ACC6429

Supported Assessment - adults

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

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

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	
Contact details / Safe contact where appropriate:		
☒ Female	☐ Male	☐ Other
Ethnicity: New Zealand European		

2. Assessor and supplier details	
Supplier name: South Coast Psychology	Supplier number: G09884
Supplier address: 95 Turner Street RD 3 Wyndham 9893	
Assessor name: x	
Assessor email address: x	Assessor phone number: x
☐ Psychiatrist	☒ Psychologist
☐ Psychotherapist	☐ Counsellor

3. Introductions	
Dates of consultations: x	Duration of consultations: 3 hours

Sources of information:

1. x Review of assessment with counsellor x
2. x Interview with x
3. x ACC6426 Early planning report counsellor x
4. x Child and family speciality services x house mental health notes various authors (repetition of CDHB notes)
5. x x district health board adult community psychiatric service Rapid assessment of patient in distress
6. x x district health board adult psychiatric services Referral screening document registered nurse x.

7. x x district health board adult psychiatric services Psychiatric review consultant psychiatrist x
8. x x district health board hospital General medicine Discharge summary x
9. x x district health board hospital Emergency medicine Medical assessment record x
10. x x medical notes various nurses and general practitioner x
11. x x district health board hospital letter to general practitioner, registered nurse x
12. x x district health board adult psychiatric services x hospital Psychiatric assessment summary
13. x x medical doctors x psychometric screening test (K10) unsigned
14. x x Brief intervention counselling letter to general practitioner, youth clinical specialist x
15. x x medical centre medical notes general practitioner x

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

x understood my role as psychologist/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 her cover and to provide guidance regarding treatment to her counsellor. She was able to understand and provide consent and provided valid information throughout the assessment process. x reports having a learning disability and the assessment was sensitive to her needs and adapted to suit.

4. About the event

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 for the client at the time of the event and after.

1. When x was aged about x her father hit her on her breasts because she and her sister didn't get out of the shower when he told them to. The next day x was dropped off to her mother who saw the bruises and took x to the police. x reports that she is not sure if this was a sexually motivated attack. The event however meets the criteria of sexual assault. After this event x reports, "always being sad, didn't have any appetite and her father was not allowed to see her for a year.

   In her teens, x can't remember the age, but she was at high school, x went out once with her brother's best mate. She felt yuk after having sex and didn't go to school.

2. Around the same time, a boy from High School stayed the night and slept in x's bed. He proceeded to have intercourse with x who told him to stop but he wouldn't listen.

3. In x, x was living in x, with her mother and her mother's partner. One day her stepfather had been drinking a lot all day and he began to make inappropriate comments, asking her if she had had sex yet and saying "have sex with me you'll only hurt and scream for a short time". x ignored the comments as she knew he was drunk and on reflection thought that he may have taken methamphetamine. x reports, "I also used to wake up at night and he was staring at me". x's mother later abandoned a unit she lived in with x and she had no-where to live so moved in with him and his children. When x was x years old, on x, she went to sleep on the bed with his daughter. In the early hours of the morning she awoke to him raping her. The next morning she felt like a robot. He told her to shower and she did so. She says, "I felt dirty, disgusted and shocked, I didn't want to stay but I had nowhere to go". He raped her 3 more times over the Christmas and new year period and again in x and x. They then had to get out of the unit so lived a garage at his parent's home. She reports the last time he went to rape her "something came over me and I was angry, I kicked him and punched him and he stopped". She felt very confused saying, he was my stepdad but he destroyed the relationship we had by using me like that. x felt used, confused, upset and angry. x told a family friend

about the abuse and she told the police. x's father challenged x about raping his daughter to which x replied "so what if I did". Her father tried to punch him and threatened him if he ever came near x again he'd hurt him. x reports, "I felt sorry for his kids and dropped the charges".

4. Later in x, x started seeing a boyfriend who lived in x and fortnightly he would bus up to see her. x consented to sex with him once and didn't want to again. On another visit x expected him to stop having sex when she told him no, but he didn't. She initially thought that it was normal, but she felt controlled and no longer enjoyed sex with him. The relationship lasted 6 months.

As a child x was shocked by her father's attack and felt like she "was in a nightmare" she felt sad and very confused when her father hit her on the breasts. She felt helpless and could not eat for a long time. She doesn't understand why he would do that to a young girl.

Since the rapes and sexual abuse by her mother's partner, x has experienced nightmares, flashbacks and intrusive thoughts, feelings and memories, she began drinking heavily, and whenever she saw or thought about her mother she was triggered by memories of her stepfather "knowing he was her ex and he took my virginity". x worked with her mother 15-20 hours a week x. Her mother accused x of "being in love with him" and blamed x for the sexual abuse. x reports she became depressed and suicidal and quit her job. When she was x, x drank 12 cans of Mavericks (7% alcohol premix), and handfuls of her pills in an attempt to kill herself. She reports, "I just gave up it's too hard".

In x x met her current partner on-line. Her mother had kicked her out in x so she came to x and began a relationship with him. They were together for about a year until x's mood swings and behaviours impacted negatively on the relationship. Her partner stopped the sexual activity and he remains a friend to x. x feels safe with him as he's the only guy who would stop if she said 'no' to sexual activity.

5. Background client 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 on x at her parent's home in x on the due date. x reports that "dad was too busy drinking to be at the birth". Her mother told her that her father was "always at the pub". x reports the midwife that attended her birth told her mother that she was fine. She was the x child of x in her parents union, having a x and a x. x reports that her mother also had 3 stillborn babies. X also has a maternal ½ brother and ½ sister to men whom her mother had affairs with. She has always gotten along well with her ½ sister. As an adult, she has difficulty relating with the boys. Her parents relationship in her early childhood was characterised by a lot of fighting. x reports, "mum used to like to ring the cops on her partners for nothing. Her parents broke up when she was x years old and her relationship was closer to her father than her mother in childhood.

When x was a preschool child her mother took the children to x, where x remembers attending Kindy. In x, at x years old she and her mother and siblings settled for a short time in x. This is where she begun primary school at x school where x remembers having a teacher aide, speech therapy and a social worker from CCS disability action. (From my knowledge of the disability sector, to receive these services, x would have had to have had a needs assessment likely with a specialist Education services Educational Psychologist, and been assessed as meeting criteria for learning support both academically and socially).

Part way through her first year at school x reports, "mum had a breakdown", and her mother dropped x and her siblings off to her father. She lived with her father and his partner and attended x primary school in x, between x and x years old. x reports she did not have a teacher aide and that cannot remember the work at school and how she found it, however remembers that she liked school and was "always going up for awards in year x assembly" at primary school. She reports her father's partner would hit her around the head with a book, send her to her room for long periods of time and threaten to send her away.

x reports that her parents had custody battles in court her whole life over who would have the day to day care of the children and they ended up going backward and forwards between their parents. When x was aged about x years old her father assaulted her (see event 1 above). x felt terrified and did not want to live with her father anymore although she stayed with him on the weekends. From about x when she was x years old x reports that she began "loosing it" at school and at home shortly after the abuse. She would fly into rages,

couldn't focus to read anymore. She remembers the age because at x years old the family shifted to x and she bused back to x primary school. She also remembers attending x primary school when living in a house in the same street.

In x when she was x years old x attended x College in year x and stayed at school until year x. A reports that the first year of high school was hard because of all the violence she lived around. She says, "mum would hit guys and they would hit her, I got so sick of these men in mums life". x found that her fits of rage increased in both frequency and in intensity. She reports, "no-one would listen to me and I'd flip out, slamming doors, throwing stuff, kicking holes in the walls, and loose it. Later I'd have no memory of doing half the stuff I did". In x x reports that she, her half-x and mother went to x on holiday and stayed with her x and she loved the holiday. She reports they were going to live up there but her mother decided to come back to x.

When x was growing up her mother's partners at the time would hit her when her mother told them to. Her mother was drinking extensively and child youth and family services came and put her younger sister into her dad's care. x refused to go and she was left with her mother. During this time x experienced the x and had to change schools from x to x high school. Around this time x had her first consensual sexual experience and later was raped by a classmate (see event 2).

x mis-behaved at high school and was on daily report for her behaviour. In x, when she was x, x began living with x in x. x reports that her acting out behaviour stopped whilst there, and she got on well with her extended family.

x would spend time at her mother's home and remembers an incident where she tipped out her mother's alcohol as she'd been drinking all day. Her mother grabbed her and repeatedly hit her head against a brick wall. x ran away and went to the home of one of her mother's ex boyfriends who x thinks of as another stepfather. x states there were lots of arguments during their relationship. He used to chat up x's x year old school mates and buy alcohol for them. After she had been there a few days the police turned up at the x, where she would go to use the free internet, and took her and put her in a holding cell. They then sent her back to her mother although x told them they were not allowed to as it was on her CYFs file. A felt she was punished for her mother's bad behaviour.

x was x when she left her x care and went to live with her father who "needed me to babysit", she says. She returned to x at different times after this.

In x, when she was x years old, her x came to x for x's prize giving at x high school. She achieved NCEA level 1 and has only one more credit to achieve NCEA level 2. She went with her x to x where she lived and attended x College for 2 weeks, and had a part-time school girl job vacuuming a house.

She then went to live with her x again. In x while she was living with x, x began a job as a cleaner at x in x. Since then, x has worked at various cleaning jobs at x in x. When she was x she began cleaning the x in x.

In x x moved to x, with her mother and her mother's partner who felt like a father figure to her**.** Whilst still in x he began making inappropriate sexualised comments to her**.** He then attained custody of his two children and moved back to x. x and her mother also returned to x shortly after. He and his children occupied a 1 bedroom unit while x and her mother lived in another. Often the adults would be in one unit while the children were in the other. One night in x at 8 pm x texted her mother's partner, telling him that her mother wasn't home. She was still not home at 9.30 pm reports x, so his daughter took her to their unit. Her mother never came back and texted x and to dump this man for her. x lived with this man as he had become like a father figure to her, and x had no-where to live so moved in with him and his children.

When x was x years old on x late at night this man raped her. The sexual abuse continued until x (see event 3 above), when x fought back. x later disclosed to a woman that knew both her mother and x about the sexual abused from her father figure and she told the police. x's father challenged x about raping his daughter to which x replied "so what if I did". Her father tried to punch him and threatened him if he ever came near x again he'd hurt him. x reports, "I felt sorry for his kids and dropped the charges".

After this x "lived all over". She then moved in with her mother and began drinking heavily with her to shut out her thoughts, feelings and memories of the abuse. She quit her job as she could not concentrate or get motivated to do work. In x, when she was x, she worked again x. During this time her mother accused her of being in love with the man who abused her and blamed x for the abuse. x drank a lot of alcohol and took pills

in an attempt to kill herself. According to her mental health notes x was seen by mental health services in x following a mental health admission where xwas threatening to harm herself. She was given a diagnosis of adjustment disorder with mixed emotion and behaviour. Her GP was also sent information regarding a process for crisis respite. During this time x reports she got sick and had no job.

In x she began a relationship with her current ex-partner/friend on-line. A month later her mother kicked her out and she moved to x to live with her partner. Her partner has the same name as her mother's ex-partner who sexually abused her so this can seem confusing reading her notes. x gained her job x. After a year in x, the relationship fell apart due to x's uncontrollable emotions and behaviour. According to mental health notes, x's GP referred her to mental health services. A file review was conducted by a psychiatrist and it was suggested x engage in ACC counselling and be prescribed an SSRI antidepressant. x was also assessed by mental health clinicians in x after self-harming by scratching and attempting to scald herself. x continued to live with her ex-partner, however they stopped the sexual part of their relationship and became friends and flatmates. Recently x has moved to her own flat.

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

x reports that she has seen counsellors for brief intervention and had 1 appointment after an overdose from mental health services. She was not aware of having attracted any diagnoses. Medical notes reviewed suggest that she has had primary mental health services involvement as part of child and family services and as an adult. Her general practitioner queried abuse and depression in x. x stated she "already knew she had depression as was I diagnosed by doctor at 13"**.**

According to notes reviewed, in x, after an overdose, x attracted an adjustment disorder with mixed disturbance of emotions and conduct at x hospital psychiatric services. In x her general practitioner began diagnosing Depression/Anxiety and prescribing an SSRI antidepressant. In x x adult psychiatric services consultant psychiatrist x declined to formally assess x but conducted a file review. He noted that advice from mental health professionals has consistently been that x has a trauma history, would be eligible for ACC counselling, and would benefit from this and antidepressant medication and recommended counselling and an SSRI antidepressant.

C) Current situation and presenting problems:

A presented to ACC counselling with acute suicidal ideation and three suicidal and self-harm attempts, depression, lethargy, low motivation, self-dislike, poor attachment relationship with mother and feelings of being let down by her, social isolation, lack of friends, and fears of being judged (Waitokia, 2018)

At assessment she presented with a history of sexual abuse in both childhood and adulthood, familial dysfunction including exposure to alcohol in-utero, difficulties relating to and comprehending others, concrete thought processes, naivety and an inability to grasp complex spoken or written material. She also presented with personality dysfunction including fears of abandonment, no friendships and a pattern of relational instability, recurrent suicidal behaviours, difficulties controlling her anger, chronic feelings of aloneness and emptiness, and severe dissociative symptoms. x reported high levels of depressive symptoms including fatigue, reduced appetite, and lowered libido, difficulty concentrating and poor sleep, frequent feelings of sadness and tearfulness, low motivation feeling irritable and agitated, social withdrawal, difficulties making decisions, pessimism for her future, feeling like a total failure, hopelessness and helplessness, reduced pleasure, chronic feelings of guilt, self-dislike, and self-blame. x described symptoms of PTSD including flashbacks, intrusive thoughts, feelings and memories in relation to the sexual abuse by her mother's ex-partner, violent dreams with sexual themes, hypervigilence and hyperarousal, avoidance of people places and situations that illicit memories and feelings reminiscent of the abuse events, emotional overwhelm, activation and distress when reminded of the sexual abuse events, and an exaggerated startle response.

D) Summary of previous clinical and psychometric assessments:

See section B above

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

Currently x's general practitioner has prescribed Citalopram 25 mgs daily, Clonazepam .05 mgs daily as needed, and Metoprolo for blood pressure.

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: x	Contact email: x

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

Scores are congruent with clinical observations and indicate A displays symptoms characteristic of borderline personality disorder. Although personality disorders should not be diagnosed on the basis of one short clinical interview, it is the assessors opinion that sufficient background information and similarities across psychometric measures and self-report data lead themselves to a diagnosis of borderline personality disorder (BPD). x's personality problems appear to have manifested after her experiences of childhood sexual assault in her middle childhood, they are likely, at least in part, a consequence of a complex posttraumatic sequalae. 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)*. x's personality symptoms however are characteristic of both PTSD and BPD. It is unlikely that x would have experienced this level of intrapersonal problems if it were not for her experiences of sexual assault. Further investigation suggests x currently meets full diagnostic borderline personality disorder.

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

x sees herself as a survivor. She will ask for help when she feels she needs it. She has been able to engage in work for sustained periods of time. She also reports a caring and supportive relationship with her half-x.

C) Areas of vulnerability:

x is vulnerable to revictimization. She has few skills in interpersonal boundaries and lacks the ability to see red flags and behaviours that might suggest someone will take advantage of her.

D) Mental state examination:

x is a x year-old x woman. She was a little late to the assessment session, which she attended on her own. She presented casually and tidily dressed to the appointment. Her hair is x. She is of average height and overweight. Rapport was easily established, despite an initial wariness about the assessment process. She spoke freely but gave little eye contact. At times throughout the interview sessions, x displayed flattened affect with an air of hopelessness. She was polite and co-operative with answering questions. There was no evidence of formal thought disorder nor perceptual disturbances. She appeared somewhat naive but cognitively intact, although displayed very concrete thought processes, had some difficulty understanding

both written and spoken material at times. She was oriented to time and place. She has developing insight into her difficulties, although little insight into potential risky situations or people. She described depersonalization symptoms and thoughts of suicide, however says that she would not carry them out.

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 A's clinical presentation. The measures selected were: The DSM 5 self-rated cross cutting symptom measure – Adult, the personality assessment screener (PAS), the trauma symptom inventory (TSI-2), the Beck depression Inventory (BDI) and the AUDIT alcohol screen.

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 consists of 23 questions that assess 13 psychiatric domains (APA, 2013). x's scores on this measure showed severe elevations in depression, anger, memory problems, repetitive thoughts and behaviours (intrusive), dissociation, and addictions; moderate elevations in anxiety, suicidality, psychotic symptoms, sleep problems and personality problems; and slight elevations in somatic symptoms. These results suggest further exploration is warranted in these areas. The personality screen (PAS) has been discussed in the personality section and subsequent test results follow. x's symptoms of repetitive thoughts and behaviours, and somatic symptoms will be further tested within the TSI2 as these thoughts behaviours and symptoms relate specifically to her experiences of trauma.

The trauma symptom inventory (TSI-2) is a widely-used measure of trauma symptoms and behaviours. It consists of 136 items and assesses a wide range of potentially complex symptomatology from post-traumatic stress, dissociation and somatization to insecure attachment patterns, impaired self-capacities and dysfunctional behaviours. The critical scales highlight areas of potential risk. The factor scales (Self-disturbance, Post-traumatic-stress, Externalisation, and Somatisation) serve as summary measures of complex post-traumatic disturbance and the clinical scales and subscales highlight levels of trauma-related symptomatology that may be of clinical significance (Briere, 2011). x 's scores on the TSI-2 critical scales indicate that in the past 6 months she has frequently attempted suicide, overdosed on pills, tried to kill herself but changed her mind, done something violent because she was so upset, engaged in deliberate self-harm and tried to end her life. Further exploration suggests she may be at risk of future self-harm but reports that she wants to try and stop these suicidal behaviours. x's factor scale scores show clinical elevations in **self disturbance**, **post-traumatic stress**, **somatization, and very high elevations in externalisation**. Her pattern of scoring suggests x is clinically depressed, she has a severely compromised sense of self, has undergone one or more traumatic events in her life, experiences significant intrusive and suicidal symptomatology in relation to her traumatic experiences, engages in a high degree of emotional and behavioural avoidance and avoids reminders of abuse actively and through dissociation; has a substantially compromised affect regulation capacity due to her experiences of sexual abuse; has a tendency to act out and externalise in order to relieve tension; has a high preoccupation with bodily concerns including unprocessed trauma related somatisation; and displays post-traumatic symptoms to a level where she has a high likelihood of meeting diagnostic criteria for post-traumatic-stress-disorder (PTSD). Areas of clinical concern are indicated by very high clinical elevations in**, rejection sensitivity, depression, dissociation, general somatic complaints, suicidality (**both **ideation** and **behaviour) and tension reduction behaviours,** with very high **Impaired self-reference** score with very low levels of **self-awareness. Her scores also show** clinical elevations in **anxiety** (both **general anxiety** and **hyperarousal), anger, intrusive experiences, defensive avoidance, somatic pain, sexual disturbance in terms of sexual concerns,** and **insecure attachment** in terms of **relationship avoidance**. Her pattern of scoring suggests that she experiences very high levels of overwhelming emotions, depression, and intrusive re-experiencing material, and has very little ability to tolerate these states, and acts out, engaging in tension reduction behaviours to relieve tension and distress. She uses dissociation and active avoidance to cope with these problems, which in-turn manifest and maintain these symptoms and affects her physical self. These problems are exacerbated by her underdeveloped and compromised affect regulation and distress tolerance skills, her impaired self-reference and lack of mindful awareness. These deficits require treatment before any trauma processing occurs.

Beck's Depression Inventory (BDI) is a 21 item self-report measure used by clinicians to investigate the presence and severity of depressive symptomatology. x's score on the BDI (42) places her in the severe depression range (29-63). Further questioning determined her meeting diagnostic criteria for recurrent major depressive disorder since her teens.

The AUDIT is a well-regarded screening tool for the presence and severity of alcohol use problems. x's scores on this measure indicate she drinks 5 or 6 standard drinks of alcohol 2 or 3 times a week and at least once a week she will drink more than 6 standard drinks. Occasionally (less than once a month) she has found that she has been unable to stop drinking once she has started and also that she could not meet her responsibilities due to drinking. She never drinks first thing in the morning, but occasionally has feelings of guilt or remorse after drinking and has been unable to remember what happened the night before whilst drinking. She however is unsure if she has an alcohol problem and believes it would be very easy for her to cut down or stop drinking in the next 3 months. Her scores suggest that xs alcohol use is at a risky or hazardous level and would benefit from harm reduction strategies, setting goals, engaging in motivational interviewing, and self-monitoring of her drinking. Further exploration suggests x does not meet criteria for alcohol dependency but she does for alcohol use disorder.

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

Domain	Score	Domain	Score
Understanding and communicating:	2.3	Getting around:	1.6
Self-care:	1.5	Getting along with people:	1.8
Life activities – household:	2.5	Life activities – school or work:	4
Participation in society:	1.6	Total disability score:	52.78%

Qualitative data: x is most affected by her mental injuries in not being able to work. She also has significant difficulties in understanding and communicating and her ability to maintain her home. She has moderate to severe difficulty relating to others and moderate difficulty in self-care and ability to get around.

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

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:

315.8 (F88) Neurodevelopmental disorder associated with prenatal alcohol exposure

309.81 (F43.10) Posttraumatic stress disorder with dissociation

396.32 (F33.1) Major depressive disorder with anxious distress – moderate, recurrent

301.83 (F60.3) Borderline personality disorder. (NB this diagnosis is offered here as an indicator of personality dysfunction that has its aetiology in x's experiences of poor attachment with mother, an invalidating and chaotic childhood environment, bullying, and physical, emotional and sexual abuse in the absence of a complex posttraumatic stress disorder diagnostic category)

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: F88; F43.10; F33.1; F60.3

H) Formulation and summary:

x's mother and maternal aunt both had diagnoses of mood disorders suggesting she likely had a biological predisposition to mood disorders. Both her parents alcohol abuse and her exposure to alcohol in-utero with her mother drinking during her pregnancy would have increased x's predisposition to neurological difficulties and developing addictions. Her observational learning in her developmental years further predisposed her to alcohol abuse.

x's poor attachment to her mother and separation from her father would have further increased her likelihood of developing addictions, personality problems, and precipitated a depressive sequalae where x felt

abandoned, unloved and uncared for leading to a negative self-schema and negative cognitive triad that manifested and maintained her recurrent major depression.

The sexual assault by her father in her development years when she was still at primary school and just developing sexually, caused her confusion and emotional dysregulation resulting in a further fragmented personality structure and a dissociative relational trauma in a complex posttraumatic sequalae. Proceeding this assault x began experiencing overwhelming feelings of rage and violent behavioural outbursts. She would dissociate from her thoughts, feelings and memories and shut down emotionally and then have outburst of explosive rage.

x's father's, mother's and their partners' physical, emotional and psychological abuse of her further manifested and maintained her anger, depression, dissociation and posttraumatic stress. As did her experience of rape by a classmate in her teenage years.

The grooming, sexual abuse and rape by a man whom she trusted as a father figure further traumatised her and precipitated flashbacks, a robotic dissociative response, and an inability to look after herself and protect herself from revictimization.

x leaving the home of the abuser protected her from further revictimization. Her mother's blaming of her for the sexual abuse and her presence further triggered x's posttraumatic responses activating recurrent bouts of depression and manifesting and maintaining her PTSD. x's avoidance of her mother due to the triggering she causes, and avoidance of sexual activity and intimacy, protects her from feeling distress but also maintains her PTSD through its avoidant quality.

I) Risk assessment:

According to the TSI2 x is at high risk for suicide. Risk assessment from the emergency mental health services however found x's suicide risk as low. Due to x's high suicidality, anger and tension reduction behaviour scores I would rate her risk as moderate and believe it is imperative that her counsellor makes referrals to the emergency mental health services for crisis intervention and follow up if and when required.

J) Symptom validity:

x's TSI2 scores suggest mild overreporting of symptoms, although the level is well below the cut-off for validity. Her consistency of presentation suggests this overreporting is most likely related to her personality problems and a "cry for help" (Briere, 2011) rather that any direct attempt at malingering.

7. Opinion

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

x's current posttraumatic stress disorder with dissociation is directly related to her experiences of sexual abuse and rape by her mother's ex-partner. The intrusive symptoms and her avoidance of reminders are directly related to these events. The psychological and psychiatric literature supports this causative relationship. Although she has been distressed and likely traumatised by the assault by her father in her middle childhood, the posttraumatic stress attributed to this earlier event appears to be resolved at least currently.

x's personality problems became prominent after the sexual assault by her father. They were also influenced by poor maternal attachment and her exposure to alcohol in utero.

x's depressive sequalae has been manifested and maintained by her experiences of sexual abuse. It's aetiology however is in her genetic predisposition, her ambivalent maternal attachment pattern, and her feelings of unwanted by her mother as a child.

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

See above

8. Treatment

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

Treatment goals are best negotiated between x and her therapist. It appears they have developed a sound therapeutic alliance to date but would likely include using evidence based models (e.g. DBT, CBT, MBT, AOD counselling, etc) to work with:

- Attention to x's attachment needs and ambivalence as a basis for treatment building a strong therapeutic attachment
- Attention to her concrete thinking style and adapting therapy to suit
- Harm reduction strategies and psychoeducation around alcohol abuse and its effects including it avoidance quality which maintains PTSD
- Treatment for depression
- Self-awareness and boundaries including awareness of red flags in interpersonal encounters
- Skills development for managing emotions i.e. distress tolerance and arousal reduction skills
- Mentalising, conflict resolution and interpersonal effectiveness skills.
- Building awareness of triggers and skills to manage these
- Reduction of avoidance
- Processing of abuse related memories, thoughts and feelings.

9. Prognosis

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

x's prognosis is fair assuming she engages in long-term therapy. Her personality functioning, mood, and affect regulation has been damaged in utero due to mother drinking whilst pregnant, her insecure ambivalent attachment to her mother, her history of emotional neglect physical, psychological , and sexual abuse in her childhood; and her sexual abuse experiences in her teenage and young adulthood years by people she should have been able to rely on and trust for care and protection. Her presentation is complex and the therapeutic attachment will be primary to achieving gains in day to day functioning.

10. Other information

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

11. Provider declaration and signature

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

Signature:	Date: x
Date of last face-to-face meeting with client: Assessment feedback session x	
List other providers who contributed to the assessment.	
x	feed back assessment

☒ I have explained to the client that the information collected during the assessment will be sent to ACC and obtained their authority for this.
☒ 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
☒ I have explained to the client that they have the opportunity to participate in a feedback session prior to this report being submitted to ACC.
The client: ☒ wants to participate in the feedback session ☐ doesn't want to participate in the feedback session (please provide reasons) Feedback session undertaken on the x by counsellor x

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