Individual Planning: A Treatment Plan Overview for Individuals with Borderline Personality Problems

A Treatment Plan Overview for Individuals with Borderline Personality Problems.

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

***For a full list of 20 short term goals with dozens strategies listed next to each goal check the Child Treatment App for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps. Download the Free Demo to Evaluate***

Course Syllabus:
Introduction

Borderline personality disorder (BPD) is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. This instability often disrupts family and work life, long-term planning, and the individual's sense of self-identity. Originally thought to be at the borderline of psychosis, people with BPD suffer from a disorder of emotion regulation. While less well known than schizophrenia or bipolar disorder (manic-depressive illness), BPD is more common, affecting 2 percent of adults, mostly young women. There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases. Patients often need extensive mental health services, and account for 20 percent of psychiatric hospitalizations. Yet, with help, many improve over time and are eventually able to lead productive lives.

Symptoms:

While a person with depression or bipolar disorder typically endures the same mood for weeks, a person with BPD may experience intense bouts of anger, depression, and anxiety that may last only hours, or at most a day. These may be associated with episodes of impulsive aggression, self-injury, and drug or alcohol abuse. Distortions in cognition and sense of self can lead to frequent changes in long-term goals, career plans, jobs, friendships, gender identity, and values. Sometimes people with BPD view themselves as fundamentally bad, or unworthy. They may feel unfairly misunderstood or mistreated, bored, empty, and have little idea who they are. Such symptoms are most acute when people with BPD feel isolated and lacking in social support, and may result in frantic efforts to avoid being alone.

People with BPD often have highly unstable patterns of social relationships. While they can develop intense but stormy attachments, their attitudes towards family, friends, and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense
anger and dislike). Thus, they may form an immediate attachment and idealize the other person, but when a slight separation or conflict occurs, they switch unexpectedly to the other extreme and angrily accuse the other person of not caring for them at all. Even with family members, individuals with BPD are highly sensitive to rejection, reacting with anger and distress to such mild separations as a vacation, a business trip, or a sudden change in plans. These fears of abandonment seem to be related to difficulties feeling emotionally connected to important persons when they are physically absent, leaving the individual with BPD feeling lost and perhaps worthless. Suicide threats and attempts may occur along with anger at perceived abandonment and disappointments.

People with BPD exhibit other impulsive behaviors, such as excessive spending, binge eating and risky sex. BPD often occurs together with other psychiatric problems, particularly bipolar disorder, depression, anxiety disorders, substance abuse, and other personality disorders.

Borderline personality disorder (BPD) manifests in many different ways, but for the purposes of diagnosis, mental health professionals group the symptoms into nine major categories. In order to be diagnosed with BPD, you must show signs of at least five of these symptoms. Furthermore, these symptoms must be long-standing (usually beginning in adolescence) and pervasive across many areas of your life.

People with borderline personality disorder may experience mood swings and display uncertainty about how they see themselves and their role in the world. As a result, their interests and values can change quickly.

People with borderline personality disorder also tend to view things in extremes, such as all good or all bad. Their opinions of other people can also change quickly. An individual who is seen as a friend one day may be considered an enemy or traitor the next. These shifting feelings can lead to intense and unstable relationships.

Other signs or symptoms may include:

- Efforts to avoid real or imagined abandonment, such as rapidly initiating intimate (physical or emotional) relationships or cutting off communication with someone in anticipation of being abandoned.

- A pattern of intense and unstable relationships with family, friends, and loved ones, often swinging from extreme closeness and love (idealization) to extreme dislike or anger.
Distorted and unstable self-image or sense of self

Impulsive and often dangerous behaviors, such as spending sprees, unsafe sex, substance abuse, reckless driving, and binge eating. Please note: If these behaviors occur primarily during a period of elevated mood or energy, they may be signs of a mood disorder—not borderline personality disorder.

Self-harming behavior, such as cutting

Recurring thoughts of suicidal behaviors or threats

Intense and highly changeable moods, with each episode lasting from a few hours to a few days

Chronic feelings of emptiness

Inappropriate, intense anger or problems controlling anger

Difficulty trusting, which is sometimes accompanied by irrational fear of other people’s intentions

Feelings of dissociation, such as feeling cut off from oneself, seeing oneself from outside one’s body, or feelings of unreality

Not everyone with borderline personality disorder experiences every symptom. Some individuals experience only a few symptoms, while others have many. Symptoms can be triggered by seemingly ordinary events. For example, people with borderline personality disorder may become angry and distressed over minor separations from people to whom they feel close, such as traveling on business trips. The severity and frequency of symptoms and how long they last will vary depending on the individual and their illness.

The 9 symptoms of BPD

Fear of abandonment. People with BPD are often terrified of being abandoned or left alone. Even something as innocuous as a loved one getting home late from work or going away for the weekend can trigger intense fear. This leads to frantic efforts to keep the other person close. One may beg, cling, start fights, jealousy track your loved one’s movements, or even physically block the other person from leaving. Unfortunately, this behavior tends to have the opposite effect—driving others away.
Unstable relationships. People with BPD tend to have relationships that are intense and short-lived. May love quickly, believing each new person is the one who will make you feel whole, only to be quickly disappointed. Relationships either seem perfect or horrible, with nothing in between. Lovers, friends, or family members may feel like they have emotional whiplash from your rapid swings between idealization and devaluation, anger, and hate.

Unclear or unstable self-image. Sense of self is typically unstable. Sometimes may feel good about yourself, but other times hate self, or even view self as evil. Probably don’t have a clear idea of who you are or what he or she wants in life. As a result, may frequently change jobs, friends, lovers, religion, values, goals, and even sexual identity.

Impulsive, self-destructive behaviors. May engage in harmful, sensation-seeking behaviors, especially when upset. May impulsively spend money can’t afford, binge eat, drive recklessly, shoplift, engage in risky sex, or overdo it with drugs or alcohol. These risky behaviors may help feel better in the moment, but they hurt self and those around one over the long-term.

Self-harm. Suicidal behavior and deliberate self-harm is common in people with BPD. Suicidal behavior includes thinking about suicide, making suicidal gestures or threats, or actually carrying out a suicide attempt. Self harm includes all other attempts to hurt self without suicidal intent. Common forms of self-harm include cutting and burning.

Extreme emotional swings. Unstable emotions and moods are common with BPD. One moment, may feel happy, and the next, despondent. Little things that other people brush off can send into an emotional tailspin. These mood swings are intense, but they tend to pass fairly quickly (unlike the emotional swings of depression or bipolar disorder), usually lasting just a few minutes or hour.

Chronic feelings of emptiness. People with BPD often talk about feeling empty, as if there’s a hole or a void inside them. At the extreme, may feel as nothing; or nobody. This feeling is uncomfortable, so he or she may try to fill the hole with things like drugs, food, or sex. But nothing feels truly satisfying.

Explosive anger. May struggle with intense anger and a short temper. May also have trouble controlling self once the fuse is lit—yelling, throwing things, or becoming completely consumed by rage. It’s important to note that this anger isn’t always directed outwards, and may spend a lot of time being angry at self.

Feeling suspicious or out of touch with reality. People with BPD often struggle with paranoia or suspicious thoughts about others; motives. When under stress, may even lose touch with reality—an experience known as dissociation. May feel foggy, spaced out, or as if he or she was outside their own body.

Other Symptoms to Look For:
Extreme emotional reactivity
Anger or aggressive behaviors under minor stress
Anxiety under minor stress
Depression under minor stress
Chaotic and intense interpersonal relationships
Significant identity disturbance
Extreme impulsive self damaging behaviors
Repeated suicidal gestures or threats
Self mutilating behaviors
Chronic feelings of emptiness
Chronic feelings of boredom
Recurrent eruptions of intense anger
Feels others are treating him or her unfairly
Feels that no one can be trusted
Over analyzes most life issues in simple terms of right and wrong
A frantic fear of being left alone (abandoned)
Intense emotions and mood swings
Harmful, impulsive behaviors
Relationship problems
Low self-worth

Treatment:

Treatments for BPD have improved in recent years. Group and individual psychotherapy are at least partially effective for many patients. Within the past 15 years, a new psychosocial treatment termed dialectical behavior therapy (DBT) was developed specifically to treat BPD, and this technique has looked promising in treatment studies. Pharmacological treatments are often prescribed based on specific target symptoms shown by the individual patient. Antidepressant drugs and mood stabilizers may be helpful for depressed and/or labile mood.
Antipsychotic drugs may also be used when there are distortions in thinking.

Recent Research Findings

Although the cause of BPD is unknown, both environmental and genetic factors are thought to play a role in predisposing patients to BPD symptoms and traits. Studies show that many, but not all individuals with BPD report a history of abuse, neglect, or separation as young children. Forty to 71 percent of BPD patients report having been sexually abused, usually by a non-caregiver. Researchers believe that BPD results from a combination of individual vulnerability to environmental stress, neglect or abuse as young children, and a series of events that trigger the onset of the disorder as young adults. Adults with BPD are also considerably more likely to be the victim of violence, including rape and other crimes. This may result from both harmful environments as well as impulsivity and poor judgement in choosing partners and lifestyles.

NIH-funded neuroscience research is revealing brain mechanisms underlying the impulsivity, mood instability, aggression, anger, and negative emotion seen in BPD. Studies suggest that people predisposed to impulsive aggression have impaired regulation of the neural circuits that modulate emotion. The amygdala, a small almond-shaped structure deep inside the brain, is an important component of the circuit that regulates negative emotion. In response to signals from other brain centers indicating a perceived threat, it marshals fear and arousal. This might be more pronounced under the influence of drugs like alcohol, or stress. Areas in the front of the brain (prefrontal area) act to dampen the activity of this circuit. Recent brain imaging studies show that individual differences in the ability to activate regions of the prefrontal cerebral cortex thought to be involved in inhibitory activity predict the ability to suppress negative emotion.

Serotonin, norepinephrine and acetylcholine are among the chemical messengers in these circuits that play a role in the regulation of emotions, including sadness, anger, anxiety, and irritability. Drugs that enhance brain serotonin function may improve emotional symptoms in BPD. Likewise, mood-stabilizing drugs that are known to enhance the activity of GABA, the brain’s major inhibitory neurotransmitter, may help people who experience BPD-like mood swings. Such brain-based vulnerabilities can be managed with help from behavioral interventions and medications, much like people manage susceptibility to diabetes or high blood pressure.

Studies that translate basic findings about the neural basis of temperament, mood regulation, and cognition into clinically relevant insights which bear directly on BPD represent a growing area of NIH-supported research. Research is also underway to test the efficacy of combining medications with behavioral treatments like DBT, and gauging the effect of childhood abuse and other stress in BPD on brain hormones. Data from the first prospective, longitudinal study of BPD, which began in the early 1990s, is expected to reveal how treatment affects the course of the illness. It will also pinpoint specific environmental
factors and personality traits that predict a more favorable outcome. The Institute is also collaborating with a private foundation to help attract new researchers to develop a better understanding and better treatment for BPD.

Diagnosis:

Borderline personality disorder is rarely diagnosed on its own. Common co-occurring disorders include:

- depression or bipolar disorder
- substance abuse
- eating disorders
- anxiety disorders

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, the following criteria must be met:

A. Significant impairments in personality functioning manifest by: 1. Impairments in self functioning (a or b):

a. Identity: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self criticism; chronic feelings of emptiness; dissociative states under stress.

b. Self-direction: Instability in goals, aspirations, values, or career plans.

AND 2. Impairments in interpersonal functioning (a or b):

a. Empathy: Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.

b. Intimacy: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over involvement and withdrawal.
B. Pathological personality traits in the following domains:

1. Negative Affectivity, characterized by:
   
a. Emotional lability: Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.

   b. Anxiousness: Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.

   c. Separation insecurity: Fears of rejection by and/or separation from significant others, associated with fears of excessive dependency and complete loss of autonomy.

   d. Depressivity: Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behavior.

2. Disinhibition, characterized by:

   a. Impulsivity: Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.

   b. Risk taking: Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.

3. Antagonism, characterized by: a. Hostility: Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.

D. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.

E. The impairments in personality functioning and the individual's personality trait
expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

It's important to check for other Personality Disorders such as:

- Narcissistic Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Schizotypal Personality Disorder
- Personality Disorder Trait Specified
- Avoidant Personality Disorder
- Antisocial Personality Disorder

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
There are different sources of data that may be obtained from:

- 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 are 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 not need 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).

Behavioral Indicators for Adults with Borderline for Personality Disorders:

A. Extreme emotional reactivity (anger, anxiety, or depression) under minor stress.

B. A pattern of chaotic and intense interpersonal relationships.

C. Significant identity disturbance.

D. Impulsive behaviors that are extreme and self-damaging.

E. Repeated suicidal gestures, threats, or self-mutilating behaviors.

F. Chronic feelings and thoughts of emptiness and boredom.

G. Recurrent eruptions of intense inappropriate anger.

H. Easily feels that others are treating him or her unfairly or that no one can be trusted.

I. Over analyzes most life issues in simple terms of right and wrong (such as, black or white, trustworthy or deceitful) without regard for any circumstances or complex issues about the situations.

J. Becomes extremely anxious with any hint of a perceived abandonment in a relationship.

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 Borderline for Personality Disorders:

A. Acquire and demonstrate coping skills to deal with mood swings.
B. Acquire the ability to control impulsive behavior.
C. Learn strategies to deal with dysphoric moods.
D. Substitute dichotomous thinking with ability to tolerate ambiguity and complexity in people and issues.
E. Acquire and show anger management skills.
F. Learn and role play new interpersonal relationship skills.
G. Lower the frequency of self-damaging behaviors (such as, suicidal behaviors, reckless driving, sexual acting out, binge eating, or substance abuse).

Step 3, Objective or Short Term Goal Construction:

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 &ldquo;13. Increase positive self-descriptive statements.&rdquo; Can be restated as; &ldquo;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&rdquo; 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.

Examples of Short Term Goals for Adults with Borderline for Personality Disorders:

A. Identify and list the negative cognitive interpretation patterns that interfere the intense negative emotions.

B. Express realistic, positive self-talk to replace any distorted negative messages.

C. Record and list examples of how to implement positive self-talk and constructive automatic thoughts; including rewarding consequences.

D. Identify and list some negative consequences of self-defeating impulsive behaviors on self and others.

E. Teach and practice how to use impulse control strategy of -stop, look, listen, and think-

Step 4, 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 Strategies or Interventions for Adults with Borderline for Personality Disorders:
A. Explore situations that initiate feelings of fear, depression, and anger.

B. Record a daily journal of circumstances and feelings that he or she is reacting to.

C. Identify and list the distorted schemas and automatic thoughts that initiate anxiety response.

D. Require patient to keep a daily record of self-defeating thoughts (hopelessness, helplessness, worthlessness, catastrophizing, pessimism, etc.), and challenge each thought for accuracy, then replace each dysfunctional thought with a positive and self-enhancing thought.

E. Train patient how to revise core schema using cognitive restructuring techniques.

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 (Parenthesis Represents ICD-10-CM Codes Effective 10-2014):

Possible Diagnostic Suggestions for Adults with Borderline Personality Disorder Traits:

Cluster A Personality Disorders

301.0 (F60.0) Paranoid Personality Disorder

301.20 (F60.1) Schizoid Personality Disorder

301.22 (F21) Schizotypal Personality Disorder

Cluster B Personality Disorders
301.7 (F60.2) Antisocial Personality Disorder
301.83 (F60.3) Borderline Personality Disorder
301.50 (F60.4) Histrionic Personality Disorder
301.81 (F60.81) Narcissistic Personality Disorder

Cluster C Personality Disorders
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

309.81 (F43.1 0) Posttraumatic Stress Disorder (includes Posttraumatic Stress
Specify whether: With dissociative symptoms
Specify if: With delayed expression

312.34 (F6381) Intermittent Explosive Disorder

Bipolar I Disorder Specify: Current or most recent episode manic
296.41 (F31.1 1) Mild
296.42 (F31.12) Moderate
296.43 (F31.13) Severe
296.44 (F31.2) With psychotic features
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified
296.40 (F31.0) Current or most recent episode hypomanic
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified
296.51 (F31.31) Mild
296.52 (F31.32) Moderate
296.53 (F31.4) Severe
296.54 (F31.5) With psychotic features
296.55 (F31.75) In partial remission
296.56 (F31.76) In full remission
296.50 (F31.9) Unspecified
296.7 (F31.9) Current or most recent episode unspecified

296.89 (F31.81) Bipolar II Disorder
Specify current or most recent episode: Hypomanic, Depressed
Specify course if full criteria for a mood episode are not currently met: In partial remission, In full remission
Specify severity if full criteria for a mood episode are not currently met:
Mild, Moderate, Severe

301.13 (F34.0) Cyclothymic Disorder
Specify if: With anxious distress
Substance/Medication-Induced Bipolar and Related Disorder

293.83 Bipolar and Related Disorder Due to Another Medical Condition

Specify if:

(F06.33) With manic features

(F06.33) With manic- or hypomanic-like episode

(F06.34) With mixed features

296.89 (F31.89) Other Specified Bipolar and Related Disorder

296.80 (F31.9) Unspecified Bipolar and Related Disorder

V71.01 (Z72.811) Adult Antisocial Behavior

V15.49 (Z91.49) Other Personal History of Psychological Trauma

V62.22 (Z65.5) Exposure to Disaster, War, or Other Hostilities

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(T76.31XA) Initial encounter

995.82 (T76.3IXD) 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 short 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:

Behavioral Descriptors of Problem:

1. Easily feels that others are treating him or her unfairly or that no one can be trusted.
2. Recurrent eruptions of intense inappropriate anger.
3. Chronic feelings and thoughts of emptiness and boredom.

Long Term Goals:

1. Acquire and demonstrate coping skills to deal with mood swings.
2. Acquire the ability to control impulsive behavior.

Short Term Goals Objectives:

1. Identify and list some negative consequences of self-defeating impulsive behaviors on self and others.
2. Use cognitive methods to control impulsive behavior.

Strategy or Intervention for Goal 1:

1. Identify and list the distorted schemas and automatic thoughts that initiate anxiety response.
2. Require patient to keep a daily record of self-defeating thoughts (hopelessness, helplessness, worthlessness, catastrophizing, pessimism, etc.), and challenge each thought for accuracy, then replace each dysfunctional thought with a positive and self-enhancing thought.

Strategy or Intervention for Goal 2:

1. Reinforce positive, realistic cognitive self-talk that gives patient a sense of peace.
2. Assign patient to record examples of successfully constructive cognitive patterns. Process and reinforce positive consequences to these patterns.
Diagnostic Suggestions:

301.83 (F60.3) Borderline Personality Disorder

V1541 (Z91.410) Personal history (past history) of spouse or Partner violence

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