ACC6429

Supported Assessment - adults

Fill in this form if you're a mental injury assessor after you have finished this client's mental injury assessment as part of the Supported Assessment service. Please refer to the guidelines at the end of the form. This form is for adults, if the client is an child or young person use *ACC6424 Supported Assessment – child and young person*.

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

2. Provider and supplier details			
Supplier name: South Coast Psychology		Supplier number: G09884	
Supplier address: x			
Provider name: x			
Provider email address: x		Provider phone number: x	
Provider type:	☐ Psychiatrist	☒ Psychologist	☐ Psychotherapist
☐ Other (Please specify):			

3. Introductions	
Dates of consultations: x	Duration of consultations: 1 hour x 9 = 9 hours

Sources of information:

1. x Therapeutic assessment sessions with x
2. x Interview with x and community mental health manager x
3. x Referral Information x community mental health day programme x
4. x ACC719 Initiate return to counselling report x counsellor
5. x Letter to case manager x counsellor
6. x ACC291 counselling completion report x counsellor
7. x ACC sensitive claims peers review x clinical psychologist
8. x Diagnostic and treatment assessment report x psychologist
9. x Peer review comment x clinical psychologist
10. x ACC291 counselling progress report x counsellor
11. x Letter to case manager x counsellor

12. x ACC sensitive claims peers review x clinical psychologist
13. x ACC291 counselling progress report x counsellor
14. x Peer review comment x clinical psychologist
15. x ACC720 Return to counselling report x counsellor
16. x ACC719 Initiate return to counselling report x counsellor
17. x ACC291 counselling completion report x counsellor
18. x Peer review comment x clinical psychologist
19. x ACC291 counselling progress report x counsellor
20. x ACC20 Return to counselling report x counsellor
21. x ACC719 Initiate return to counselling report x
22. x ACC clinical advisor note x (unknown profession)
23. x Full Psychiatric Assessment x psychiatrist and psychotherapist
24. x Serious injury personal care assessment x (unknown profession)
25. x ACC counselling progress report x psychologist
26. undated Psychological report x psychologist
27. x First counselling report x psychologist
28. x Return to counselling report x counsellor
29. x ACC cover report form x counsellor
30. x ACC claim for cover and treatment expenses – x general practitioner
31. x Psychiatric impairment report x psychiatrist
32. x NZCYFS letter with information regarding claim x care and protection supervisor
33. x Lawyers letter to sensitive claims unit x staff solicitor
34. x NZ Police letter to sensitive claims unit verifying sexual abuse charges x constable
35. x ACC claim for cover and treatment expenses X
36. x ACC advice of injury form x counsellor
37. x ACC M3 Referral by a medical practitioner x
38. x Offence record x detective
39. x Police statement x
40. x Medical examination report x

Client competence:

I explained to x my role as a psychologist/ACC assessor, the purpose of the supported assessment, the extent to confidentiality and its limits, and that the information gathered for this assessment would be provided to ACC to assist in determining her cover and to direction for my treatment plan with her. She was able to understand and provide consent and is thus competent to make decisions about her life including taking part in the current assessment

4. About the event

Briefly describe the event or events identified as the basis of this mental injury claim:

1. X was subjected to multiple incidents of full sexual violation, forcing her to perform oral sex and other sexual acts and him performing oral sex on her, being forced to watch and engage in pornographic acts almost daily from before the age of x until she was taken into care by the department of social welfare (now NZCYFS), when she was x, and then every time she was brought back to her x for x 'contact visits' in the weekends, whilst she was in the care of the department. Sometimes she was so sore from the multiple rapes that she could hardly walk. As she grew older she partially enjoyed the only intimate contact she had with a family member, but she did not enjoy the sexual abuse. She had a child to x when she was x and it was adopted out. Her foster mother would continuously say to her, "go sleep with your x you little whore/slut". At x x told the police about what her x was doing to her and refused to go back. X said, "the police didn't believe me", and she was offered no support, counselling or, in her view, any "real legal" redress. According to records x was charged and convicted with one count of sexual assault against her but denied the rest and only received periodic detention and a $750 fine. This still infuriates x.

2. During the same period as above x's x would sometimes have friends around and they would be sexual towards her as well. This would happen on numerous occasions.

3. X experienced multiple incidents of rape and sexual abuse by boys who were also in care in the social welfare home that she lived in.

4. When she was aged between about x and x one of the boys from the home coerced her into a controlling and violent sexual relationship, where he forced her to perform sexual acts and x learned not to say no "because it got you in worse trouble". When x was x she became pregnant and had the baby. This child was also adopted out.

5. Her biological x at home would take her under the house and also had sex with her. X respects the fact that "he stopped because he knew it was wrong". This admission by her x was when she first came to realise that what her x and the boys at the home was doing to her was wrong, she had normalised the abuse, particularly as her x was also doing it to her x.

6. X would sometimes stay with other children when she was growing up. She says their father's would "find out who I was and take advantage", touching her sexually. She felt like she had a sign on her saying "pick on me".

7. According to her files, a stranger "severely and brutally" raped x when she was x.

8. When x was working as a prostitute, 2 of her bosses forced her to perform oral sex on them.

9. In x when x was married, a stranger raped her in her own home. She attended ACC counselling at the time.

5. Background client information

A) Client circumstances at time of assessment:

X lives with youngest x in housing NZ house in x. Although she is not formerly under mental health services, she receives support from the community mental health day programmes manager and staff. She is in receipt of supported living payments, which was called the Domestic purposes benefit and is in the process of transitioning to the invalids benefit, as she is unable to work due to her inability to cope with her current

symptoms and her inability to manage stress. X attends the day progammes and engaes in creativity, undertaking craft activities, wood work, stone and bone carving. She has a male best friend called x, whom she sees as her “soul mate without the sexual aspect”. She has a few friends and gets on well with most people. Until recently, she has kept in contact with her abuser/x on Facebook but does not want to have anything to do with him and his young x wife. She says she moved to x “ to get away from the bullshit and family”. She attended the assessment sessions alone apart from one session where she brought her x.

B) Summary of relevant background history:

X was born into a family that was severely dysfunctional from before she was born. She has x and probable foetal alcohol effects. Her parents were alcoholics, her mother was also a drug addict and both parents severely neglected the children. X and her siblings were fed pills by their mother to keep them quiet and if they vomited them up, they would be forced to re-swallow them. They were not fed or cared for properly. X’s x was a paedophile and sexually abused her forming an incestuous relationship with her from the age of x until she was x years old. He continued his abuse of her in the weekend visits she had with him when she was in social welfare care from the age of x until x. She had a child to him when she was x or x years old. In the social welfare home, she was also subjected to rape and sexual abuse by the boys in care. Her foster x was also verbally and psychologically violent towards x constantly swearing at her, putting her down and calling her names. She has had limited schooling and what she did have she was unable to concentrate on due to the level of trauma and depression she was experiencing. She did want to return to school and train to become x but her foster x would not let her. At x x lived on the street off and on and worked in prostitution. She would also work at other jobs periodically. When she was x and again at x she was raped by strangers, the first in a seclude street and the latter in a home invasion. She drank and drugged in her teenage and early adulthood and had many overdoses and suicide attempts but became clean when she became pregnant with her x whom she delivered when she was x. She now has x children and x grandchildren, whom she says, “saved“ her and are the focus of her life. There is likely a psychological enmeshment between x and her children and grandchildren, which is less than healthy but is a significant improvement on her own upbringing. Her eldest x now has x children of her own and x supports her in parenting them, having her grandchildren for holidays and extended periods.

C) Presenting problems:

X presented with flashbacks and intrusive memories, thoughts and feelings that she is struggling to block out and ignore. She says, “I have trouble when I have phlegm in my mouth because of him - He was all about him. It was humiliating when he used to take photos”. She says “I spend my life in a bubble”, she is detached from people, has diffculty focussing or concentrating on anything, and sometimes days have gone by without her realising it. She is “sometimes out of my body, its like a light switch goes off, and when the light comes on again things have changed, and things have happened and I haven’t realised”. A strategy she learned in counselling was to focus on something, so she focusses on the clock as she knows she needs to pick her x up from school. She says her “symptoms get really heavy, like a ton of weight on me, I get a foggy and stupid head and want to hurt myself, drink and do things, so I go to bed and try to block it out”. X becomes agitated when talking about her family of origin, and gets distressed when remembering the abuse and says, “Thoughts go round and round in my head or I see a red curtain coming down and lash out, usually with my mouth, I don’t hit out anymore”. She has left x to be “as far away from reminders as possible”. X still blames herself to a degree for her x’s abuse of her even though she realises that she was just a child, she has a poor self image, is neglecting her self-care and feels down and angry much of the time. She says that she has lost her confidence as her “persona has changed”. She is often irritable and says that she is more often needing to apologise to her x for “snapping” at her. She only feels comfortable and safe when she is “snuggled up with my x”, She says, “I feel like a kid but I feel safe”

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

X first saw an ACC registered counsellor, x, in x, although reports suggest therapy, there is no indixcation this took place, and x has no memory of this. Dr x conducted an ACC assessment in x, where she was assessed X as 40% impaired by the sexual abuse by her x and the boys at the home, and outlines a complex post-traumatic sequalae. X then met with 2 counsellors x in x and x in x, but did not appear to engage with either and x has no memory of them. X engaged for a year with psychologist x. X says, “therapy with x was always a drama and she would use other people’s scenarios and it felt creepy. At an assessment with x, in x, x was reported to have said that she was changing her counsellor as she had “lost trust in her”. Dr x’s assessment found that although she presented with many PTSD and Depressive symptoms he felt she did not meet

diagnostic criteria for these and queried a neurological disorder/brain injury due to her alcohol and drug history. Prior to her therapy with x, x spent a year in therapy with x, whom x also has no memory of. Reports indicate that x frequently missed sessions and had difficulty engaging. From x, x spent nearly two years in therapy with x (early x until late x) whom she found helpful and “saw her for ages”. Reports indicate that x recognised that x had difficulty engaging witth counsellors past initial engagement. And she took time to establish a sound therapeutic alliance and worked with x’s strengths, whilst building her self-capacities. x undertook a DATA assessment with x in x, endorsing the counsellors approach and providing further reccommendations for treatment. She diagnosed PTSD, generalised anxiety disorder and dysthymic disorder, and recommended continuing treatment with her counsellor. In x x moved to x where she met with x, whom she did not relate to. Her support has been via the community mental health day programme staff until her referral to my waiting list in x. She eventually engaged in therapy with me in x and we have engaged in a therapeutic assessment process, where we have met longitudinally for 10 sessions, and the assessment becomes part of her therapy. X says she enjoys meeting with me and is finding the process helpful.

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

Contact name: Sue x	Contact email:
Contact name: Dr x	Contact email:
Contact name: x	Contact email:
Contact name: x	Contact email:
Contact name: x	Contact email:
Contact name: x	Contact email:
Contact name: Dr x	Contact email:
Contact name: x	Contact email:
Contact name: x	x
Contact name: x	x

E) Relevant medical history:

X reports problems with recurring urinary tract infections, poly cystic ovaries and having a baby (her first child) prematurely.

F) Current medications and dosages:

Cholopromazine – antipsychotic to stabilize mood

G) Alcohol, drug and gambling history:

X says that she was “drinking as a kid”, and that she would also take some of her mother valium and diazepam as a child. When she has pills she says she keeps “taking them and taking them and OD whenever I have pills”. X realises that having any pills around her can lead to trouble she says, “ I can be totally happy and next thing I wake up in A&E”. She relates this to childhood learning saying, “when I was happy as a kid something would happen to ruin it, so I learnt no to get happy”. X has an extensive drug and alcohol history in her teens and early twenties. She stopped all drugs when she became pregnant, restarted again when her x was young, attended addictions counselling in x and has only used pot to ease her symptoms rarely since. She has been drug and alcohol free for a long-time. She smokes cigarettes.

H) Family history:

x believes that most of family is depressed, and that her x was very depressed when they were growing up - saying, “she threw knives at my x”, and was very moody. She never got any help though, she had her kids taken of her and was left to it”. She believed her x had mental health problems as “a teacher initiated sex with him when he was young, the trouble is he liked it”.

I) Cultural and spiritual background:

X has x with x heritage. She believes in god, and prays now and then. She also believes in the x living in the light.

J) Employment and education-related issues:

X attended school until she was x and engaged in and completed x programmes where she undertook work experience for x – working at a x when she was in her final years at school then her "foster x refused to let me go back". She also attempted to train as x, but was also discouraged in this. From x and after she left school x worked part-time in prostitution, and worked as a x for x. When x's eldest child was x she went to x and tried to train as a x and when her x was x, to get her out of the house and get her interacting with other people, she worked for a short time doing x, however "the medical staff disallusioned me as people were ripping off the system". After that she has been a full-time mother, was a tutor when she home schooled her x, and has been in receipt of income support. Since coming to x x has attended the mental health day programmes, has attempted to seek work and is about to be transitioned on to the sickness benefit by her doctor. She has also learnt to x through the mental health day activity centres.

K) Personal history:

X was born on the x, she says that even her birthdate has "a dirty sexual connotation". X has quite some difficulty placing the ages of her siblings and half siblings she initially said that she was the middle child of x to her mother and father, her older x was, "very self centred" and her younger x was "manipulative". Past assessments however say that she is the eldest of x or x. She asked family members who know for this assessment, and she is the x youngest of x and her x "had other younger children, we just called them the little ones". Her mother and father were both alcoholic and had histories of abuse. She said that her x was in and out of psychiatric wards, was depressed and a drug addict, She had other children who all lived with her. X said that NZCYFS was involved with her family before she was born as her x didn't know how to parent, and was physically, emotionally and psychologically abusive towards the girls and also sexually abusive towards the boys. She remembers her x "feeding the little kids pills to keep them quiet". X also remembers being forced by her x to eat her vomit off the floor when she vomitted up the pills she fed her. She remembers her x and her going to stay at a social welfare home in x when she was aged between x and x and her x only came to see them once. X was initially excited to see her x, but her feelings quickly turned to dissappointment when her x ignored her and went over and hugged her x.

X's x began sexually abusing her from the age of about x or x and this continued on an almost daily basis until social welfare removed her for the second time when she was x years old. X says "I used to pretend it wasn't happening when I was being sexually abused when I was really little". The social worker at the time told them that they were going on holiday. She and other assessors have since been told that the Social Wefare (now NZCYFS) family file is "the most horrific abuse of children they have ever seen".

Life at the foster home was "better but not a lot". The foster x was nice to her but he was quite ineffectual allowing his wife to do the fostering work with the children. X was subjected to putdowns and verbal abuse being called a slut and whore by her foster x, whom she experienced as cold and distant, from a very young age. Also she would be raped and sexually abused by the boys at the home, they would say she instigated the sex, and her foster x would say, "go and have sex with your x you little whore/slut".

Whilst in social welfare care, x would be taken to her x home for weekends and he would sexually abuse her and eventually had full vaginal, anal and oral sex with her and subjected her to humiliation when he would force her to watch and be involved in pornography whilst he took photographs of her. He would sometimes have friends around and they would be sexual towards her as well. X came to see this as normal behaviour and became concerned when her x didn't have sex with her. Whenever she went to other children's places their x would "find out who I was and take advantage of me", sexually abusing her. Her biological x would also "take me under the house and have sex with me". She began to wonder why he was being so secretive if the sex was normal. When this x stopped have sex with her "because it was wrong", she finally realised that being sexually abused was not normal. By the time she was x she had endured x full term pregnancies and deliveries, one to her x at x and the x as the result of a coercive and controlling sexual relationship with one of the boys at the home at x. At her first child's birth it was found that she had extensive scarring and damage from being sexually abused so extensively at such a young age. Both babies were adopted. Still nothing more was done and the sexual abuse continued until she was x, when she told the police and refused to go back

there for visits.

X remembers starting primary school at x primary school when she was about x or x. She remembers her foster x dropping her off to the office and the office person taking her to the classroom. She found it hard to make friends and the children called her and her siblings, “orphan kids”. X desperately wanted a normal life. She would dream that she won lotto and would buy the house where she lived with her foster carers and “turn it into a happy home”. Throughout her primary schooling she would go back and forwards between her foster carers and her parents. X says, “randomly throughout life there were periods when my biological family felt real and functional, even though I just visited every now and then.”

At x intermediate school x walked to school. She remembers staying and practicing x after school, “to get out of going home”. One report on file mentions a possible concussion in this period, but X is not sure about this.

Throughout all of her life x remembers losing time, going into “a real world in my head”, having periods where “I feel like another person and sometimes speak differently”, Most of her life x has felt “empty”, aggressive”, and “always felt different”. She remembers when the pop singer x released her first song when she was about x or x she had a poster of her and 2 other famous women on her wall and “it was like a switch turned on like a spark and bits of me could relate to each of them”. After this she began to feel her sexual power as a woman.

X went to x high school until x. She says it had a “bad reputation but x would just give us a look and we’d behave”. X was held back a year due to her behaviour. She remembers going to camp x and she was a junior leader. She remembers chatting and playing with kids at school, “but foster x discouraged friendships”. X trained in x in her final year at school then her “foster x refused to let me go back”, she also attempted to train as x when she was x at x polytechnic but was also discouraged by her foster x and everyone around her.

By the time she was x x was highly sexualised and she began using prostitution as a way to reclaim her power. She says, “prostitution was good for me … if I hadn’t done that I would have ended up an empty vacant person”. She worked on the game until she was x in either a full time or part-time capacity. After she left school she also began working for x as a x during the week. She was using drugs and drinking heavily (up to a bottle of gin a day) but loved her work, she felt she wasn’t judged and “could just be me”. Two of her bosses forced her to “give them blow jobs, no wonder I spent so much time on the street” . She also became quite aggressive and has historic charges of assaulting police officers, and would assault men who looked at her the wrong way. She also was charged with soliciting “a couple of times”.

For a short time during her teenage years x says, “I tried to live with x, but x would steal my money while I was asleep and she would pawn my stuff for booze money.”

X first went to an ACC counsellor when she was x, x, after being raped by a stranger when she was x, however she does not remember this. X says she has been to heaps of counsellors but does not remember most of them because she could not relate to them. She does remember having numerous miscarriages around this time. Her files also briefly touch on her having children under adoptive mothers names so that “there was no trouble with paper work”, but this has not been discussed in her therapy with me as yet.

X’s relationship with her x’s father began as a client and then they moved in together. He was x and the relationship worked well as he was mostly x. She became pregnant and she stopped prostitution, drinking and drugs and had her x when she was x. At this point her partner “moved his mother into the home” and x could not handle her control. She says she just said, “fuck this I’m outta here” and left. She went on the domestic purposes benefit and has been on income support with small part-time jobs alongside her full time mothering ever since. Her x still has contact with her father. From that point forward her x “became my life, she saved me and I felt love for the first time ever when she was born”. She did resume drugs and alcohol after her x birth however, as “the pills helped me cope”.

In x, x was raped by a stranger in her home. She was married to a man that was also somewhat controlling. relationship that lasted for x months. During this time, she filed a claim with ACC for a lump sum payment and her husband “took the money and brought a house in his name with it”. She left the relationship with nothing as she found it difficult to have him around her x. She was very anxious that her x didn’t experience the things that she had gone through in her life. Around this time, she was referred to more counselling with x, but x doesn’t remember this and thinks she “only attended a session or so, if that”.

Around x, when her x was about x, x says that she became very depressed, she went to a doctor and was put

on antidepressants. In x she re-entered counselling initially with x, who she also does not remember, and then began working with psychologist x. X says that “counselling with x was always a drama and felt creepy”, reports indicate some stabilisation and some difficulty approaching abuse processing work, however x believes she just told x what she wanted to hear to “keep CYFS off my back” and her psychiatric assessment in x noted that x had lost trust in her counsellor and was feeling pressured to lay charges against her x and other abusers in her life. She did however cease her use of drugs and alcohol over the period that she was in therapy with x, as she was also engaged in drug and alcohol counselling through x. Although there is file evidence of her engagement in fortnightly counselling with x between x and x, x has no memory of this. She does however remember her time working for nearly x years with x and credits the work with x to her being able to manage herself more effectively and having skills to focus on being a good mother.

In x x’s x moved closer to where she and her x were living in x and she was visited by CYFS and threatened that if they saw her near him they would uplift her x and take x into care. She was depressed and had to make daily pick ups of her medication, was home schooling her x and was feeling very lonely despite the fact that she was living with boarders. X decided that she was best to move away from x, she planned this with her counsellor, got a map and picked a spot, packed her x up and followed her x direction to “keep driving til I tell you to stop”, and ended up in x.

X has a very close male friend x who has lived with her as a boarder at one point in the past, but they found they got on better apart. x has always helped her out with her children and has been in her second x life since before x was born in x. After her second x was born x became severely depressed and suicidal and required inpatient care. She says, “x just took over the role of parenting x from x, that’s him he is just always there for the kids and me”. Since being in x x has begun to establish a support network of professionals - a community mental health day programme manager, the day programme staff, x, some friends, her x school teachers, preschool staff and so forth. She attempted to enter into ACC counselling once with x, but could not relate to her. She heard about me through a couple of friends and also her doctor and mental health staff and decided to wait on my waiting list until I was able to see her this year.

L) Forensic history:

X says that she has charges for soliciting when she was aged x. At about x she received diversion for “beating up a few cops and damaging their car”. In her x she also had an assault charge as she bit a police woman as she and another police officer took off her pants in the cell, and another assault charge against a nurse, when she touched her and wouldn’t stop. X also beat up a number of men in her teenage years for “looking at me”, but charges were never laid.

M) Summary of previous tests or assessments:

See above. Two of the assessments, on x’s file (reported in x and x) formulate a causal relationship between the severe and protracted sexual abuse she has been subjected to by her x and her current difficulties. Both of these assessments offer diagnoses of PTSD and the latter also adds generalised anxiety disorder and dysthymic disorder. Another assessment on file opines that x does not meet criteria for either PTSD or Dissociative Disorder, although she has marked symptomatology of both and suggests a possible brain injury as the cause of some of x difficulties, alongside her dysfunctional and traumatic childhood.

6. Diagnosis

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 moderate impairment in overall personality function and indicates areas of moderate to severe personality dysfunction. Her scores indicate moderate to severe

detachment and psychoticism, reflecting both social and personal withdrawal and detachment and withdrawal into herself through dissociation and a relative inability to be in the real world alongside a strong belief in a spiritual world; Moderate negative affect and disinhbition, suggesting she experiences moderately high levels of affect dysregulation and low affect tolerance or ability to regulate emotions, low levels of impulse control showing a recklessness. It should be noted that x qualifying statement of "this would have been a 3 in the past suggests her levels of disinhibition have lowered markedly, in part due to therapy but also due to the responsibility she carries in her role as a mother. Finally, x's scores also show mild antagonism suggesting she may have some repressed anger.

Scores are congruent with clinical reports from her previous counsellor and previous medical, psychological and psychiatric reports and indicate x displays compromised personality functioning; experiences at least some symptoms characteristic of a personality disorder; has difficulty managing her emotions; withdraws from others; experiences very high levels of dissociative depersonalisation and derealisation, and is impulsive with little but developing impulse control. Diagnostically x may meet diagnostic criteria for borderline personality disorder, all of her symptoms however appear to form part of her post-traumatic sequalae and is best subsummed within her Post-Traumatic-Stess-Disorder with dissociative and psychotic features diagnosis. 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)*

B) Mental state examination:

This mental status examination (MSE) took place over the 10 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 of x and x genealogy. She is about average weight and height. Her skin is pallid, and her complexion marked, evidence of a 'hard life'. Her apparent age is somewhat older than she is as both her wisdom and her appearance belie her relatively young age. X arrived on time to the assessment sessions, and attended them on her own apart from one session where she brought her x. At some sessions she said she had been unable to shower due to the level of traumatic material she was experiencing, and this was evident in her appearance. She has not had her hair done or dressed up or wore any make up to any of the assessment sessions to date, saying, "I don't really care about me, my baby is all that is important". 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 not cried in sessions to date rather 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 blurts out a comment in a blunt unemotional way. Throughout the assessment sessions her psychomotor response has been flat apart from when she talks about her children and grandchildren. She does volunteer information regarding her history or the abuse but prefers to focus on her youngest child, her activities and being a mother. 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 has been continuously down and depressed throughout the assessment sessions. She has been able to show some joy but only in relation to her children and grandchildren. Her affect was flat or numb and only heightened when speaking about her children and grandchildren.

Speech and Language: X is x. She did her best to speak slowly and fluently, and 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 some problems with reading and writing but has enough proficiency to get by.

Thought Process, Thought Content and Perception: x 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. She did however describe obsessive checking of doors at night related to lack of her safety. When I brought up the abuse she also 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 session.

Cognition: X's cognition appeared relatively 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 relatively good insight into the nature of her abuse and much of the effects. She has less insight into steps forward from here. She has some awareness of her dissociation but has little 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.

C) 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 – anger short form, the Altman self rating mania scale (ASRM), the PROMIS – anxiety short form, the patient health questionnaire physical symptoms (PHQ-15), the trauma symptom inventory (TSI2), the PROMIS emotional distress – sleep disturbance – short form, the Florida obsessive-compulsive inventory adapted (FOCI), the brief dissociative experiences scale (DES-B) – modified.

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 scores on this measure showed severe elevations in depression, mania, anxiety, psychoticism, sleep problems, memory, repetitive thoughts, dissociation, and personality functioning; moderate elevations in somatic complaints and addictions. 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 has not been tested further, and subsequent test results follow.

The PROMIS emotional distress – depression – short form has been selected by the researchers involved in the development of the DSM 5 as an emerging 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 severe levels of depression suggesting x may be experiencing a depressive episode.

The PROMIS emotional distress – anger –short form 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 pure domain of anger in individuals aged 18 and older. X's score on this measure indicates moderate levels of anger.

The Altman self rating mania scale (ASRM) has been sellected by the reseachers 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 25 item measure designed to assess the presence and/or severity of manic symptoms. X's score on this measure indicates that she is unlikely to have any significant symptoms of mania.

The PROMIS emotional distress – anxiety – short form 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 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 post-traumatic stress (PTS), and externalisation (EXT) factor scales suggesting that X is highly likely to meet diagnostic criteria for PTSD and that she is currently acting out to relieve post-traumatic stress and emotional distress. Her scores on the clinical scales show elevations in anxious arousal, particularly hyperarousal; depression; anger; intrusive experiences; defensive avoidance; dissociation, general somatic complaints; sexual concerns; suicidal ideation; relational avoidance, and reduced self-awareness indicating a complex post-traumatic sequalae and implying areas for clinical attention in treatment (Briere, 2011).

The PROMIS emotional distress – sleep disturbance – short form has been selected by the researchers involved in the development of the DSM 5 as an emerging 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 sleep disturbance in individuals aged 18 or over. 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 Florida obsessive-compulsive inventory (FOCI) is a 5 item measure that has been selected by the researchers in the development of the DSM 5 as an emerging 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 domain of repetitive thoughts and behaviours in individuals 18 years and over. X's score on this measure indicates severe levels of repetitive thoughts severely compromising all areas of her life.

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 severe levels of dissociative symptoms

D) Formulation:

X is a x-year-old x mother of x. She presented to therapy with severe post-traumatic stress, depressive, and dissociative symptoms. Her roles of mother and grandmother are the main protective factors keeping her going from day to day. X's mother's drinking both whilst pregnant and afterwards, combined with her abuse and neglect of x resulted in probable foetal alcohol effects and related neural, learning, educational, and behavioural effects, and predisposed x to developing mental health problems. Her x sexual abuse of her from a very young age caused vaginal and uteral physical problems, developed a severe relational trauma dynamic within her psyche, caused her to cope through dissociation, and precipitated a complex post-traumatic sequalae. The sense of hopelessness and helplessness that x felt when the people who were supposed to keep her safe (the state) allowed her to be further sexually abused by her x and others around her precipitated a sense of deep depression and dysthymic state, and developed in her a deep sense of distrust in anyone. This caused her to develop a dissociative capacity where she would act out of different parts of herself, developing different identities, without having a cohesive sense of self. Although her engagement in prostitution may have been a somewhat protective factor in that it masked her depression and allowed her to regain some power, it also acted as a replication of both the abuse dynamic further reinforcing it and her dissociative identities as she moved through many roles. Furthermore, her service of others sexual needs reinforced that her needs were secondary or non-existent and manifested and maintained her belief of herself as a sexual object for the service of others. Likewise the birth of each of her x, her mothering and grand mothering have been protective as they have helped her gain valued roles and kept her going on a daily basis, yet at the same time they have been a source of avoidance as her enmeshment in her children's lives have "become her life" and allowed her to avoid facing her inner turmoil and developing her own cohesive identity.

E) Client strengths:

X is creative and caring. She has begun to turn her hand to x. She is also a caring mother and grandmother

and supports both her x including participating in parent help at her youngest x school. X is developing insight into her problems and wants to feel better and to allow her children to have good lives.

F) 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 dissociative symptoms

300.14 (F44.81) Dissociative Identity Disorder

296.31(F33.41) Major depressive disorder (severe) with melancholic features (current)

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, F44.81, F33.41

G) Risk assessment:

X's risk to herself is currently low due to her feeling the need to be there for her x. This protective factor could be tentative should here depression become such that she begins to neglect her children. X's risk of harm to others is also relatively low for the same reason, if her x or x were to be threatened or harmed however x would be highly at risk of offending as she has little impulse control.

H) Symptom validity:

The TSI-2 validity and reliability scales are well regarded measures to identify malingering and over-reporting of symptoms. X's scores indicate validity and reliability suggesting it is highly unlikely that she has over-reported or engaged in malingering.

7.Opinion

A) Relationship between the sexual abuse or sexual assault and the diagnosed mental conditions:

There is a clear causal relationship between the early and prolonged sexual abuse by her x and the onset of X's dissociative and post-traumatic symptoms. Her depression is clearly linked to the hopelessness and helplessness she felt when she was abused by both the boys and her x when she was supposed to be in receipt of state care and protection. Her dissociative identity disorder manifested out of her dissociation as has been caused by her response to the effects of her sexual abuse.

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

Her probable foetal alcohol effects and the rejection, neglect, and physical abuse from her biological x acted as predisposing factors in X's development of mental health problems. The lack of care, coldness and verbal abuse in foster care and impacted the trajectory of x's poor mental health as a result of the sexual abuse in her life.

8. Prognosis

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

The prognosis for x is poor to fair given her probable foetal alcohol effects and her heavy reliance on dissociation. Therapy however and a possible assessment for medication to ward off her current developing depressive episode should help her to have more comfort in life. It will be complex work over an extended period and it will be quite some time, if ever before x develops the self-capacities to endure abuse processing, without her retreating into avoidance and dissociation.

9. WHODAS 2.0

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

Domain	Score	Domain	Score
Understanding and communicating:	2.5	Getting around:	2.2
Self-care:	3.2	Getting along with people:	3.4
Life activities – household:	3.5	Life activities – school or work:	4
Participation in society:	3.7	Total disability score:	81.25%

Qualitative data: X's ability to understand and communicate and get around is less impaired than the areas of her life that have been more affected by her mental injuries as a result of sexual abuse. That is she is currently unable to work and is significantly impaired in her ability to participate in her community, develop and maintain relationships, and to care for herself and her home.

☐ A copy of the form is attached. A copy is on file.

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. Treatment

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

Treatment with X will initially require focus on treating her developing depressive episode with CBT and liaison with her GP for medication. Once her depression has resolved to a degree, the focus of therapy will be on skills building and developing both internal and external resources, using a DBT based framework and with the assistance of social work support. Once she has the necessary skill development the focus will be on managing anxiety and helping her build mastery over her dissociative capacities using the APA guidelines and the work of Van der Hart et al. After this has been established x may work towards maintaining her sense of self in work and/or abuse processing. The trajectory of treatment is difficult to determine at this stage.

12. Provider declaration and signature

By entering my name in the signature field I confirm that the information contained in this report is accurate, and that I have followed the standards explained in the Operational Guidelines.

Signature: x	Date: x

List other providers responsible for completing this form.

☒ I have explained to the client that the information collected during the assessment will be sent to ACC and obtained their authority for this.

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. 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.