unknown

6. Diagnosis

Please refer to the guidelines at the end of the form when completing this section.

A) Personality assessment:

The personality assessment screener (PAS) –is a highly reliable and valid self-report screening tool to assess personality traits in adults over the age of 18. It has been developed with reference to its parent instrument the personality assessment inventory (PAI). It assesses personality traits under 10 domains – negative affect, acting out, health problems, psychotic features, social withdrawal, hostile control, suicidal thinking, alienation, alcohol problems, and anger control (Morey, 1997).

X's overall P score (37) on this measure indicate marked personality dysfunction (24-44). This suggests x is experiencing emotional and/or behavioral problems significantly greater that those experienced by the general population. Trait scores indicate marked elevations in negative affect, psychotic features (dissociative and other orientation), social withdrawal, and suicidal thinking and moderate elevations in acting out, hostile control, and anger control.

X's pattern of scoring suggests that she experiences: high levels of personal distress, unhappiness and apprehension which are *"highly correlated with measures of depression and anxiety"* (Morey, 1997 p.10); irrational thoughts and fears and delusions that appear to be trauma related difficulties rather than specifically psychotic in nature; social withdrawal probably stemming from both "… *apathy (as in depression)", and " … from trauma induced alienation (as in PTSD)"* (Morey 1997 p.13); suicidal ideation that is above the norm and warrants ongoing monitoring. To a lesser degree x is or has been troubled by moderate levels of acting out (i.e. past drug use and emotional spending); Moderate P score elevation in hostile control due to *"low raw scores, which are generally reflective of a very submissive perhaps self-defeating interpersonal style"* (Morey, 1997 p.14) , suggesting dependency needs that may put her at risk of being exploited in close relationships and which, in x's case, may account for her withdrawal from family and social relationships that have been exploitative: elevations in anger control suggesting she has difficulty regulating and perhaps effectively expressing anger suggestive of personality and/or posttraumatic stress problems.

Scores are congruent with clinical observations and indicate x displays some areas of personality dysfunction, experiencing negative affect, suppressed anger and dysregulated emotion, trauma related thoughts, fears and

preoccupations, social withdrawal due to depression and PTSD, risk of exploitation, and worsening suicidal ideation.

These personality features have developed due to both an invalidating family environment, and as a result of the sexual abuse and her parents inability to protect her from harm in her early childhood and in her developmental years, and as such are likely to form part of her complex posttraumatic sequalae rather than a personality disorder. According to the DSM5: "*Interpersonal difficulties that had their onset, or were greatly exacerbated, after exposure to a traumatic event may be an indication of PTSD , rather than a personality disorder, in which such difficulties would be expected independently of any traumatic exposure" (2013. p.279).* It is unlikely that x will have developed these problems was it not for the sexual abuse.

B) Client strengths and protective factors. Please describe factors such as relationships, family/whānau connectedness, cultural/spiritual identity.

X is an independent, free thinking intelligent young woman. She is fit and healthy and has a strong desire to be the best she can be and a good role model for her children. She has a strong support in her partner and a robust personal support network in his family and her friends. She is very engaged in therapy and supplements her therapy with engagement in self-help activities and independent research.

C) Areas of vulnerability:

X is vulnerable to revictimization, however as her self-confidence, boundaries and assertiveness grows this is reducing.

D) Mental state examination:

This mental status examination (MSE) took place over the 10 assessment sessions with X and reporting is based on a standard format (Baker & Trzepacz, 2013) including appearance, attitude and activity, mood and affect, speech and language, thought process, content and perception, cognition, and insight and judgement

Appearance, Attitude and Activity: X is a x year old x woman. She is about average height and an athletic build from working x most of her life. She is fit and well. X presented on time to pre assessment and assessment sessions and mostly gave advanced warning when she was unable to attend. Her apparent age is congruent with her chronological age, and she presents with youthful energy and appearance. She is reflective and measured, showing the wisdom that belies her age. She has x hair tied back in a ponytail for most of the assessment sessions, it was curly when loose. She has x visible tattoos, pierced ears, and wore no jewellery or make up. She presented clean, tidily dressed in casual attire. Although notably anxious initially, she engaged well in the assessment sessions with a positive attitude to the assessment and towards me as the assessor. She was attentive, maintaining eye contact throughout the sessions. Her posture was open and inviting, and after initial engagement she relaxed and remained so throughout the sessions. She displayed normal activity given the nature of the assessment. She displayed no unusual activity. The sessions were conducted by telehealth which she had no trouble navigating.

Mood and Affect: During the therapeutic assessment sessions x has displayed a normal range of affect. Although it has oscillated between numb, down, and heightened, depending on the topics discussed. She has been tearful, but only fleetingly in the assessment sessions. at times appeared depressed, flat and numb. She has still been able to access humour.

Speech and Language: X's speech is normal to fast paced mostly, at times her answers voluble. Her non-verbal language matches her spoken language. Her comprehension, repetition, naming, writing, prosody, and speech quality all appear normal.

Thought Process, Thought Content and Perception: X's thought processes appeared normal and communications displayed consistent connectedness of thought and no peculiar thought processes. Her thought content was also spontaneous with no indications of delusions, overvalued ideas, obsessions, hallucinations or phobias. She did however describe repetitive thoughts in times of stress that were self-deprecating. She also described internal negative self-talk that worsens with stress and being around people who are negative or whom she perceives as against her, and if she has made a mistake. During the assessment sessions, she showed emotional detachment and dissociation from her emotions at times particularly in relation to conversations around the abuse and her parents "lack of regard for her safety as a child. She perceives them as complicit in some way due to their inability to provide safety.

Cognition: Although not formally tested, x's cognition appeared normal for all of orientation, attention and

concentration, registration, visuoconstruction ability, and executive functions. She has been able to maintain her work x as well as mothering.

Insight and Judgement: X thinks things through and is able to exercise good judgement. She has good and further developing insight into the nature of her difficulties.

E) Psychometric testing (if relevant):

Psychometric measures have been used to quantify interview findings, provide clinical validation for the diagnoses and provide useful baselines for clinical intervention. The measures selected were appropriate to X's clinical presentation. The measures selected were: the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult, the personality assessment screener (PAS), the trauma symptom inventory (TSI-2), the Beck Depression Inventory (BDI-II), and the Burns anxiety inventory.

The DSM 5 self-rated level 1 cross cutting symptom measure consists of 23 questions that assess 13 psychiatric domains: depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory problems, repetitive thoughts and behaviours, dissociation, personality problems, and substance use (APA, 2013). X's scores on this measure showed severe elevations in mania, anxiety, somatic symptoms, sleep problems, repetitive thoughts and behaviours, dissociation, and personality problems; and moderate elevations depression and memory problems; and mild elevations in anger. These results suggest further exploration is warranted in these areas. The personality screen (PAS) has been discussed in the personality section and subsequent test results follow. Further questioning suggests that the manic and OCD symptoms are trauma related and will be measured within the TSI2:

The trauma symptom inventory (TSI-2) is a widely-used measure of trauma symptoms and behaviours. It consists of 136 items and assesses a wide range of potentially complex symptomatology from post-traumatic stress, dissociation and somatization to insecure attachment patterns, impaired self-capacities and dysfunctional behaviours. The critical scales highlight areas of potential risk, the factor scales (Self-disturbance, Post-traumatic-stress, Externalisation, and Somatisation) serve as summary measures of complex post-traumatic disturbance and the clinical scales and subscales highlight levels of trauma-related symptomatology that may be of clinical significance (Briere, 2011). X's scores on the TSI-2 validity scales show no over-reporting, indicating validity and reliability (Briere, 2011) indicating she is highly unlikely to have engaged in over reporting or malingering. The critical scale scores indicate areas of potential risk for x and should be taken into account in treatment and safety planning. Scores indicate she often has thoughts and fantasies of killing someone. Further questioning suggests that her desire to be around for her children and be a role model for them ameliorates her risk.

X's factor scale scores show clinical elevations in **post-traumatic stress**, and **externalization.** This pattern of scoring suggests she: has experienced one or more traumatic events in her life which has affected her sense of self causing her to act out and look to others for information about herself due to an unstable sense of self. According to the clinical scales and subscales, X experiences extremely high levels of **anger, intrusive phenomena**, **defensive avoidance** and **dissociation** in relation to her abuse experiences. Scores also show high levels of **anxious arousal**, particularly **hyperarousal, sexual disturbance** in terms of **sexual concerns**, and **insecure attachment** in terms of both **relational avoidance** and **rejection sensitivity.** Other clinically elevated scores**, general anxiety, impaired self-reference** in terms of **other directedness, and tension reduction behaviour** completes X's clinical symptom nomenclature. This pattern of scoring suggests x is currently experiencing active posttraumatic stress symptoms, which are likely due to trauma that is sexual in nature. She displays post-traumatic symptoms to a level where she has a high likelihood of meeting diagnostic criteria for post-traumatic-stress-disorder (PTSD). She copes with overwhelming internal trauma related distress by both cognitive and behavioral avoidance, defensively avoiding reminders, dissociating and/or engaging in acting out/tension reduction behaviour to distract herself relieve stress. This triggers her insecure ambivalent attachment pattern, causing her to have feelings of insecurity and ambivalence towards both herself and her relationship with her partner and children, and leads her to look outside of herself for direction, and also a cohesive reality, not valuing her own thoughts and feelings when other disagree, and having varying access to a coherent sense of self. This is overlaid with a general anxiety which further maintains her distress.

The Beck Depression Inventory (BDI-II) is a 21 item self-report measure used by clinicians to investigate the presence and severity of depressive symptomatology. X's score on the BDI (41) places her in the severe depression range (29-63), indicating the need for treatment and suggests her current pharmacological support may be insufficient. X reports she has had depressive episodes since the abuse as a child and her parents' inability to protect her and keep her safe.

The Burn's Anxiety Inventory (BAI) is a 33 item self-report measure used by clinicians to investigate the presence and

severity of anxiety symptomatology across anxious feelings, thoughts and physical symptoms. X's score (45) on the BAI indicates severe anxiety (31-50).

F) Results of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0):

Domain	Score	Domain	Score
Understanding and communicating:	1	Getting around:	0.8
Self-care:	0	Getting along with people:	0
Life activities – household:	2.2	Life activities – school or work:	0
Participation in society:	2.1	Total disability score:	26.39%

Qualitative data: X's ability to undertake household tasks, her ability to participate fully in society and her ability to understand and communicate with others have been impacted by her mental health difficulties

☐ A copy of the form is attached – a copy is on file	Date completed: x

G) Diagnosis (and classification system used):

Taking into account all of the information presented in this report the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) alongside the ICD 10 classification system has been used to make the following diagnosis:

309.81 (F43.10) Posttraumatic Stress Disorder (PTSD) with dissociation

296.22 (F32.1) Major Depressive Disorder with anxious features, recurrent moderate (diagnosed previously)

302.72 (F52.22) Female sexual arousal/interest disorder, lifelong (situational), moderate

If the diagnosis is not made using the ICD9, ICD10 or ICD11 classification systems, please enter the ICD diagnostic code that corresponds to the diagnosis you are making here: F43.10; F32.1, F52.22

H) Formulation and summary:

X is a x year old x woman presenting with a history of attachment problems, childhood sexual abuse, domestic violence in a past relationship, and symptoms of posttraumatic stress, depression and anxiety. X was predisposed to mental health problems as a result of both paternal and maternal family histories of anxiety and depression. Furthermore, her vulnerability was further increased by a poor attachment with her parents and the invalidating family environment she grew up in. The conditional love by her x and the reckless unsafety of her x created an anxious ambivalent attachment pattern, precipitating a depressive with anxious distress sequalae.

The sexual abuse perpetrated by a more older peer, in her early childhood, and the lack of care or protection afforded by her x, caused x confusion, causing her to engage in fantasy and structural dissociation, escaping from reality, and thus protecting her from psychological distress whilst at the same time arresting her developing regulation and relational capacities, greatly exacerbating her attachment, and mood problems, and impacting her ability to develop a coherent sense of self, in a complex posttraumatic sequalae.

The subsequent sexual abuse perpetrated by the boys in her middle childhood reinforced her defensive coping through avoidance and dissociation, causing her to act out sexually, affecting her developing sexuality and further entrenching dissociation and her posttraumatic stress. Her parents denial and disbelief of her precipitated a depressive episode and further entrenching her negative core beliefs entrenching her depression with anxious distress.

The sexual assault by the girl, although the least traumatising for x caused a breakdown of her dissociation triggering memories of her earlier abuse experiences and full blown posttraumatic stress disorder symptoms.

The violent relationships, her separation from her son, and the ongoing conditional caring from her parents further manifested and maintained her depression and developed a Stockholm syndrome response where x relived the sense

of hopelessness and helpless she did as a x year old with no-one there to protect her.

Her ability to develop herself in her x role and her sense of security developed in her current relationship allowed her to begin the task of repairing her attachment patterns, to support her in parenting her younger children and to begin therapeutic work

I) Risk assessment:

The TSI2 suggests risk should be monitored. The fact that x wants to be a positive role model for her children mitigates her risk.

J) Symptom validity:

The TSI2 profile is valid indicating it is highly unlikely that x has engaged in over-reporting or malingering. There is consistency across measures, symptom nomenclature across reports, providers and family, and between different measures. I have no symptom validity concerns.

7. Opinion

In order for a Mental Injury caused by Sexual Abuse to be covered by ACC, the injury must have resulted from a Schedule 3 event/s. The Schedule 3 event/s do not have to be the sole reason for the mental injury. However, the Schedule 3 event/s must be a material or significant cause of the mental injury.

A) Relationship between the Schedule 3 event/s and the diagnosed mental conditions (for each diagnosis):

Depression– x's depression is likely multifactorial, with it likely beginning with the poor attachment relationship with x in infancy. The sexual abuse incidents in the context of poor parental response is also a likely causal mechanism for depression, particularly as it engendered beliefs of being worthless, helpless and hopeless. Furthermore, the sexual assault by the older girl in her middle childhood and not believed about that event or the earlier abuse events also engendered a hopelessness and helplessness core belief, suggesting at least partial material causality

Anxiety- x's anxious ambivalent relationship with her x is likely the primary causal mechanism of her anxiety problems. However, his x inability to protect her when the initial sexual abuse occurred likely also caused an anxious response even if it had not been for the prior attachment difficulties, suggesting the sexual abuse incident at x years old at a critical period for emotion regulation development is at least partially causative in x's development of anxiety

PTSD with dissociation - The primary causal mechanism in x's PTSD with dissociation is her early childhood experience of sexual abuse which triggered PTSD symptoms and both fantasy and structural dissociation. It did not present as such however until her teens when the full manifestation of PTSD symptoms arose in response to the sexual assault by the older girl. Her PTSD was retriggered and intensified in her abusive relationships.

Sexual Dysfunction – X's sexual dysfunction relates to her childhood sexual abuse experiences manifested and maintained by her engagement with pornography as a way of dealing with internal Trauma related distress.

B) Relationship between other life events and the diagnosed mental conditions:

See above

8. Treatment

Please provide any broad recommendations for treatment derived from your assessment:

Evidence suggests integrated trauma focussed cognitive behavioural therapy would be the most effective treatment for x. She is experiencing early gains in therapy to date. Future therapy would likely include:

- Maintenance of the therapeutic attachment relationship
- Reduction of avoidance by assisting her to engage with problems rather than avoid them through active

avoidance and dissociation.

- Build self-capacities including affect regulation, relational mindfulness, body awareness, self-awareness using ACT, DBT, Yoga CBT, and sand-tray skills and strategies
- Utilise x in developing her sense of self and regulating emotion
- Development of action strategies such as yoga, yoga based ACT and CBT, mindful movement, tai-chi, and other therapies to assist body awareness, and movement of bodily holding, develop affect tolerance and arousal reduction skills and decrease somatic symptoms – this may require physiotherapy and/or therapeutic massage and/or yoga classes and/or MBSR.
- Treatment of dysregulated emotion using dialectical behaviour therapy (DBT)
- Treatment of sexual dysfunction with a sex therapist
- Treatment of anxiety and depression using ACT and CBT
- Treatment of PTSD using integrated trauma focussed CBT (Briere)

9. Prognosis

What is your prognosis for this client's mental injury?

X's prognosis is good. She is experiencing important gains from early engagement in therapy and is motivated to make changes in her life and functioning.

10. Other information

Please provide any other information that you consider relevant, eg genograms. You may attach additional pages if required and expand this section as much as you need. N/A

11. Provider declaration and signature

☒ I have informed the client that the information collected for this report will be sent to ACC [and will be used to help ACC make a decision about cover for a Mental Injury caused by Sexual Abuse] and I have obtained the client's authority for this.

I confirm that the information contained in this report is accurate and that when completing the report I have followed the standards in both the Guidelines for completing Supported Assessments at the end of the report and the ISSC Operational Guidelines.

Signature (Assessment Provider):	Date: x
Assessment Provider name: x	Assessment Provider ID: x

Date of last face-to-face meeting with client: x

List other providers who contributed to the assessment: N/A

Client confidentiality

☒ I have explained to the client that a copy of this report will be sent by ACC to their Lead Provider (if relevant)

☐ The client would like a copy of this report to be sent to them by ACC.

☒ The client was offered a feedback session prior to this report being submitted to ACC.

ACC6429 Supported Assessment - adults

The client:

☒ participated in the feedback session

☐ did not participate in the feedback session (please provide reasons)

When we collect, use and store information, we comply with the Privacy Act 2020 and the Health Information Privacy Code 2020. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.