ACC6429

Supported Assessment - adults

PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

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: N/A		
Contact details / Safe contact where appropriate: x		
Are there any reasons why ACC should not contact the client? x		
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: 26 x 1 hour assessment and continuity sessions whilst waiting for notes which were not available
Sources of information (list all documents, including dates and authors): Clinical interviews with x Despite x having let ACC know where medical notes should be, medical centres have returned messages reporting there are no notes relating to mental health recorded in their files. Should notes become available I would like the opportunity to review them and make any necessary adjustments to my formulation and	

diagnoses.

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 understood my role as a psychologist/ACC ISSC assessor, and the purpose of the supported assessment, the extent to confidentiality and its limits, and that the information gathered would be provided to ACC to assist in determining cover and to provide guidance regarding treatment. X was able to understand and provide consent and 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. When x was x years old she was very shy. She was coerced to have sex with an older boy. One night she got out of her window and met up with some girlfriends, they then met up with a bunch of x year old girls and boys. They all went to this house. X didn't really understand what was going on. She didn't want to make a scene or look stupid so "just went along with it". A guy came out of a bedroom, looked at her and said, "You're next". She was dazed and just complied. He led her to the bedroom, pulled back the bedcovers and said, "Get in". She got into the bed and he pulled down her pants and she lay frozen. He got on top of her and had sex with her. She didn't tell anyone because of the shame she felt. She blamed and admonished herself for getting out the window and being where she shouldn't have been. A year later her x flatted with the guy, and she avoided her x and the flat during this time. She feels a sense of fear and frozen when she thinks about the event.

2. Another night not long after event 1, when x was x years old, she again jumped out her window to meet a boy at the primary school. He arrived with a friend and they stood over her when she was in an alcove in the toilets. They made her take her clothes off and one guy raped her. He then stood up and said, "your turn" to the other guy. The other guy, however couldn't gain an erection. She remembers, "He was standing over me, forcing his penis in my face and yelling at me to suck it. I was crying and he said that he would rape me unless I did. Remembers lying there for ages naked on the concrete I blamed myself because, I shouldn't have gone there, I believed that I'd asked for it and It was my own fault. I was really embarrassed and confused." The effects since this event include "not really trusting anyone, everyone wants something from me, can't let people get close, protect myself a lot by pulling away from friends when they get close". These symptoms get worse when x is stressed. She reports being very protective of her x, freezing when she is forced to do things, feeling avoidant, sick and getting flashbacks when oral sex is mentioned. After these 2 events x thought this is who I am now, there is no going back. Couldn't talk to anyone about her feelings and so she shut her feelings and memories down

3. At x x began sexually acting out with older boys, some of whom were over the age of 16

4. At x to x years old, x was in a sexual relationship with a x year old man. Despite the fact that she did not see this relationship as coercive at the time, she now sees the power dynamics involved.

5. X reports that her violent ex-husband, who she was married to from the age of x until she was x, had a "high sex drive". He often pressured her for sex and she became tired of the arguments and just complied. Despite knowing about the above event, he also often pressured her for oral sex and eventually wore her down, she once again just froze and let him do what he wanted to do to her. He forced her to perform oral sex on him numerous times and raped her anally once.

X didn't tell her parents about the childhood sexual abuse event, "cos they would be really hurt, and I couldn't bear them blaming themselves", she reports. Since the first event she reports having a "view of myself as bad and untrustworthy". X began drinking the Christmas after the 2 first sexual abuse events. She began sexually acting out and had her first consensual sex at x. She remembers thinking, "this is who I am now". She reports that during her marriage she "hated living that lie, but I couldn't get out". She became very depressed and, "contemplated suicide".

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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 on the x. She was the x child to her parents, having an older x. Her parents also had x x years before she was born, x. Her eldest x was high needs. He died when x was x. Her other x was a bully to her and used to chase her. X was close to her parents and also close to both sets of grandparents. She met the developmental milestones and had mumps and a tonsillectomy as a small child. She also broke her leg x, and in this same year her grandad died. She was described as an easy child growing up. Her x worked hard at x and her x worked as x.

At x years old x began school at x primary school in x. She loved school and found the work easy and was popular and enjoyed a lovely group of friends both boys and girls. She remembers having boyfriends and feeling special, in a normal way and has lots of good memories. At x years old she began x and continued this until she was x.

In her first year of high school, at x, x was sexually abused twice (see event 1 and 2 above). These events changed the way x saw herself and others. Almost immediately her behaviour and who she was changed. She began drinking that Christmas, and got drunk, numerous times. She began shoplifting, was caught and the police were involved, she was sexually acting out, jumping out windows to be with a “naughty group of friends”. X had her first consensual sex at x. She can remember thinking, “this is who I am now, following the rapes”. She began sexually acting out with a number of boys (some of whom were over the age of 16).

At high school x continued to do well. She reports, “I was in the brainy class, but not studious, I felt dumb”. She compartmentalised her life, having “different groups of friends, x, school, and the naughty kids”. At x, x was diagnosed with genital warts, and at x had laser surgery for precancerous cells.

From x until x x had a relationship with a boy who was 20 years old. She was had sex with him at her place when her parents went to bed or at his place, when she jumped out her window or wagged school. He became controlling and physically assaulted her and she ended it. She realises now that this sex was coercive (see event 3). He began stalking her after this.

When she was x years old x met a kind boy who was an independent thinker who had each other’s back. They were in a relationship from x years old. One night “mum and dad came home and found him in the wardrobe naked”. Although her parents banned her from seeing him, she continued. She remembers that she had changed and was damaged, and that she “couldn’t be who they wanted me to be”.

At x x was working after school at x and at x. At x she enrolled in x at x and enjoyed it.

At x, she moved out of home, after a fight with her parents and began flatting with her boyfriend and another flatmate She would become really jealous and could not stand him talking to anyone else. She also stopped liking sex. Despite loving him she slept with their flatmate. X felt too messed up and couldn’t be with him, couldn’t stand seeing him with someone else, so she moved to x.

At x, she moved to x and lived on a guys couch for a bit whilst working at x. She then moved to x, and lived with a friend, her x year old x, and her friend’s x She worked for x and had 2 other jobs.

She met the, “man of my dreams”, when she was x years old. She reports, “He had a good family and friends”. “The relationship was just really natural”, she describes. He was x, and x remembers very clearly saying goodbye to him, with plans for how they were staying in touch and her meeting up with him in x in a few weeks. When x was x her partner died. He had stopped off in x on his way to x, was x and was hit by a x. X was devastated.

X stopped working and “was a shell”. She “felt like my life had ended. It was hell waiting for his funeral, they took a week to bring his body back”. At this time, she deliberately overdosed on panadol, as a serious attempt to end her life and “make the pain stop”, however she vomited the pills up. She was not admitted to hospital. She engaged in brief intervention and then attended a psychotherapist. She reports that she was down, not working and in a rut for about a year. She now believes that she was depressed, her hope was diminished

because everything had been taken away. “I was not just grieving for him but for my life”, she reports.

X was on the dole, finding it financially difficult. Her GP prescribed Prozac, but x was unsure whether or not to take it. “Mum helped”, she reports, by saying to me, “take a week to make a decision”. After a week, x “picked myself up and went looking for work”. She found a new job x and did this for at least a year, and brought her first car. She didn’t begin the antidepressants.

After about a year, she began a new relationship with a man from x who was living in x. She was living x in the x and working in x. He was involved in the x gang and he grew marijuana. She got engaged to this man. X had forgotten about much of this time of her life until asked, “I just blocked it all out”. After some time, about 6 months later, when she was going to x to visit her parents, her fiancée was contacted telling him that he was a father. She remembers that he was dismissive, and “I didn’t like that”, she reports, and they broke up shortly after.

After the breakup x moved back to stay with her friend in x. She reports, “I felt like I needed direction”. She studied for x.

When she was aged x, x met a man. They began a x year relationship. She reports, initially he was really nice, and was x where they were working. However, she reports, she “felt insecure about him being so nice, he couldn’t motivate himself, he made no move towards settling down or getting married, and we were x years together and going nowhere”. X ended the relationship.

At x x was qualified and began working x in x for a year. In the following October she met her current ex-husband and father of her x. Throughout the relationship her partner was sexually coercive and abusive and forced oral sex, coerced sex with others, and subjected her to anal rape (see event 5). She reports I hated living that lie but couldn’t leave. She has little memory of any feelings during this time. In March, the following year, she and her new partner packed up everything and x. They lived in x for a month staying with friend and her partner. X describes this time of her life as exciting. She was living her dream, as she had always wanted to travel. She thought that the relationship was also exciting and had no idea about the control he gradually exerted over her

Initially they went to x and lived with her new partner’s x. “They appeared to believe that I was not good enough for her x and ostracised me”. X developed a really good group of friends in x. She began working at x. During this time, her partner gave one of her friends a massage. She later told x that she was creeped out by his massage. Her partner began subtle moves to put a wedge between her and this friend.

In x, they continued their plans to travel. X went to the doctor for vaccinations and found out she was pregnant. She had always wanted to be a mum, so was thrown into a state of confusion. She didn’t trust herself and her partner said emphatically, no you are having a termination, and implied to keep the baby would be stupid. This brough back the feelings of being stupid she felt as a x year old. She reports, “I know I didn’t want to have the termination but couldn’t trust that what I thought was right for me”.

From x they travelled through x for x months. X reports, it was my life dream and I made it happen. It was cool to make something this big turn into reality”. Between the ages of x they went to x. X got a job 2 days after they arrived. She enjoyed it. Her partner was not working and continued travelling around and looking for work. He went to x and was not allowed back into x. X is not really sure why. He got deported. X continued working and it hadn’t really sunk in, x remembers feeling “very fearful without her partner there”, however she just carried on robotically, “It’s like I was in a dream”, she reports. A week later, in x, the x bombings occurred just after x had disembarked from x. She was shocked, and “even more fearful”. Her partner arrived back in x in x and they visited x and x, then came home to NZ in x.

When they arrived home, they moved down to x where both of their parents lived. X reports, “it took a while to get a job and I felt depressed, then I got offered 3 in 1 week”. They leased a house. Her partner worked x and she worked x, “so I just worked 14 hour days, I was lonely, and looking for a purpose”. The sexual coercion got worse and her partner pressured her to have sex with him and a couple who were friends with him. Eventually they ceased the friendship. X felt like she compartmentalised this part of her life. In the abusive relationship at home she felt like she was “a x year old kid again, thinking this is who I am now”. Yet whilst at work she was climbing the corporate management ladder and doing well, impressing her bosses with her management skills and abilities. She “felt like 2 different people”.

She worked for a large company, and after a year they bought a house

On the x a stranger told x that he had caught her partner in bed with his wife x years earlier. She confronted her partner, who made light of the whole situation and agreed to see a relationship counsellor. They stayed together, but her façade of what her relationship was like was beginning to break down. She stayed as in her mind she needed to uphold “the dream of my baby having his dad”.

In x, at x, x had her x. X reports, “The birth was the happiest I ever felt in my life”. She asserts, “My baby was something that no-one else could ruin for me. It gave me a purpose. I never had any doubts about my ability to parent, I just relished the time”. After the birth the doctors “thought he had an infection and we spent a week in neonatal with other families in a bubble pretending my husband was not how he was, but when I went home reality struck and he went straight back to how he was. He gave me no help or support. He was straight back to work, at x”.

In x that year x went back to work, whilst her parents had time with the baby after day care on x which still happens. This was a lovely time for them all. In x the following year x applied for a job in the company as a x. She got the job and became the only woman in the x. She was proud of herself, but couldn’t reconcile the work self and her personal self. She reports that during her marriage she “hated living that lie, but I couldn’t get out”. She became very depressed and “contemplated suicide”.

She and her husband stayed together for x years in total. In x he wanted to separate. She went into shock and ‘felt like the x year old again”. She felt like she had to try everything to make it work and she allowed sexual stuff that she didn’t want, to just happen. He agreed initially to try and work on their relationship, then on the x, x reports, “he woke me up and said he didn’t want to do this anymore. He walked away and wouldn’t talk about it”. X was in shock, she went to her mums, and felt devastated. For quite some time they were still living in house together, “it was a living hell”, she says. She had to tell their x herself and her partner would not talk to their x at all. X gained the support of women’s refuge. She attended the stopping violence programme and learned about domestic violence. She saw her situation in the stories but felt in a fog and unreal. All of her childhood abuse experiences began presenting themselves in dreams, flashbacks, thoughts, feelings and memories, “I was losing it”, she reports. X was referred by women’s refuge for psychology input with me.

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

After her partner died when she was x, x reports her GP prescribing Prozac, and attending a psychotherapist. She did not take the medication. She remembers very little of the therapy sessions, but believes she went weekly for a couple of months. She remembers searching for help at different periods of her life but didn’t find help. She went to a grief counsellor a couple of times and they just listened and asked questions but did not give her any strategies to help.

C) Current situation and presenting problems:

At presentation to ACC counselling, x was on no medication and does not want medication, this is still the case. She was and continues experiencing periods of deep sadness and a general low mood, flashbacks, ruminating memories and admonishing herself. She avoids people and has difficulty letting anyone get close. She avoids people places and situations reminiscent of the sexual abuse situations. She has had lots of periods where she has lost time and describes dissociative derealisation and depersonalisation.

X has forgotten many aspects of her life and it has taken time and titration to gather a robust history, she is highly avoidant of any topics regarding sex and/or relationships, and often zones out during discussions of her relational history. She described numerous general anxiety symptoms and hyperarousal in relation to triggers of past relationships, sexual experiences, people and places reminiscent of her childhood abuse situations and then zones out, goes blank and describes feeling numb. During assessment sessions she has been both emotionally overwhelmed, heated and tearful and emotionally numb, blank and dissociated.

D) Summary of previous clinical and psychometric assessments:

No clinical or psychometric assessments

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

X doesn't want medication.

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:

6. Diagnosis

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

A) Personality assessment:

The DSM 5 self-rated level 1 cross cutting symptom measure – Adult was developed by the researchers involved in the development of the DSM 5. It is a highly reliable and valid self-report screening tool to identify possible psychopathology in clinical populations. It consists of 23 questions that assess 13 psychiatric domains (APA, 2013). X's score on this measure suggested additional testing in regard to personality, among other areas (see psychometrics section later in this report).

The personality inventory for DSM 5 – Brief form (PID-5-BF) – Adult was developed by the researchers involved in the development of the DSM 5. It is a highly reliable and valid self-report screening tool to assess personality traits under 5 domains – negative affect, detachment, antagonism, disinhibition, psychoticism. (APA, 2013). X's scores on this measure reflects minimal impairment in overall personality function and indicates areas of no significant personality dysfunction. Her scores indicate mild negative affect and mild detachment, reflecting her difficulty regulating overwhelming emotions currently, and her social withdrawal, and personal withdrawal into herself through dissociation.

X's scores do not reflect any significant personality dysfunction.

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

X is an intelligent, independent woman, who is financially secure and has a strong parent child relationship with her x. She has significant support from her family and has good friends, a supportive workplace and a sound career network to support herself in work.

C) Areas of vulnerability:

X's strong other orientation makes her vulnerable to exploitation and not putting her own needs first.

D) Mental state examination:

This mental status examination (MSE) took place over the supported 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 weight and height. Her build is athletic. She has a tanned x complexion. Her apparent age is congruent with her chronological age. X arrived precisely on time to the assessment sessions and attended them all. She presented smartly dressed in x to most sessions. She was well kempt and well manicured. She engaged well with a positive attitude towards me as the assessor, was attentive, maintained safe and respectful eye contact, and she appeared comfortable with talking to me. Her posture varied from closed to open depending on what was being talked about. X has cried in sessions yet at times when she is affected her affect becomes notably blunted when talking about being abused and tends to avoid talking about the subject or when she does pushes out comments in either a blunt unemotional way or with emotional flooding. Throughout the assessment sessions her psychomotor response has oscillated between flat and overwhelmed. She can however access

happiness, pride and joy when discussing her x, her work and her friends. She displayed many instances of sitting and staring blankly. The gathering of information required skilful questioning being careful to be open yet to keep her on track regarding her sexual abuse and its effects. She displayed normal activity given the nature of the assessment and her heavy reliance on her dissociative capacities.

Mood and Affect: X's mood seemed generally appropriate to the topics discussed but was often labile oscillating with a flatness.

Speech and Language: X spoke speak slowly and fluently, showing some non-verbal language indicating some sparks of insight into a given topic area. Her comprehension, repetition, naming, prosody, and speech quality all appeared normal. She has no problems with reading and writing.

Thought Process, Thought Content and Perception: X's thought process appeared normal and communications displayed consistent connectedness of thought and no peculiar thought processes. Her thought content was spontaneous with no indications of delusions, overvalued ideas, obsessions, violent ideas, hallucinations or phobias. When I brought up the abuse she showed dissociative depersonalisation (e.g. talking of herself in the third person) or derealisation (e.g. blankly staring and taking a moment to respond) symptoms at times throughout the assessment sessions.

Cognition: X's cognition appeared normal for all of orientation, attention and concentration, registration, short-term and long-term memory, visuo-construction ability, and executive functions

Insight and Judgement: X appears to have x. She has less insight into steps forward from here. She displays little some awareness of her dissociation and has no mastery over her dissociative capacities. Over the course of the assessment sessions, she used a lot of defensive coping including dissociation and deflection, particularly in relation to discussion of the abuse, other aspects of her life, and where to from here.

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 cross cutting symptom measure – Adult, The personality inventory for DSM 5 – Brief form (PID-5-BF), the PROMIS – depression short form, the PROMIS – anxiety short form, the trauma symptom inventory (TSI2), the PROMIS emotional distress – sleep disturbance – short form, and the brief dissociative experiences scale (DES-B) – modified.

The DSM 5 self-rated level 1 cross cutting symptom measure is a highly reliable and valid self-report screening tool, developed to identify possible psychopathology in clinical populations. It consists of 23 questions that assess 13 psychiatric domains (APA, 2013). X's scores on this measure showed severe elevations in dissociation; moderate elevations in anxiety and sleep problems, and mild elevations in personality and substance use. These results suggest further testing is warranted in these areas. The personality screen PID-5-BF has been discussed in the personality section earlier in this report, the addictions in only in relation to cigarette smoking and alcohol use when out with friends and have not been tested further. Subsequent test results follow.

The PROMIS emotional distress – depression is a measure for the use of clinicians and researchers to enhance clinical decision making, to serve as baseline data and to monitor progress in clinical settings. It is an 8 item, highly reliable and valid self-report screening tool designed to assess the pure domain of depression in individuals aged 18 or over. X's score on this measure indicates mild levels of depression.

The PROMIS emotional distress – anxiety – is a measure for the use of clinician and researchers to enhance clinical decision making, to serve as baseline data and to monitor progress in clinical settings. It is a 7 item, highly reliable and valid self-report screening tool designed to assess the pure domain of anxiety in individuals aged 18 or over. X's score on this measure indicates moderate levels of anxiety suggesting the need for clinical intervention in relation to anxiety management and affect tolerance and regulation.

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. It also contains validity and reliability scales that identify possible malingering

and/or over-reporting of symptoms. (Briere, 2011).

X's scores on the TSI-2 were both valid and reliable and show clinical elevations on the self-disturbance (SELF) and post-traumatic stress factor scales. These factor elevations suggest, X is highly likely to meet diagnostic criteria for PTSD and that she has developed a distorted relational schema with a relative inability to access a stable sense of self or identity from which to interact with the external world, leading to problematic relations, a tendency to rely on others rather than self for information about herself, and as such a greater susceptibility to influence by others. This can lead to an ongoing dysthymic state.

Her scores on the clinical scales show very high elevations in the dissociation, defensive avoidance, hyperarousal, and impaired self-reference in terms of both other directedness and reduced self-awareness, and clinical elevations in anxious arousal, depression and sexual concerns; indicating a complex post-traumatic sequalae and implying areas for clinical attention in treatment (Briere, 2011).

The PROMIS emotional distress – sleep disturbance – short form is a measure developed for the use of clinicians and researchers to enhance clinical decision making, to serve as baseline data and to monitor progress in clinical settings. It is an 8 item, highly reliable and valid self-report screening tool designed to assess the pure domain of sleep disturbance in individuals aged 18 or over. X's answers on this measure suggests she has significant trouble falling asleep, her sleep quality is poor, she sometimes finds sleep refreshing, but sometimes finds it difficult to sleep. X's score on this measure indicates moderate levels of sleep disturbance, suggesting that her sleep requires clinical intervention in order to gain the full benefit of therapeutic interventions.

The Brief Dissociative Experiences Scale (DES-B) – modified has been selected by the researchers involved in the development of the DSM 5 as an emerging measure for the use of clinician and researchers to enhance clinical decision making, to serve as baseline data and to monitor progress in clinical settings. It is a highly reliable and valid self-report screening tool designed to assess the severity of dissociative symptoms. X's score on this measure indicates moderate levels of dissociative symptoms suggesting that intervention is required.

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

Domain	Score	Domain	Score
Understanding and communicating:	1.2	Getting around:	0.6
Self-care:	1	Getting along with people:	1.6
Life activities – household:	0.3	Life activities – school or work:	0.3
Participation in society:	2.5	Total disability score:	30.6%

Qualitative data: X's functioning has been compromised by her experiences of sexual abuse and the resultant injuries of PTSD, dissociation, dysthymia and anxiety. She is most compromised in her social withdrawal and difficulties understanding others and feeling heard. Her abilities to get around, work and maintain her home are strength however also foster avoidance by keeping herself too busy to think.

☐ 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 diagnoses:

309.81 (F43.10) Posttraumatic stress disorder with dissociation - chronic

300.4 (F34.1) Persistent depressive disorder (Dysthymia) with anxious features

If the diagnosis is not made using the ICD9 or ICD10 classification systems, please enter the ICD9 or ICD10

diagnostic code that corresponds to the diagnosis you are making here: F43.10; F34.1

H) Formulation and summary:

X is a x year old x woman who is undertaking majority care of her x. She is x at her work in x of a major company. She is currently living in rented accommodation whilst navigating matrimonial property and parenting arrangements following exiting a physically, sexually and psychologically violent relationship. She presented to assessment with significant depressive, anxiety, dissociative, and post-traumatic symptoms.

X has an unremarkable family history with no familial mental health nor addiction problems. Her temperament was described as easy and she enjoyed numerous activities in childhood. Her childhood attachment history is secure, with attachments to both parents and all of her grandparents. Her x was a bully however x had enough resilience for this not to affect her significantly. She did well at primary school and had sound peer relationships. She had a good sense of self-esteem and there was no indications of low mood, anxiety or any behavioural nor mental health problems.

The sexual abuse that x experienced in her early teens caused x to cope through dissociation, compartmentalisation and the use of different persona. The sexual abuse events interrupted her secure attachment pattern, causing a disruption to her relational schema, impacting her sense of self and others, compromising her affect regulation abilities and precipitating a posttraumatic stress sequalae.

X's fractured sense of self and the developed belief that she was now a sexual object, lowered her sense of self-worth, caused her to lack trust in herself and to look outside herself for cues as to what was right and wrong. Her high levels of dissociation manifested and maintained this form of coping leading her to develop ambivalent insecure relations with others precipitating a dysthymic mood state (Briere).

Working hard became a way that x began to feel good about herself. She had a strong work ethic and was determined to work hard. In her late teens her work ethic served as a protection from feeling unprocessed trauma related thoughts and feelings. It also reinforced her posttraumatic stress through avoidance.

The relationship with her partner at x, the intense feelings of love and security and his untimely death precipitated grief and a deep sadness. X's teenage schema and beliefs of being unworthy, and not good enough resurfaced precipitating a depressive episode. X's relationship with her next fiancée and association with the gang was totally out of character and incongruent with her values. This relationship manifested and maintained the belief that she was unworthy and wasn't good enough further entrenching her distorted relational schema.

The long-term relationship with her x's father also perpetuated her negative view of self, and strengthened her use of compartmentalisation further entrenching her dissociation, depression and PTSD.

I) Risk assessment:

X's risk is considered low currently, however risk will be monitored throughout therapy with referrals made to mental health services if required.

J) Symptom validity:

There are no symptom validity concerns. 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 between different measures.

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):

There is a clear temporal and symptom onset and reappearance relationship between posttraumatic stress including dissociative symptoms and x’s experiences of childhood sexual abuse. There is also a temporal relationship with x’s experiences of sexual abuse and her dysthymic mood state. These conditions were retriggered in her adult relationship in relation to the sexual abuse where she “felt like a x year old again”.

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

X also experiences protracted grief in relation to the death of a much-loved fiancée, which further manifests and maintains her dysthymia. Her experiences of physical and psychological abuse in her marriage has complicated and cemented her PTSD.

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8. Treatment

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

Evidence suggests integrated trauma focussed 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 equine therapy, art and music 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 dissociation using the work of Boon, Steele and Van der Hart and the APA guidelines for treating dissociation.
- Treatment of anxiety and dysthymia using ACT, DBT and CBT
- Treatment of PTSD using integrated trauma focussed therapy (Briere)

9. Prognosis

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

The prognosis for x is good, however the presentation is complex with entrenched defences. Ongoing maintenance of the therapeutic attachment will be important

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.	
The client: ☒ participated in the feedback session ☐ did not participate in the feedback session (please provide reasons) Feedback session held x	

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.