Part 1

VICTIM ISSUES

ANGER DIFFICULTIES*

BEHAVIORAL DEFINITIONS

1. Unexpected and unpredictable feelings of rage have occurred since having been sexually abused.
2. History of suppression of anger regarding having been sexually abused, resulting in depression, self-destructive behaviors, or somatic symptoms.
3. Dissociation or numbing of feelings of anger toward the sexual offender.
4. History of explosive, aggressive outbursts that are out of proportion to precipitating stressors leading to assaultive acts or destruction of property.
5. Overreactions of hostility to insignificant irritants.
6. Use of verbally abusive language.
7. Body language or tense muscles (e.g., clenched fist or jaw, glaring looks, or refusal to make eye contact).
8. Use of passive-aggressive patterns (e.g., social withdrawal due to anger, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, or nonparticipation in meeting expected behavioral norms).

__. _____

_____

__. _____

_____

__. _____

_____

*Much of the content of this chapter is adapted from "Anger Management" in *The Complete Adult Psychotherapy Treatment Planner* by A. Jongsma and L. M. Peterson, New York, John Wiley & Sons, 1999. Used with permission.

LONG-TERM GOALS

1. Accept the right to have and express anger toward the victim in ways that are self-empowering and healing.
2. Decrease overall intensity and frequency of angry feelings, and increase ability to recognize and appropriately express angry feelings as they occur.
3. Develop an awareness of current angry behaviors, clarifying origins of and alternatives to aggression, passive-aggressive behaviors, or suppression of anger.
4. Come to an awareness and acceptance of angry feelings while developing better control and more serenity.
5. Become capable of handling angry feelings in constructive ways that enhance daily functioning.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbally acknowledge experiencing feelings of anger. (1, 2)	1. Assist the victim in coming to the realization that he/she is angry by asking him/her to explore and label his/her feelings. 2. Assign the victim to read the book *Of Course You're Angry* (Rosellini and Worden) or *The Angry Book* (Rubin).
2. Identify targets of and causes for anger in daily life. (2, 3, 4)	2. Assign the victim to read the book *Of Course You're Angry* (Rosellini and Worden) or *The Angry Book* (Rubin).

	3. Ask the victim to keep a daily journal that documents actions, environmental events, or internal thoughts that cause anger, frustration, or irritation.
	4. Assign the victim to write a list of targets of and causes for anger, and process this list in session.
3. Verbalize an increased awareness of anger expression patterns. (5, 6)	5. Gently confront the victim about the transfer of angry feelings toward the therapist, either directly or indirectly, such as indicated by missed appointments, critical comments, or angry outbursts.
	6. Refer the victim to an anger management class or group.
4. Identify how significant others in childhood have modeled ways to handle anger. (7)	7. Explore family-of-origin rules regarding anger expression, and use a genogram to identify how significant others in childhood (e.g., parents, caretakers, siblings, teachers) expressed angry feelings.
5. Identify the pain and hurt of past or current life that fuels ongoing anger. (8, 9)	8. Assign the victim to list the experiences of life that have hurt and led to anger.
	9. Empathize with and clarify the victim's feelings of hurt and anger tied to traumas of the past.
6. Verbalize feelings of anger in a controlled, assertive way. (10, 11, 12, 13)	10. Teach the victim assertiveness skills, or assign him/her assertiveness training classes.

	11. Process the victim's angry feelings or angry outbursts that have recently occurred, and review alternative behaviors that are available (e.g., taking a time-out, using deep breathing and relaxation techniques, speaking assertively but not aggressively, sharing feelings in writing or with a friend to diffuse anger).
	12. Use role-playing techniques to assist the victim in developing non-self-defeating ways of handling angry feelings (e.g., assertive use of "I" messages).
	13. Assign a specific exercise from an anger management workbook (e.g., *Dr. Weisinger's Anger Work Out Book* by Weisinger or *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan), and process the exercise with the victim.
7. Use relaxation techniques to cope with angry feelings. (14)	14. Teach the victim relaxation techniques (e.g., deep breathing, positive guided imagery, deep muscle relaxation) to cope with initial response to angry feelings when they occur.
8. Verbalize an increased awareness of how maladaptive ways of expressing angry feelings have had a negative impact on self and others. (15, 16)	15. Ask the victim to list ways that the maladaptive expression of anger had resulted in negative consequences for himself/herself and others; process the list of consequences.

16. Expand the victim's awareness of the negative effects that perpetually feeling angry has on his/her body and spirit.

9. Identify the physical manifestations of anger, aggression, or violence. (11, 17, 18)

11. Process the victim's angry feelings or angry outbursts that have recently occurred, and review alternative behaviors that are available (e.g., taking a time-out, using deep breathing and relaxation techniques, speaking assertively but not aggressively, sharing feelings in writing or with a friend to diffuse anger).

17. Encourage the victim to observe and label angry feelings while describing specific body sensations that are associated with the anger.

18. Review the victim's violent expressions of anger and the negative consequences for himself/herself and others (e.g., personal shame, distrust and fear from others, legal conflicts, injuries, loss of freedom, financial loss).

10. Report an increased awareness of anger triggers and the ability to react in a nonaggressive manner. (3, 19, 20)

3. Ask the victim to keep a daily journal that documents actions, environmental events, or internal thoughts that cause anger, frustration, or irritation.

19. Assist the victim in developing the ability to recognize his/her triggers that lead to angry outbursts.

20. Help the victim to develop emotional regulation skills, which entails viewing anger as a wave that comes and goes and encourage a willingness to feel anger. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

11. Write an angry letter to the target of anger, and process this letter with the therapist. (21, 22)

21. Ask the victim to write an angry letter to his/her sexual perpetrator, or whomever, focusing on the reasons for his/her anger toward that person. Process this letter in session.

22. Encourage the victim to express and release (while in session) feelings of anger, rage, and violent fantasies or plots for revenge.

12. Verbalize a recognition of how holding on to angry feelings, fighting them, or denying them increases emotional suffering. (16, 23)

16. Expand the victim's awareness of the negative effects that perpetually feeling angry has on his/her body and spirit.

23. Explore the victim's feelings about forgiving the offender, and help him/her see it as an option, not a requirement; explore the pros and cons. Address other options such as delaying the decision to forgive or not.

13. Write out the pros and cons of forgiving those who hurt self. (23, 24)

23. Explore the victim's feelings about forgiving the offender, and help him/her see it as an option, not a requirement; explore the pros and cons. Address other options such as delaying the decision to forgive or not.

14. Clearly articulate anger toward the offender. (25, 26, 27)

15. Verbalize the need and ability to control rage at the offender. (28, 29)

24. Assign the victim to write a list of pressures to forgive the offender (e.g., urging by family members, financial and social pressures, guilt, or self-blame). (See the Self-Blame chapter in the Victim Issues part of this Planner.)

25. Encourage the victim to explore whether he/she experiences self-blame for the abuse and to redirect appropriate anger at the offender. (See the Self-Blame chapter in the Victim Issues part of this Planner.)

26. Help the victim to see anger at the offender as part of the recovery process.

27. Listen empathically while the victim shares anger feelings about the offender while pointing out suppression or dissociation.

28. Assist the victim in understanding his/her feelings of rage toward the offender as an appropriate emotional response to the experience of being sexually assaulted, and separate this from violent actions.

29. Have the victim explore specific feelings of wanting to harm the offender and ask for an agreement not to physically harm anyone. Discuss the difference between feelings and behavior.

16. List some positive aspects of anger. (30, 31)

17. Cooperate with a medication evaluation. (32)

__. _____

_____

__. _____

30. Explore with the victim how anger can be an appropriate response or signal to some environmental dangers (e.g., physical threat).

31. Ask the victim to list the positive aspects of anger (e.g., motivating him/her to take action or preventing another from doing something harmful).

32. Refer the victim for a medication evaluation if he/she appears overwhelmed, explosive, or out of control.

__. _____

_____

__. _____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
312.34	F63.81	Intermittent Explosive Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
312.8	F91.x	Conduct Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition
309.81	F43.10	Posttraumatic Stress Disorder
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

DISSOCIATION

BEHAVIORAL DEFINITIONS

1. An episode of inability to remember important information regarding the traumatic sexual abuse that is too extensive to be explained by ordinary forgetfulness.
2. Persistent or recurrent experiences of depersonalization, feeling automated or as if detached from or outside of one's mental processes or body, during which reality testing remains intact.
3. Persistent or recurrent experiences of derealization, feeling as if one is in a dream, where the environment feels unreal, strange, and unfamiliar.
4. Sudden, unexpected travel away from home with the inability to recall one's past, resulting in confusion about personal identity or assumption of a new identity.
5. The existence of two or more distinct personalities or personality states that recurrently take full control of one's behavior.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Resolve the emotional trauma that underlies the dissociative disturbance.
2. Reduce the frequency and duration of dissociative episodes.

3. Regain full memory.
4. Integrate the various personalities.
5. Reduce the level of daily distress caused by dissociative disturbances.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Describe the signs and symptoms that are experienced in the process of dissociation. (1, 2, 3)

2. Cooperate with a referral to a neurologist to rule out organic factors in amnestic episodes. (4)

THERAPEUTIC INTERVENTIONS

1. Explore the victim's dissociative experiences, assessing the nature and extent of the symptoms (e.g., altered perception of time, space, and sense of self; confusion; flashbacks; numbing; amnesia; panic).
2. Administer a standardized or structured dissociative assessment technique to the victim (e.g., the Dissociative Experience Scale, the Dissociation Questionnaire, or the Dissociative Disorder Interview Schedule), and give him/her feedback.
3. Ask the victim to give a detailed description of the onset of the dissociative process.
4. Refer the victim to a neurologist for an evaluation of any organic cause for memory loss experiences.

3. Read material that is informative regarding dissociation to gain information about the condition. (5, 6)

4. Describe alternate personalities (alters) that function with some amount of autonomy. (7)

5. Implement the use of art and journal writing to gain a better understanding of the feelings and needs of each alter. (8, 9)

6. List ways that dissociation has been helpful in coping with the abuse. (10)

5. Ask the victim to read material on dissociation (e.g., *Courage to Heal* by Bass and Davis and/or *Multiple Personality Disorder from the Inside Out,* edited by Cohen, Giller, and Lynn); process these reading materials.

6. Educate the victim about the process of dissociation, that it is a coping strategy used by individuals who are predisposed to high hypnotizability in order to deal with painful affect and trauma.

7. Gently probe for information regarding alters and their role in the victim's emotional survival, being careful not to encourage increased dissociation.

8. Assign art and journal writing homework assignments to be completed by the victim's various alters as they appear; process these with him/her.

9. Teach the victim and his/her alters that integration is the general treatment goal, and help to decrease fears and resistance of the alters by assurances that integration will not lead to their annihilation.

10. Explore with the victim how dissociation helped him/her to survive when the sexual abuse was occurring and afterward.

7. Keep a journal of dissociative episodes. (11)

8. Increase self-awareness feelings and thoughts by identifying emotionally stressful situations, which can elicit dissociation. (12)

9. Work in a collaborative way with trusted family members and significant others to identify parameters of personality changes. (13)

10. Cooperate with gradual exposure to stimuli that evoke dissociation. (14)

11. Identify the somatic and emotional reactions that occur prior to and during dissociation. (15, 16)

12. List alternate coping strategies to replace dissociation. (17)

11. Assign the victim to keep a journal of daily thoughts, feelings, and dissociative experiences; pay special attention to precursors of the dissociative episodes.

12. Process with the victim his/her journal information to identify and work through emotionally stressful situations that have become precursors to dissociative episodes.

13. Assign the victim to discuss dissociative experiences with one trusted social or family contact; process the sharing experience.

14. With the victim's input, develop and implement gradual exposure using a systemic desensitization hierarchy of nonabusive stimuli that are associated with the trauma and those that evoke dissociation.

15. Help the victim to identify the somatic reactions that occur prior to and during dissociation.

16. Help the victim to identify the strong emotions that trigger dissociation.

17. Assist the victim in listing alternate responses to replace dissociation [e.g., writing out in a journal the descriptions of the thoughts of fear; implementing

tactile stimulation (e.g., holding ice or touching a rough texture); drawing a visual representation of thoughts and feelings of anxiety and fear], and practice these in the session.

13. Practice taking control of the dissociation process while in session. (18)

18. As a way of practicing increasing control over dissociation, ask the victim to deliberately dissociate in the session and to note how the dissociation waxes and wanes.

14. Implement techniques that demonstrate mastery over the dissociative experience. (19, 20, 21)

19. Ask the victim to experiment at home with stimuli that will stop the dissociation (e.g., snapping a rubber band on the wrist, setting an alarm, splashing his/her face with cold water).

20. Give the victim homework sheets where he/she practices bringing himself/herself out of dissociation several times a day, rating how dissociated he/she was and how successful he/she was in stopping the dissociation.

21. Reinforce the victim for experiencing and acknowledging a sense of mastery and control over dissociative experiences.

15. Reveal, explore, and talk about the history of the sexual abuse. (22)

22. Explore the victim's traumatic memories that are dissociated, assuming a supportive neutral stance regarding the accuracy of memories.

16. Verbalize a belief in own ability to endure painful affect without dissociating. (23, 24)

23. Acknowledge and reinforce the victim's ability to tolerate intense affect as he/she discusses the traumatic experiences in the session.

24. Encourage the victim in self-acceptance of his/her own feelings and thoughts and to take responsibility for his/her own behaviors.

17. Practice intimacy skills by sharing personal art or written material regarding the sexual abuse with trusted significant others, group members, or family members. (25)

25. Encourage the victim to share art or written material regarding his/her sexual abuse with trusted others as a way of building confidence, self-esteem, and improving stress tolerance.

18. Use emotional regulation techniques as a way of gaining control over emotionality. (26)

26. Treat the victim for emotional lability. (See the Emotional Dysregulation chapter in the Victim Issues part of this Planner.)

19. Implement the use of a positive fantasy scene as a way to cope with a stressful situation. (27)

27. Train the victim in positive guided imagery as a stress reduction technique (e.g., imagining himself/herself on a beach or in a forest).

20. Use self-hypnosis as a collaborative tool to decrease anxiety, improve self-esteem, improve self-soothing skills, and encourage control of own fantasy life. (28, 29)

28. Teach the victim about hypnosis/self-hypnosis, a facilitated, focused state of awareness, helping him/her become calmer and take more control of his/her fantasy life.

29. Use hypnosis/self-hypnosis to help the victim to reorient himself/herself to external reality, calm himself/

herself when his/her emotions are intense, and increase his/her self-esteem and confidence.

21. Using new coping strategies and without dissociation, discuss specific memories of abuse and the impact that the abuse had. (30)

22. Agree to cooperate with a reevaluation of the treatment plan during times of crisis, considering increased session frequency and hospitalization as viable options. (31)

23. Verbalize an acceptance that the treatment will be a long process when dealing with the goal of integrating alters. (32)

30. Help the victim to experience success in controlling dissociation in the session when discussing sexual trauma using new coping skills; reinforce calm mastery over emotions.

31. Increase sessions to two or three times per week if the victim becomes significantly destabilized during times of crisis. Assess for the need for hospitalization if he/she shows signs of being unable to attend to his/her basic needs.

32. Help the victim to accept that therapy with alters will be a long-term process in order to reach a point of stability and integration.

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

EATING DISORDERS

BEHAVIORAL DEFINITIONS

1. Chronic, rapid consumption of large quantities of high-carbohydrate food.
2. Self-induced vomiting and/or abuse of laxatives due to fear of weight gain.
3. Extreme weight loss (and amenorrhea in females) with a refusal to maintain a minimal healthy weight.
4. Very limited ingestion of food and high frequency of secret, self-induced vomiting, inappropriate use of laxatives, and/or excessive strenuous exercise.
5. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight, in spite of being normal or underweight.
6. Predominating irrational fear of becoming overweight.
7. Escalating fluid and electrolyte imbalance resulting from the eating disorder.
8. Strong denial of seeing self as emaciated even though severely under recommended weight.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Restore normal eating patterns, body weight, balanced fluid and electrolytes, and a realistic perception of body size and satiety.
2. Terminate the pattern of binge eating and purging behavior with a return to normal eating of enough nutritious foods to maintain a healthy weight.
3. Restructure the distorted thoughts, beliefs, and values that contribute to eating disorder development.
4. Gain an awareness of the interconnectedness of low self-esteem and society pressures with dieting, binge eating, and purging, in order to eliminate eating disorder behaviors.
5. Change the definition of self, so that it does not focus on weight, size, and shape as the primary criteria for self-acceptance.
6. Achieve a healthy goal weight at which point normal menstruation and ovulation occurs.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history and nature of eating patterns. (1, 2)	1. Gather a history of the victim's eating pattern (e.g., frequency, amounts, types of food). 2. Evaluate and confront minimization or denial of eating-related problems.
2. Reveal dysfunctional behavior patterns engaged in that are related to food consumption. (2, 3)	2. Evaluate and confront minimization or denial of eating-related problems.

	3. Explore the victim's use of dysfunctional behaviors to cope with concerns about eating and weight gain (e.g., vomiting, binging, purging, hoarding, laxative and diuretic use, excessive exercise).
3. Cooperate with a dental examination. (4)	4. Refer the victim for a dental examination in order to assess the need for remediation.
4. Cooperate with a physical evaluation and verbalize acceptance of medical recommendations. (5, 6, 7)	5. Refer the victim to a physician for a complete physical examination to rule out any undiagnosed medical condition and identify current medical needs (e.g., target weight range, vitamin deficiencies, somatic symptom evaluation).
	6. Consult with the victim's physician to determine normal, healthy weight criteria (e.g., between 20 and 25 percent body fat, return of ovulation as determined by pelvic sonography, resumption of normal sexual and physical development).
	7. Ask the victim to verbalize a commitment to follow the physician's recommendations.
5. Describe the nature of psychiatric symptoms experienced. (8)	8. Evaluate the victim for a comorbid psychiatric disorder (e.g., an affective disorder or anxiety), and address his/her treatment needs.

6. Cooperate with psychological testing. (9, 10)

7. Cooperate with a referral to evaluate the need for psychotropic medication, and comply with all recommendations. (11, 12)

8. Cooperate with admission to an inpatient treatment center if an evaluation indicates a need for such treatment. (13)

9. Identify fears of weight gain. (14, 15)

9. Administer psychological tests [e.g., the Minnesota Multiphasic Personality Inventory—2 (MMPI-2) or Beck Depression Inventory) to gain a clearer diagnostic picture of the victim's mental and emotional status.

10. Give the victim feedback on the psychological testing, and incorporate the results into the treatment plan.

11. Refer the victim to a physician for a medication evaluation to decrease depression and anxiety, to reduce the frequency of binge eating and purging, and to decrease the likelihood of relapse.

12. Encourage the victim to take the medication as prescribed and report on the side effects and effectiveness.

13. Arrange for hospitalization for the victim if there is a risk of suicide due to depression or a serious medical crisis due to low weight and a fragile physical condition.

14. Discuss the victim's fear of weight gain, and consult with his/her primary care physician regarding realistic weight goals.

15. Express empathic understanding for the victim regarding his/her feelings about the struggle with issues concerning weight; counter the victim's dysfunctional thoughts with realistic perceptions.

10. Cooperate with a dietician/nutritionist to develop healthy mean plans, minimum caloric intake, and implement these in daily life. (16, 17)

16. Refer the victim to a dietician/nutritionist for assistance in initiating adequate nutrition to lead him/her to a realistic weight, identify healthy eating habits, and vanquish food-related myths.

17. Process the results of the dietician's consultation, and identify the changes that the victim should make, how he/she could start implementing these changes, and the feelings around making these changes.

11. Keep a journal of eating patterns, dysfunctional behaviors related to eating, and the thoughts and feelings associated with these behaviors. (18, 19)

18. Assign the victim to keep a daily journal of food consumption, laxative and diuretic use, vomiting, exercise, binging, and purging, as well as the thoughts and feelings that are associated with these behaviors.

19. Teach the victim to accurately perceive hunger and satiety through the use of rating hunger levels in his/her daily eating journal.

12. Identify irrational feelings and beliefs that impact eating patterns. (20, 21)

20. Assist the victim in identifying and exploring his/her emotions that lead to dysfunctional eating behavior.

21. Process the victim's negative cognitive messages (e.g., catastrophizing or exaggerating) that mediate his/her avoidance of food intake.

13. Set goals for daily food consumption, and keep a daily journal of food consumed. (22, 23)

22. Assist the victim in setting daily food consumption goals, and assign him/her to keep daily journal entries of food consumed; process in session and adjust daily criteria, as necessary.

23. Teach the victim coping strategies (e.g., positive affirmations, daily meditation, support group attendance) to use in ameliorating the anxiety of eating normally and maintaining a normal weight without using eating disorder behaviors.

14. Verbalize positive self-talk in session, and practice frequently during the daily routine. (24, 25, 26, 27, 28)

24. Reinforce the victim's positive verbalizations about himself/herself in session through the use of praise and verbal support.

25. Assign the victim to complete self-esteem-building exercises [e.g., listing positive traits and accomplishments (such as those found in *Building Blocks of Self-Esteem* by Shapiro) or a selected individual exercise].

26. Ask the victim to complete and process an exercise in the book *Ten Days to Self-Esteem!* (Burns).

27. Assist the victim in developing positive self-talk as a way of boosting his/her confidence and self-image.

28. Assign mirror exercises where the victim talks positively about himself/herself.

15. Identify distorted body perceptions and replace them with more realistic, healthy perceptions. (21, 29)

21. Process the victim's negative cognitive messages (e.g., catastrophizing or exaggerating) that mediate his/her avoidance of food intake.

29. Challenge the victim's distorted body image by discussion and assignment of relevant reading materials (e.g., *Body Traps* by Rodin or *Feeding the Hungry Heart—The Experience of Compulsive Eating* by Roth).

16. Implement new communication and assertiveness skills. (30, 31)

30. Enhance the victim's relationship skills by training him/her in assertiveness and problem-solving skills.

31. Teach the victim communication skills (e.g., how to make "I" statements, fair-fighting techniques, and feelings expression).

17. Verbalize an understanding of how eating disorder behaviors can bring a false sense of self-control and temporary alleviation of negative emotions. (32)

32. Teach the victim that, as a victim of sexual abuse, eating disorder behaviors can bring a false sense of self-control and temporary alleviation of negative emotions (e.g., guilt, anger, and self-disgust).

18. Acknowledge and overcome the role that dysfunctional family patterns have in the initiation and maintenance of eating disorder behaviors. (33, 34, 35)

33. Help the victim to identify family patterns of interaction that contribute to the maintenance of the eating disorder.

34. Assist the victim in completing a family genogram that focuses on a family history of eating patterns and messages about food and body weight.

35. In a family therapy session, focus on issues related to emotional support for each other and remediation of communication difficulties.

19. Verbalize an insight regarding separation and emancipation issues related to the family of origin. (36)

20. Attend eating disorder group therapy meetings in order to support recovery. (37)

21. Identify sources of ongoing support to help in maintaining gains and constructively dealing with triggers for food obsessions, dysfunctional behaviors, and emotional distress. (38, 39)

22. Verbalize an acceptance of body flaws and imperfections. (40, 41)

36. Address the victim's separation issues, discussing his/her feelings toward becoming independent from the family, and family cognitive messages regarding dependency and emancipation.

37. Recommend that the victim attend group counseling that is specifically designed to address eating disorder issues.

38. Refer the victim to Internet message boards and online chat groups that are pro-recovery, and teach him/her to avoid those that support dysfunctional thinking or dispense misinformation; process the information that is collected, dispelling myths and correcting cognitive distortions.

39. Refer the victim to an eating disorders support group (e.g., Eating Disorders Anonymous with information on the Internet at www.eatingdisordersanonymous.org) in order to help him/her get emotional support, decrease shame surrounding the disease, and increase his/her self-esteem.

40. Confront the victim's perfectionistic standards regarding body image, and establish realistic cognitions to develop a positive body image.

41. Assign behavioral exercises that are targeted to improve body image (e.g., positive self-talk, asking for positive feedback from support persons, shopping for flattering clothes and accessories).

23. Implement coping strategies to reduce emotionality. (42)

24. Identify potential relapse triggers, and list strategies for constructively coping with each trigger. (43)

42. Address emotional dysregulation, which can be a major trigger of binge eating and purging; assist the victim in listing constructive ways to reduce emotionality. (See the Emotional Dysregulation chapter in the Victim Issues part of this Planner.)

43. Assist the victim in identifying factors that lead to a relapse of eating disorder behaviors; outline relapse prevention strategies (e.g., stress management techniques, continuing contact with support persons, individual and family therapy).

__. _____
_____

__. _____
_____

__. _____
_____

__. _____
_____

__. _____
_____

__. _____
_____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
307.1	F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
307.50	F50.9	Unspecified Feeding or Eating Disorder
301.6	F60.7	Dependent Personality Disorder
_____	_____	_____
_____	_____	_____

EMOTIONAL DYSREGULATION

BEHAVIORAL DEFINITIONS

1. Under minor stress occurs extreme emotional reactivity that usually does not last more than a few hours to a few days.
2. Frequent eruptions of intense, inappropriate anger.
3. Chronic feelings of emptiness and boredom.
4. A history of intense, chaotic interpersonal relationships.
5. Chronic feelings of emotional vulnerability.
6. Engages in impulsive behaviors that are potentially self-damaging as a way to deal with painful emotions (e.g., binge eating, substance use, hypersexuality).
7. Recurrent suicidal gestures, threats, or self-mutilating behavior.
8. Easily believes that others are treating him/her unfairly or that they can't be trusted.
9. Difficulty in coping with stress and frequently blames others for making unreasonable demands.
10. Sets unrealistic expectations and unreasonable goals for self, feeling shame and guilt when failing to meet these.
11. Becomes very anxious with any hint of perceived abandonment in a relationship.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Develop and implement coping skills to deal with mood swings.
2. Develop the ability to control impulses.
3. Learn and demonstrate strategies to deal with dysphoric moods.
4. Develop and implement emotional regulation and anger management skills.
5. Learn and practice interpersonal relationship skills and improve social adjustment.
6. Terminate self-damaging behaviors (e.g., substance abuse, reckless driving, sexual acting out, binge eating, parasuicidal, or suicidal behaviors).

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Describe the nature, history, and causes for emotional dysregulation. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Gather a history of the victim's emotional lability, interpersonal conflicts, self-damaging behaviors, and anger symptoms.
2. Teach the victim the origins of emotional dysregulation (biological and environmental factors and their interactions during childhood) and the resulting difficulties (e.g., mood instability, tendency toward substance abuse, and difficulty to tolerate any strong emotion).

2. Report feeling accepted by the therapist, and verbalize a commitment to participate in treatment. (3, 4, 5)

3. Express empathic acceptance of the victim while confronting dysfunctional behaviors (e.g., suicidal gestures, self-mutilation, substance abuse).

4. Support the victim by accurate reflection of feelings to validate his/her feelings and increase his/her trust in the therapeutic relationship.

5. Develop the goals of therapy in a collaborative manner, orienting the victim to the concept of a treatment contract and addressing his/her needs and dissatisfactions and the therapist's limitations regarding tolerating missed appointments, suicidal gestures, and demanding behavior; set clear guidelines.

3. Verbalize an understanding of the cyclic nature of impulsive behavior leading to guilt and shame, which lead to more impulsive behavior. (6, 7)

6. Facilitate the victim's understanding that impulsive behaviors can bring temporary relief from negative affect, but usually make him/her feel worse not long after the short respite from intense affect.

7. Address how impulsive behaviors ultimately lead to shame and guilt later and a cyclic increase in more impulsive behavior to alleviate the guilt.

4. Reframe dysfunctional behavior and verbalize an acceptance of self. (8)

8. Point out that the victim's dysfunctional actions (e.g., attempting to manipulate, seeking attention, sabotaging treatment) are an effort to reduce negative affect and to feel better.

5. Verbalize a commitment to terminate self-destructive behaviors. (9)

6. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (10)

7. Take medication as prescribed on a regular, consistent basis, reporting as to the side effects and effectiveness. (11)

8. Describe honestly the extent of engaging in dysfunctional or self-destructive behaviors. (12)

9. Consent to giving information to and cooperating with consultation from other professionals as part of the treatment process. (13)

10. Identify cognitive methods of increasing tolerance for intense affect. (14)

9. Solicit the victim's agreement that he/she will work to decrease suicidal and parasuicidal behaviors and other behaviors that interfere with treatment (e.g., substance abuse, prostitution, manipulation).

10. Refer the victim to a psychiatrist to evaluate his/her mood instability and to consider prescribing psychotropic medications.

11. Monitor the victim's compliance with the physician's prescription for psychotropic medication; consult with the physician as to the effectiveness and side effects.

12. Thoroughly assess the victim for other significant psychopathology (e.g., compulsive gambling, prostitution, shoplifting).

13. Use a team approach in treating the victim, consulting colleagues, including the victim's psychiatrist, primary care physician, group therapy leader, and support network.

14. Assign the victim to complete homework exercises on understanding and coping with strong feelings (e.g., Chapter 1 in *Surviving Childhood Sexual Abuse Workbook* by Ainscough and Toon); process the methods learned.

11. Read material that is informative regarding borderline personality disorder to gain knowledge about the condition. (15)

12. Cooperate with an assessment of and treatment plan for suicidal ideation and impulses. (16)

13. Verbalize a commitment to report urges to self-injure, and use coping strategies to avoid acting on impulses. (17)

14. Journal the daily level of self-abuse urges, negative and positive behaviors engaged in, and intensity of positive and negative emotions. (18, 19)

15. Refer the victim to books (e.g., *Lost in the Mirror: An Inside Look at Borderline Personality Disorder* by Moskovitz and *The Angry Heart: Overcoming Borderline and Addictive Disorders: An Interactive Self-Help Guide* by Santoro and Cohen) and Internet sources (e.g., www .psychcentral.com) that can provide information about borderline personality disorder.

16. Address the victim's suicidal ideation and gestures by asking him/her to agree to a contract for his/her safety. (See the Suicidal Ideation/ Attempt chapter in the Offender and Victim Issues part of this Planner.)

17. Teach the victim problem-solving strategies regarding coping with self-injury behavior and ideation. (See the Self-Injury chapter in the Victim Issues part of this Planner.)

18. Teach the victim how to label and regulate emotional states by giving homework exercises of journaling feelings, thoughts, and behavior. (See the "Emotional Regulation" handouts in *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

19. Teach the victim that he/she must learn to tolerate some emotional pain and recognize that it will ebb and flow.

15. Develop and implement a personal metaphor as a technique for coping with intense affect. (20)

16. Report increased confidence in own ability to manage affect through the use of cognitive-behavioral and distress tolerance strategies. (21, 22)

17. Implement effective social skills to improve relationships. (23, 24)

20. Help the victim to create a metaphor that has personal impact on how to deal effectively with intense emotions (e.g., emotions are like clouds passing by in the sky or a wave rolling by on the ocean; observe them; do not try to make them bigger or smaller or judge them, but accept them); encourage him/her to use this metaphor for coping with urges and feelings.

21. Teach the victim to use distress tolerance skills as an alternative way to find relief from intense affect. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

22. Assist the victim in developing a cue card to prompt himself/herself to focus on sensory experiences (e.g., What sounds do you hear? What colors do you see? What are the textures that you can feel that are within your reach?) as a way of living in the here and now. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

23. Teach the victim how to be respectful of others in interpersonal interactions.

24. Teach the victim social skills (e.g., using "I" messages, assertiveness, and eye contact). (See the Social Withdrawal chapter in the Victim Issues part of this Planner.)

18. Learn ways to self-soothe, concentrate on the here and now, and reduce distracting thoughts and evaluations. (22, 25, 26)

19. Attend and participate in group therapy focusing on borderline personality issues. (27, 28)

20. Identify triggers of dysfunctional behaviors, and develop strategies for constructively dealing with each trigger. (29)

22. Assist the victim in developing a cue card to prompt himself/herself to focus on sensory experiences (e.g., What sounds do you hear? What colors do you see? What are the textures that you can feel that are within your reach?) as a way of living in the here and now. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

25. Instruct the victim in mindfulness skills to assist him/her in balancing and regulating emotions. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

26. Help the victim accept himself/herself and reality without judgment by using positive cognitive affirmations and meditation.

27. Refer the victim to a weekly dialectical behavioral skills training group. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)

28. Review the lessons learned by the victim in the dialectical behavioral skills group; reinforce their use in his/her daily life.

29. Periodically reevaluate with the victim the triggers for the behaviors that continue to interfere with therapy; develop strategies to cope with these triggers.

21. Use telephone consultation to get encouragement from the therapist, limiting the time and topic discussion as directed by the treatment plan. (30)

22. Verbalize an acceptance of limits set by others without falling back on dysfunctional coping mechanisms. (31, 32)

23. Disclose incidents of abuse or neglect and the symptoms that have resulted from these traumas. (33)

24. Participate in community or religious organizations that offer opportunities for service to others. (34)

30. Set up a telephone consultation schedule in order to provide support to the victim to increase the likelihood of the generalization skills to daily living. Set a clear time and topic limits.

31. Inform the victim that a completely unconditional, therapeutic relationship is not possible and that limits must be set, that he/she has the ability to violate boundaries and exhibit behaviors that will result in the therapist rejecting him/her; point out situations where boundaries have been crossed, and work on specific skills that will result in more effective and appropriate behaviors.

32. Assign the victim to read material on setting and accepting personal boundaries. (See *Where to Draw the Line: How to Set Healthy Boundaries Every Day* by Katherine.)

33. Explore with the victim his/her history of sexual, physical, and emotional abuse, and address posttraumatic stress disorder (PTSD) symptoms. [See the Posttraumatic Stress Disorder (PTSD) chapter in the Victim Issues part of this Planner.)

34. Refer the victim to supportive organizations (e.g., religious, charitable, or social service organizations) that will continue to encourage him/her to live a happy existence/life through giving of himself/herself to help others, rather than focus totally on himself/herself.

__. _____ __. _____
_____ _____
__. _____ __. _____
_____ _____
__. _____ __. _____
_____ _____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
300.14	F44.81	Dissociative Identity Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
296.89	F31.81	Bipolar II Disorder
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

POSTTRAUMATIC STRESS DISORDER (PTSD)

BEHAVIORAL DEFINITIONS

1. Exposure to acts of sexual abuse/assault (along with physical or psychological abuse) directed toward the victim that resulted in an intense emotional response of fear, helplessness, or horror.
2. Intrusive, distressing thoughts or images or sensory flashbacks that relive the traumatic event.
3. Disturbing dreams associated with the sexual trauma.
4. A sense that the events are reoccurring, as in illusions or flashbacks.
5. Intense distress when exposed to reminders of the sexual abuse.
6. Physiological reactivity when exposed to internal or external cues that symbolize the abuse.
7. Avoidance of thoughts, feelings, or conversations about the sexual trauma.
8. Avoidance of activity, places, or people associated with the sexual trauma.
9. Inability to recall some important aspect of the sexual abuse.
10. Lack of interest and participation in significant life activities.
11. A sense of detachment from others.
12. Inability to experience the full range of emotions, including love.
13. A pessimistic, fatalistic attitude regarding the future.
14. Sleep disturbance.
15. Irritability.
16. Autonomic hyperarousal.
17. Lack of concentration.
18. Hypervigilance.
19. Exaggerated startle response.

20. Sad or guilty affect and other signs of depression.
21. Alcohol and/or drug abuse.
22. Suicidal thoughts.
23. A pattern of interpersonal conflict, especially in intimate relationships.
24. Verbally and/or physically violent threats or behavior.
25. Inability to maintain employment due to authority/coworker conflict or anxiety symptoms.
26. Symptoms have been present for more than one month.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Reduce the negative impact that the trauma of sexual abuse/assault has had on many aspects of life and improve functioning.
2. Develop and implement effective coping skills to carry out normal responsibilities and participate constructively in relationships.
3. Recall the sexual trauma events without becoming overwhelmed with negative emotions.
4. Terminate the destructive behaviors that serve to maintain escape and denial while implementing behaviors that promote healing, acceptance of the past events, and responsible living.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Cooperate with and complete psychological testing to help evaluate trauma symptoms. (1)	1. Administer or refer for administration of psychological testing to assess for the presence and strength of PTSD symptoms [e.g., Minnesota Multiphasic Personality Inventory—2 (MMPI-2); Impact of Events Scale; Clinician Administered PTSD Scales—I (CAPS-I); Trauma Symptom Checklist; Posttraumatic Cognitions Inventory (PTCI)].
2. Describe the signs and symptoms of PTSD that are experienced and how they interfere with daily living. (2, 3)	2. Ask the victim to identify how the sexual trauma has negatively impacted his/her life. 3. Ask the victim to list and then rank the order of the strength of his/her symptoms of PTSD.
3. Identify negative coping strategies that have been used to cope with the feelings associated with the trauma. (4)	4. Evaluate with the victim what negative coping strategies he/she has used in dealing with PTSD symptoms (e.g., substance abuse, anger outbursts, social isolation, avoidance of any reminder or thoughts of the abuse).
4. Identify internal and external stimuli that trigger PTSD symptoms. (5, 6, 7)	5. Ask the victim to identify what parts of his/her conscious memories are the most distressing and act as triggers for stress symptoms. 6. Assign the victim to list what environmental stimuli evoke the most the most distressing symptoms; suggest that he/she keep a journal of instances of stress being triggered.

	7. Assign the victim to identify triggers to feelings that are associated with the sexual trauma by completing exercises in the *Surviving Childhood Sexual Abuse Workbook* (Ainscough and Toon); process the material that is produced.
5. Verbalize an acceptance that trauma symptoms are common and can originate in abusive childhood experiences. (8, 9)	8. Explain to the victim that PTSD symptoms (e.g., autonomic hyperarousal and intrusive memories) are part of the normal coping process that occurs with any traumatic abnormal event.
	9. Explain to the victim that exposure to prolonged early trauma (e.g., childhood sexual abuse) may result in brain and hormonal changes that can lead to difficulties with memory, learning, emotional regulation, poor impulse control or depression that carry on into adulthood.
6. Verbalize an understanding of the fact that recurring memories of trauma rarely cease completely and that coping with them is a lifelong process. (10, 11)	10. Help the victim to accept that healing from trauma is not the same as forgetting and that memories of the abuse will wax and wane over his/her life.
	11. Encourage the victim to accept that sexual trauma memories will not be erased as the result of therapy; however, life can become manageable.
7. Acknowledge that healing from PTSD is a gradual process. (12, 13)	12. Outline the treatment process to the victim, explaining that it will include a gradual processing of the details and feelings associated with the trauma and developing new, more appropriate coping strategies.

13. Educate the victim as to the origins of PTSD, common symptoms, and how it affects abuse survivors.

8. Verbalize the strong emotions that are associated with the sexual trauma. (14)

14. Explore the victim's strong feelings (e.g., shame, guilt, and anger), which are common feelings for abuse and other trauma survivors.

9. Describe any signs and symptoms of dissociation that are experienced. (15)

15. Assess whether the victim experiences dissociative symptoms (e.g., flashbacks, memory loss, identity disorder), and treat or refer for treatment. (See the Dissociation chapter in the Victim Issues part of this Planner.)

10. Cooperate with the eye movement desensitization and reprocessing (EMDR) technique to reduce emotional reaction to the traumatic event. (16)

16. Use the EMDR technique to reduce emotional reactivity.

11. Identify coping strategies to deal with trauma memories and the associated emotional reaction. (17)

17. Teach the victim coping strategies (e.g., writing down thoughts and feelings in a journal; taking deep, slow breaths; calling a support person to talk about memories) to deal with trauma memories and sudden emotional reactions without becoming emotionally numb or feeling overwhelmed and out of control.

12. Cooperate with a medication evaluation by accurately reporting suicidal ideation, depression, anxiety, or disruptive emotional symptoms, if present. (18)

18. Refer the victim to a psychiatrist for a consultation regarding medication management of symptoms.

13. Follow a medication regimen as recommended by the physician, and report any side effects that are experienced. (19)

19. Process with the victim the results of the psychiatric evaluation and medication recommendations; encourage

him/her to comply with these recommendations and report any side effects as they occur.

14. Participate in developing a concrete plan for increasing social contacts in order to form a social support network. (20, 21, 22)

20. Encourage the victim to slowly increase interpersonal contacts with supportive family members and significant others who were not responsible for the sexual trauma.

21. Encourage the victim to slowly increase overall social contacts, decreasing isolation from others in general; devise a plan and list of such contacts.

22. Assist the victim in identifying a support system of people with whom he/she can talk when feeling overwhelmed.

15. Reduce the amount and frequency of using mood-altering substances. (23)

23. Teach the victim how to manage urges to use alcohol or drugs when feeling overwhelmed by flashbacks (e.g., attend a 12-step meeting, call a sponsor, engage in exercise).

16. Comply with an evaluation and treatment for chemical dependency. (24)

24. Assess the depth of the victim's substance abuse pattern; refer or treat the victim for chemical dependence. (See the Substance Abuse chapter in the Offender and Victim Issues part of this Planner.)

17. Participate in a desensitization procedure in which gradual exposure to nonharmful stimuli that are associated with the abuse is initiated. (25, 26)

25. Use a systemic desensitization procedure to gradually expose the victim to nonharmful stimuli that are associated with the sexual abuse.

18. Practice relaxation methods that do not increase the physical sensations associated with the abuse. (27)

19. Make a list of 20 distracting techniques, and practice using them when feelings become overwhelming. (28)

20. Verbalize an increased sense of mastery over PTSD symptoms by using a number of techniques to cope with flashbacks, decrease the power of triggers, and decrease negative thinking. (29, 30, 31, 32)

26. Help the victim to challenge thoughts that something horrible will happen if he/she experiences a flashback while participating in the desensitization procedure; focus him/her on more positive coping thoughts.

27. Teach the victim a relaxation or calming technique (e.g., meditation, yoga, deep breathing techniques, prayer, and progressive relaxation) that he/she can institute as a daily ritual.

28. Assist the victim in listing 20 ways that he/she could distract himself/herself (e.g., take a warm bath, listen to soothing music, sing a song or church hymn) when flashbacks or feelings become intense.

29. Increase the victim's confidence in coping with PTSD symptoms by assigning him/her to list at least two positive actions or small successes daily in a journal; process these success experiences.

30. Assist the victim in retelling abuse experiences to a therapist and to significant others in sessions as a means of gaining a feeling of mastery over PTSD.

31. Assign the victim to read about other trauma survivors (e.g., holocaust victims or war veterans) and some of the coping strategies they use. (See *The Color Purple* by Walker and *When Bad Things Happen to Good People* by Kushner.)

32. Assign the victim to write a list of positive affirmations (e.g., "I love and accept myself more and more each day"; "I will overcome this trauma and become a strong survivor"; recite a short, positive verse from the Bible or other spiritual writing), put the list up at home, and read them at least once per day.

21. Articulate in writing a stress inoculation plan for coping with environmental stressors. (33)

33. Assist the victim in developing a stress-hardy lifestyle to include critical elements (e.g., seeing stressors, such as holidays, school exams, or visits from relatives, as challenges and opportunities; daily reviewing his/her commitment to family, home, and personal growth; exercising regularly) and eating nutritious meals.

22. Implement the use of physical exercise on a daily basis in order to reduce PTSD symptoms and increase the sense of control and mastery over the body. (34)

34. Help the victim to start participating in a physical program (e.g., exercise or dance) where he/she can feel more competent and more in control of his/her body.

23. Increase involvement in positive, pleasurable activities. (35)

35. Explore with the victim his/her interests in cultural, artistic, or athletic activities; list those activities in which he/she can commit to increasing his/her involvement.

24. Increase involvement in community service activities on a volunteer basis. (36)

36. Encourage the victim to become involved in creative outlets by giving something back to the community, as opposed to a life script of avoiding triggering stimuli.

25. Join a support group with other abuse survivors, and commit to a six-month attendance. (37)

37. Encourage the victim to join a sexual abuse or sexual trauma support group.

__. _____ .__. _____
_____ _____
__. _____ __. _____
_____ _____
__. _____ __. _____
_____ _____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
309.81	F43.10	Posttraumatic Stress Disorder
300.14	F44.81	Dissociative Identity Disorder
300.15	F44.9	Unspecified Dissociative Disorder
300.15	F44.89	Other Specified Dissociative Disorder
309.0	F43.21	Adjustment Disorder, With Depressed Mood
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical

V62.83	Z69.82	Encounter for Mental Health Services for Perpetrator of Nonspousal Adult Abuse
308.3	F43.0	Acute Stress Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

SELF-BLAME

BEHAVIORAL DEFINITIONS

1. Chronic and recurrent thoughts of blaming self for the sexual abuse/trauma.
2. Feelings of inappropriate guilt and shame; viewing self as damaged goods.
3. Persistent feelings of being alone and isolated.
4. Chronic feelings of hopelessness, worthlessness, or inappropriate guilt.
5. Low self-esteem.
6. Avoids social relationships because of deep-seated sense of shame about self.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Decrease attribution of blame to self as having caused or having any responsibility for the abuse/assault.
2. Place responsibility for the offense on the offender.
3. Identify and restructure belief system and decrease primary identification with the abuse, with the abuse becoming a part, rather than the entirety, of personal life experiences.

4. Improve emotional functioning based on the abuse being only a part of history rather than a total focus of life.
5. Develop healthy cognitive patterns and beliefs leading to increased hopefulness, empowerment, and increased self-esteem.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Verbalize thoughts and feelings surrounding the sexual abuse. (1, 2, 3)

2. Eliminate self-blame statements when talking about the abuse, and place blame on the offender. (4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Explore the victim's incidents of sexual abuse victimization, allowing him/her to disclose only as much detail as he/she is comfortable with.
2. Monitor the victim's self-blame statements as he/she talks about the sexual abuse; gently highlight this self-blame when it occurs.
3. Assist the victim in identifying the themes of shame and guilt that occur in his/her daily thinking about the assault.
4. Have the victim practice verbalizations that assign blame to the offender for the sexual assault; use modeling to reframe self-blame statements.

	5. Assist the victim in identifying his/her cognitive distortions that underlie the self-blame (e.g., "I was probably too friendly"; "I should have resisted more"; or "I am a bad person").
	6. Help the victim to put responsibility on the offender for the sexual trauma by assignment of reading *The Courage to Heal* (Bass and Davis).
3. Express feelings of powerlessness and anger surrounding the abuse experience. (7)	7. Express empathy to the victim about his/her feelings of anger and powerlessness regarding the traumatic sexual abuse.
4. Verbalize an increased knowledge of how the perpetrator used manipulation before, during, and after the abuse to influence the attribution of the crime. (8)	8. Teach the victim about manipulation and cognitive distortions used by sexual offenders in order to deny responsibility for the abuse (e.g., minimizing, blaming the victim, denial).
5. Verbalize an understanding of the different forms that sexual abuse takes. (9)	9. Clarify for the victim the different types of abuse and that sexual abuse does not always mean physical contact (e.g., exposing genitals, showing the victim pornography, masturbating in front of the victim).
6. Express acceptance of the fact that by placing responsibility on the offender, feelings of anger and rage may increase. (10, 11)	10. Teach the victim that being angry with the perpetrator may be an essential part of the process of recovery and healing as blame is clearly placed on the offender.

7. Read material that is informative regarding the feelings of self-blame and manipulation. (12)

8. Write a confrontational letter to the abuser to clarify that the abuser is responsible for the offense. (13)

9. Process a victim clarification letter from the abuser in which the offender clearly accepts the blame for the sexual abuse. (14, 15, 16)

11. Teach the victim specific strategies to deal with his/her anger toward the offender. (See the Anger Difficulties chapter in the Victim Issues part of this Planner.)

12. Have the victim read material regarding anger and self-blame (e.g., *When Bad Things Happen to Good People* by Kushner and the *Surviving Childhood Sexual Abuse Workbook* by Ainscough and Toon).

13. Assign the victim to write a letter (unsent) to the offender regarding feelings about abuse; critique the letter about appropriately assigning blame to the offender for abuse/assault.

14. Evaluate the emotional stability of the victim to see if he/she is ready to read the victim clarification letter from the offender. (See the Denial chapter in the Offender Issues part of this Planner.)

15. Review the victim clarification letter from the offender before allowing the victim to read it to evaluate for manipulation, cognitive distortions, and denial.

16. Ask the victim read the victim clarification letter; process his/her feelings, evaluating for emotional stability and need for support.

10. Verbalize an understanding that while guilt may be a signal to evaluate a specific behavior, global shame about self as a person is destructive to self-esteem. (17, 18)

11. Identify distorted automatic thoughts that underlie shame in situations not related to the sexual abuse. (19)

12. Ask others for their views on when guilt and shame are warranted. (20)

13. Identify and replace dysfunctional thoughts about the abuse/assault that result in acceptance that the abuse was deserved or somehow a punishment for sin. (21, 22)

17. Assign the victim to read material regarding recovery from shame (e.g., *Healing the Shame That Binds You* by Bradshaw or *Shame* by Kaufman); process key concepts with him/her.

18. Obtain a detailed family history that examines the role of the family of origin in teaching the victim attitudes regarding guilt and shame.

19. Probe the victim's distorted automatic thoughts that trigger shame in different situations apart from the sexual abuse (e.g., when making mistakes, being assertive, asking for help); replace his/her distorted thoughts with positive, realistic self-talk.

20. Assign the victim to initiate three discussions with other people over a week regarding their views on the topic of when it is appropriate to feel guilt; process the insights that are gained from these discussions.

21. Ask the victim to keep a daily record of thoughts that are associated with shame and guilt, particularly noting those that are associated with deserving punishment and committing a sin.

22. Use logic and reality to challenge each dysfunctional assumption regarding having committed a sin or deserving punishment, replacing it with a realistic assumption.

14. Report improved self-esteem due to decreasing guilt and shame thoughts and increasing positive thoughts about self. (23, 24, 25)

23. Assist the victim in identifying and listing positive traits about himself/herself.

24. Use specific cognitive strategies to build self-esteem (e.g., ask the victim to express positive statements about himself/herself in front of a mirror daily; teach the victim to challenge negative self-talk).

25. Assign the victim to read *Feeling Good: The New Mood Therapy* (Burns) and to discuss with the therapist how thoughts impact feelings.

15. List reasons why the offender is responsible for the abuse/assault. (26)

26. Assist the victim in listing the reasons why the offender is solely responsible for the sexual abuse (e.g., use of force, use of position of power, victim was under the age of consent).

16. List the ways that the offender possessed power over the victim. (27, 28)

27. Discuss ways the offender had power over the victim (e.g., the offender was larger or stronger that the victim; the offender was in a position of authority over the victim; the offender was an adult, and the victim was a child).

28. Address issues of powerlessness and hopelessness regarding the abuse and how it impacts current life.

17. Describe the perceived and anticipated negative consequences of reporting the abuse to the authorities. (29)

29. Assist the victim in understanding the reasons victims don't tell about the abuse (e.g., fear of retaliation, fear of physical harm, fear of family breakup); compare these reasons with his/her experience.

18. Verbalize an understanding that the sexual arousal experienced during the abuse does not mean the abuse was desired. (30)

30. Help the victim to understand that genital stimulation can cause sexual arousal during abuse in childhood, but that does not mean that he/she was responsible for the abuse or desired it.

19. Verbalize a decrease in shame and guilt regarding experiencing sexual arousal as a natural consequence to genital stimulation, even during abuse. (31)

31. Assist the victim in identifying his/her cognitive distortions that result in guilt feelings and shame about enjoying the attention or sexual arousal associated with the abuse (e.g., "It must have been my fault because my body was aroused"; "I could have fought back harder"; "There must have been something I could have done to stop it").

20. Identify how an abuser can manipulate an emotionally needy victim into initiating the abuse. (32)

32. Assist the victim in understanding how low self-esteem and the need for attention or nurturance could be manipulated by distorted messages from the offender and lead to a victim seeking out or even inciting the abuse.

21. Use art to express feelings about the abuse. (33)

33. Use art (along with other creative and expressive methods) to encourage the victim to depict himself/herself being assertive with the abuser, reclaiming power, and assertively blaming the offender.

22. Verbalize an understanding that recovery from abuse/assault proceeds in stages, as in the grieving process for the loss of a loved one. (34, 35)

23. Participate in dance, movement, music, or art therapy as a means of feeling freer, less anxious, self-conscious, and inhibited. (36)

24. List constructive strategies for dealing with the recurrence of distorted cognitions regarding guilt, shame, and attribution of blame for the abuse. (37, 38)

34. Teach the victim the stages of the grieving process, and point out that the process of recovering from sexual trauma is similar to the stages of recovering from the loss of a loved one (e.g., denial, bargaining, anger).

35. Assign the victim to read material on grief and recovery. (See *On Death and Dying* by Kubler-Ross, *When Bad Things Happen to Good People* by Kushner, or *Good Grief* by Westberg.)

36. Recommend that the victim become involved in supporting therapies (e.g., art, dance, music, and movement therapy).

37. Help the victim to identify abuse as in the past, and restructure his/her belief system to help facilitate this.

38. Teach the victim that periodic recurrences of shame, guilt, and anger will recur and assist him/her in listing coping strategies to use at that time [e.g., repeating positive affirmations about himself/herself; reading a book about victimization, such as *The Courage to Heal* (Bass and Davis); attending a victim support group].

__. _____ .__. _____

_____ _____

__. _____ __. _____

_____ _____

__. _____ __. _____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
309.81	F43.10	Posttraumatic Stress Disorder
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.9	Unspecified Dissociative Disorder
300.15	F44.89	Other Specified Dissociative Disorder
309.0	F43.21	Adjustment Disorder, With Depressed Mood
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
V62.83	Z69.82	Encounter for Mental Health Services for Perpetrator of Nonspousal Adult Abuse
308.3	F43.0	Acute Stress Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

SELF-INJURY

BEHAVIORAL DEFINITIONS

1. Consistent pattern of burning, cutting, scraping flesh, hitting, or bruising self.
2. Uses self-injury to reduce negative affect.
3. Repeated pattern of self-mutilation despite negative physical consequences.
4. Extreme emotional reactivity (e.g., anger, anxiety, or depression) under minor stress that usually does not last more than a few hours to a few days.
5. Chronic feelings of emptiness and boredom.
6. A pattern of intense, chaotic interpersonal relationships.
7. Easily feels that others are treating him/her unfairly or that they can't be trusted.
8. Marked identity disturbance.
9. Becomes very anxious with any hint of perceived abandonment in a relationship.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Break the cycle of self-abuse.
2. Decrease the frequency of urges to engage in self-mutilation.

3. Develop adaptive methods to reduce high levels of negative affect rather than using self-damaging behavior.
4. Identify the triggers for self-harm, and develop a safety plan.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Describe details of when and how self-injury first began. (1, 2)
2. Rate the intensity of the urge to self-injure by using a 10-point Likert scale, noting how the intensity rises and falls during the day. (3)
3. Identify high-risk times and circumstances when the urge to self-injure is greatest. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Explore with the victim the history of his/her self-injury behavior.
2. Ask the victim to make a list of all the ways that he/she has self-injured, including less obvious methods (e.g., picking at scabs or pulling hair out).
3. Show the victim how to use a journal or log book to record the intensity of the urge to self-injure, and practice rating the urge in session using a 10-point Likert scale with defined anchor points.
4. Review the victim's self-injury journal to identify times when the urge to self-injure is high, and determine if it relates to meals, sleep deprivation, time of day, or other factors.

5. Review the victim's self-injury journal to identify triggers of self-injury (e.g., thoughts of being bad, need to be in control, perfectionism, turning anger inward, feelings of worthlessness, self-hatred, abandonment).

4. Identify the negative consequences of self-injury. (6)

6. Assign the victim to make a list of all the ways self-injury has made a negative impact on his/her life (e.g., social, medical, occupational, emotional); process the list.

5. Get feedback from significant others regarding their feelings and thoughts about the self-injury behavior. (7)

7. Assign the victim the task of asking significant others how they feel about his/her self-injury; process these responses in session.

6. Identify distorted thoughts associated with the cycle of self-abuse, and correct thinking errors. (8, 9, 10)

8. Assist the victim in identifying his/her thoughts that precede self-injury behavior, and challenge these thoughts.

9. Examine the victim's distorted cognitions that accompany self-injury (e.g., "It's the only way I can feel better; I have no idea why I cut myself . . . I can't control it"); teach adaptive, positive thoughts to replace distortions.

10. Ask the victim to list his/her fears of imagined consequences (e.g., fear of being overwhelmed by emotions, fear of being out of control, fear of having no way to express himself/herself) if he/she stops self-injuring; process this list in session.

7. Describe experiences of sexual and other abuse and the feelings associated with these painful memories. (11, 12)

11. Help the victim to understand how self-injury may serve the purpose of distracting him/her from painful memories of abuse by exploring abuse memories in session and verbalizing associated feelings.

12. Use modeling and role play to teach the victim appropriate ways to express his/her feelings, the expression of which may have been punished in childhood.

8. Accurately identify feelings that precede or lead to the urge to self-injure. (12, 13, 14)

12. Use modeling and role play to teach the victim appropriate ways to express his/her feelings, the expression of which may have been punished in childhood.

13. Give the victim a printed sheet of words that describe many feelings to help him/her identify feelings (see *Skills Training for Children with Behavior Disorders* by Bloomquist); practice using this cue sheet in session.

14. Help the victim to learn to outline the thoughts and feelings that precede a self-injury incident, and assign him/her to record these in a self-injury journal.

9. List instances where self-injury has functioned to distract from emotionally disturbing memories of abuse. (11, 15)

11. Help the victim to understand how self-injury may serve the purpose of distracting him/her from painful memories of abuse by exploring abuse memories in session and verbalizing associated feelings.

15. Help the victim to understand that self-injury may serve the purpose of distracting him/her from painful memories of abuse by identifying specific abuse stimuli that increase negative affect (e.g., the smell of beer, watching a violent television program, experiencing feelings of sexual arousal).

10. Implement adaptive techniques to cope with uncomfortable negative feelings that are associated with painful experiences. (16, 17)

16. Teach the victim ways to cope with uncomfortable feelings other than self-injury (e.g., practicing assertive behaviors, implementing relaxation techniques).

17. Teach the victim alternative methods to stop his/her intrusive memories and flashbacks, and to refocus on the present (e.g., deep breathing techniques, deep muscle relaxation, positive memory insertion, thought-stopping techniques).

11. Gain information about self-injury by reading books or Internet sources. (18)

18. Refer the victim to information in books on self-injury (e.g., *Women Who Hurt Themselves: A Book of Hope and Understanding* by Miller; *Bodily Harm: The Breakthrough Healing Program for Self-Injurers* by Contario, Lader, and Kingson; *Understanding Self-Injury: A Workbook for Adults* by Trautman and Connors) and Internet self-injury informational message boards or web sites (e.g., www.safe-alternatives.com or www.healthyplace.com).

12. Use specific behavioral and cognitive techniques that decrease the urge to self-injure. (19, 20, 21, 22)

19. Assist the victim in listing 10 alternatives to self-injury when the urge is high (e.g., call a support person and talk about the urge; take a warm bath; draw a picture of current feelings using many vivid colors).

20. Identify and challenge the victim's thoughts that fuel escalation of self-injury urges, and teach him/her to focus instead on calm-ing thoughts and deep breathing.

21. Suggest that the victim implement constructive activities as substitute actions for self-injury (e.g., scrubbing the floor with a brush, sweeping the sidewalk, or walking very fast).

22. Assist the victim in making a list of actions to use specifically when angry or frustrated, that in some way substitute for the action of self-injury (e.g., hitting a punching bag, drawing on a piece of paper with a red marker, tearing paper into little pieces, stomping and yelling, throwing nonbreakable objects at a brick wall).

13. Verbalize positive statements about self when observing even small decreases in self-injury behavior. (23)

23. Encourage the victim to verbalize positive statements about himself/herself even when small gains are made (e.g., not self-injuring for 24 hours).

14. List the benefits of stopping self-injury. (24)

24. Assist the victim in listing the positive aspects of stopping self-injury (e.g., decreased risk for infection, increased self-esteem, decreased conflict with significant others because of self-inflicted injuries).

15. When experiencing urges to self-injure, practice delay techniques. (25, 26)

16. Use sensory stimulation techniques to decrease the desire to self-injure. (27)

17. Develop a written plan of increasing social contacts to help decrease the urge to self-injure. (28, 29, 30)

18. Develop a written procedure regarding how to get appropriate medical care for self-injury wounds. (31)

25. Assign the victim to use a delay task using cognitive-behavioral techniques (e.g., thought stopping or reframing) when experiencing an urge to self-injure.

26. Have the victim set a few-minute time limit using an alarm clock to delay self-injury and note how the intensity of the urge changes.

27. Assist the victim in listing 10 distracting things to do that are intensely stimulating to one of the senses instead of engaging in self-injury (e.g., chewing on ice, smelling different strong spices such as ginger or mint, listening to loud music, taking a cold shower).

28. Assist the victim in listing a support network of people who know about the self-injury and who will be supportive when the urge to self-injure is strong.

29. Reinforce and encourage the victim to have emotional needs met by more direct means of communication rather than using self-injury; use role playing and modeling to teach him/her how to make direct requests to significant others.

30. Assign the victim to tell someone about the self-injury who previously was unaware of it; process the feelings in session.

31. Help the victim to develop a plan to access medical care through an emergency room, urgent care center, or primary

care physician, so that he/she can have wounds treated with dignity and in a supportive environment.

19. Write a letter to the physician outlining the safety plan and self-care contract. (32, 33)

32. Develop a contract with the victim that he/she will seek medical attention within a specific time limit (as recommended by the physician) if he/she self-injures.

33. Ask the victim to write a letter regarding a safety plan and self-care contract to medical professionals; review this letter in session.

20. List ways to cope with scars from self-injury. (34, 35)

34. Assist the victim in listing 10 ways to decrease anxiety and shame regarding scars from self-injury (e.g., consulting with a plastic surgeon, using a concealing makeup such as Dermablend, wearing long sleeves).

35. Teach the victim alternative assertive and/or humorous ways to respond to people who ask about the self-injury scars (e.g., "I'd rather not talk about it"; "What scars?").

21. Consult with a psychiatrist for a medication evaluation, and comply with the recommendations. (36)

36. Refer the victim for a medication evaluation to remediate mood instability or anxiety and to help decrease his/her self-injury urge.

22. Take medications as prescribed, and report any side effects to appropriate professionals. (37)

37. Monitor medication compliance, side effects, and effectiveness. Confer with the physician regularly.

23. Contract with the therapist to agree to an evaluation for inpatient hospitalization if the urge to self-injure becomes uncontrollable. (38)

24. Participating as a team member, agree to cooperate with medical and psychiatric professionals in order to promote a decrease in self-injury. (39)

38. Develop a specific written plan for hospitalization if the threat of self-injury is severe, and ask the victim to sign an agreement to the plan.

39. Manage self-injury with a team, including, if possible, a psychiatrist, a primary care physician, a group therapist and individual therapist, and the victim.

__. _____

__. _____

__. _____

__. _____

__. _____

__. _____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
309.81	F43.10	Posttraumatic Stress Disorder
301.83	F60.3	Borderline Personality Disorder
300.14	F44.81	Dissociative Identity Disorder
300.15	F44.89	Other Specified Dissociative Disorder
300.15	F44.9	Unspecified Dissociative Disorder
_____	_____	_____
_____	_____	_____

SOCIAL WITHDRAWAL

BEHAVIORAL DEFINITIONS

1. Avoidance of activities with others because of anxiety, fear, shame, mistrust, or feelings of inadequacy.
2. Excessive and persistent worry about interacting with others in a social environment.
3. Overall pattern of social anxiety, shyness, or timidity that presents itself in most social situations.
4. Isolation or involvement in solitary activities during most waking hours.
5. Symptoms of hypervigilance, such as being constantly on edge when with people.
6. Strong feelings of panic or fear, such as increased heart rate, sweating, muscle tension, and shakiness when faced with social interactions.
7. Abuse of alcohol or chemicals to help avoid or ease the anxiety of becoming involved in social situations.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Interact socially without excessive fear or anxiety.
2. Develop the essential social skills that will enhance the quality of a relationship life.
3. Develop the ability to form relationships and to attend group functions that will enhance sexual trauma recovery support system.

4. Reach a healthy personal balance between solitary time and interpersonal interaction with others.
5. Terminate the use of alcohol or chemicals to relieve social anxiety and implement constructive coping behaviors.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Identify socially avoidant behaviors that are engaged in as the result of shame, anxiety, fear, low self-esteem, and so forth. (1, 2)

2. Identify the connection between family-of-origin experiences and current interpersonal functioning. (3)

3. Identify the impact that the sexual abuse/trauma has had on social interactions. (4)

THERAPEUTIC INTERVENTIONS

1. Assist the victim in coming to the realization that he/she is withdrawn from others because of negative affect (e.g., fear, anxiety, guilt, or shame) and distorted cognitions that precipitate those feelings.
2. Engage in building rapport by expressing empathy for the victim's feelings of isolation and anxiety.
3. Probe the victim's childhood experiences of criticism, perfectionism, or patterns of family social avoidance or anxiety that would fos-ter his/her current social withdrawal.
4. Ask the victim to describe the change in himself/herself since the sexual assault, clarifying how sexual abuse influenced self-image and how that impacts socializing with others.

4. Replace distorted, negative cognitions related to sexual abuse with more realistic, positive self-talk. (5, 6)	5. Assist the victim in identifying internal thought processes that impact self-esteem, listing negative thoughts about himself/herself that originated with the sexual abuse. 6. Apply logical reasoning to replace each of the victim's distorted assumptions about himself/herself with more realistic, positive self-talk.
5. Comply with recommendations for psychological testing. (7)	7. Refer for or administer psychological testing to assess social anxiety, general anxiety, self-esteem, and/or depression [e.g., Leibowitz Social Anxiety Scale, Social Phobia Inventory, Beck Depression Inventory (BDI), or Minnesota Multiphasic Personality Inventory—2 (MMPI-2)]; give feedback of results and target areas for intervention.
6. Cooperate with and complete a psychiatric evaluation. (8)	8. Refer the victim to a psychiatrist for a psychotropic medication evaluation.
7. Take medication as ordered on a consistent basis, reporting effectiveness and any side effects to the physician. (9)	9. Monitor the victim's medication effectiveness and side effects, and encourage compliance with the prescription.
8. Identify situations that lead to social discomfort by a daily journal notation of cognitions and feelings. (6, 10, 11)	6. Apply logical reasoning to replace each of the victim's distorted assumptions about himself/herself with more realistic, positive self-talk. 10. Ask the victim to keep a daily feelings journal in which he/she documents situations that result in fear, shame, anxiety, and withdrawal from socializing.

	11. Challenge the victim's distorted cognitions that lead to feelings of shame, hopelessness, and inferiority by probing with questions designed to have the victim produce evidence of the anxiety and logical reasons for it being present. (See *Anxiety Disorders and Phobias* by Beck and Emery.)
9. Report an increased understanding of how distorted cognitions regarding assignment of blame to the victim lead to negative affect and low self-esteem. (12, 13)	12. Assign the victim to read *The Courage to Heal* (Bass and Davis), and process key ideas regarding his/her tendency to blame himself/herself.
	13. Explore the victim's tendency to blame himself/herself for the sexual assault; replace the cognitive distortions that precipitate that feeling of self-blame.
10. Use relaxation methods to decrease anxiety and improve ability to calm self in social situations. (14)	14. Teach the victim relaxation methods used to cope with anxiety associated with social interaction (e.g., progressive muscle relaxation, deep breathing techniques, self-hypnosis, positive guided imagery).
11. Replace the cognitive distortions used to deny needs for interpersonal interaction. (15)	15. Process with the victim his/her fears of intimacy, and his/her anxiety about close relationships to others; correct cognitive distortions that feed this fear. (See the Trust Impairment chapter in the Victim Issues part of this Planner.)
12. Report an increase in the use of assertiveness skills. (16, 17)	16. Use role playing and modeling to teach the victim about the difference between aggressive, passive, and assertive behavior,

and how to use assertiveness to solve problems in relationships (e.g., how to say no to a request from another person, how to discuss feelings with friends, how to discuss anger).

17. Assign the victim to attend assertiveness training classes as a way of improving social skills.

13. Use desensitization techniques to overcome any persistent and unreasonable fear of social situations that leads to an intense anxiety reaction and subsequent social avoidance. (18)

18. Assist the victim in developing an exposure hierarchy to be used in vivo to desensitize himself/herself to anxiety-producing stimuli; ask him/her to track progress by keeping a daily journal.

14. Verbalize an understanding that the feelings of social anxiety result from irrational self-talk and that the phobic avoidance of social situations functions as an escape from feeling out of control and uncomfortable. (19, 20)

19. Assign the victim to read books on overcoming social anxiety (e.g., *Mastery of Your Anxiety and Panic* by Barlow and Craske or *Dying of Embarrassment: Help for Social Anxiety and Phobia* by Carmin, Pollard, and Flynn); process key concepts.

20. Teach the victim that feelings of social anxiety result from irrational self-talk and that the anxiety feelings lead to avoidance or escape behaviors.

15. Verbalize an increased feeling of confidence in and approval of self. (21, 22)

21. Assist the victim in establishing a goal to reduce the power that anxiety has over his/her life by learning how to reduce his/her fear of social disapproval by reducing his/her disapproval of himself/herself.

22. Encourage the victim to verbalize positive beliefs about himself/herself, practicing once daily while looking in the mirror.

16. Report an increased tolerance for accepting self when making small mistakes in front of others. (23, 24, 25, 26, 27)

23. Have the victim keep a daily journal and plot thoughts, occurrences, and level of anxiety at regular intervals on a 10-point Likert scale. Discuss antecedent cognitions (e.g., perfectionism) that lead to an increase in anxiety levels in social situations.

24. Encourage the victim to record the small mistakes that he/she makes on a daily basis and monitor the cognitions that occur as a result of each mistake.

25. Support the victim when he/she reports increased tolerance for himself/herself when he/she makes mistakes.

26. Explore more adaptive cognitions (e.g., "Everybody makes mistakes"; "It's okay to make mistakes"; "I'm doing fine") to employ as self-talk in social situations when faced with anxiety symptoms (e.g., rapid heart rate, increased sweating, urge to run out of the room), based in perfectionism.

27. Use paradoxical strategy and assign the victim to deliberately make a small mistake in a social situation (e.g., wear a slightly mismatching outfit to a social function; exit a crowded row in a theater during a movie; accidentally spill water on himself/herself at a social function); process these feelings with him/her, and identify negative cognitions about himself/herself.

17. Increase social interactions with others who have survived sexual abuse/trauma. (28)

18. Increase social group activities to at least two per week. (29, 30)

19. Attend a sexual abuse survivors group. (31)

20. Implement the use of guided visualization of success in social situations. (32)

21. Participate in a weekend activity with other people. (33)

28. Encourage and support the victim to have contact with other supportive survivors of sexual trauma (e.g., support meetings, group therapy, Internet message boards).

29. Ask the victim to list activities in which he/she would enjoy engaging that included others (e.g., sports, hobbies, religious worship); solicit a commitment from him/her to engage in two such activities per week.

30. Review the victim's experience with social activity participation; reinforce success, and redirect to reduce anxiety using behavioral and cognitive techniques.

31. Refer the victim to interpersonal groups that could offer support for healing from abuse/trauma (e.g., Survivors of Incest Anonymous, Incest Survivors Anonymous, Families United).

32. Lead the victim in a guided visualization in which he/she views himself/herself as being successful in social situations, and ask him/her to practice this visualization daily.

33. Assign the victim to join others in a group activity that lasts for one or two days (e.g., a camping trip organized by the Sierra Club, a weekend trip to visit a museum, a weekend CPR class); process feelings and thoughts about being with others.

22. Develop a life plan that includes a commitment to meeting social needs balanced with time alone. (34, 35)

34. Explore with the victim balancing social and individual time in a way that would result in a satisfying, fulfilled life. Reinforce the victim for interacting with others even when anxiety accompanies socialization.

35. Ask the victim to verbalize a commitment to a lifelong plan of increasing social confidence and comfort, and decreasing social anxiety.

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.22	F40.00	Agoraphobia
300.01	F41.0	Panic Disorder
309.81	F43.10	Posttraumatic Stress Disorder
301.82	F60.6	Avoidant Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
_____	_____	_____
_____	_____	_____

TRUST IMPAIRMENT

BEHAVIORAL DEFINITIONS

1. Consistent distrust of others.
2. Expectation of being exploited or harmed by others.
3. Expectation of being shunned by others because of shame regarding the sexual trauma.
4. Tends to be socially and emotionally isolated out of fear of being hurt.
5. Avoidance of emotional intimacy with others leads to a pattern of superficial relationships.
6. Lacks a positive support network.
7. Excessive involvement in activities (e.g., work, hobbies) that allows for avoidance of closeness with others.
8. Difficulties in judging the trustworthiness of others.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Interact with others with reduced vigilance, decreased defensiveness, and increased trust.
2. Develop emotionally supportive close friends.
3. Increase social interaction with trustworthy others.
4. Gradually take the risk of building an intimate relationship with a trustworthy partner.

5. Develop a cognitive strategy for judging others' and own behavior for impediments to intimacy such as untrustworthy behaviors.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Describe the history of difficulties experienced with respect to trust and the impact on relationships. (1, 2, 3)

2. Identify fears that lead to social and emotional isolation. (4)

3. Verbalize an increased awareness of feelings of shame and the role that shame plays in relationships. (5, 6)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the victim's feelings of fear and anxiety regarding trusting others.
2. Probe family-of-origin history for sources of difficulties with intimacy and negative learned attitudes about relationships.
3. Explore how the victim's reasons for avoiding intimacy are related to the sexual abuse.
4. Assist the victim in identifying his/her fears that lead to avoidance of being close to others (e.g., fear of being rejected, fear that he/she is unworthy of love, fear of his/her own anger).
5. Explore the victim's feelings of shame and how shame plays a role in keeping him/her isolated from others.
6. Assign the victim to read books on shame recovery (e.g., *Healing the Shame That Binds You* by Bradshaw and *Facing Shame* by Fossum and Mason); process key issues, particularly those related to sexual abuse.

4. Identify and replace distorted thoughts that lead to distancing self from people. (7, 8)

7. Assist the victim in identifying distorted self-talk messages that lead to fear and avoidance of others (e.g., "I feel so dirty"; "They think I'm responsible for the sexual activity"; or "Everyone is out to take advantage of me").

8. Assist the victim in replacing dysfunctional thoughts with rational, positive cognitive messages (e.g., "I am a good person"; "No one who truly loves me blames me for being a victim"; "Many people can be gradually trusted").

5. Participate in art or drama techniques to resolve and heal past relationship traumas. (9, 10)

9. Use art to help the victim decrease his/her affective response of fear of rejection because of his/her shame related to the abuse. Instruct the victim to produce an abstract expression of his/her emotions through the use of crayons, paints, or collage.

10. Use drama therapy to play out worst possible scenarios regarding rejection from others, feelings of shame, and subsequent recovery.

6. Identify ways in which the offender betrayed trust. (11, 12)

11. Assist the victim in seeing how the offender betrayed his/her trust and did not have integrity.

12. Use drama techniques in group therapy to help the victim process feelings regarding betrayal in a confrontation with the offender about trust; direct him/her to explore different ways of confrontation and to increase his/her understanding of the betrayal.

7. Terminate verbalizations of attribution of blame to self as having caused the abuse and give responsibility for the offense to the offender. (13)

13. Consistently teach the victim that the offender is responsible for the sexual abuse; confront his/her self-attributions of blame, and reinforce his/her placing blame directly on the offender.

8. List the indicators of trustworthiness in a relationship. (14)

14. Have the victim list the aspects of integrity and trustworthiness (e.g., kindness, interest in others' welfare, honesty, keeping commitments, accepting responsibility) that he/she desires in a relationship.

9. Identify how others and self measure up to indicators of trustworthiness. (15, 16)

15. Have the victim list current significant others and describe how they meet or fail the standards of trustworthiness that he/she has identified.

16. Discuss with the victim how he/she meets or fails his/her own standards of trustworthiness.

10. Identify and implement the basic skills necessary to facilitate maintenance of relationships. (17)

17. Teach the victim or refer him/her to a social skills group addressing the essential social skills that will enhance the quality of relationships. (See the Social Withdrawal chapter in the Victim Issues part of this Planner.)

11. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (18)

12. Verbalize an increase in the desire for and pleasure in physical touch by setting clear and appropriate boundaries with a consensual sexual partner. (19, 20)

13. Participate in volunteer activities, and verbalize fears that are generated by social contact. (21)

14. Practice skills that encourage intimate attachments in long-term relationships. (22)

18. Make a referral to a physician to evaluate the victim for medication to remediate mood instability, and decrease anxiety, panic attacks, and/or depression.

19. Explore and define with the victim what kind of touch is acceptable, ranging from a handshake at a social event to intercourse in a consensual, supportive sexual relationship.

20. Encourage the victim to verbalize his/her physical sensitivities to his/her sexual partner by giving clear information about boundaries regarding the type of touch to avoid in order to not exacerbate PTSD or anxiety symptoms.

21. Assign the victim to choose and commit to minimal regular attendance at volunteer work in a nonthreatening environment (e.g., nursing home, soup kitchen, church-related activity); explore fears regarding relating to others, anxiety about others seeking to touch, or fears of rejection).

22. Teach the victim behaviors that increase intimacy (e.g., honesty, expressing and resolving anger, sharing attraction and other positive feelings, frequent eye contact), and explore which to use with safe people.

15. Keep a daily log of social interactions. (23)

16. Verbalize feelings in an appropriate manner with others daily. (24)

17. Verbalize a desire for positive intimate relationships. (25)

18. List goals for improved social interactions. (26)

23. Assign the victim to keep a journal of his/her taking mild social interaction risks one time per day; discuss his/her thoughts, feelings, and behavior.

24. Encourage the victim to share his/her feelings on a regular basis with others who meet his/her standards of trustworthiness in order to decrease anxiety about expressing feelings and improving intimacy skills.

25. Reinforce the victim's verbal expressions of a desire for closeness in relationships.

26. Encourage the victim to commit to positive goals regarding relationships (e.g., seek friends who are trustworthy, increase integrity in all relationships, give and seek emotional support from others, enter relationships based on personal moral values).

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

__. _____

_____

DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
300.01	F41.0	Panic Disorder
300.22	F40.00	Agoraphobia
300.02	F41.1	Generalized Anxiety Disorder
300.09	F41.8	Other Specified Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
301.83	F60.3	Borderline Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
_____	_____	_____
_____	_____	_____