Individual Planning: A Treatment Plan Overview for Individuals with Obsessive-Compulsive Disorder

Duration: 3 hours

Learning Objectives:

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

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

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Course Syllabus:

Introduction
Common Obsessions and Compulsions

Signs and Symptoms

Risks Factors

Treatment and Therapies

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

Introduction:

Obsessive-Compulsive Disorder (OCD) is a common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. It causes people to have unwanted thoughts (obsessions) and to repeat certain behaviors (compulsions) over and over again. We all have habits and routines in our daily lives, such as brushing our teeth before bed. However, for people with OCD, patterns of behavior get in the way of their daily lives. Most people with OCD know that their obsessions and compulsions make no sense, but they can't ignore or stop them.

Obsessions are ideas, images and impulses that run through the person's mind over and over again. A person with OCD doesn't want to have these thoughts and finds them disturbing, but he or she can't control them. Sometimes these thoughts just come once in a while and are only mildly annoying. Other times, a person who has OCD will have obsessive thoughts all the time.

Obsessive thoughts make people who have OCD feel nervous and afraid. They try to get rid of these feelings by performing certain behaviors according to rules that they make up for themselves. These behaviors are called compulsions. (Compulsive behaviors are sometimes also called rituals.) For example, a person who has OCD may have obsessive thoughts about germs. Because of these thoughts, the person may wash his or her hands repeatedly after using a public toilet. Performing these behaviors usually only makes the nervous feelings go away for a short time. When the fear and nervousness return, the person who has OCD repeats the routine all over again.

Common Obsessions and Compulsions:

The following are some common obsessions:
Fear of dirt or germs

Disgust with bodily waste or fluids

Concern with order, symmetry (balance) and exactness

Worry that a task has been done poorly, even when the person knows this is not true

Fear of thinking evil or sinful thoughts

Thinking about certain sounds, images, words or numbers all the time

Need for constant reassurance

Fear of harming a family member or friend

The following are some common compulsions:

Cleaning and grooming, such as washing hands, showering or brushing teeth over and over again

Checking drawers, door locks and appliances to be sure they are shut, locked or turned off

Repeating actions, such as going in and out of a door, sitting down and getting up from a chair, or touching certain objects several times

Ordering and arranging items in certain ways

Counting to a certain number, over and over

Saving newspapers, mail or containers when they are no longer needed

Seeking constant reassurance and approval

Signs and Symptoms:

People with OCD may have symptoms of obsessions, compulsions, or both. These symptoms can interfere with all aspects of life, such as work, school, and personal relationships.

Obsessions are repeated thoughts, urges, or mental images that cause anxiety. Common symptoms include:
Fear of germs or contamination
Unwanted forbidden or taboo thoughts involving sex, religion, and harm
Aggressive thoughts towards others or self
Having things symmetrical or in a perfect order

Compulsions are repetitive behaviors that a person with OCD feels the urge to do in response to an obsessive thought. Common compulsions include:

Excessive cleaning and/or handwashing
Ordering and arranging things in a particular, precise way
Repeatedly checking on things, such as repeatedly checking to see if the door is locked or that the oven is off
Compulsive counting

Not all rituals or habits are compulsions. Everyone double checks things sometimes. But a person with OCD generally:

Can’t control his or her thoughts or behaviors, even when those thoughts or behaviors are recognized as excessive
Spends at least 1 hour a day on these thoughts or behaviors
Doesn’t get pleasure when performing the behaviors or rituals, but may feel brief relief from the anxiety the thoughts cause
Experiences significant problems in their daily life due to these thoughts or behaviors

Some individuals with OCD also have a tic disorder. Motor tics are sudden, brief, repetitive movements, such as eye blinking and other eye movements, facial grimacing, shoulder shrugging, and head or shoulder jerking. Common vocal tics include repetitive throat-clearing, sniffing, or grunting sounds.

Symptoms may come and go, ease over time, or worsen. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves. Although most adults with OCD recognize that what they are doing doesn’t make sense, some adults and most children may not realize that their behavior is out of the ordinary. Parents or teachers typically recognize OCD symptoms in children.

Other Symptoms to Check for:

1. Failure to control these thoughts or impulses or neutralize them with other thoughts and
2. Failed attempts to ignore these thoughts or impulses or replace them with other thoughts and actions

3. Fear of being contaminated by germs or dirt or contaminating others

4. Fear of causing harm to yourself or others

5. Intrusive sexually explicit or violent thoughts and images

6. Excessive focus on religious or moral ideas

7. Fear of losing or not having things you might need

8. Order and symmetry: the idea that everything must line up just right

9. Superstitions; excessive attention to something considered lucky or unlucky

10. Excessive double-checking of things, such as locks, appliances, and switches

11. Repeatedly checking in on loved ones to make sure they're safe

12. Counting, tapping, repeating certain words, or doing other senseless things to reduce anxiety.

13. Spending a lot of time washing or cleaning

14. Ordering or arranging things just so

15. Praying excessively or engaging in rituals triggered by religious fear

16. Accumulating “junk” such as old newspapers or empty food container

17. Can recognize that obsessive thoughts are a product of the mind

18. Repetitive and intentional behaviors responding to obsessive thoughts or according to eccentric rules

19. Repetitive and excessive behavior attempted to neutralize or prevent discomfort

20. Understands that repetitive behaviors as excessive and unreasonable

Risk Factors:

OCD is a common disorder that affects adults, adolescents, and children all over the world. Most people are diagnosed by about age 19, typically with an earlier age of onset in boys than in girls, but onset after age 35 does happen.
The causes of OCD are unknown, but risk factors include:

Genetics

Twin and family studies have shown that people with first-degree relatives (such as a parent, sibling, or child) who have OCD are at a higher risk for developing OCD themselves. The risk is higher if the first-degree relative developed OCD as a child or teen. Ongoing research continues to explore the connection between genetics and OCD and may help improve OCD diagnosis and treatment.

Brain Structure and Functioning

Imaging studies have shown differences in the frontal cortex and subcortical structures of the brain in patients with OCD. There appears to be a connection between the OCD symptoms and abnormalities in certain areas of the brain, but that connection is not clear. Research is still underway. Understanding the causes will help determine specific, personalized treatments to treat OCD.

Environment

People who have experienced abuse (physical or sexual) in childhood or other trauma are at an increased risk for developing OCD.

In some cases, children may develop OCD or OCD symptoms following a streptococcal infection—this is called Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).

Treatment and Therapies:

OCD is typically treated with medication, psychotherapy or a combination of the two. Although most patients with OCD respond to treatment, some patients continue to experience symptoms.

Sometimes people with OCD also have other mental disorders, such as anxiety, depression, and body dysmorphic disorder, a disorder in which someone mistakenly believes that a part of their body is abnormal. It is important to consider these other disorders when making decisions about treatment.

Medication

Serotonin reuptake inhibitors (SRIs) and selective serotonin reuptake inhibitors (SSRIs) are used to help reduce OCD symptoms. Examples of medications that have been proven effective in both adults and children with OCD include clomipramine, which is a member of an older class of antidepressants, and several newer SSRIs, including:

fluoxetine
SRIs often require higher daily doses in the treatment of OCD than of depression, and may take 8 to 12 weeks to start working, but some patients experience more rapid improvement.

If symptoms do not improve with these types of medications, research shows that some patients may respond well to an antipsychotic medication (such as risperidone). Although research shows that an antipsychotic medication may be helpful in managing symptoms for people who have both OCD and a tic disorder, research on the effectiveness of antipsychotics to treat OCD is mixed.

Psychotherapy

Psychotherapy can be an effective treatment for adults with OCD. Research shows that certain types of psychotherapy, including cognitive behavior therapy (CBT) and other related therapies (e.g., habit reversal training) can be as effective as medication for many individuals. Research also shows that a type of CBT called Exposure and Response Prevention (EX/RP) is effective in reducing compulsive behaviors in OCD, even in people who did not respond well to SRI medication. For many patients EX/RP is the add-on treatment of choice when SRIs or SSRIs medication does not effectively treat OCD symptoms.

Cognitive-Behavioral Therapy (CBT): Is a psycho-social intervention that is the most widely used evidence-based practice for improving mental health. Guided by empirical research, CBT focuses on the development of personal coping strategies that target solving current problems and changing unhelpful patterns in cognitions (e.g. thoughts, beliefs, and attitudes), behaviors, and emotional regulation. It was originally designed to treat depression, and is now used for a number of mental health conditions, for example anxiety.

The CBT model is based on the combination of the basic principles from behavioral and cognitive psychology. This wave of therapy has been termed the second wave. Behavioral therapy is thus now referred to as the first wave. The most recent wave is the third wave, containing the mindfulness-based therapies. CBT sits firmly within the second wave. It is different from historical approaches to psychotherapy, such as the psychoanalytic approach where the therapist looks for the unconscious meaning behind the behaviors and then formulates a diagnosis. Instead, CBT is a "problem-focused" and "action-oriented" form of therapy, meaning it is used to treat specific problems related to a diagnosed mental disorder. The therapist's role is to assist the client in finding and practicing effective strategies to address the identified goals and decrease symptoms of the disorder. CBT is based on the belief that thought distortions and maladaptive behaviors play a role in the development and maintenance of psychological disorders, and that symptoms and associated distress can be reduced by teaching new information-processing skills and coping mechanisms.

When compared to psychoactive medications, review studies have found CBT alone to be as effective for treating less severe forms of depression and anxiety, posttraumatic stress disorder (PTSD), tics, substance abuse (with the exception of opioid use disorder), eating disorders and borderline personality disorder. It is often recommended in combination with medications for treating other conditions, such as severe obsessive compulsive disorder (OCD) and major depressive disorder, opioid addiction, bipolar disorder and psychotic disorders. In addition, CBT is recommended as the first line of treatment for majority of
Mainstream cognitive behavioral therapy assumes that changing maladaptive thinking leads to change in behavior and affect, but recent variants emphasize changes in one's relationship to maladaptive thinking rather than changes in thinking itself. The goal of cognitive behavioral therapy is not to diagnose a person with a particular disease, but to look at the person as a whole and decide what can be altered. The basic steps in a cognitive-behavioral assessment include:

Step 1: Identify critical behaviors
Step 2: Determine whether critical behaviors are excesses or deficits
Step 3: Evaluate critical behaviors for frequency, duration, or intensity (obtain a baseline)
Step 4: If excess, attempt to decrease frequency, duration, or intensity of behaviors; if deficits, attempt to increase behaviors.

These steps are based on a system created by Kanfer and Saslow. After identifying the behaviors that need changing, whether they be in excess or deficit, and treatment has occurred, the psychologist must identify whether or not the intervention succeeded. For example, "If the goal was to decrease the behavior, then there should be a decrease relative to the baseline. If the critical behavior remains at or above the baseline, then the intervention has failed."

Therapists use CBT techniques to help individuals challenge their patterns and beliefs and replace "errors in thinking such as overgeneralizing, magnifying negatives, minimizing positives and catastrophizing" with "more realistic and effective thoughts, thus decreasing emotional distress and self-defeating behavior". These errors in thinking are known as cognitive distortions. Cognitive distortions can be either a pseudo-discrimination belief or an overgeneralization of something. CBT techniques may also be used to help individuals take a more open, mindful, and aware posture toward cognitive distortions so as to diminish their impact. Mainstream CBT helps individuals replace "maladaptive... coping skills, cognitions, emotions and behaviors with more adaptive ones", by challenging an individual's way of thinking and the way that they react to certain habits or behaviors, but there is still controversy about the degree to which these traditional cognitive elements account for the effects seen with CBT over and above the earlier behavioral elements such as exposure and skills training.

Modern forms of CBT include a variety of diverse but related techniques such as exposure therapy, stress inoculation, cognitive processing therapy, cognitive therapy, relaxation training, dialectical behavior therapy, and acceptance and commitment therapy. Some practitioners promote a form of mindful cognitive therapy which includes a greater emphasis on self-awareness as part of the therapeutic process.

CBT has six phases:
Assessment or psychological assessment;

Reconceptualization;

Skills acquisition;

Skills consolidation and application training;

Generalization and maintenance;

Post-treatment assessment follow-up.

There are different protocols for delivering cognitive behavioral therapy, with important similarities among them. Use of the term CBT may refer to different interventions, including "self-instructions (e.g. distraction, imagery, motivational self-talk), relaxation and/or biofeedback, development of adaptive coping strategies (e.g. minimizing negative or self-defeating thoughts), changing maladaptive beliefs about pain, and goal setting". Treatment is sometimes manualized, with brief, direct, and time-limited treatments for individual psychological disorders that are specific technique-driven. CBT is used in both individual and group settings, and the techniques are often adapted for self-help applications. Some clinicians and researchers are cognitively oriented (e.g. cognitive restructuring), while others are more behaviorally oriented (e.g. in vivo exposure therapy). Interventions such as imaginal exposure therapy combine both approaches.

Exposure and Response (Ritual) Prevention (EX/RP): EX/RP consists of exposing the triggers that cause anxiety and fear and teaching how to resist doing any compulsions or rituals to reduce the distress. The basic principles of EX/RP can be boiled down to three steps that need to be practiced consistently to overcome OCD:

Confront the things one fears as often as possible.

Do not avoid something, when feeling a strong desire to do so.

Do not perform a ritual to feel better.

With EX/RP, the brain learns to tolerate anxiety and that the anxiety will eventually come down and pass without any need or avoidance or rituals. The brain will learn that the feared catastrophe does not happen or that one could handle it if it did. Gradually, the brains starts to realize just how ridiculous or unrealistic obsessionial fears are and how much OCD is taking away from life. Basically, It teaches you how to take charge and not give OCD the attention it craves.
The main treatment components of EX/RP include:

Assessment, Education and Treatment Planning: We will identify all triggers, obsessional fears and related rituals and make a plan to systematically approach fears without engaging in rituals. Will learn about the sneaky ways OCD tries to trick and lie into submission. Will learn that OCD is like a tic in the brain that is trying to protect one, but instead OCD is making one a slave and ruining life.

In Vivo Exposure: Exposures are the heart of OCD treatment. In this step, we will expose real life triggers that elicit fear, anxiety and/or disgust in a gradual hierarchical manner. We will start with easy exposures and, as one gain confidence and can cope with anxiety, then one can move up the hierarchy to confront situations that are more challenging.

Imaginal Exposure: This involves prolonged exposure in an imagination of worst fears without doing any rituals. Learn to develop a script (or series of scripts) for to record and listen to every day until one is no longer scared of the content of the obsessions and can visualize one facing any fears without any rituals.

Response (Ritual) Prevention: RP is the identification and elimination of all physical and mental compulsions to learn to cope with distress without doing rituals or avoidance. And learning that while rituals reduce anxiety/distress in the short term, they are not building courage that can handle anxiety without them. Rituals are actually fuel to OCD's fire and maintain the OCD cycle.

Cognitive Processing: The key to long term, permanent change is gaining new beliefs and increasing self-confidence. OCD is making one believe things that aren't true and exaggerating the danger of fears. In order to help overcome OCD, one does not focus on what to think because OCD will just argue any thinking patterns. Instead, the focus is in what one has actually learned through EX/RP activities and reinforce experiential learning in order to create new beliefs about the meaning of obsessions.

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
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:

- 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 must be able to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client's or patient's own prioritization of the problems presented. The client's or patient's cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate may exclude some of the client's or patient's needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).
Behavioral Definitions for Individuals with OCD:

Recurrent impulses that are viewed as intrusive, senseless, and time-consuming, or that interfere with patient’s daily routine, or social relationships.

Recurrent and persistent ideas viewed as intrusive, senseless, and time-consuming, or that interfere with patient’s daily routine, or social relationships.

Recurrent and persistent thoughts viewed as intrusive, senseless, and time-consuming, or that interfere with patient’s daily routine, or social relationships.

Recurrent and persistent ideas, thoughts, or impulses that are viewed as intrusive, senseless that interfere with patient's daily routine, or social relationships.

Failure to control these thoughts or impulses or neutralize them with other thoughts and actions.

Failed attempts to ignore these thoughts or impulses or replace them with other thoughts and actions.

Can recognize that obsessive thoughts are a product of the mind.

Repetitive and intentional behaviors responding to obsessive thoughts or according to eccentric rules.

Repetitive and excessive behavior attempted to neutralize or prevent discomfort, but the behavior is not connected in any realistic way with what it is designed to neutralize or prevent.

Understands that repetitive behaviors as excessive and unreasonable.

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 OCD:
Lower time involved with or interference from obsessions and compulsions.

Increase daily function at a consistent level with minimal interference from obsessions and compulsions.

Solve key life conflicts and emotional stresses that fuels obsessive-compulsive behavior patterns.

Eliminate key thoughts, beliefs and past life events in to increase chances of been free from obsessions and compulsions.

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 &ldquo;13. Increase positive self-descriptive statements.&rdquo; Can be restated as; &ldquo;By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem&rdquo; Remember, that it must be stated in a way one can measure effectiveness.
It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

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:

Obtain and explore the complete history and severity of obsessive thoughts and compulsive behavior.

Therapeutic Interventions For Goal 1:

Explore the nature, frequency, duration, severity, and history of the obsessive-compulsive disorder problems.

Establish well rapport and therapeutic relationship with client to build trust and a therapeutic relationship to bring about real change.

Short Term Goal Goal 2:
Identify and list distorted thinking, negative self talk, and belief errors and how each impacts daily functioning.

Therapeutic Interventions For Goal 2:

Explore schemas and negative self-talk that control and mediate obsessional fears and compulsive behaviors, and identify ways to generate thoughts that correct these fears.

Identify and list distorted thinking and belief errors and how each impacts daily functioning, and ways to replace thinking and beliefs with reality tested thoughts and beliefs.

Identify and list distorted automatic thoughts and beliefs.

Develop reality-based self-talk as a strategy to assist in controlling obsessive thoughts.

Identify and list distorted thinking and belief errors and how each impacts daily functioning.

Use a Rational Emotive Therapy approach and teach how to analyze, attack and destroy self-defeating beliefs.

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 Diagnostic Suggestions for Adults Suffering Obsessive Compulsive Disorder:

300.3 (F42) Obsessive-Compulsive Disorder
Specify if: Tic-related

300.7 (F45.22) Body Dysmorphic Disorder
Specify if: With muscle dysmorphia

300.3 (F42) Hoarding Disorder
Specify if: With excessive acquisition

312.39 (F63.2) Trichotillomania (Hair-Pulling Disorder)

698.4 (L98.1) Excoriation (Skin-Picking) Disorder

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder

294.8 (F06.8) Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
Specify if: With obsessive-compulsive disorder-like symptoms
With appearance preoccupations
With hoarding symptoms, With hair pulling symptoms
With skin-picking symptoms

300.3 (F42) Other Specified Obsessive-Compulsive and Related Disorder

300.3 (F42) Unspecified Obsessive-Compulsive and Related

.___ (.___) Major Depressive Disorder
296.21 (F32.0) Mild
296.22 (F32.1) Moderate
296.23 (F32.2) Severe
296.20 (F32.9) Unspecified

296.21 (F33.0) Mild
296.32 (F33.1) Moderate
296.33 (F33.2) Severe
296.30 (F33.9) Unspecified

Adjustment Disorders Specify whether:
309.24 (F43.22) With anxiety
309.28 (F43.23) With mixed anxiety and depressed mood
309.4 (F43.25) With mixed disturbance of emotions and conduct
309.9 (F43.20) Unspecified

309.89 (F43.8) Other Specified Trauma- and Stressor-Related Disorder

300.02 (F41.1) Generalized Anxiety Disorder
300.09 (F41.8) Other Specified Anxiety Disorder
300.00 (F41.9) Unspecified Anxiety Disorder
309.89 (F43.8) Other Specified Trauma- and Stressor-Related Disorder
309.9 (F43.9) Unspecified Trauma- and Stressor-Related Disorder
309.81 (F43.1 0) Posttraumatic Stress Disorder (includes Posttraumatic Stress)
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 behavioral definition is not listed feel free to define your own behavioral definition.

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

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

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

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

Sample Treatment Plan:

***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:

Recurrent impulses that are viewed as intrusive, senseless, and time-consuming, or that interfere with patient’s daily routine, or social relationships

Recurrent and persistent ideas viewed as intrusive, senseless, and time-consuming, or that interfere with patient’s daily routine, or social relationships
Long Term Goals:

Lower time involved with or interference from obsessions and compulsions.
Increase daily function at a consistent level with minimal interference from obsessions and compulsions.

Short Term Goal Goal 1:

Obtain and explore the complete history and severity of obsessive thoughts and compulsive behavior.

Therapeutic Interventions For Goal 1:

Explore the nature, frequency, duration, severity, and history of the obsessive-compulsive disorder problems.

Establish well rapport and therapeutic relationship with client to build trust and a therapeutic relationship to bring about real change.

Short Term Goal Goal 2:

Identify and list distorted thinking, negative self talk, and belief errors and how each impacts daily functioning.

Therapeutic Interventions For Goal 2:

Explore schemas and negative self-talk that control and mediate obsessional fears and compulsive behaviors, and identify ways to generate thoughts that correct these fears.
Identify and list distorted thinking and belief errors and how each impacts daily functioning, and ways to replace thinking and beliefs with reality tested thoughts and beliefs.

Identify and list distorted automatic thoughts and beliefs.

Develop reality-based self-talk as a strategy to assist in controlling obsessive thoughts.

Identify and list distorted thinking and belief errors and how each impacts daily functioning.

Use a Rational Emotive Therapy approach and teach how to analyze, attack and destroy self-defeating beliefs.

Diagnostic Suggestions:

300.3 (F42) Obsessive-Compulsive Disorder

300.02 (F41.1) Generalized Anxiety Disorder