Individual Planning: A Treatment Plan Overview for Individuals with Paranoid Disorder

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

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Course Syllabus:

Introduction
Symptoms

Causes

Diagnosis

Subtypes of Paranoid Disorder

Treatment

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

Introduction:

Excessive distrust and suspicion characterize this condition. People with paranoid personalities rarely confide in others, and tend to misinterpret harmless comments and behavior as malicious. The word personality describes deeply ingrained patterns of behavior and the manner in which individuals perceive, relate to, and think about themselves and their world. Personality traits are conspicuous features of personality and are not necessarily pathological, although certain styles of personality traits may cause interpersonal problems. Personality disorders are enduring patterns of inner experience and behavior that deviate markedly from the expectations of an individual's culture. They must be rigid, inflexible, and maladaptive and of sufficient severity to cause significant impairment in functioning or internal distress.

Paranoid personality disorder is an unwarranted tendency to interpret the actions of other people as deliberately threatening or demeaning. The disorder, surfacing by early adulthood, is manifested by an omnipresent sense of distrust and unjustified suspicion that yields persistent misinterpretation of others' intentions as being malicious. People with a paranoid personality disorder are usually unable to acknowledge their own negative feelings toward others but do not generally lose touch with reality. They will not confide in people, even if they prove trustworthy, for fear of being exploited or betrayed. They will often misinterpret harmless comments and behavior from others and may build up and harbor unfounded resentment for an unreasonable length of time.

Symptoms:

Paranoid personality disorder (PPD) is a type of eccentric personality disorder. An eccentric personality disorder means that the person's behavior may seem odd or unusual to
An individual with paranoid personality behavior is very suspicious of other people. They mistrust the motives of others and believe that others want to harm them. Additional hallmarks of this condition include being reluctant to confide in others, bearing grudges, and finding demeaning or threatening subtext in even the most innocent of comments or events. A person with PPD can be quick to feel anger and feel hostile toward others.

People with PPD are always on guard, believing that others are constantly trying to demean, harm, or threaten them. These generally unfounded beliefs, as well as their habits of blame and distrust, might interfere with their ability to form close relationships.

Often, people with paranoid personality disorder don’t believe that their behavior is abnormal. It may seem completely rational to a person with PPD to be suspicious of others. However, those around them may believe this distrust is unwarranted and offensive. The person with PPD may behave in a hostile or stubborn manner. They may be sarcastic, which often elicits a hostile response from others, which may seem to confirm their original suspicions.

Someone with PPD may have other conditions that can feed into their PPD. For example, depression and anxiety can affect a person’s mood. Mood changes can make someone with PPD more likely to feel paranoid and isolated.

Some symptoms of PPD can be similar to symptoms of other disorders. Schizophrenia and borderline personality disorder are two disorders with symptoms similar to PPD. It can be difficult to clearly diagnose these disorders.

People with this disorder:

- Doubt the commitment, loyalty, or trustworthiness of others, believing others are using or deceiving them
- Are reluctant to confide in others or reveal personal information due to a fear that the information will be used against them
- Are unforgiving and hold grudges
- Are hypersensitive and take criticism poorly
- Read hidden meanings in the innocent remarks or casual looks of others
- Perceive attacks on their character that are not apparent to others; they generally react with
anger and are quick to retaliate

Have recurrent suspicions, without reason, that their spouses or lovers are being unfaithful

Are generally cold and distant in their relationships with others, and might become controlling and jealous

Cannot see their role in problems or conflicts and believe they are always right

Have difficulty relaxing

Are hostile, stubborn, and argumentative

Other symptoms to check for:

1. Extreme obsessive distrust of others or someone specifically
2. Expectation of being exploited by others
3. Expectation of being harmed by others
4. Misinterpretation of non-threatening events
5. Hypersensitivity to opinions
6. Hypersensitivity to critical judgment by others
7. Tendency to keep distance from others
8. Avoids getting hurt or taken advantage of
9. Easily offended and quick to anger
10. Very defensive behavior tendencies
11. Suspicious of loyalty or fidelity
12. Extreme social anxiety
13. Having beliefs of being harassed or persecuted
14. Belief that one is being treated unfairly
15. Beliefs involving general suspiciousness about others' motives or intent.
16. An exaggerated sometimes grandiose belief or suspicion
17. Beliefs not of a delusional nature
18. Inappropriate constricted affect
19. Odd behaviors or thinking
20. No close friends or confidants - non relative

Causes:

The exact cause of PPD is not known, but it likely involves a combination of biological and psychological factors. The fact that PPD is more common in people who have close relatives with schizophrenia suggests a genetic link between the two disorders. Early childhood experiences, including physical or emotional trauma, are also suspected to play a role in the development of PPD.

A genetic contribution to paranoid traits and a possible genetic link between this personality disorder and schizophrenia exist. Psychosocial theories implicate projection of negative internal feelings and parental modeling.

Paranoid personality disorder occurs in about 0.5%-2.5% of the general population. It is seen in 2%-10% of psychiatric outpatients. It occurs more commonly in males. A large long-term Norwegian twin study found paranoid personality disorder to be modestly heritable and to share a portion of its genetic and environmental risk factors with schizoid and schizotypal personality disorder.

Diagnosis:

Paranoid personality disorder generally isn’t diagnosed when another psychotic disorder, such as schizophrenia or a bipolar or depressive disorder with psychotic features, has already been diagnosed in the person.

Because personality disorders describe long-standing and enduring patterns of behavior, they are most often diagnosed in adulthood. It is uncommon for them to be diagnosed in childhood or adolescence, because a child or teen is under constant development, personality changes, and maturation. However, if it is diagnosed in a child or teen, the features must have been present for at least 1 year.

Paranoid personality disorder is more prevalent in males than females, and occurs somewhere between 2.3 and 4.4 percent in the general population.

Like most personality disorders, paranoid personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the
time they are in their 40s or 50s.

Paranoid personality disorder is a psychiatric diagnosis characterized by paranoia and a pervasive, long-standing suspiciousness and generalized mistrust of others.

Those with the condition are hypersensitive, are easily slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions to validate their prejudicial ideas or biases. They tend to be guarded and suspicious and have quite constricted emotional lives. Their incapacity for meaningful emotional involvement and the general pattern of isolated withdrawal often lend a quality of schizoid isolation to their life experience.

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR, a widely used manual for diagnosing mental disorders, defines paranoid personality disorder (in Axis II Cluster A) as:

A) A pervasive distrust and suspicion of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3. is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4. reads benign remarks or events as threatening or demeaning.
5. persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
6. perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7. has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B) Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features or another psychotic disorder and is not due to the direct physiological
effects of a general medical condition.

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Diagnostic criteria (ICD-10):

The World Health Organization's ICD-10 lists paranoid personality disorder as (F60.0) Paranoid personality disorder. It is characterized by at least 3 of the following:

1. excessive sensitivity to setbacks and rebuffs;
2. tendency to bear grudges persistently, i.e. refusal to forgive insults and injuries or slights;
3. suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous;
4. a combative and tenacious sense of personal rights out of keeping with the actual situation;
5. recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner;
6. tendency to experience excessive self-importance, manifest in a persistent self-referential attitude;
7. preoccupation with unsubstantiated conspiratorial explanations of events both immediate to the patient and in the world at large.

Includes expansive paranoid, fanatic, querulant and sensitive paranoid personality (disorder), and excludes delusional disorders and schizophrenia

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Differential diagnosis: associated and overlapping conditions commonly coexist (comorbid) with paranoid personality disorder:
very brief psychotic episodes (lasting minutes to hours)
delusional disorder
schizophrenia
major depressive disorder
agoraphobia
obsessive-compulsive disorder
alcohol and substance-related disorders
schizoid personality disorder
schizotypal personality disorder
narcissistic personality disorder
avoidant personality disorder
borderline personality disorder

Subtypes of Paranoid Disorder:

The Fanatic Paranoid: The fanatic paranoid pattern often resembles the narcissistic personality, as this variant is an interweaving of both paranoid and narcissistic traits. Like the narcissist, the fanatic variant of the paranoid pattern comes across as arrogant, pretentious, and expansive and maintains an air of contempt toward others. A major difference is that narcissists often achieve some success, whereas fanatic paranoids run hard into reality, their narcissism profoundly wounded. Fallen from grace, their self-image of perfection shattered, fanatic paranoids seek to reestablish lost pride through extravagant claims and intricate fantasies, endowing themselves with illusory powers, becoming superheroes ready to prevail against an evil universe.

Delusions of grandeur becomes the primary coping mechanism. By assuming a grandiose identity, fanatic paranoids offset the collapse of self-esteem produced by hard reality. They present themselves as inspired leader, or talented genius. Elaborate schemes are devised by which to deliver the world from sin, lead the planet to world peace, solve long-standing scientific problems, or create utopian societies. Often, their plans are sufficiently detailed to gain an interest from others. When their ideas are dismissed by others, they attribute interference to intangible powers, perhaps secret government agencies that have conspired to preserve the status quo. Projection, righteous indignation, and a sense of omnipotence create a defensive armor in this subtype.
Developmentally, fanatic paranoids are similar to compensating narcissists. Overindulged and unrestrained by parents, their imagination of what they might become in life was given free reign and encouraged by caretakers, perhaps as a means of compensating for poor family status. Once beyond the protective confines of the household, however, the image of superiority was quickly and unmercifully destroyed by the outside world. Completely defeated and a crushed sensed of self-worth, and unwilling to face reality, they retreat deeper inside their private world of fantasy, creating a compensatory universe in which they can assume their former station, fulfill previous ambitions, and salvage their existence.

The Malignant Paranoid: Malignant paranoids combine paranoid and sadistic personalities. They are highly sensitive to power issues, they focus on strategies is to dominate you before you can dominate them. Intimidating and belligerent, they have a ruthless desire to avenge past wrongs and triumph over others. They build expectations that they can be on the receiving end of others’ aggressions. The long list of perceived wrongs done to them constantly rises into awareness, always keeping a potential for aggression surfacing to awareness. If efforts at abusing and terrorizing others backfire, it leads them to seek retribution more through fantasy than action. These setbacks are wrought by their own hand, provoking abundant opposition.

As they become isolated, they are left to ruminate over this self-created perpetual cycle of interpersonal hostility, and they focus on the perceived malicious nature of their hostile environment, complete with the evil individuals who inhabit it. Via the mechanism of projection, they begin to attribute their own bitterness to others, projecting to them all of the enmity they feel within themselves. As the line between objective antagonism and imagined hostility blurs, the belief that others are intentionally persecuting them may takes delusional proportions.

The need to protect their autonomy against any and all outside influence is a major feature of malignant paranoids because nothing is so valuable and vulnerable to them as their sense of self-worth. This is particularly evident within the content of their persecutory delusions. The evil they perceive emanating from others is neither casual nor random but designed to intimidate, offend, undermine their self-esteem. Especially, focussed to control their thoughts, and weaken their will. Always alert against their darkest fears: Others will forced them to submit to authority, or worse, tricked into surrendering their self-determination.

The Obdurate Paranoid: Obdurate paranoids combine aspects of the paranoid and compulsive personalities, but like all paranoid patterns, they are more unstable and pathological than their compulsive counterparts. Like the compulsive, they are rigid, perfectionistic, grim, humorless, tense, overcontrolled, small-minded, peevish, legalistic, and self-righteous. However, whereas compulsives temper their angst with the belief that success and happiness can be achieved by conforming to the dictates of authority, obdurate paranoids renounce this dependency, taking on a posture of unabashed self-assertion. They actively rebel against any and all external constraints in a maladaptive effort to regain their
sense of perceived control and overturn injustices previously doled out on them.

While they do continue to seek clarity from imposed rules and regulations, they are now the imposers of a system that is used to attack others, usually through either legal action or the setting of impossible rules that cannot realistically be followed. Those in this paranoid personality wake are despised for their weakness, their sloppiness and lack of regard for disciplined behavior, their failure to live an organized life, and their hypocrisy.

Despite these assertions of nonconformity and dominance, however, obdurate paranoids are not likely to eschew deep-seated feelings of guilt and fear of retribution. Further, they may appear to function normally much of the time but possess tightly compartmentalized persecutory delusions. These tendencies go largely unnoticed, but the individual’s hypersensitive antennae are perpetually in alert mode, noticing any unusual twitch, remark, or facial expression emanating from nearby others. It is not unusual for this paranoid pattern to project their anger onto others—thereby creating the perception of hostile intent from innocuous or absent signals. In fact, what we now think of as “classical paranoia,” that is, compartmentalized beliefs separate and apart from a patient’s usual thought process, usually emanates from those of the obdurate variant because of their tightly controlled, segmented belief structure: When a sensitive nerve is touched, their otherwise normal functioning is impaired and the hidden beliefs become manifest.

The Querulous Paranoid: The querulous paranoid combines aspects of the paranoid with negativistic patterns, with the latter contributing characteristics such as discontentment, pessimism, stubbornness, vacillation, and vengefulness. When combined with paranoid projection, these traits are amplified into overt hostility and forthright delusions. This result manifests in tones of faultfinding, sullenness, resentfulness, contentiousness, jealousy, and insistence on being forever wronged or cheated. It is rare to find these individuals in sustained, healthy relationships. Instead, these persons tend to give up their quests for affection and move to a contrived stance of autonomy and self-determination, renouncing their social needs yet harboring a cloaked sense of dejection. While they state their newfound independence with vengeful fury, the querulous variant remains deeply troubled by interpersonal discontentedness and feelings of indecisiveness, with hidden feelings vacillating between desiring the company of others and feeling repulsed by them.

As envy mounts, they often complain that the achievements of others reflect unfair advantages or preferential treatment. Grumbling turns to anger and spite as their fantasies of being taken advantage of accrete ever more injustices. Legal action against those who have wronged them is common, as are erotic delusions because the querulous paranoid does still seek affection even while refusing it. This is done via the intrapsychic projection mechanism, whereby the individual comes to believe that the feelings of the self are actually emanating from others. Thus, by projecting their own desires onto others, it becomes “them” who make lewd remarks or otherwise suggest sexual intentions. Accusations of infidelity, deceit, and betrayal are often made against innocent relatives and friends, a further synthesis of the negativistic and paranoid patterns.
The Insular Paranoid: The insular paranoid combines aspects of the paranoid and avoidant personalities. Such individuals are often moody, apprehensive, and hypersensitive to criticism, especially where their worth and achievements are concerned. Extremely vulnerable, many insular paranoids seek solace in self-focused ways. For example, they may engage in abstruse intellectual activities to enhance their self-esteem or indulge in drugs and alcohol to calm their fears. Especially fearful of shame and humiliation, insular paranoids seek to defend themselves against both real and imagined dangers. More than most, they seek to protect themselves from a world both threatening and destructive. As such, they may isolate themselves for long periods of time, a means of keeping the inevitable judgments of others out of their lives.

Insular paranoids also have an unusually strong fear of being controlled. They not only seek to prevent external influence but also desire to rely solely on their own conclusions and beliefs. Unwilling to check their thoughts against consensual reality, they grow more and more out of touch with the surrounding world, eventually losing the ability to distinguish fantasy from reality. Fears of shame and humiliation, an important component of both the paranoid and avoidant patterns, easily inflate to full-blown conspiracies. Eventually, their thoughts may become so painful and terrifying that they begin intentionally to interrupt the continuity and focus of their perceptions, distracting themselves from their own thoughts. By deserting themselves, their inner world becomes a chaotic mélange of distorted, incidental, and unconnected notions, the threshold of a decompensated paranoid state.

Treatment:

People with PPD often do not seek treatment on their own because they do not see themselves as having a problem. When treatment is sought, psychotherapy (a form of counseling) is the treatment of choice for PPD. Treatment likely will focus on increasing general coping skills, as well as on improving social interaction, communication, and self-esteem.

Because trust is an important factor of psychotherapy, treatment is challenging since people with PPD have such distrust of others. As a result, many people with PPD do not follow their treatment plan.

Treatment of paranoid personality disorder can be very effective in controlling the paranoia but is difficult because the person may be suspicious of the doctor. Without treatment this disorder will be chronic. Medications and therapy are common and effective approaches to alleviating the disorder.

The thinking and behaviors associated with PPD can interfere with a person's ability to maintain relationships, as well as their ability to function socially and in work situations. In many cases, people with PPD become involved in legal battles, suing people or companies they believe are "out to get them."
The social consequences of serious mental disorders-family disruption, loss of employment and housing-can be calamitous. Comprehensive treatment, which includes services that exist outside the formal treatment system, is crucial to ameliorate symptoms, assist recovery, and, to the extent that these efforts are successful, redress stigma. Consumer self-help programs, family self-help, advocacy, and services for housing and vocational assistance complement and supplement the formal treatment system. Consumers (people who use mental health services themselves) operate many of these services. The logic behind their leadership in delivery of these services is that consumers are thought to be capable of engaging others with mental disorders, serving as role models, and increasing the sensitivity of service systems to the needs of people with mental disorders.

Medications for paranoid personality disorder are generally not encouraged, as they may contribute to a heightened sense of suspicion that can ultimately lead to patient withdrawal from therapy. They are suggested, however, for the treatment of specific conditions of the disorder, such as severe anxiety or delusions, where these symptoms begin to impede normal functioning. An anti-anxiety agent, such as diazepam, is appropriate to prescribe if the client suffers from severe anxiety or agitation where it begins to interfere with normal, daily functioning. An anti-psychotic medication, such as thioridazine or haloperidol, may be appropriate if a patient decompensates into severe agitation or delusional thinking which may result in self-harm or harm to others. Medications prescribed for precise conditions should be used for the briefest interval possible.

Psychotherapy is the most promising method of treatment for paranoid personality disorder. People with this disorder often have deep-rooted problems with interpersonal functioning that necessitate intense therapy. A strong therapist-client relationship offers the most benefit to people with the disorder, yet is extremely difficult to establish due to the dramatic skepticism of patients with this condition. People with paranoid personality disorder rarely initiate treatment and often terminate it prematurely. Likewise, building therapist-client trust requires care and is complicated to maintain even after a confidence level has been founded. Most patients with this disorder experience symptoms for the duration of their lifetime and require consistent therapy.

The outlook for people with PPD varies. It is a chronic disorder, which means it tends to last throughout a person's life. Although some people can function fairly well with PPD and are able to marry and hold jobs, others are completely disabled by the disorder. Because people with PPD tend to resist treatment, the outcome often is poor.

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 the built-in 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 Individuals with Paranoid Disorder:**
Extreme distrust of others or someone specifically, without sufficient basis.

Expectation of being exploited by others.

Expectation of being harmed by others.

Misinterpretation of non-threatening events as having threatening personal significance.

Hypersensitivity to opinions or personal critical judgment by others.

Tendency to keep distance from others to avoid getting hurt or taken advantage of.

Easily offended and quick to anger; defensive behavior.

Very defensive behavior tendencies.

Suspicious of loyalty or fidelity of spouse or significant other without reason.

Obsessional mistrust to the point of disrupting patient’s daily functioning.

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 Individuals with Paranoid Disorder:

Learn to trust in others by speaking positively about others and reporting a comfort in socializing.

Engage and interact with others without becoming defensive or angry.

Express trust of significant other and terminate accusations of disloyalty.

Reduce vigilance and suspicion around others and be more relaxed, trusting, and open to interaction.
Accomplish a level of ability to concentrate on important matters without any interference from suspicious obsessions.

Normal appropriate functioning at work, in social relationships with only minimal interference from distrustful obsessions.

Step 3 and 4, 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 measurables 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:

Explore fears of personal inadequacy and vulnerability.

Therapeutic Interventions For Goal 1:

Assess historical sources of vulnerability in family of origin experiences, and explore fears of personal inadequacy and vulnerability.

Identify and verbalize fears of own anger as the source for mistrust of others.

Explore and identify feelings and fears of personal inadequacy and vulnerability.

Short Term Goal Goal 2:

Identify and list core beliefs that others are untrustworthy and evil.

Therapeutic Interventions For Goal 2:
Assess social interactions and explore distorted cognitive beliefs operative during interactions, and replace these core beliefs that are irrational and trigger paranoid feelings.

Identify the basis untrusting others, and list fears and degree of irrational thinking and how it impacts the ability to trust others.

Identify problems with anxious and irrational thinking thoughts that client may know are irrational, and yet he or she struggles to convince themselves, and identify more logical and reasoned response when relating and trusting others.

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 Experiencing Paranoid Behaviors: Disorders

300.23 (F40.10) Social Anxiety Disorder (Social Phobia)
301.22 (F21) Schizotypal (Personality) Disorder
297.1 (F22) Delusional Disorder
Specify whether:
Erotomanic type, Grandiose type, Jealous type, Persecutory type, Somatic type, Mixed type, Unspecified type

Specify if: With bizarre content

298.8 (F23) Brief Psychotic Disorder
Specify if: With marked stressor(s), Without marked stressor(s), With postpartum onset

295.40 (F20.81) Schizotypal Disorder
Specify if: With good prognostic features
Without good prognostic features

295.90 (F20.9) Schizophrenia
Schizoaffective Disorder
Specify whether:
295.70 (F25.0) Bipolar type
295.70 (F25.1) Depressive type

Substance/Medication Induced Psychotic Disorder
Specify if:
With onset during intoxication,
With onset during withdrawal

Psychotic Disorder Due to Another Medical condition
Specify whether:
293.81 (F06.2) With delusions
293.82 (F06.0) With hallucinations
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
301.0 (F60.0) Paranoid Personality Disorder
301.20 (F60.1) Schizoid Personality Disorder
301.22 (F21) Schizotypal Personality Disorder

***Check for Other Substance Addictive Disorders

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:
Behavioral Descriptors of Problem:

Extreme distrust of others or someone specifically, without sufficient basis.

Expectation of being exploited by others.

Expectation of being harmed by others.

Long Term Goals:

Learn to trust in others by speaking positively about others and reporting a comfort in socializing.

Engage and interact with others without becoming defensive or angry.

Express trust of significant other and terminate accusations of disloyalty.

Short Term Goal Goal 1:

Explore fears of personal inadequacy and vulnerability.

Therapeutic Interventions For Goal 1:

Assess historical sources of vulnerability in family of origin experiences, and explore fears of personal inadequacy and vulnerability.

Identify and verbalize fears of own anger as the source for mistrust of others.

Explore and identify feelings and fears of personal inadequacy and vulnerability.
Short Term Goal Goal 2:

Identify and list core beliefs that others are untrustworthy and evil.

Therapeutic Interventions For Goal 2:

Assess social interactions and explore distorted cognitive beliefs operative during interactions, and replace these core beliefs that are irrational and trigger paranoid feelings.

Identify the basis untrusting others, and list fears and degree of irrational thinking and how it impacts the ability to trust others.

Identify problems with anxious and irrational thinking thoughts that client may know are irrational, and yet he or she struggles to convince themselves, and identify more logical and reasoned response when relating and trusting others.

Diagnostic Suggestions:

300.23 (F40.10) Social Anxiety Disorder (Social Phobia)

297.1 (F22) Delusional Disorder - Grandiose type, With bizarre content

298.8 (F23) Brief Psychotic Disorder - With marked stressor(s),