COURSES ARTICLE - THERAPYTOOLS.US

Child Planning: A Treatment Planning Approach for Children with Anger Problems

A Treatment Overview for Children with Anger Problems

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms of children with lying problems or history, and learn 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

Most children have occasional tantrums or meltdowns. They may sometimes lash out if they're frustrated. Or they may be defiant if asked to do something they don't want to do. But when kids do these things repeatedly, or can't control their tempers a lot of the time, it may be more than typical behavior.

We all become angry at times. Anger is a natural human emotion, one of many responses we can express when we are frustrated and prevented from reaching our goals. Since anger is a universal emotion, it seems logical to conclude that there is nothing wrong with feeling angry. The problem occurs when anger leads to inappropriate actions or behavior. The problem, then, is not being angry but dealing with angry feelings in an ineffective way.

Childhood experiences as well as inborn temperament powerfully influence the way parents express anger and teach their children to manage anger. How do you respond when you're angry? Do you become cynical or overreact? Do you yell? Do you hit your children? How did your parents respond to you when you were angry as a child? Did they punish you? Did they shame or blame you? Do you have a tough time dealing with anger because your parents didn't know how to deal with it?

We choose to view anger as a signal, an indication to the individual that a goal or outcome is being blocked and that frustration is building. How children - or adults, for that matter - learn to respond to this signal will determine ultimately whether they manage anger or anger manages them. In response to anger, some blame others as the source of their problems. They use anger as fuel to drive and justify what they view as a necessary response. Yet anger is best viewed as a signal to take action rather than a sign of being treated unfairly.
What Role Does Anger Play in Everyday Life?

Anger begins as an emotion of varying intensity. It can be experienced as a mild irritation or as unbearable frustration. At the extreme end, particularly for children who are impulsive or inflexible, anger often leads to intense fury and rage. As with other emotions, anger is accompanied by physical and biological changes in the body. Heart rate and blood pressure increase. Levels of certain hormones, such as adrenaline, increase, leading to other physical changes in the body. Some researchers have suggested that aggression in response to anger may be instinctual. They believe that anger may be a natural, adaptive response to stress, allowing people to respond to a perceived threat and defend themselves. Therefore, a certain amount of anger is likely necessary for survival, even in our complex, civilized society. But when defense occurs in the absence of true provocation, anger becomes a liability. It also becomes a liability when we react verbally or physically in an extreme way to angry feelings, when children are unable to modulate anger, or when problems occur at home, on the playground, and in the classroom.

Causes:

When children continue to have regular emotional outbursts, it's usually a symptom of distress. The first step is understanding what's triggering your child's behavior. There are many possible underlying causes, including:

ADHD: Many children with ADHD, especially those who experience impulsivity and hyperactivity, have trouble controlling their behavior. They may find it very hard to comply with instructions or switch from one activity to another. That makes them appear defiant and angry. More than 50 percent of kids with ADHD also exhibit defiance and emotional outbursts. Their inability to focus and complete tasks can also lead to tantrums, arguing, and power struggles. That doesn't necessarily mean they've been diagnosed with ADHD. In fact, ADHD is sometimes overlooked in kids who have a history of severe aggression because there are so many bigger issues. (Read more about the connection between ADHD and aggression.)

Anxiety: Children who seem angry and defiant often have severe, and unrecognized, anxiety. If your child has anxiety, especially if he's hiding it, he may have a hard time coping with situations that cause him distress. He may lash out when demands at school, for
instance, put pressure on him that he can’t handle. In an anxiety-inducing situation, your child’s “fight or flight” instinct may take hold. He may have a tantrum or refuse to do something to avoid the source of acute fear.

Trauma or neglect: A lot of acting out in school is the result of trauma, neglect or chaos at home. "Kids who are struggling, not feeling safe at home can act [out] at school, with fairly intimidating kinds of behavior," says Nancy Rappaport, M.D., a Harvard Medical School professor who specializes in mental health care in a school setting. Most at risk, she says, are kids with ADHD who’ve also experienced trauma.

Physical Abuse or Sexual Abuse is a cause of anger. Physical abuse of a child is certain to create excessive anger. Children who are abused learn to solve their problems through violence and force. They feel powerless during the time of their abuse and often suppress the feelings of anger at their parent, but later, when they are teens, it may resurface in violent and out of control behavior.

Emotional Abuse is a cause of anger. A family environment where anger is suppressed is also likely to create a child who has poor anger management skills. If a child is not allowed to express their feelings of anger, or is made to feel bad or guilty because of their feelings of anger, it is possible that they will have a very hard time with emotional regulation.

Inconsistent Parenting is a cause of anger. Children who experience inconsistent parenting, when a parent or multiple caregivers have different or unpredictable expectations, rules or consequences, can develop anger management problems. A child who is unsure of the rules may consistently feel frustrated by a sense of confusion and lack of control.

Undiagnosed learning problems: When your child acts out repeatedly in school or during homework time, it’s possible that he has an undiagnosed learning issue. Say he has a lot of trouble with math, and math problems make him frustrated and irritable. Rather than
ask for help, he may rip up an assignment or start something with another child to create a diversion from his real issues.

Sensory processing issues: Some children have trouble processing the sensory information they're getting from the world around them. If your child is over- or under-sensitive to stimulation, things like scratchy clothes and too much light or noise can make him uncomfortable, anxious, distracted or overwhelmed. That can lead to meltdowns for no reason that's apparent to you or other caregivers.

Autism: Children on the autism spectrum are also often prone to dramatic meltdowns. If your child is on the spectrum, he may tend to be rigid. He may need a consistent routine to feel safe. Any unexpected change can set him off. Sensory issues may cause him to be overwhelmed by stimulation. He could short-circuit into a meltdown that continues until he exhausts himself. And he may lack the language and communication skills to express what he wants or needs.

Environmental Stress is a cause of anger. Children who are otherwise healthy can develop anger problems because of their environment. A child can experience more stress than they are able to handle. For example, a child who is three who experiences a car accident, loses a parent, or has to struggle to meet his basic needs because of parental neglect. Overwhelming stress in childhood can interfere in the development of frustration tolerance, problem solving skills and emotional regulation all of which are required to manage anger.

Modeled Behavior is a cause of anger. An environment that models poor anger control is likely to create a child with poor anger management skills. If family members manage their anger through violence or other aggressive methods the child may imitate what they have learned. Many children I see in my practice who have anger control problems have learned this from their parents or other caregivers.
Symptoms:

Here are some signs that outbursts might be more than typical behavior:

- Your child’s tantrums and outbursts are occurring past the age at which they're developmentally expected (up to about 7 or 8 years old)

- His behavior is dangerous to himself or others

- His behavior is causing him serious trouble at school, with teachers reporting that he is out of control

- His behavior is interfering with his ability to get along with other kids, so he’s excluded from playdates and birthday parties

- His tantrums and defiance are causing a lot of conflict at home and disrupting family life

- He’s upset because he feels he can’t control his anger, and that makes him feel bad about himself

Other signs of Anger issues are:

- They can’t control their aggressive impulses and hits people; this behavior continues past the age of five.

- Frequent explosive outbursts, indicating that they are carrying a “full tank” of anger that is always ready to spill.

- They are reflexively oppositional (and they are older than age 2).

- They are unable to engage in constructive problem solving and do not acknowledge their
role in creating the situation, instead feeling constantly victimized and "picked on."

They frequently lose friends, alienate adults or are otherwise embroiled in interpersonal conflict.

They seem preoccupied with revenge.

They threaten to hurt themselves physically (or actually does so).

They damage property.

Repeatedly expresses hatred toward their self or someone else.

They hurt smaller children or animals.

Also check for:

Constant angry tantrum that are out of control

Extreme yelling

Extreme swearing

Extreme crying

Extreme use of verbally abusive language
Continuous fighting

Intimidation of others

Acts of aggression toward people

Acts of aggression toward animals

Hostile statements to authority figures

Hostile statements to siblings and or peers

Hostile statements to parents

Continuous pattern of damage property

Failure to accept responsibility

Use passive-aggressive behaviors to aggravate others

Weak interpersonal relationships with peers because of anger issues

Feelings of hopelessness or unease

Lack of confidence
History of abuse

Underlying depressive behavior

Diagnosis and Treatment:

Teaching Anger Management, The goal of teaching children anger management is to reduce excessive reactions when angry and to develop skills to use anger as a signal to redirect their behavior. As with learning to swim or ride a bicycle, as you begin to work with your child it is important to be patient. Not all children learn to swim in the first lesson or master riding a bicycle that first day. Some children require much longer periods of practice to develop proficiency.

Keep in mind also that some children are born more likely to be irritable and easily angered. These symptoms usually appear at an early age. Yet, it is also important to remember that some children behave this way because they live in households in which they are exposed to models of poor anger management. Some children experience both risks, leading to a significant probability that they will struggle to learn to manage anger effectively. Some of these children may require professional help.

The primary goal is to help children and adolescents express anger in an assertive rather than aggressive manner. This means they are neither pushy nor demanding, but learn to be respectful advocates for themselves. This also means that they learn to cope with, not simply suppress, their anger. Suppression is only a partially effective strategy. When angry feelings are suppressed they often emerge later on, usually in an excessive way in response to a minor event related to an earlier anger-provoking experience. Suppressed anger is also thought to contribute to passive-aggressive behavior such as getting back at people indirectly without telling them why or confronting them directly. It also fuels cynical or hostile behavior, leading children to be excessively critical and fault-finding.

Every young child can be engaged in a discussion that includes consideration of:

what makes us angry.
what are different options for dealing with anger.

what might be the consequence of each option, and

what option might be most effective.

Medication won’t necessarily fix defiant behavior or aggression. But it can reduce the symptoms of ADHD, anxiety and other disorders. And it can improve the conditions for working on those behaviors. Behavioral approaches in which parents and children work together to rein in problem behavior are key.

The first step in managing anger is understanding what triggers a child’s outbursts. Is getting out the door for school a chronic issue for your child? Solutions might include laying out clothes and showering the night before, waking up earlier and using time warnings. Some kids respond well to having tasks broken down into steps and posted on the wall.

Your response to outbursts affects the likelihood of the behavior happening again.

If your child’s behavior is out of control, or causing major problems, you can try step-by-step parent training programs. These programs (like Parent-Child Interaction Therapy and Parent Management Training) train you to positively reinforce behavior you want to encourage, and give consistent consequences for behaviors you want to discourage. Most children respond well to a more structured relationship, with calm, consistent responses that they can count on.

Don’t give in. Resist the temptation to end your child’s tantrum by giving him what he wants when he explodes. Giving in only teaches him that tantrums work.

Remain calm and consistent. You’re in a better place to teach and follow through with consistent consequences when you’re in control of your own emotions. Harsh or angry responses tend to escalate a child’s aggression, whether verbal or physical. By staying calm, you’re also modeling-and teaching-your child the type of behavior you want to see in him.
Ignore negative behavior and praise positive behavior. Ignore minor misbehavior, since even negative attention like reprimanding or telling the child to stop can reinforce his actions. Instead, lavish labeled praise on behaviors you want to encourage. (Don’t just say “good job.” Say “good job calming down.”)

Use consistent consequences. Your child needs to know what the consequences are for negative behaviors, such as time-outs, as well as rewards for positive behaviors, like time on the iPad. And you need to show him you follow through with these consequences every time.

Wait to talk until the meltdown is over. One thing you don’t want to do is try to reason with a child who is upset. Stephen Dickstein, M.D., a pediatrician and child and adolescent psychiatrist, says, “Don’t talk to the kid when he’s not available.” You want to encourage a child to practice at negotiation when he’s not blowing up, and you’re not either.

Build a toolkit for calming down. Both you and your child need to build what Dickstein calls a toolkit for self-soothing—things you can do to calm down, like slow breathing, because you can’t be calm and angry at the same time. There are lots of techniques, he adds, but “The nice thing about breathing is it’s always available to you.”

It is important to note that most therapist will use Adjustment disorders to diagnose anger issues:

- 309.9 Unspecified
- 309.24 With Anxiety
- 309.0 With Depressed Mood
- 309.3 With Disturbance of Conduct
However, the DSM-5 defines intermittent explosive disorder as “recurrent behavioral outbursts representing a failure to control aggressive impulses.” (American Psychiatric Association, 2013). Intermittent explosive disorder, which can be diagnosed in children as young as six, is characterized by a wide variety of aggressive outbursts. Intermittent explosive disorder is extremely common, as more than half of youth and young adults have experienced at least one angry outburst. Still, certain populations, such as those who have served in combat, those who have experienced trauma and morbidly obese adults are at increased risk. Intermittent explosive disorder is important to address because a pattern of aggressive behavior can lead to a host of relational and occupational problems. Although many patients resist intervention, cognitive behavioral therapy is an effective treatment for managing anger and learning positive coping skills. Intermittent explosive disorder is considered to be in remission when only one or two symptoms of the disorder persist.

**Symptoms of Intermittent Explosive Disorder**

According to the DSM-5, intermittent explosive disorder is characterized by impulsive and aggressive outbursts. These outbursts can be in the form of verbal tirades or physical aggression. These outbursts are impulsive, not premeditated and extremely difficult to predict. Additionally, the outbursts happen without trigger or are not proportionate to the preceding trigger or stressor. To qualify for diagnosis, outbursts must occur about twice a week for at least three months (American Psychiatric Association, 2013).

**Prevalence of Intermittent Explosive Disorder**

In the United States, more than 60% of adolescents have reported at least one angry outburst that resulted in violence, threat of violence, or destruction of property. Of these young people around 8% meet the DSM-5 criteria for intermittent explosive disorder (McLaughlin, et al., 2012). Although the disorder can persist throughout the lifespan, symptoms are most likely to begin in individuals younger than 40. The DSM-5 explains that individuals with a high school education or less are more likely to be diagnosed than more educated adults (American Psychiatric Association, 2013). Little is known about the prevalence of intermittent explosive disorder outside the United States, although it is predicted that individuals from war-torn areas are at increased risk. Many experts believe that because intermittent explosive disorder is understudied, it is also under-diagnosed (McLaughlin, et al, 2012).

Studies have found that intermittent explosive disorder is particularly prevalent among the military population. Engaging in combat requires some level of aggression or hostility to be effective. Combat training places heavy emphasis on aggression, while traits such as fear or compassion can lead or distraction or even death. These traits are necessary in combat, but are maladaptive in the civilian world (Morland, et al., 2012). The prevalence of intermittent
explosive disorder is also high among the morbidly obese population. In a study of 100 bariatric surgery candidates, 27% met criteria for an impulse control disorder. 10% of the patients studied met criteria for intermittent explosive disorder (Schmidt, et al., 2012).

Social Consequences of Intermittent Explosive Disorder

The DSM-5 explains that because of the violent and intimidating nature of intermittent explosive disorder, the patient is likely to experience significant impairment in many areas (American Psychiatric Association, 2013). Common behavioral manifestations of intermittent explosive disorder include road rage, domestic violence, child abuse, and property damage. Violent and aggressive behavior creates a sense of distrust among family members and friends. (Morland, et al., 2013). Relationships are likely to suffer. If the outbursts occur at work, the patient may be faced with employment. Additionally, public and private outbursts, particularly those that cause injury or property damage may result in arrest or other legal trouble (American Psychiatric Association, 2013).

Causes and Course of Intermittent Explosive Disorder

Onset of intermittent explosive disorder usually begins around age 12 (McLaughlin, et al., 2012), but can be diagnosed in children as young as six (American Psychiatric Association, 2013). At least 80% of patients diagnosed with experience an explosive episode at least once per year throughout the lifespan (McLaughlin, et al., 2012). Although no direct cause of intermittent explosive disorder has been identified, several studies have linked the disorder to childhood trauma. In addition to being high among those in military service, high rates of intermittent explosive disorder is also found among individuals who has survived abuse, assault, and human rights violations. Refugees and emergency service workers are also at higher risk (Nickerson, et al., 2012). Although alcohol use is not a cause of intermittent explosive disorder, intoxication significantly increases aggressive behavior (Coccaro, 2012).

Remission is the treatment goal for intermittent explosive disorder. Remission is achieved when only one or two symptoms persist (Coccaro, 2012). It is often difficult for people diagnosed with intermittent explosive disorder to seek help. Most patients are treated as result of court order or a loved one presenting an ultimatum. Patients usually have poor insight and a tendency to externalize blame. Many see aggressive behavior as a positive thing, supporting their strength as a person. Patients also tend to see the therapist as an enemy. Consequently, therapeutic relationships may be difficult to establish and maintain. Because of this, intermittent explosive disorder is typically treated with medications such as antidepressants or mood stabilizers. Still, when the patient is cooperative, psychotherapy is extremely helpful. The most effective psychotherapy intervention for intermittent explosive disorder is cognitive behavioral therapy that focuses on the direct treatment of anger. This approach is helpful because it addresses the affective, cognitive, and behavioral components of violent outbursts. Patients learn anger management skills, deal with underlying concerns, learn to manage stress, and build positive coping skills (Morland, et al., 2012).

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 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 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 loss 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 can 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).

**ANGER BEHAVIORAL DESCRIPTORS**

1. Constant angry tantrum that are out of control to the sudden event.

2. Extreme yelling, swearing, crying, or use of verbally abusive language when attempts to meet requests are irritated or restrictions are placed upon behavior.

3. Continuous fighting, intimidation of others.
4. Acts of unkindness or aggression toward people or animals.

5. Hostile statements of harm to parents, authority figures, siblings, and or peers.

6. Continuous pattern of damage property.

7. Failure to accept responsibility for problems stemming from poor anger control.

8. Extensive history of passive-aggressive behaviors to purposely aggravate others.

9. Weak interpersonal relationships with peers because of argumentative and poor anger management.

10. Feelings of hopelessness, unease, or lack of confidence that lead to angry tantrum and aggressive behaviors.

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:

1. Cooperate with adults and peers in a reciprocally respectful manner.
2. Clearly lessen frequency of passive-aggressive behaviors by Conveying anger and frustration through controlled, respectful, and direct statements.

3. Solve the core problems that add to the surfacing of anger control problems.

4. Institute and preserve suitable parent-child boundaries, setting firm, consistent limits when the client reacts in a verbally or physically aggressive or passive-aggressive manner.

5. Convey anger through suitable statements and healthy physical outlets on a consistent basis.

6. Extensively decrease the frequency and intensity of temper tantrum.

7. End all property destruction, physical aggression, and acts of violence or cruelty.

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 “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.

EXAMPLES OF SHORT TERM GOALS:

1. Lessen the incidence and strength of tantrums and aggressive behaviors.

2. Have parents increase the occurrence or praise and positive reinforcement to the client for showing controlled management of anger.

3. Make sure parents agree to and follow through with the execution of a reward system to reinforce the controlling of anger and prevent aggressive behaviors.

4. Convey anger through controlled, respectful statements and suitable physical outlets.

5. Intensify observance with rules at home and school without objection or declaring strong feelings of anger.

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 INTERVENTIONS:

1. Carry out family therapy sessions to discover the circumstances that contribute to the appearance of the client’s anger control problems.

2. Give instruction to detached or disconnected parent(s) to spend more time with the client in leisure, school, or work activities.

3. Investigate family background for a history of physical, sexual, or substance abuse that may be a cause to his or her anger control problems.

4. Be firm that the parents stop physically abusive or overly corrective methods of discipline.

5. Apply the steps necessary to protect the client or siblings from further abuse.

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.
Possible DSM V CODE Paired With ICD_9-CM Codes (parenthesis Represents ICD-10-CM Codes Effective 10-2014):

Diagnostic Suggestions For Children With Anger Problems:

313.81 (f91.3) Oppositional Defiant Disorder
Specify Current Severity: Mild, Moderate, Severe

312.34 (f6381) Intermittent Explosive Disorder

Conduct Disorder Specify Whether:
312.81 (f91.1) Childhood-onset Type
312.32 (f91.2) Adolescent-onset Type
312.89 (f91.9) Unspecified Onset
specify If: With Limited Prosocial Emotions
specify Current Severity: Mild, Moderate, Severe

301.7 (f60.2) Antisocial Personality Disorder
312.33 (f63.1) Pyromania
312.32 (f63.3) Kleptomania
312.89 (f91.8) Other Specified Disruptive, Impulse-control, And Conduct Disorder

312.9 (f91.9) Unspecified Disruptive, Impulse-control, And Conduct Disorder

Attention-Deficit/Hyperactivity Disorder Specify Whether:
314.01 (f90.2) Combined Presentation
314.00 (f90.0) Predominantly Inattentive Presentation

314.01 (f90.1) Predominantly Hyperactive/impulsive Presentation

specify If: In Partial Remission

specify Current Severity: Mild, Moderate, Severe

314.01 (f90.8) Other Specified Attention-deficit/hyperactivity Disorder

314.01 (f90.9) Unspecified Attention-deficit/hyperactivity Disorder

Problems Related To Family Upbringing

v611.20 (z62.820) Parent-child Relational Problem

v61.8 (z62.891) Sibling Relational Problem

v61.8 (z62.29) Upbringing Away From Parents

v611.29 (z62.898) Child Affected By Parental Relationship Distress

Other Problems Related To Primary Support Group

611.03 (z63.5) Disruption Of Family By Separation Or Divorce

v61.8 (z63.8) High Expressed Emotion Level Within Family

Child Maltreatment And Neglect Problems Child Physical Abuse

Child Physical Abuse, Confirmed

995.54 (t74.1 2xa) Initial Encounter

995.54 (t74.1 2xd) Subsequent Encounter

Child Physical Abuse, Suspected

995.54 (t76.12xa) Initial Encounter

995.54 (t76.1 2xd) Subsequent Encounter
Sample Treatment Plan:

Present Behavioral Descriptors of Problem:

Continuous fighting, intimidation of others.
Extensive history of passive-aggressive behaviors to purposely aggravate others.

Feelings of hopelessness, unease, or lack of confidence that lead to angry tantrums and aggressive behaviors.

Long Term Goals:

1. Control excessive feelings of anger and aggression. Establish a suitable practice of expressing and recognizing feelings of anger.

2. Come to terms with feelings of anger, this develops a higher level of tranquility through the acceptance of such emotions.

3. Practice anger management skills to be able to become more constructive throughout daily routines.

Short Term Goals Objectives:

1. Have parents increase the occurrence or praise and positive reinforcement to the client for showing controlled management of anger.

2. Recognize and express how illogical thoughts add to the surfacing of anger control problems.
Strategy or Intervention for Goal 1:

Educate the parent’s efficient penalizing techniques to help manage the client’s anger control problems and intensify conforming behaviors.

Build the level of trust between child and parents, and school, through constant eye contact, active listening, unrestricted positive regard, and warm acceptance to help increase his or her ability to convey underlying feelings of hurt, sadness, and anxiety, as well as recognize times when angry feelings have not been controlled.

Strategy or Intervention for Goal 2:

1. Teach the client efficient communication and assertiveness skills to convey anger in a controlled fashion and to meet his or her needs through more practical actions.

2. Assist the client in recognizing successful strategies that have been used on days when he or she controls his or her temper and does not hit siblings, peers, or others.

3. Recognize and challenge the client’s illogical thoughts that are part of the cause to the emergence of his or her anger control problems.

DSM V Diagnosis:

DSM V CODE Paired With ICD_9-CM Codes (parenthesis Represents ICD-10-CM Codes Effective 10-2014):
Diagnostic Suggestions For Children With Anger Problems:

313.81 (f91.3) Oppositional Defiant Disorder
specify Current Severity: Mild, Moderate, Severe

611.03 (z63.5) Disruption Of Family By Separation Or Divorce

v61.8 (z63.8) High Expressed Emotion Level Within Family