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

Duration: 3 hours

Learning Objectives:

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

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

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Course Syllabus:
Introduction

Types

Causes

Treatment

Signs and Symptoms

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:

The ability to control our impulses—or urges—helps distinguish us from other species and marks our psychological level. Most of us take our ability to think before we act for granted, but not for people who have problems controlling their impulses.

People with an impulse control disorder are unable to resist the urge to do something harmful to themselves or others. Impulse control disorders include addictions to alcohol, drugs, eating disorders, compulsive gambling, paraphilias sexual fantasies and behaviors involving non-human objects, suffering, humiliation or children, compulsive hair pulling, stealing, fire setting and intermittent explosive attacks of rage etc.

Disorders, such as intermittent explosive disorder, kleptomania, pyromania, compulsive gambling and trichotillomania, are very similar in terms of when how they progress. Usually, a person feels increasing tension or arousal before committing the act that characterizes the disorder. During the act, the person probably will feel pleasure, gratification or relief. After the impulse act, the person may blame himself or feel regret or guilt.

People with these disorders may or may not plan the acts, but the acts generally fulfill their immediate, conscious wishes. Most people, however, find their disorders highly distressing and feel a loss of control over their lives.

Impulse-control disorder (ICD) is a class of psychiatric disorders characterized by impulsivity—failure to resist a temptation, an urge, an impulse, or the inability to not speak on a thought. Many psychiatric disorders feature impulsivity, including substance-related disorders, behavioral addictions, attention deficit hyperactivity disorder, antisocial personality disorder, borderline personality disorder, conduct disorder and some mood disorders.
Five behavioral stages characterize impulsivity: the impulse, growing tension, pleasure on acting, relief from the urge and finally guilt (which may or may not arise)

Types of Impulse Control:

Disorders characterized by impulsivity that were not categorized elsewhere in the DSM-IV-TR were also included in the category "Impulse-control disorders not elsewhere classified". Trichotillomania (hair-pulling) and skin-picking were moved in DSM-5 to the obsessive-compulsive chapter. Additionally, other disorders not specifically listed in this category are often classed as impulsivity disorders. Terminology was changed in the DSM-V from "Not Otherwise Classified" to "Not Elsewhere Classified"

Sexual compulsion: Sexual compulsion includes an increased urge in sexual behavior and thoughts. This compulsion may also lead to several consequences in the individual's life, including risky partner selection, increased chance for STD and depression. There has not yet been a determined estimate of its prevalence due to the secretiveness of the disorder. However, research conducted in early 1990's in the United States gave prevalence estimates between 5%-6% in the U.S. population, with male cases being higher than female.

Internet addiction: The disorder of Internet addiction has only recently been taken into consideration and has been added as a form of ICD. It is characterized by excessive and damaging usage of Internet with increased amount of time spent chatting, web-surfing, gambling, shopping or exploring pornographic websites. Excessive and problematic Internet use has been reported across all age, social, economical, and educational ranges. Although initially thought to occur mostly in males, increasing rates have been also observed in females. However, no epidemiological study has been conducted yet to understand its prevalence.

Compulsive shopping: Compulsive shopping or buying is characterized by a frequent irresistible urge to shop even if the purchases are not needed or cannot be afforded. The prevalence of compulsive buying in the U.S. has been estimated to be 2-8% of the general adult population, with 80-95% of these cases being females. The onset is believed to occur in late teens or early twenties and the disorder is considered to be generally chronic.[5]
Pyromania: Pyromania is characterized by impulsive and repetitive urges to deliberately start fires. Because of its nature, the number of studies performed for fire-setting are understandably very few. However studies done on children and adolescents suffering from pyromania have reported its prevalence to be between 2.4%-3.5% in the United States. It has also been observed that the incidence of fire-setting is more common in juvenile and teenage boys than girls of the same age.

Intermittent explosive disorder: Intermittent explosive disorder or IED is a clinical condition of experiencing recurrent aggressive episodes that are out of proportion of any given stressor. Earlier studies reported a prevalence rate between 1%-2% in a clinical setting, however a study done by Coccaro and colleagues in 2004 had reported about 11.1% lifetime prevalence and 3.2% one month prevalence in a sample of a moderate number of individuals (n=253). Based on the study, Coccaro and colleagues estimated the prevalence of IED in 1.4 million individuals in the US and 10 million with lifetime IED.

Kleptomania: Kleptomania is characterized by an impulsive urge to steal purely for the sake of gratification. In the U.S. the presence of kleptomania is unknown but has been estimated at 6 per 1000 individuals. Kleptomania is also thought to be the cause of 5% of annual shoplifting in the U.S. If true, 100,000 arrests are made in the U.S. annually due to kleptomaniac behavior.

Causes:

Scientists don’t know what causes these disorders. But many factors play a role, including physical or biological, psychological or emotional and cultural or societal factors. Certain brain structures-including the limbic system, linked to emotions and memory functions, and the frontal lobe, the part of the brain's cortex linked to planning functions and controlling impulses-affect the disorder.

Hormones associated with violence and aggression, such as testosterone, also play a role in the disorders. Women might be predisposed to less aggressive types of impulse control disorders such as kleptomania or trichotillomania, and men might be predisposed to more violent and aggressive types such as pyromania and intermittent explosive disorder.

Research also has shown connections between certain types of seizure disorders and violent impulsive behaviors. And studies have revealed that family members of people with impulse control disorders have a higher rate of addiction and mood disorders than families with no history of impulse disorders. Chronic stress, childhood trauma or neglect, and other mitigating environmental factors may also influence the disorder onset. Some medical disorders such as seizures, other things that may cause trauma to the brain, or an imbalance in some of the brain's natural chemistry that may be produced by an underlying mental health disorder or substance abuse may increase the odds that a person will suffer from an impulse control disorder as well.

Mental Health professionals have not identified a specific cause as to why impulse control
disorders develop. There is agreement that a combination of multiple factors come into play when leading up to the onset of an impulse control disorder. Included in the following are examples of such contributing factors:

Genetic: There appears to be a strong genetic tie to the presence of impulse control disorders. Studies have shown that children and adolescents who have family members who struggle with illnesses such as mood disorders are more susceptible to developing symptoms of impulse control disorders.

Physical: Research has shown that there is a strong probability that when the specific brain structures that are linked to the functioning of emotions, planning, and memory become imbalanced, symptoms of impulse control behaviors are more likely to develop.

Environmental: Environmental factors play a significant role in the onset of behaviors that are symptomatic of impulse control disorders. Children are raised in families where violence, verbal abuse, emotional abuse, physical abuse, and explosive emotional reactions to certain situations are prevalent, will be at a higher risk for developing some type of impulse control disorder. The onset of such behaviors may be a somewhat unconscious means of gaining control over situations in which they would otherwise not have any control and provide them with a sense of escape from the chaos that surrounds them.

Risk Factors:

Being male

Being of younger age

Chronic exposure to violence and aggressive

Being the subject of physical, sexual, and/or emotional abuse and neglect

Pre Existing mental illness

Family history of mental illness

Personal or family history of substance abuse and addiction

Treatment:

Some health professionals consider impulse control disorders subgroups of other conditions, such as anxiety disorders or obsessive-compulsive disorders. Medications for treating depression and anxiety also have been successful in treating impulse disorders, particularly antidepressants known as serotonin reuptake inhibitors. This suggests the neurotransmitter serotonin plays a role in these disorders.

Impulse control disorders are characterized by four main qualities which include:

The perpetuation of repeated negative behaviors regardless of negative consequences
Progressive lack of control over engaging in these behaviors

Mounting tension or craving to perform these negative behaviors prior to acting on them

Sense of relief or pleasure in performing these problematic behaviors

Changes to the Diagnostic and Statistical Manual of Mental Disorders, place impulse control disorders in a category entitled “Disruptive, Impulse Control, and Conduct Disorders.” The changes also moved disorders like compulsive gambling, sexual addiction, and other addictive disorders, as well as trichotillomania (skin picking), out of the impulse disorder category. The new category in the DSM-5 includes various disorders, such as kleptomania, pyromania, intermittent explosive disorder, conduct disorder, antisocial personality, and oppositional defiant disorder. All of these disorders may interfere with a person’s ability to function in daily life as they all include issues with controlling impulses and harmful behavior towards others.

Males may be more prone to impulse control disorders than females. Impulse Control disorders may commonly co-occur with other mental health disorders or with issues involving substance abuse. Impulse control disorders may be regularly overlooked or misdiagnosed, meaning that many individuals suffering from these disorders may not always get the correct treatment. Treatment for impulse control disorders may be largely therapeutic in nature, with behavioral therapies frequently implemented and medications also potentially beneficial.

Medications may be helpful in treating impulse control disorders, although there are no drugs specifically approved for the treatment of these disorders. Selective serotonin reuptake inhibitors (SSRIs) are antidepressant medications that have shown some promise in treating impulse control disorders. There may be an indication of improvement in aggression and irritability in studied individuals battling intermittent explosive disorder who took Prozac (fluoxetine). Other SSRIs may be helpful in treating kleptomania and pyromania as well. Agonist drug naltrexone, which is often used in the treatment of opioid dependence to help maintain long-term abstinence and prevent relapse, may be useful in treating kleptomania and pyromania as well as addiction. Other medications like glutamatergic agents and mood stabilizers are also being researched for their usefulness in treating these disorders.

Drug and alcohol abuse and addiction may complicate impulse control disorder treatment and the pharmacological management of these disorders, as drugs and medications may interact with each other or lead to unintended consequences. Some medications are not recommended for individuals with a history of substance abuse as they may be habit-forming or have a potential for abuse. It is imperative then that individuals undergo a thorough drug screening upon entrance into a treatment program, so providers are able to provide the highest and safest level of care possible. Individuals who are dependent on psychoactive substances may benefit from a medical detox program prior to treatment.

Signs and Symptoms:

The signs and symptoms that will present themselves in children and adolescents who are struggling with an impulse control disorder will vary depending on the specific type of impulse control disorder they have, how old they are, the environment in which they are surrounded, and whether they are female or male. The following is a list of different
behavioral, physical, cognitive, and psychosocial symptoms that may indicate the presence of an impulse control disorder:

Behavioral symptoms:

Stealing
Compulsive lying.
Starting fires
Participating in risky sexual behaviors
Acting out aggressively or violently against people, animals, objects, and/or property

Physical symptoms:

Presence of injuries or scars from engaging in physical fights or episodes of aggressively acting out
Burn marks on those who engage in fire-starting behaviors
Presence of sexually-transmitted diseases as a result from participating in risky sexual behaviors

Cognitive symptoms:

Obsessive thought patterns
Compulsive thought patterns
Inability to control impulses
Inability to remain patient

Psychosocial symptoms:

Irritability
Agitation
Depression
Anxiety
Isolating oneself from friends and family
Lowered feelings of self-worth
Random episodes of emotional detachment

Other Symptoms to Check for:
1. History of episodes of loss of control
2. History of aggressive impulses out of proportion to the situation
3. History of assaultive acts
4. History of destruction of property
5. A history or pattern of acting before thinking
6. Negative impacts on life due to impulsive behavior
7. Over-reactivity to mildly aversive situations
8. Quick to lose temper if stopped from following impulse
9. Pleasure-oriented stimulation
10. Shifting from one activity to another
11. Rarely if ever completing anything
12. Difficulty organizing self without supervision
13. Difficulty waiting for his or her turn
14. Talking out over others in a group
15. Failure to resist an impulse
16. Failure to resist desires or temptation
17. Failure to resist acts that are harmful to self or others
18. Overwhelmed by number of thoughts that trigger impulses
19. Unable to stop-think or listen before acting
20. Possible drug or alcohol abuse

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 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,
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 five 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, it 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 on 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 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 of 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 Definitions for Individuals with Impulse Control Problems:

History of episodes of loss of control of aggressive impulses out of proportion to the situation and resulting in assaultive acts or destruction of property.

A history or pattern of acting before thinking resulting in numerous negative impacts on his or her life.

Over-reactivity to mildly aversive or pleasure-oriented stimulation.

Shifting from one activity to another and rarely, if ever, completing anything.

Difficulty organizing self without supervision.

Difficulty waiting for his or her turn, such as, standing in line, talking out over others in a group, and the like.

Failure to resist an impulse, desire, or temptation.

Failure to resist perform some act that is harmful to self or others.

Overwhelmed by number of thoughts that trigger impulses.

Unable to stop, think or listen before acting

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 Impulse Control Problems:

Reduce the frequency of impulsive acts.

Decrease the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.

Decrease thoughts that trigger impulsive behavior and increase self-talk that controls behavior.

Learn to stop, think, listen, and plan before acting out.

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:

Identify all impulsive behaviors and its antecedents, mediators, and consequences.
Therapeutic Interventions For Goal 1:

Teach client how to keep a journal listing impulsive behaviors and its antecedents or triggers, mediators, and consequences.

Identify and verbalize what is going within his mind, and what feelings are evident before the impulsive act, and identify triggers and impulsive episodes.

Encourage client to keep a journal of impulsive acts (time, place, thoughts, what was going on prior to act) and process journal with therapist.

Identify and list past experiences to explore cognitive, situational, emotional triggers, and how they contribute to impulsive episodes.

Short Term Goal Goal 2:

Identify and verbalize acceptance of responsibility for and connection between impulsive behavior and negative consequences.

Therapeutic Interventions For Goal 2:

Identify connections between impulsivity and negative consequences for self and others.

Continually encourage verbalization and acceptance of responsibility for identified connections between impulsive behaviors and consequences.

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 Impulse Control Problems:

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

Alcohol Use Disorder
305.00 (F10.10) Mild
303.90 (F10.20) Moderate
303.90 (F10.20) Severe
Check for Other Substance Addictive Disorders

Bipolar I Disorder

Specify: Current or most recent episode manic

296.41 (F31.11) Mild
296.42 (F31.12) Moderate
296.43 (F31.13) Severe

296.44 (F31.2) With psychotic features
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified

296.40 (F31.0) Current or most recent episode hypomanic
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified

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: Hypomanic, Depressed
Specify course if full criteria for a mood episode are not currently met: In partial remission, In full remission
Specify severity if full criteria for a mood episode are not currently met:
Mild, Moderate, Severe

301.13 (F34.0) Cyclothymic Disorder
Specify if: With anxious distress

Substance/Medication-Induced Bipolar and Related Disorder

293.83 Bipolar and Related Disorder Due to Another Medical Condition
Specify if:
(F06.33) With manic features
(F06.33) With manic or hypomanic like episode
(F06.34) With mixed features

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

296.80 (F31.9) Unspecified Bipolar and Related Disorder

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

301.82 (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

312.34 (F6381) Intermittent Explosive 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

Overall Integration of a Treatment Plan:

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

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

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

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

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

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

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

Behavioral Descriptors of Problem:

History of episodes of loss of control of aggressive impulses out of proportion to the situation and resulting in assaultive acts or destruction of property.

A history or pattern of acting before thinking resulting in numerous negative impacts on his or her life.

Over-reactivity to mildly aversive or pleasure-oriented stimulation.

Long Term Goals:

Decrease the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out.

Decrease thoughts that trigger impulsive behavior and increase self-talk that controls behavior.

Short Term Goal Goal 1:

Identify all impulsive behaviors and its antecedents, mediators, and consequences.

Therapeutic Interventions For Goal 1:
Teach client how to keep a journal listing impulsive behaviors and its antecedents or triggers, mediators, and consequences.

Identify and verbalize what is going within his mind, and what feelings are evident before the impulsive act, and identify triggers and impulsive episodes.

Encourage client to keep a journal of impulsive acts (time, place, thoughts, what was going on prior to act) and process journal with therapist.

Identify and list past experiences to explore cognitive, situational, emotional triggers, and how they contribute to impulsive episodes

Short Term Goal Goal 2:

Identify and verbalize acceptance of responsibility for and connection between impulsive behavior and negative consequences.

Therapeutic Interventions For Goal 2:

Identify connections between impulsivity and negative consequences for self and others.

Continually encourage verbalization and acceptance of responsibility for identified connections between impulsive behaviors and consequences.

Diagnostic Suggestions:

314.01 (F90.8) Other Specified Attention-Deficit/Hyperactivity Disorder
312.89 (F91.8) Other Specified Disruptive, Impulse-Control, and Conduct Disorder

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