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Individual Planning: A Treatment Plan Overview for Individuals with Anger Problems.

A Treatment Overview for Adults 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

***Coming Soon - For a full list of 24 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

Causes and Consequences

Expression of Anger Behaviors

Symptoms

Strategies to Help Control Anger

Diagnosis

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

Sample Treatment Plan

Introduction:

Anger is a normal and basic human emotion. Depending on how it is managed and expressed, anger can have positive or negative consequences. Awareness of angry feelings can be helpful as it can signal when our rights are being violated or our needs are being ignored by others. Anger can also help to energize and motivate us to work to address problems with another person or to change our life situation.

However, there are potential negative consequences of anger when it is not managed or expressed appropriately or effectively. Some people are chronically angry at others, or at themselves. Often, angry people were criticized or abused themselves earlier in life, and react to others in the same manner they were treated. Prolonged or intense anger and frustration contributes to physical conditions such as headaches, digestive problems, high blood pressure and heart disease. Problems dealing with angry feelings may be linked to psychological disorders such as anxiety or depression. Angry outbursts can be a way of trying to cope with unhappiness, or depressed feelings. Chronic anger creates problems getting along with others, and can lead to involvement in physically or emotionally abusive relationships. Having “a short fuse” is often a factor in other problematic behaviors such as “road rage,” accidents, and getting into verbal or physical fights.

Causes:
Feelings of anger arise due to how we interpret and react to certain situations. Everyone has their own triggers for what makes them angry, but some common ones include situations in which we feel:

- threatened or attacked
- frustrated or powerless
- like we're being treated unfairly

People can interpret situations differently, so a situation that makes you feel very angry may not make someone else feel angry at all (for example, other reactions could include annoyance, hurt or amusement). But just because we can interpret things differently, it doesn't mean that you're interpreting things 'wrong' if you get angry. How you interpret and react to a situation can depend on lots of factors in your life, including:

- childhood and upbringing
- past experiences
- current circumstances

Whether anger is about something that happened in the past or something that's going on right now, thinking about how anger is interpreted and reacts to different situations can help learn how to cope with emotions better. It can also help find productive strategies to handle our anger.

How we learn to cope with angry feelings is often influenced by our upbringing. Many people are given messages about anger as children that may make it harder to manage it as an adult. For example:

- Raised thinking that it's always okay to act out anger aggressively or violently, and the person didn't learn how to understand and manage angry feelings. This could mean having angry outbursts whenever there is a situation where we don't like the way someone is behaving, or whenever we are in a situation we don't like.

- Raised to believe that one shouldn't complain, and may have been punished for expressing anger as a child. This could mean that one may tend to suppress anger and it becomes a long-term problem, where one reacts inappropriately to new situations we are not comfortable with.

- Witnessed parents' or other adults' anger when it was out of control, and learned to think of anger as something that is destructive and terrifying. This could mean one is afraid of our own anger and don't feel safe expressing feelings when something makes us angry. Those
feelings might then surface at another unconnected time, which may feel hard to explain.

Expression of Anger Behaviors:

How one behaves when angry depends on how well we will be able to identify and cope feelings, and how we learned to express them. Not everyone expresses anger in the same way. For example, some unhelpful ways to express anger include:

Outward aggression and violence — such as shouting, swearing, slamming doors, hitting or throwing things and being physically violent or verbally abusive and threatening towards others.

Inward aggression — such as telling oneself that we hate ourselves, denying our own basic needs (like food, or things that might make you happy), cutting off from the world and self-harming.

Non-violent or passive aggression — such as ignoring people or refusing to speak to them, refusing to do tasks, or deliberately doing things poorly, late or at the last possible minute, and being sarcastic or sulky while not saying anything explicitly aggressive or angry.

While some people openly rage, others have difficulty acknowledging their anger and hold their feelings inside as they avoid the issue that angers them. They may express anger in a passive-aggressive; way that can take the form of baiting others, or frustrating them. People who express anger in a passive-aggressive manner may fear hurting others or being a bad person; if they openly express negative feelings. However, they usually end up damaging the relationship because other people usually sense their anger on some level and begin to build resentment toward them. People who are unable to acknowledge anger in themselves often feel hurt by others; hostility, abusive behavior, or withdrawal from them.

Anger is frequently a result of frustration, or of feeling blocked or thwarted from something we feel to be important. Anger can also be a defensive response to underlying fear or feelings of vulnerability or powerlessness. Many people with anger problems are out of touch with signs that anger is building. Our body gives us important clues to when we are angry, sometimes before we are consciously aware of it. When anger builds, we react as we do to stress. We may feel tension or stress in our body as adrenaline is released, our breathing may quicken, or our heart may start to beat faster.

Symptoms:

The following are some possible signs of difficulty coping with anger:

A. Fears of being out of control when you are angry.
B. Often feels tense, irritable or frustrated.

C. Frequently gossiping or complaining about others rather than speaking to them directly about what is bothering you.

D. Frequently feel hurt or resentful that others treat you unfairly.

E. Hurt others, especially those you care about, by demeaning or putting them down, cursing at them, or being verbally abusive. You end up regretting something you said or did when angry.

F. Takes out your anger on someone or something else rather than the person or situation that is bothering you.

G. Have physically lashed out when angry (e.g. destroyed property, hit someone, etc.).

H. Have lost or are in danger of losing a relationship, job, or something else important to you because of your anger.

I. Have been arrested or have legal difficulties because of your anger.

J. Use alcohol or drugs to try and calm your emotions.

K. Others (e.g. friends, family, professors, academic administrators, bosses) have expressed concern about your anger.

Other Symptoms to Check for:

1. Record of extreme outbursts
2. History of making threats
3. History of assault
4. History of destruction of property
5. Overly sensitive
6. Hostile to minor irritants
7. Quick to label
8. Quick to judge others
9. Body languages exude tension-aggression and resistance
10. Passive-aggressive attitudes evident in behavior
11. Disparagement of authority figures
12. Verbally abusive towards others
13. Exposure to explosive behaviors at home
14. Having experienced physical trauma
15. Having experienced emotional trauma
16. History of substance abuse
17. Certain medical conditions
18. Low frustration tolerance
19. Feeling a loss of control over one’s thoughts
20. Racing thoughts

Strategies to Help Control Anger:

A. Learn to become more aware of feelings, and recognize anger when it occurs. Notice particular signs that anger is building (e.g. becoming tense, short with others, developing a headache, etc.).

B. Ask “What is really bothering me?” Notice whether it is an interaction with someone else or something inside you. Avoid displacing anger toward individuals who are not the cause of your anger.

C. Keep an anger log to identify the kinds of situations that provoke anger. Learn to identify what triggers anger (e.g. authority figures, jealousy), what behaviors are problematic (e.g. yelling, criticizing, name-calling, cursing, throwing things, avoiding) and the consequences of behaviors (e.g. others avoid you, disciplinary action, etc.).

D. Learn what underlying emotions might lead to get angry (e.g. feelings of rejection, powerlessness, etc.).

E. De-escalate with a “time out” and recognize the signs of anger. Let significant others know that the need to walk away to calm down when one is really angry. Take a deep breaths. Go to a quiet place, and continue to use deep breathing to calm down.

F. Examine options for behaving when angry, and visualize how one might respond. Recognize that one is responsible for his or her anger. Identify those situations that may contribute to feeling angry, remember that one is responsible for how we behave. One may be legitimately and appropriately frustrated with something, but we don’t have to be inappropriately hostile or hurtful to others. We are bigger than our feelings and we can make choices about how we respond. Work on developing more positive behaviors to replace the negative ones.

G. Learn how to assert oneself, and talk to the person who is triggering the anger. Use the
physical and mental energy that is generated from feeling angry to channel the response to the situation. Help the person to see how their behavior is affecting you in a way that they can hear and is not threatening. Use “I statements” that describe how you feel, rather than accusing the other person.

H. Recognize that it’s your responsibility to express yourself appropriately to others, but their responsibility to deal with their own feelings in response.

I. Seek support from others when you struggling with anger.

J. Cultivate a sense of humor. Humor can lighten feelings.

K. Develop activities that help cope with anger. Exercise can help to diminish feelings of agitation and frustration. Practicing relaxation techniques on a daily basis can also help in coping with anger.

L. Avoid alcohol and drugs if there is a history of anger problems.

M. Anger problems can be related to family experiences. How was anger expressed in the family, and how we were affected by significant others? If anger was expressed in destructive or hurtful ways, think about how one felt when were physically or verbally attacked, criticized, shunned or ignored. Consider the effect on present relationships with others if we are perpetuating this same pattern.

Diagnosis:

Intermittent explosive disorder (sometimes abbreviated as IED) is a behavioral disorder characterized by explosive outbursts of anger and violence, often to the point of rage, that are disproportionate to the situation at hand (e.g., impulsive screaming triggered by relatively inconsequential events). Impulsive aggression is not premeditated, and is defined by a disproportionate reaction to any provocation, real or perceived. Some individuals have reported affective changes prior to an outburst (e.g., tension, mood changes, energy changes, etc.).

The disorder is currently categorized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) under the "Disruptive, Impulse-Control, and Conduct Disorders" category. The disorder itself is not easily characterized and often exhibits comorbidity with other mood disorders, particularly bipolar disorder. Individuals diagnosed with IED report their outbursts as being brief (lasting less than an hour), with a variety of bodily symptoms (sweating, stuttering, chest tightness, twitching, palpitations) reported by a third of one sample. Aggressive acts are frequently reported accompanied by a sensation of relief and in some cases pleasure, but often followed by later remorse.

The current DSM-5 criteria for Intermittent Explosive Disorder include:
Recurrent outbursts that demonstrate an inability to control impulses, including either of the following:

Verbal aggression (tantrums, verbal arguments or fights) or physical aggression that occurs twice in a week-long period for at least three months and does not lead to destruction of property or physical injury (Criterion A1)

Three outbursts that involve injury or destruction within a year-long period (Criterion A2)

Aggressive behavior is grossly disproportionate to the magnitude of the psychosocial stressors (Criterion B)

The outbursts are not premeditated and serve no premeditated purpose (Criterion C)

The outbursts cause distress or impairment of functioning, or lead to financial or legal consequences (Criterion D)

The individual must be at least six years old (Criterion E)

The recurrent outbursts cannot be explained by another mental disorder and are not the result of another medical disorder or substance use (Criterion F)

It is important to note that DSM-5 now includes two separate criteria for types of aggressive outbursts (A1 and A2) which have empirical support:

Criterion A1: Episodes of verbal and/or non damaging, non-destructive, or non injurious physical assault that occur, on average, twice weekly for three months. These could include temper tantrums, tirades, verbal arguments/fights, or assault without damage. This criterion includes high frequency/low intensity outbursts.

Criterion A2: More severe destructive/assaultive episodes which are more infrequent and occur, on average, three times within a twelve-month period. These could be destroying an object without regard to value, assaulting an animal or individual. This criterion includes high-intensity/low-frequency outbursts.

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 my 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 Individuals with Anger Problems:

A. Record of extreme outbursts, usually followed by threats, assault, and or destruction of property.

B. Overly sensitive and hostile to minor irritants.

C. Quick to label and judge others.

D. Tension, aggression, and resistance evident in physical appearance and behavior, body language usually exuding such traits.

E. Passive-aggressive attitudes evident in behavior.

F. Disparagement of authority figures.

G. Verbally abusive towards others
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 Anger Problems:

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

B. Recognize existing feelings of anger, discover origins of such feelings and find alternative ways to ease, express, and resolve such feelings.

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

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

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 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
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 for Individuals with Anger Problems:

A. Be able to acknowledge and express anger verbally.

B. Recognize causes and triggers for anger.

C. Increase and verbalize aware of patterns of aggression.

D. Acknowledge experiences and persons from the past that have influenced current patterns of aggression.

E. Recognize what events from present day and the past that currently fuel 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 Strategies or Interventions for Individuals with Anger Problems:
A. Help client in arriving to the understanding that he or she is angry.

B. Recommend client to read a book on anger management and cooperation.

C. Have client log daily events, situations, and encounters that cause him or her to become upset, angry, disappointed, and or irritated.

D. Construct and review an outline of triggers that cause anger.

E. Acknowledge occurrences of angry behaviors.

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 Anger Issues:

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 hypomaniac
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified

Current or most recent episode depressed
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: Hypomaniac, 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

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

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(T76.3IXA) Initial encounter
995.82 (T76.3IXD) Subsequent encounter
Spouse or Partner Violence, Physical, Confirmed
995.81 (T74.I IXA) Initial encounter
995.81 (T74.1 1 XD) Subsequent encounter

Spouse or Partner Violence, Physical, Suspected
995.81 (T76.1 1XA) Initial encounter
995.81 (T76.1 1XD) Subsequent encounter

Overall Integration of a Treatment Plan:

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

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

Select at least 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

Present Behavioral Descriptors of Problem:

Overly sensitive and hostile to minor irritants.

Quick to label and judge others.
Long Term Goals:

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

Recognize existing feelings of anger, discover origins of such feelings and find alternative ways to ease, express, and resolve such feelings.

Short Term Goals Objectives:

Attempt to decrease these occurrences by amount of individual outbursts and duration time of each outburst.

In therapy patient will learn and practice one relaxation method to manage anger.

Strategy or Intervention for Goal 1:

Have client log daily events, situations, and encounters that cause him or her to become upset, angry, disappointed, and or irritated.

Help client identify past figures and how they have influenced client's current aggression style.
Strategy or Intervention for Goal 2:

Teach client different forms of relaxation techniques as an alternative way to deal with internal aggression and frustration

Train the client to cope with feelings of aggression through Rational Emotive Therapy (RET).

DSM V Diagnosis:

312.34 (F6381) Intermittent Explosive Disorder

V71.01 (Z72.811) Adult Antisocial Behavior

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