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RITA BUDRIONIS AND ARTHUR E. JONGSMA, JR.

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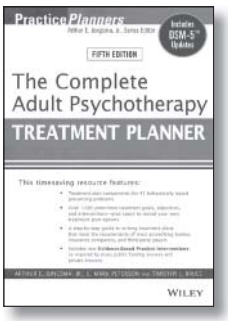


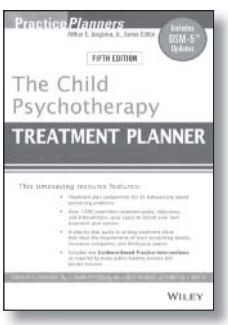


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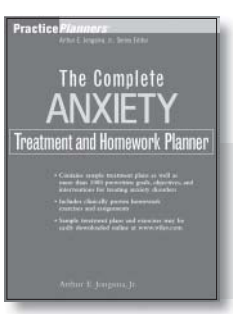


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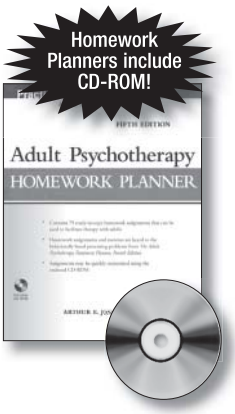


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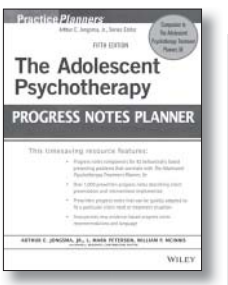


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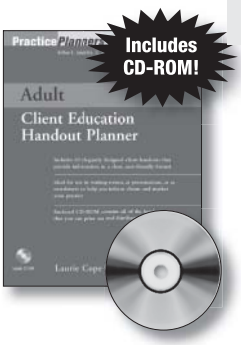


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# The Sexual Abuse Victim and Sexual Offender Treatment Planner, with DSM-5 Updates

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Arthur E. Jongsma, Jr., Series Editor

# The Sexual Abuse Victim and Sexual Offender Treatment Planner, with DSM-5 Updates

*Rita Budrionis*

*Arthur E. Jongsma, Jr.*

WILEY

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To Alfa, Bill, Christopher, Elizabeth, Mary, and Vito. You have all been my shining inspirations, my strong supporters, my gentle critics, and my patient teachers while sharing the joys of our family.

*—Rita Budrionis*

To Peggy Alexander, Cristina Wojdylo, and Judi Knott—a publication team that is unsurpassed in quality, dedication, creativity, and supportiveness.

*—Arthur E. Jongsma, Jr.*

# CONTENTS

# PRACTICE*PLANNERS*® SERIES PREFACE

Accountability is an important dimension of the practice of psychotherapy. Treatment programs, public agencies, clinics, and practitioners must justify and document their treatment plans to outside review entities in order to be reimbursed for services. The books in the Practice*Planners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The Practice*Planners*® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner*, *Child Psychotherapy Treatment Planner*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fifth editions, but also *Treatment Planners* targeted to specialty areas of practice, including:

- Addictions
- Co-occurring disorders
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- Family therapy
- Gays and lesbians
- Group therapy
- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders

- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work
- Severe and persistent mental illness
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- Suicide and homicide risk assessment
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- Women's issues

In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, substance use, anger control problems, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner.*
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
*Grand Rapids, Michigan*

# ACKNOWLEDGMENTS

First, I would like to thank Art Jongsma as the originator of this truly valuable series of Practice*Planners* books. Before working on this project, I frequently used his books to assist with treatment options, and particularly as documentation demands on clinicians continued to increase. I thought I did a good job of writing behavioral objectives, and then I met Art. Both Art and Jen stuck by me through my difficulties with "Plannerese" and my ADD style. Thank you!

It was particularly difficult with the sexual abuse topic to address treatment issues for victims and offenders in the same book. This was not my original plan, but the suggestion of Peggy Alexander at Wiley. With the change of plans, my focus became "No More Victims," and it became easy to conceptualize the structure of this Treatment Planner that included objectives for both victims and offenders. Peggy, thank you for your wisdom and grace.

I owe a debt of gratitude to a number of professional colleagues and friends for their support and critiques: my dear buddy, Jane Hollingsworth, Psy.D., who tirelessly gave research information, feedback, and friendship through this project and others; Sue Casselman, Psy.D., through short and long distances before and during this project was supportive, insightful, and my very good friend; Geoff Ludford, Ed.D., for his clinical wisdom and sense of humor; and Tom Plante, Ph.D., and Tim Horton, LCSW, both gave invaluable insight into their own treatment experiences with priests and other clerics. The Female Offenders chapter was enriched by the insights provided by Julia Hislop, Ph.D. (personal communication) and Barbara Schwartz, Ph.D. (conference presentation entitled "Looking Forward: Critical Issues in the Management of the Sex Offender," March 2002). David Cohen, M.A., at Magen Prison in Israel gave me his insights on Yetser HaRah. Two Virginia Beach probation officers par excellence, John Williams and Kate Shellman, also gave me useful feedback. And finally, credit is due to Bill Marshall for his pioneering work with sex offenders, along with other researchers and clinicians such as Tony Ward, Ph.D., Richard Laws, Ph.D., Steve Hudson, Ph.D., and Anna Salter, Ph.D.

In many ways, this was a family book, where all members contributed. Elizabeth and Christopher were understanding about changes in their routine and mostly understanding when they had to share the Internet with their mom. My husband, Bill, in his inimitable style reassured me many times, "Just go do it, I'll take care of dinner." And dear Mary, thanks for the weekends and doing the laundry. And thank you to Mom and Dad, who showed me right from the very beginning how to solve problems, how to heal, how to have joy, and how to love.

Finally, I'd like to thank all of the patients who have taught me, challenged me, and surprised me.

RITA BUDRIONIS

# The Sexual Abuse Victim and Sexual Offender Treatment Planner, with DSM-5 Updates

# INTRODUCTION

## PLANNER FOCUS

*The Sexual Abuse Victim and Sexual Offender Treatment Planner* is designed to assist clinicians, social service workers, probation officers, and other professionals who are working with either survivors of sexual abuse/assault or the perpetrators of such crimes. The issues of these two groups are intertwined, as it is crucial for offenders to break through their denial and to acknowledge and empathize with the devastating harm that abuse has on the victims, and offenders are often victims of sexual abuse themselves. Important points of contact between these two groups are victim healing, victim safety, and a decreased recidivism rate.

This Planner can be used in a number of settings ranging from outpatient to residential to prison settings. Treatment objectives can be used for a wide range of clients ranging from juveniles to adults. Because offender treatment necessitates a melding of criminal justice concerns and psychological needs, many of the objectives and interventions will address collaboration with probation/parole officers.

Victim treatment is a specialized area of clinical expertise, although it is frequently encountered in the mental health field. This Planner can serve as the framework for the novice clinician to begin to build skills working with this population with the supervision of an experienced clinician. Victim treatment is frequently lengthy and demanding on both the client and therapist, and the difficulty increases with the severity of the trauma. This Planner assists in clarifying treatment options for the clinician in such critical areas as suicide and eating disorders, along with sensitive issues such as families with an impetus toward reunification and survivors with destabilizing trauma symptoms.

Treatment of sex offenders is a highly specialized area and based on a relatively recent body of research with many differing viewpoints and current controversies. When research data conflict or are not yet definitive, intervention

choices are offered, such as in the Denial chapter where objective options range from programmatic discharge of a denying offender to placement into a pre-treatment denial group. In the Clergy Offender chapter, the bulk of the interventions are based on the clinical expertise of the generous professionals who shared their experiences with the authors. Overall, clinicians who treat sex offenders should receive extensive didactic training and clinical supervision. This Planner can serve as a support for the clinician who is licensed as a sex offender treatment provider or a clinician-in-training with such a population with the assistance of an experienced supervisor. Probation/parole officers, social service workers, and other professionals can use this Planner to evaluate current treatment needs, treatment progress, and the adequacy of programs that are available.

It is our goal to present information to assist in making clinical and programmatic decisions for psychotherapeutic treatment of those individuals who have been sexually assaulted and those individuals who are the perpetrators of sexual assault. Even the offender chapters, however, are victim-driven, maintaining the goal of victim support, healing, safety, and restorative justice. In this challenging and controversial area, our goal is a respectful treatment of all clients and "no more victims."

## HISTORICAL BACKGROUND

Since the early 1960s, formalized treatment planning has gradually become a vital aspect of the entire health care delivery system, whether it is treatment related to physical health, mental health, child welfare, or substance abuse. What started in the medical sector in the 1960s spread into the mental health sector in the 1970s as clinics, psychiatric hospitals, agencies, and so on began to seek accreditation from bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to qualify for third-party reimbursements. For most treatment providers to achieve accreditation, they had to begin developing and strengthening their documentation skills in the area of treatment planning. Previously, most mental health and substance abuse treatment providers had, at best, a bare-bones plan that looked similar for most of the individuals they treated. As a result, clients were uncertain as to what they were trying to attain in mental health treatment. Goals were vague, objectives were nonexistent, and interventions were applied equally to all clients. Outcome data were not measurable, and neither the treatment provider nor the client knew exactly when treatment was complete. The initial development of rudimentary treatment plans made inroads toward addressing some of these issues.

With the advent of managed care in the 1980s, treatment planning has taken on even more importance. Managed care systems *insist* that clinicians move rapidly from assessment of the problem to the formulation and implementation of the treatment plan. The goal of most managed care companies is to expedite the treatment process by prompting the client and treatment provider to focus on identifying and changing behavioral problems as quickly as possible. Treatment plans must be specific as to the problems and interventions, individualized to meet the client's needs and goals, and measurable in terms of setting milestones that can be used to chart the patient's progress. Pressure from third-party payers, accrediting agencies, and other outside parties has therefore increased the need for clinicians to produce effective, high-quality treatment plans in a short time frame. However, many mental health providers have little experience in treatment plan development. Our purpose in writing this book is to clarify, simplify, and accelerate the treatment planning process for youth involved in the juvenile justice system.

## TREATMENT PLAN UTILITY

Detailed written treatment plans can benefit not only the client, therapist, treatment team, insurance community, and treatment agency, but also the overall psychotherapy profession. The client is served by a written plan because it stipulates the issues that are the focus of the treatment process. It is very easy for both provider and client to lose sight of what the issues were that brought the client into therapy. The treatment plan is a guide that structures the focus of the therapeutic contract. Because issues can change as therapy progresses, the treatment plan must be viewed as a dynamic document that can and must be updated to reflect any major change of problem, definition, goal, objective, or intervention.

Clients and therapists benefit from the treatment plan, which forces both to think about therapy outcomes. Behaviorally stated, measurable objectives clearly focus the treatment endeavor. Clients no longer have to wonder what therapy is trying to accomplish. Clear objectives also allow the client to channel effort into specific changes that will lead to the long-term goal of problem resolution. Therapy is no longer a vague contract to just talk honestly and openly about emotions and cognitions until the client feels better. Both client and therapist are concentrating on specifically stated objectives using specific interventions.

Providers are aided by treatment plans because they are forced to think analytically and critically about therapeutic interventions that are best suited for objective attainment for the client. Therapists were

traditionally trained to "follow the patient," but now a formalized plan is the guide to the treatment process. The therapist must give advance attention to the technique, approach, assignment, or cathartic target that will form the basis for interventions.

Clinicians benefit from clear documentation of treatment because it provides a measure of added protection from possible patient litigation. Malpractice suits are increasing in frequency, and insurance premiums are soaring. The first line of defense against allegations is a complete clinical record detailing the treatment process. A written, individualized, formal treatment plan that is the guideline for the therapeutic process, that has been reviewed and signed by the client, and that is coupled with problem-oriented progress notes is a powerful defense against exaggerated or false claims.

A well-crafted treatment plan that clearly stipulates presenting problems and intervention strategies facilitates the treatment process carried out by team members in inpatient, residential, or intensive outpatient settings. Good communication between team members about what approach is being implemented and who is responsible for which intervention is critical. Team meetings to discuss patient treatment used to be the only source of interaction between providers; often, therapeutic conclusions or assignments were not recorded. Now, a thorough treatment plan stipulates in writing the details of objectives and the varied interventions (e.g., pharmacologic, milieu, group therapy, didactic, recreational, individual therapy) and who will implement them.

Every treatment agency or institution is constantly looking for ways to increase the quality and uniformity of the documentation in the clinical record. A standardized, written treatment plan with problem definitions, goals, objectives, and interventions in every client's file enhances that uniformity of documentation. This uniformity eases the task of record reviewers inside and outside the agency. Outside reviewers, such as JCAHO, insist on documentation that clearly outlines assessment, treatment, progress, and termination status.

The demand for accountability from third-party payers and health maintenance organizations (HMOs) is partially satisfied by a written treatment plan and complete progress notes. More and more managed care systems are demanding a structured therapeutic contract that has measurable objectives and explicit interventions. Clinicians cannot avoid this move toward being accountable to those outside the treatment process.

The psychotherapy profession stands to benefit from the use of more precise, measurable objectives to evaluate success in mental health treatment. With the advent of detailed treatment plans, outcome data can be more easily collected for interventions that are effective in achieving specific goals.

## HOW TO DEVELOP A TREATMENT PLAN

The process of developing a treatment plan involves a logical series of steps that build on each other much like constructing a house. The foundation of any effective treatment plan is the data gathered in a thorough biopsychosocial assessment. As the client presents himself/herself for treatment, the clinician must sensitively listen to and understand what the client struggles with in terms of family-of-origin issues, current stressors, emotional status, social network, physical health, coping skills, interpersonal conflicts, self-esteem, and so on. Assessment data may be gathered from a social history, legal file physical exam, clinical interview, psychological testing, or contact with a client's guardian, social service worker, and/or probation officer. The integration of the data by the clinician or the multidisciplinary treatment team members is critical for understanding the client, as is an awareness of the basis of the client's struggle. We have identified six specific steps for developing an effective treatment plan based on the assessment data.

### Step One: Problem Selection

Although the client may discuss a variety of issues during the assessment and court orders may request specific services, the clinician must ferret out the most significant problems on which to focus the treatment process. Usually a *primary* problem will surface, and *secondary* problems may also be evident. Some *other* problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems, or treatment will lose its direction. *The Sexual Abuse Victim and Sexual Offender Treatment Planner* offers 27 problems from which to select those that most accurately represent your client's presenting issues.

As the problems to be selected become clear to the clinician or the treatment team, it is important to include opinions from the client as to his or her prioritization of issues for which help is being sought. A client's motivation to participate in and cooperate with the treatment process depends, to some extent, on the degree to which treatment addresses his or her greatest needs.

### Step Two: Problem Definition

Each individual client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is

evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *Diagnostic and Statistical Manual* (*DSM*-5) or the *International Classification of Diseases.* The Planner, following the pattern established by *DSM*-5*,* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements. You will find several behavior symptoms or syndromes listed that may characterize 1 of the 32 presenting problems.

## Step Three: Goal Development

The next step in treatment plan development is that of setting broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. The Planner suggests several possible goal statements for each problem, but one statement is all that is required in a treatment plan.

## Step Four: Objective Construction

In contrast to long-term goals, objectives must be stated in behaviorally measurable language. It must be clear when the client has achieved the established objectives; therefore, vague, subjective objectives are not acceptable. Review agencies (e.g., JCAHO), HMOs, and managed care organizations insist that psychological treatment outcome be measurable. The objectives presented in this Planner are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem. The clinician must exercise professional judgment as to which objectives are most appropriate for a given client.

Each objective should be developed as a step toward attaining the broad treatment goal. In essence, objectives can be thought of as a series of steps that, when completed, will result in the achievement of the long-term goal. There should be at least two objectives for each problem, but the clinician may construct as many as are necessary for goal achievement. Target attainment dates should be listed for each objective. New objectives should be added to the plan as the individual's treatment progresses. When all the necessary objectives have been achieved, the client should have resolved the target problem successfully.

## Step Five: Intervention Creation

Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan.

Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. *The Sexual Abuse Victim and Sexual Offender Treatment Planner* contains interventions from a broad range of therapeutic approaches, including cognitive, dynamic, behavioral, multisystemic, pharmacologic, family-oriented, and client-centered therapy. Other interventions may be written by the provider to reflect his/her own training and experience. The addition of new problems, definitions, goals, objectives, and interventions to those found in the Planner is encouraged because doing so adds to the database for future reference and use.

Some suggested interventions listed in the Planner refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. The books are arranged under each problem for which they are appropriate as assigned reading for clients. When a book is used as part of an intervention plan, it should be reviewed with the client after it is read, enhancing the application of the content of the book to the specific client's circumstances. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Books* (1994) by Santrock, Minnett, and Campbell (available from The Guilford Press, New York).

A list of reference resources is also provided for the professional provider in Appendix B. These books are meant to elaborate on the methods suggested in some of the chapters.

Assigning an intervention to a specific provider is most relevant if the patient is being treated by a team in an inpatient, residential, or intensive outpatient setting. Within these settings, personnel other than the primary clinician may be responsible for implementing a specific intervention. Review agencies require that the responsible provider's name be stipulated for every intervention.

## Step Six: Diagnosis Determination

The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents

to the criteria for diagnosis of a mental illness condition as described in *DSM*-5. The issue of differential diagnosis is admittedly a difficult one that research has shown to have rather low interrater reliability. Psychologists have also been trained to think more in terms of maladaptive behavior than disease labels. In spite of these factors, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. (However, recently, managed care agencies are more interested in behavioral indices that are exhibited by the client than the actual diagnosis.) It is the clinician's thorough knowledge of *DSM*-5 criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis. An accurate assessment of behavioral indicators will also contribute to more effective treatment planning.

## HOW TO USE THIS PLANNER

Our experience has taught us that learning the skills of effective treatment plan writing can be a tedious and difficult process for many clinicians. It is more stressful to try to develop this expertise when under the pressure of increased patient load and short time frames placed on clinicians today by managed care systems. The documentation demands can be overwhelming when we must move quickly from assessment to treatment plan to progress notes. In the process, we must be very specific about how and when objectives can be achieved, and how progress is exhibited in each client. *The Sexual Abuse Victim and Sexual Offender Treatment Planner* was developed as a tool to aid clinicians in writing a treatment plan in a rapid manner that is clear, specific, and highly individualized according to the following progression:

1. Choose one presenting problem (Step One) that you have identified through your assessment process. Locate the corresponding page number for that problem in the Planner's table of contents.
2. Select two or more of the listed behavioral definitions (Step Two), and record them in the appropriate section on your treatment plan form. Feel free to add your own defining statement if you determine that your client's behavioral manifestation of the identified problem is not listed. (Note that while our design for treatment planning is vertical, it will work equally well on plan forms formatted horizontally.)
3. Select a single long-term goal (Step Three), and again write the selection, exactly as it is written in the Planner or in some appropriately modified form, in the corresponding area of your own form.

4. Review the listed objectives for this problem, and select the ones that you judge to be clinically indicated for your client (Step Four). Remember, it is recommended that you select at least two objectives for each problem. Add a target date or the number of sessions allocated for the attainment of each objective.
5. Choose relevant interventions (Step Five). The Planner offers suggested interventions related to each objective in the parentheses following the objective statement. But do not limit yourself to those interventions. The entire list is eclectic and may offer options that are more tailored to your theoretical approach or preferred way of working with clients. Also, just as with definitions, goals, and objectives, there is space allowed for you to enter your own interventions into the Planner. This allows you to refer to these entries when you create a plan around this problem in the future. You will have to assign responsibility to a specific person for implementation of each intervention if the treatment is being carried out by a multidisciplinary team.
6. Several *DSM*-5 diagnoses are listed at the end of each chapter that are commonly associated with a client who has this problem. These diagnoses are meant to be suggestions for clinical consideration. Select a diagnosis listed, or assign a more appropriate choice from the *DSM*-5 (Step Six).
7. To accommodate those practitioners that tend to plan treatment in terms of diagnostic labels rather than presenting problems, Appendix B lists all of the *DSM*-5 diagnoses that have been presented in the various presenting problem chapters as suggestions for consideration. Each diagnosis is followed by the presenting problem that has been associated with that diagnosis. The provider may look up the presenting problems for a selected diagnosis to review definitions, goals, objectives, and interventions that may be appropriate for their clients with that diagnosis.

Congratulations! You should now have a complete, individualized treatment plan that is ready for immediate implementation and presentation to the client. It should resemble the format of the sample plan that follows.

## A FINAL NOTE

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's

strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns *must* be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. It is our hope that *The Sexual Abuse Victim and Sexual Offender Treatment Planner* will promote effective, creative treatment planning—a process that will ultimately benefit the client, clinician, and mental health community.

## SAMPLE TREATMENT PLAN

**PROBLEM:**SELF-BLAME

**Definitions:** Chronic and recurrent thoughts of blaming self for the sexual abuse/trauma.
Feelings of inappropriate guilt and shame; views self as damaged goods.

**Goals:** Decrease attribution of blame to self as having caused or having any responsibility for the abuse/assault.
Place responsibility for the offense on the offender.

| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
|---|---|
| 1. Verbalize thoughts and feelings surrounding the sexual abuse. | 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.<br>2. Monitor the victim's self-blame statements as he/she talks about the sexual abuse; gently highlight this self-blame when it occurs. |
| 2. Eliminate self-blame statements when talking about the abuse, and place blame on the offender. | 1. Have the victim practice verbalizations that assign blame to the offender for the sexual assault; use modeling to reframe self-blame statements.<br>2. 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"). |

| | |
|---|---|
| 3. Verbalize an increased knowledge of how the perpetrator used manipulation before, during, and after the abuse to influence the attribution of the crime. | 1. 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). |
| 4. Express acceptance of the fact that by placing responsibility on the offender, feelings of anger and rage may increase. | 1. 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. |
| 5. Write a confrontation letter to the abuser to clarify that the abuser is responsible for the offense. | 1. 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. |
| 6. Identify and replace dysfunctional thoughts about the abuse/assault that result in acceptance that the abuse was deserved or somehow a punishment for sin. | 1. 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.<br>2. Use logic and reality to challenge each dysfunctional assumption regarding having committed a sin or deserving punishment, replacing it with a realistic assumption. |

**Diagnosis:** F43.21 Adjustment Disorder with Depressed Mood