Individual Planning: A Treatment Plan Overview for Individuals with History of Sexual Abuse

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms and learning different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations
Course Syllabus:

Introduction

Mental Health Issues Resulting from Sexual Assault

Psychological Harm

Dissociation and Posttraumatic Stress Disorders in Sexual Abuse (PTSD)

Signs and Symptoms

Treatment for Survivors of Sexual Abuse

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction:

Sexual abuse is any form of sexual violence, including rape, child molestation, incest, and similar forms of non-consensual sexual contact. Most sexual abuse experts agree sexual abuse is never only about sex, and it is often an attempt to gain power over victims. Immediate crisis assistance after sexual assault can prove invaluable and even save lives, but therapy can also be helpful for those who experienced sexual abuse in the past. Some therapists specialize in addressing the trauma of sexual assault, and long-term assistance may be beneficial to some survivors of sexual abuse.
Adults with a history of sexual abuse often present for treatment with a secondary mental health issue, which can include substance abuse, eating disorders, personality disorders, depression, and conflict in romantic or interpersonal relationships.

Generally the approach is to the present problem, rather than the abuse itself. Treatment is highly varied and depends on the person’s specific issues. For instance, a person with a history of sexual abuse suffering from severe depression would be treated for depression. However, there is often an emphasis on cognitive restructuring due to the deep-seated nature of the trauma. Some newer techniques such as Eye Movement Desensitization and Reprocessing (EMDR) have been shown to be effective.

Sexual abuse is associated with many sub-clinical behavioral issues as well, including re-victimization in the teenage years, a bipolar-like switching between sexual compulsion and shut-down, and distorted thinking on the subject of sexual abuse (for instance, that it is common and happens to everyone). When first presenting for treatment, the patient can be fully aware of their abuse as an event, but their appraisal of it is often distorted, such as believing that the event was unremarkable (a form of isolation). Frequently, victims do not make the connection between their abuse and their present pathology.

Mental Health Issues Resulting from Sexual Assault:

Sexual abuse victims often report feelings such as shame, terror, depression, and guilt, and many blame themselves for the assault. Some of the mental health challenges survivors of sexual abuse face include:

Depression: The loss and ability to control your own bodily autonomy is often difficult to cope with. It can create feelings of hopelessness, despondency, and lead to diminishment in one's sense of self-worth and confidence. These feelings can lead to depression that may range from mild and fleeting to intense and debilitating depressive symptoms.

Anxiety: Sexual abuse survivors, and their strong feelings regarding the loss of bodily
autonomy, and the ongoing fear that the attack could happen again, can cause intense anxiety. Some victims of sexual abuse may develop agoraphobia and become terrified to leave their homes. Others suffer panic attacks symptoms of physical anxiety, and a chronic fear of the type of person who harmed them. Someone who was sexually assaulted may instinctively dislike, mistrust, or fear all men or women who produced the sexual abuse and match the same description.

Post Traumatic Stress: Post Traumatic stress (PTSD) a strong level of anxiety, depression, and intense memories of the abuse. Intensely disruptive flashbacks can occur, and in some cases the flashbacks can be so real that it may cause the survivor to lose track of surroundings. A related condition, complex posttraumatic stress (C-PTSD), yields symptoms of traditional PTSD in addition to strong chronic fear of abandonment. Some victims of sexual abuse with C-PTSD also experience personality disruptions.

Personality disruptions: Personality disruptions such as borderline personality can sometimes be the result of sexual abuse. The behavior associated with these personality disruptions could actually be an adaption to experienced sexual abuse. For example, a characteristic of borderline personality is a strong fear of abandonment. While that fear might not make sense in a normal adult, avoiding abandonment might have been what protected someone from childhood sexual abuse.

Attachment disruptions: It can be challenging, particularly in children who have been abused, to form healthy attachments with others as adults. Adults who were abused as children may experience insecure attachment patterns and problems with connecting, and struggle with intimacy, or be too eager to form close attachments.

Addiction: Sexual abuse survivors are 26 times more likely to use drugs. Drugs and alcohol can help numb and deal with the pain of abuse, but often, substance abuse can lead to the development of different mental health issues.

Triggers: Triggers are the stimuli that causes survivors of the abuse to recall the sexual abuse they experienced. For example, a rape victim whose attacker chewed gum might be triggered into a flashback by the smell of gum or similar characteristics of the abuser. Though triggers vary widely, violence, subsequent abuse, and intense discussions of abuse are among the most common triggers.
Sexual abuse produces psychological scars, and possible long-lasting health consequences. A person who is assaulted may sustain bruises and cuts or more severe injuries such as knife wounds, sprained or broken bones, and torn or damaged genitals. Some victims develop sexually transmitted infections. Others may become pregnant as the result of an attack. Survivors may also experience health concerns such as sexual dysfunctions, chronic pain and fertility problems and decreased immunity, and other c unexplained aches, pains, or illnesses.

Psychological Harm:

Child sexual abuse can result in both short-term and long-term harm, including psychopathology in later life. Psychological, emotional, physical, and social effects include depression, post-traumatic stress disorder, anxiety, eating disorders, poor self-esteem, dissociative and anxiety disorders; general psychological distress and disorders such as somatization, neurosis, chronic pain, sexualized behavior, school/learning problems; and behavior problems including substance abuse, self-destructive behaviour, animal cruelty, crime in adulthood and suicide. A specific characteristic pattern of symptoms has not been identified and there are several hypotheses on the causality of these associations.

A study funded by the US National Institute of Drug Abuse found that "Among more than 1,400 adult females, childhood sexual abuse was associated with increased likelihood of drug dependence, alcohol dependence, and psychiatric disorders. The associations are expressed as odds ratios: for example, women who experienced nongenital sexual abuse in childhood were 2.93 times more likely to suffer drug dependence as adults than were women who were not abused."

Long term negative effects on development leading to repeated or additional victimization in adulthood are also associated with child sexual abuse. Studies have established a causal relationship between childhood sexual abuse and certain specific areas of adult psychopathology, including suicidality, antisocial behavior, PTSD, anxiety and alcoholism. Adults with a history of abuse as a child, especially sexual abuse, are more likely than people with no history of abuse to become frequent users of emergency and medical care services. A study comparing middle-aged women who were abused as children with non-abused counterparts found significantly higher health care costs for the former.
Sexually abused children suffer from more psychological symptoms than children who have not been abused; studies have found symptoms in 51% to 79% of sexually abused children. The risk of harm is greater if the abuser is a relative, if the abuse involves intercourse or attempted intercourse, or if threats or force are used. The level of harm may also be affected by various factors such as penetration, duration and frequency of abuse, and use of force. The social stigma of child sexual abuse may compound the psychological harm to children, and adverse outcomes are less likely for abused children who have supportive family environments.

Dissociation and Posttraumatic Stress Disorders in Sexual Abuse (PTSD):

Child abuse, including sexual abuse, especially chronic abuse starting at early ages, has been found to be related to the development of high levels of dissociative symptoms, which includes amnesia for abuse memories. The level of dissociation has been found to be related to reported overwhelming sexual and physical abuse. When severe sexual abuse (penetration, several perpetrators, lasting more than one year) had occurred, dissociative symptoms were even more prominent.

Child sexual abuse independently predicts the number of symptoms for PTSD a person displays, after controlling for possible confounding variables, according to Widom (1999), who wrote "sexual abuse, perhaps more than other forms of childhood trauma, leads to dissociative problems ... these PTSD findings represent only part of the picture of the long-term psychiatric sequelae associated with early childhood victimization ... antisocial personality disorder, alcohol abuse, and other forms of psychopathology." Children may develop symptoms of posttraumatic stress disorder resulting from child sexual abuse, even without actual or threatened injury or violence.

Signs and Symptoms:

Adult survivors of childhood sexual abuse may struggle with a wide range of psychological and behavioral symptoms, including, but not limited to, the following:
Depression
Anxiety
Guilt
Fear
Sexual dysfunction
Withdrawal
Dissociation
Low self-esteem
Immaturity and regression
Aggression
Decreased physical health
Digestive and gastrointestinal distress
Sleep disruptions
Memory problems
Dramatic mood swings
Substance abuse
Inappropriate sexual behavior
Sexual promiscuity or refusal

Some of these symptoms may become evident in the immediate aftermath of the sexual assault, while others may not occur until years later.

Other Symptoms to Check for:
1. Vague or unclear memories of inappropriate childhood sexual abuse

2. Sexual abuse can be corroborated by significant others

3. Clear detailed memories of being sexually abused

4. Inability to recall a time period or years of childhood

5. Having difficulty becoming intimate with others

6. Unable to enjoy any sexual contact with a partner

7. Disturbances of desire - arousal and orgasm

8. Unexplainable feelings of anger-rage when is close perpetrator

9. Unexplainable feelings of fear when is close to perpetrator

10. Pervasive pattern and history of promiscuity

11. Views relationships on sexualization basis

12. Low self esteem related to the experience of sexual abuse

13. Feelings of shame humiliation or guilt

14. Intrusive or recurring thoughts - nightmares or flashbacks.

15. Distorted self-perception

16. Engages in high risk sexual behavior

17. Feelings of anxiety

18. History of depressive behavior

19. Self-neglect

20. Other disorders such use of illicit drugs-eating disorder

Treatment Survivors of Childhood Sexual Abuse:

Sexual Abuse survivor treatment may incorporate empirically supported trauma treatments that have been specifically selected for their ability to meet your unique needs. Depending upon those needs, one or more of the following techniques and therapies may be used:
Interpersonal therapy (IPT) can help you repair damaged relationships and reconstruct healthier roles. The strategies learned will help restore social networks and strengthen bonds with loved ones.

Cognitive-behavioral therapy (CBT) can teach how to replace negative thoughts related to abuse experiences, especially those related to shame, guilt, or self-blame. Survivor learns that she or he can replace negative thoughts to see the world in a realistic manner, and gain control over thoughts and the way they impact emotions and behaviors.

Dialectical behavior therapy (DBT) incorporates treatments from behavioral therapy, interpersonal therapy, and CBT, and can help gain balance and acceptance of past events, and identify which factors can be changed in positive ways. It helps identify inner strengths to help stabilize emotional experiences.

Intensive family therapy, including our dynamic Family Week, develops healthier and more productive relationships with family members and other personal support network. It also teaches loved ones more about how they can best support and continued reinforcement and recovery from childhood sexual abuse.

In addition, depending upon your specific strengths, needs, and goals, treatment may also include the following experiential activities:

- Art therapy
- Creative expression
- Dramatic experiencing
- Meditation
- Ropes courses
- Equine therapy
Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps that build on each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. This may include:

issues with family of origin,
current stressors,
present and past emotional status,
present and past social networks,
present and past coping skills,
present and past physical health,
self-esteem,
interpersonal conflicts
financial issues
cultural issues
There are different sources of data that may be obtained from a:

clinical interview,
Gathering of social history,
physical exam,
psychological testing,
contact with client’s or patient’s significant others at home, school, or work

The integration of all this data is very critical for the clinician’s effect in treatment. It is important to understand the client’s or patient’s present awareness and the basis of the client’s struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There 5 basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

Step 1, Problem Selection and Definition:

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the treatment process continues. The clinician may must be able to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.
It is important to be clear with the client or patient and include the client’s or patient’s own prioritization of the problems presented. The client’s or patient’s cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate may exclude some of the client’s or patient’s needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).

***For a full listing of Goals and Strategies aligned next to each other, check the Apps for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps, and Download the Free Demo***

Behavioral Definitions for Adults with Sexual Abuse History:

Vague or unclear memories of inappropriate childhood sexual abuse that can be corroborated by significant others.

Clear memories of being sexually abused with clear, detailed memories.

Inability to recall a time period or years of childhood.

Having difficulty becoming intimate with others.

Unable to enjoy any sexual contact with a partner.

Unexplainable feelings of anger, rage, when coming into contact with a close family relative or family friend.
Unexplainable feelings of fear when coming into contact with a close family relative or family friend.

Pervasive pattern and history of promiscuity.

Views relationships on sexualization basis.

Low self esteem related to the experience of sexual abuse.

Step 2, Long Term Goal Development:

This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

Long Term Goals for Adults with Sexual Abuse History:

Explore the issue of being sexually abused with a better capacity for intimacy in relationships.

Start the healing process from sexual abuse with gaining a new enjoyment of appropriate sexual contact.

Successfully work through the issues related to being sexually abused with a greater understanding and better control of feelings.

Learn to recognize and accept the sexual abuse without sexualization of relationships.

Determine whether sexual abuse occurred.

Help patient move away from being a victim of sexual abuse and become a survivor of sexual abuse.
Objective or Short Term Goal Construction and Strategies to Accomplish Goals:

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurable objectives or short term goals.

It is important to include the patient’s or client’s input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously stated in non-measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment progresses. Any changes or modifications must include the client’s or patient’s input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal “13. Increase positive self-descriptive statements.” Can be restated as; “By the end of the session the patient or client will list at least 5 positive self-descriptions of himself or herself, and assess how they can help alleviate the presenting problem.” Remember, that it must be stated in a way one can measure effectiveness.
It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

Strategies or Interventions:

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short term goal should have at least one strategy. In case, short term goals are not met, new short term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client’s needs and presenting problem.

Examples of a short term goals and its aligned strategies:

Short Term Goal Goal 1:

Increase the ability to talk openly about the feelings of the sexual abuse, reflecting acceptance of the abuse.

Therapeutic Interventions For Goal 1:

Encourage open in talk about the abuse without shame or embarrassment remind that she or he was not responsible for the abuse.

Encourage, and support client in verbally expressing and clarifying feelings associated with the abuse
Short Term Goal Goal 2:

Eliminate feelings of shame by allowing client to be able to verbally affirm self as not responsible for abuse.

Therapeutic Interventions For Goal 2:

Give and discuss reading sections such as books from, Healing the Shame That Binds You (Bradshaw), and process key points in therapy as it applies to present feelings of shame.

Assist client identify, express, and process any feelings of guilt linked to feelings of physical pleasure, emotional fulfillment, or responsibility connected with the sexual abuse.

Confront and discuss with client any statements that reflect self-responsibility for the abuse or indicate feelings that he or she is a victim. Then help client develop feelings of empowerment by working through the issues and letting go of the abuse.

Analyze the cost And benefit relationship between being a victim of sexual abuse vs being a survivor of sexual abuse And forgiving vs holding On resentment.

Step 5, Diagnosis:

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider. Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. it is important to note that when completing a diagnosis the clinician must have a very clear picture all
behavioral indicators as they relate to the DSM-5 diagnostic manual.

DSM V Code Paired with ICD_9-CM Codes:

Possible Diagnostic Suggestions for Children with Sexual Abuse History:
(Parenthesis Represents ICD-10-CM Codes Effective 10-2014).

309.89 (F43.8) Other Specified Trauma- and Stressor-Related Disorder
309.9 (F43.9) Unspecified Trauma- and Stressor-Related Disorder
309.21 (F93.0) Separation Anxiety Disorder
312.23 (F94.0) Selective Mutism
309.81 (F43.10) Post Traumatic Stress Disorder (includes Posttraumatic Stress
Specify whether: With dissociative symptoms
Specify if: With delayed expression

308.3 (F43.0) Acute Stress Disorder
Adjustment Disorders Specify whether:
309.0 (F43.21) With depressed mood
309.24 (F43.22) With anxiety
309.28 (F43.23) With mixed anxiety and depressed mood
309.3 (F43.24) With disturbance of conduct
309.4 (F43.25) With mixed disturbance of emotions and conduct
309.9 (F43.20) Unspecified
307.47 (F451.5) Sleep Terror
307.47 (F51.5) Nightmare Disorder
300.23 (F40.1 0) Social Anxiety Disorder (Social Phobia)

Specify if: Performance only

300.01 (F41.0) Panic Attacks

(Only if causes for Panic Attack can not be better explain as a specifier within the context of that main disorder such as Anxiety Disorder, Post Traumatic Stress Disorder etc.).

Panic Attack Specifier

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

Major Depressive Disorder

Single episode

296.21 (F32.0) Mild

296.22 (F32.1) Moderate

296.23 (F32.2) Severe

296.24 (F32.3) With psychotic features

296.25 (F32.4) In partial remission

296.26 (F32.5) In full remission

296.20 (F32.9) Unspecified

Recurrent episode

296.31 (F33.0) Mild

296.32 (F33.1) Moderate

296.33 (F33.2) Severe
296.34 (F33.3) With psychotic features
296.35 (F33.41) In partial remission
296.36 (F33.42) In full remission
296.30 (F33.9) Unspecified

300.4 (F34.1) Persistent Depressive Disorder (Dysthymia)
Specify if: In partial remission, In full remission
Specify if: Early onset, Late onset
Specify if: With pure dysthymic syndrome; With persistent major depressive episode; With intermittent major depressive episodes, will current episode; With intermittent major depressive episodes, without current episode
Specify current severity: Mild, Moderate, Severe

311 (F32.8) Other Specified Depressive Disorder
311 (F32.9) Unspecified Depressive Disorder

301.0 (F60.0) Paranoid Personality Disorder
301.7 (F60.2) Antisocial Personality Disorder
301.83 (F60.3) Borderline Personality Disorder
301.82 (F60.6) Avoidant Personality Disorder
301.6 (F60.7) Dependent Personality Disorder
301.4 (F60.5) Obsessive-Compulsive Personality Disorder

Other Personality Disorders
310.1 (F07.0) Personality Change Due to Another Medical Condition
Specify whether: Labile type, Disinhibited type, Aggressive type, Apathetic type, Paranoid type, Other type, Combined type, Unspecified type
301.89 (F60.89) Other Specified Personality Disorder
301.9 (F60.9) Unspecified Personality Disorder (684)

V71.01 (Z72.811) Adult Antisocial Behavior
V15.49 (Z91.49) Other Personal History of Psychological Trauma
V1541 (Z91.410) Personal history (past history) of spouse or Partner violence
Spouse or Partner Violence, Sexual
Spouse or Partner Violence, Sexual, Confirmed
995.83 (T74.21) Initial encounter
995.83 (T74.2IXD) Subsequent encounter

Spouse or Partner Violence, Sexual, Suspected
995.83 (T76.21) Initial encounter
995.83 (T76.21) Subsequent encounter

Spousal or Partner Abuse, Psychological, Confirmed
995.82 (T74.31 XA) Initial encounter
995.82 (T74.3IXD) Subsequent encounter

Spousal or Partner Abuse, Psychological, Suspected
995.82 (T76.3IXA) Initial encounter
995.82 (T76.3IXD) Subsequent encounter

Spouse or Partner Violence, Physical, Confirmed
995.81 (T74.1 IXA) Initial encounter
995.81 (T74.1 1 XD) Subsequent encounter

Spouse or Partner Violence, Physical, Suspected
995.81 (T76.1 1XA) Initial encounter
995.81 (T76.1 1XD) Subsequent encounter
Overall Integration of a Treatment Plan:

Choose one presenting problem. This problem must be identified through the assessment process.

Select at least 1 to 3 behavioral definitions for the presenting problem. If a behavior definition is not listed feel free to define your own behavioral definition.

Select at least one long-term goal for the presenting problem.

Select at least two short-term goals or objectives. Add a Target Date or the number of sessions required to meet this sure term goals. If none is listed feel free to include your own.

Based on the short-term goals selected previously choose relevant strategies or interventions related to each short term goal. If no strategy or intervention is listed feel free to include your own.

Review the recommended diagnosis listed. Remember, these are only suggestions. Complete the diagnosis based on the client’s assessment data.

Sample Treatment Plan:

***For a full listing of Goals and Strategies aligned next to each other, check the Apps for Windows or Apple PC and Android Devices, under the main menu Windows-Apple Apps, and Download the Free Demo***

Behavioral Descriptors of Problem:

Unexplainable feelings of fear when coming into contact with a close family relative or family friend.

Pervasive pattern and history of promiscuity.
Views relationships on sexualization basis.

Low self esteem related to the experience of sexual abuse.

Long Term Goals:

Start the healing process from sexual abuse with gaining a new enjoyment of appropriate sexual contact.

Successfully work through the issues related to being sexually abused with a greater understanding and better control of feelings.

Learn to recognize and accept the sexual abuse without sexualization of relationships.

Short Term Goal Goal 1:

Increase the ability to talk openly about the feelings of the sexual abuse, reflecting acceptance of the abuse.

Therapeutic Interventions For Goal 1:

Encourage open in talk about the abuse without shame or embarrassment remind that she or he was not responsible for the abuse.

Encourage, and support client in verbally expressing and clarifying feelings associated with
Short Term Goal Goal 2:

Eliminate feelings of shame by allowing client to be able to verbally affirm self as not responsible for abuse.

Therapeutic Interventions For Goal 2:

Give and discuss reading sections such as books from, Healing the Shame That Binds You (Bradshaw), and process key points in therapy as it applies to present feelings of shame.

Assist client identify, express, and process any feelings of guilt linked to feelings of physical pleasure, emotional fulfillment, or responsibility connected with the sexual abuse.

Confront and discuss with client any statements that reflect self-responsibility for the abuse or indicate feelings that he or she is a victim. Then help client develop feelings of empowerment by working through the issues and letting go of the abuse.

Analyze the cost And benefit relationship between being a victim of sexual abuse vs being a survivor of sexual abuse And forgiving vs holding On resentment.

Diagnostic Suggestions:

300.4 (F34.1) Persistent Depressive Disorder (Dysthymia)

Specify if: In partial remission, In full remission
Specify if: Early onset, Late onset

Specify if: With pure dysthymic syndrome; With persistent major depressive episode; With intermittent major depressive episodes, will current episode; With intermittent major depressive episodes, without current episode

Specify current severity: Mild, Moderate, Severe

301.0 (F60.0) Paranoid Personality Disorder

301.82 (F60.6) Avoidant Personality Disorder