14

Mental Health Disorders and Case Management

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LEARNING OBJECTIVES

Upon completion of the chapter the reader will be able to:

1. Develop a general understanding of the *categories* listed under the *Diagnostic and Statistical Manual for Mental Health Disorders* (Fifth Edition, *DSM-5*),
2. Develop a general understanding of the *mental health disorders* listed under each category of the *DSM-5*,
3. Understand the psychosocial implications of the mental health disorders/categories outlined in the chapter,
4. Recognize appropriate case management strategies and incorporate an interdisciplinary approach when working with clients with a mental health disorder.

INTRODUCTION

This chapter begins with a review of the categories of mental health disorders and a brief discussion of the medical and psychosocial challenges experienced by persons with mental health disorders. Employment outcomes for this population have been lower than for other populations of persons with disabilities, and the chapter explores how stigma, prejudice, and discrimination create unique barriers to full participation in families, communities, and the workplace. Specific approaches to case management and coordination of services with medical and other human services professionals are explored. Emerging evidence-based strategies for intervention and case management of this population are discussed.

We now turn our attention to an overview of the most commonly known mental health disorders and provide an overview of each category and the psychosocial implications for each. The purpose of providing such a thorough and comprehensive review of mental health disorders is to help educate and eliminate any stigma generally associated with particular conditions. For instance, have you ever heard someone say, “she’s bipolar” yet have no formal training in mental health, but make the assumption based on various television shows and movies? Or how about, perceiving a person has a substance use problem from one or two encounters? Moreover, we provide tables with some of the most common mental health disorders under each of the categories listed in this chapter. It should be noted,

however, due to the vast number of mental health disorders outlined in the *Diagnostic and Statistical Manual of Mental Health Disorders* (Fifth Edition; *DSM-5*; American Psychiatric Association, 2013), the following categories were not included in the chapter: (a) Disruptive, Impulse-Control, and Conduct Disorders, Neurocognitive Disorders, (b) Personality Disorders, (c) Paraphilic Disorders, and (d) Other Mental Disorders. Each category (e.g., Neurodevelopmental Disorders, Depressive Disorders) has specific mental health disorders assigned to it. Therefore, we provide a table outlining each of the most commonly associated mental health disorders, the prevalence rate for each, and a description of the mental disorder. Thus, the reader should become familiar and knowledgeable with each category listed, understand the psychosocial implications for each, and become familiar with case management approaches in an effort to provide effective treatment for the clients with a mental health disorder.

NEURODEVELOPMENTAL DISORDERS

Neurodevelopmental disorders are characterized by deficits or impairments in personal, social, academic, or occupational functioning and generally manifest during early developmental stages. Developmental deficits vary from specific limitations of learning (e.g., impairment in reading), executive functioning (i.e., working memory, cognitive flexibility, and inhibitory control, which includes self-control), social skills, and/or intelligence. If you are wondering why we included the *and/or* in the previous sentence, it is because there is a strong likelihood for two or more disorders to be present. For instance, a person with attention-deficit hyperactivity disorder (ADHD) is at an increased risk of meeting the diagnostic criteria for a specific learning disorder. Additionally, a person with an autism spectrum disorder frequently has associated structural language disorders. For a brief description of the disorders listed under the category of neurodevelopmental disorders, please see Table 14.1.

Table 14.1 Neurodevelopmental Disorders		
Category	Prevalence	Description
Intellectual disability	1% of gen. pop.	Deficits in general mental abilities and impairment in everyday adaptive functioning
Global developmental delay	4.5% children	Delay in cognition, social functioning, speech, language, and motor skills among children under the age of 5
Communication disorders	8% children	Disorders of communication including deficits in language, speech, and communication
Autism spectrum disorder	1%	Impairment in reciprocal social communication and interaction, and repetitive patterns of behavior, interests, or activities
Attention-deficit/hyperactivity disorder	5% children; 2.5% adults	Persistent pattern of inattention (wandering behavior and difficult with focusing) or hyperactivity (excessive motor activity)
Specific learning disorder	5%–15% children; 4% adults	Difficulty with learning and using academic skills such as impairment in reading (i.e., slow reading), written expression (i.e., spelling accuracy), and mathematics (i.e., difficulty with mathematical reasoning or number sense)

(continued)

Table 14.1 Neurodevelopmental Disorders (*continued*)

Category	Prevalence	Description
Motor disorder		
Developmental coordination disorder	5%–6%	Coordination of motor skills considerably below average for one's age
Stereotypic movement disorder	3%–4%	Repetitive and driven motor behavior such as hand shaking, head banging, self-biting, or hitting ones' body, which interferes with social, academic, or other activities that can result in bodily injury
Tic disorder	0.3%–0.8%	Sudden, rapid, recurrent, nonrhythmic motor movement or vocalization

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>; Black, L. I., Vahratian, A., & Hoffman, H. J. (2015). *Communication disorders and use of intervention services among children aged 3-17 years: United States, 2012*. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/data/databriefs/db205.pdf>

PSYCHOSOCIAL ISSUES

Because the range of symptoms associated with neurodevelopmental disorders is so vast, individuals in this diagnostic category may experience a variety of different challenges. For example, an individual with a mild intellectual development disorder may have to exert extra effort in academic, social, and vocational situations. They may have difficulty with math or reading skills, interacting with peers or authority figures, regulating emotions, communicating effectively, interpreting social cues, and managing time and money. However, with proper support and intervention, they may be quite capable of maintaining employment, living independently, and enjoying satisfying relationships (Falvo & Holland, 2018). An individual with a profound intellectual disability may have a much different life experience and require assistance in almost every area of daily activities. Co-occurring motor and sensory impairments are common in individuals with a profound level of intellectual developmental disorder, and communication exists mainly through nonverbal, gestural means (APA, 2013). Fortunately, however, the myth that individuals with severe intellectual impairment are incapable of enjoying rich lives is diminishing. Advocates, fighting for the recognition that people with disabilities are equally worthy of a high quality of life, are working to eliminate discrimination and aiming to improve conditions for all.

A distinctive and pervasive symptom often observed in individuals with autism spectrum disorders involves difficulty with social interaction. These social challenges can include difficulty with recognizing the emotions and intentions of other individuals, recognizing and expressing one's own emotions, and feeling overwhelmed in social situations. Additionally, individuals with autism spectrum disorder may have challenges with social communication, including understanding and appropriately using spoken language (some individuals with autism are nonverbal), eye contact, tone of voice, and facial expressions. Individuals with autism spectrum disorder may also engage in restricted and repetitive behaviors like repetitive body movements or motions with objects (Pratt et al., 2017). Abnormal speech and behavioral patterns, difficulty empathizing and understanding others, and under- or overreaction to stimuli may cause individuals relational, educational, and vocational challenges (Kilgus et al., 2016).

Children with attention-deficit/hyperactivity disorder (ADHD) frequently experience negative reactions from teachers, parents, and peers, who may lack understanding or patience for their impulsive and distracting behavior. The reader may imagine how challenging it can

be for a teacher to manage a classroom full of developmentally average adolescents; the addition of a child with ADHD engaging in distracting or impulsive behaviors may be overwhelming for the teacher. At this critically important stage of development, children may become ostracized, labeled as problematic or unmotivated, and their confidence, academic opportunities, and friendships may suffer. Individuals with ADHD frequently seek sensation and stimulation to engage the parts of their brain that are underactive. They may lack the capacity to weigh the consequences of their behavior. As a result, accidental injuries, substance misuse, and inconsistent employment are more commonly seen in individuals with ADHD (APA, 2013). Maintaining work and interpersonal relationships may be difficult for adults with undiagnosed or improperly treated ADHD. Judgments from coworkers and other adults that they should have grown out of their disorderly behavior may cause resentment toward others, decreases in self-esteem, and challenges working in collaborative environments. Parents are forced to make tough decisions regarding proper treatment for a child with a neurodevelopmental disorder, adding to their potentially already heightened level of familial stress. Large amounts of time, money, and emotional energy must be expended, regardless of whether they choose to medicate or manage the symptoms through other interventions.

Undiagnosed, co-occurring mental health issues, including depression, anxiety, addiction, and suicidal thoughts and behaviors are a concern for individuals with neurodevelopmental disorders, as they may struggle to adequately express their needs or engage in maladaptive behaviors to cope with symptoms (Falvo & Holland, 2018). Stigmatization based on misinformation and misplaced public fear is common, and individuals may experience discrimination, oppression, rejection, or isolation. An individual's perception of their mental health and the significance the disorder has for their self-concept are critical factors in understanding the impact they have on their quality of life (Shaw et al., 2002).

SCHIZOPHRENIA SPECTRUM AND OTHER RELATED PSYCHOTIC DISORDERS

Schizophrenia spectrum and other related psychotic disorders have overlapping diagnostic similarities, which consist of delusions, hallucinations, disorganized thinking, abnormal motor behavior, and negative symptoms (APA, 2013). *Delusions* are defined as fixed beliefs despite conflicting evidence. Delusions generally consist of persecutory (an idea that people are out to get them), somatic (false beliefs over the appearance of one's body), religious (preoccupied with religious subjects that do not align with the person's cultural and educational background), and grandiose (over-inflated sense of worth) beliefs. With delusions operating as a false belief, *hallucinations* are characterized as real perceptions involving one's senses (i.e., auditory, vision, smell, and touch). *Disorganized thinking*, on the other hand, occurs when a person has disorganized speech. For example, the client may shift from topic to topic without a clear direction of where they are going with their communication. *Grossly disorganized* or *abnormal motor behavior* can range from catatonic behavior (decreased reaction) to excessive motor activity, or increased motor movements. Lastly, *negative symptoms* are generally associated with schizophrenia (although found in other psychotic disorders) and include diminished emotional expression and anhedonia (inability to feel pleasure). See Table 14.2 for a description of the disorders classified as schizophrenia spectrum and other related psychotic disorders.

PSYCHOSOCIAL ISSUES

For individuals with schizophrenia spectrum disorders, psychosocial considerations include the emotional toll of hearing persecutory voices or bizarre commands, inability to communicate effectively, social withdrawal, loss of capacity to feel joy, loss of employment,

Table 14.2 Schizophrenia Spectrum and Other Related Psychotic Disorders

Category	Prevalence	Duration	Description
Delusional disorder	0.2%		Delusional disorder is the presence of one or more delusions which include perceiving another to be in love with that person (erotomantic), believing that one has extreme talent (grandiose), the belief that the individual's partner is unfaithful (jealous), the belief that they are being conspired against (persecutory), etc. Impairments in psychosocial functioning tend to be restricted.
Brief psychotic disorder	Unknown	<1 month	Brief psychotic disorder is a sudden onset of psychotic symptoms which include delusions, hallucinations, disorganized speech, and disorganized or catatonic behavior.
Schizophreniform disorder	0.3%–0.7%	1–6 month	Schizophreniform disorder is similar to schizophrenia, but there is a marked difference in the duration.
Schizophrenia	0.3%–0.7%	1 month or longer	Schizophrenia is a dysfunction in cognition, behavior, and emotions affecting occupational and social functioning. Diagnosis requires the presence of two or more symptoms: (a) delusions, (b) hallucinations, (c) disorganized speech, (d) disorganized or catatonic behavior, and (e) negative symptoms.
Schizoaffective disorder	0.3%	Delusions for 2 weeks or longer	Schizoaffective disorder is a chronic mental health condition characterized by symptoms of schizophrenia (i.e., two or more of the following: delusions, hallucinations, disorganized speech, disorganized or catatonic behavior), and symptoms of a mood disorder such as mania and depression.
Substance/medication-induced psychotic disorder	Unknown	Varies based on substance	Substance medication-induced psychotic disorder causes delusions and/or hallucinations as a direct result of a substance (i.e., alcohol, medication, cocaine, etc.).

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

the possibility of isolation for those who pose a risk of violence to oneself or others, higher rates of substance use, financial strain, and drastically changing family roles (Addington et al., 2010). The initial onset of symptoms is frequently seen during the late teens or early 20s, which is already a period of critical development for individuals' bodies and brains, as well as for their social and academic responsibilities (Holtzman et al., 2013). For an emerging teenager whose life includes a considerable amount of pressure from school, peers, parents, as well as significant decisions regarding college and career, the addition of a psychotic episode or diagnosis of mental illness will cause a new level of emotional challenge. The alterations in cognition seen in these patients make it difficult to choose one's next steps and create a sense of independence that is characteristic of this time period. Friends may be unable to empathize, as they deal with their own teenage angst, and romantic relationships may dissolve, as young partners are often ill-equipped to handle such challenges. Individuals with schizophrenia spectrum disorders experience higher rates of divorce and lower numbers of children than the general population, reflecting the difficulty of intimacy they may experience (Kilgus et al., 2016).

Family discord is common in patients with schizophrenia spectrum disorders. Parents must adjust their plans for their children, which may ignite a profound sense of loss, as they grieve the vision they had for their future. Siblings may have to deal with their own distress

as they learn to share a home with an individual with a schizophrenia spectrum disorder. Resentment at having to take a backseat to their brother or sister, guilt for feeling that way, loneliness if a sibling is hospitalized, and fear of their own possibly impending illness, are all plausible emotions they may experience (Kilgus et al., 2016). Activities of daily living become challenging for those whose disorder is unmanaged, and family members may have to help with meal preparation, bathing, dressing, hygiene, and completing simple tasks that require decision-making or problem-solving (Falvo & Holland, 2018). Social stigmatization is also a concern that may affect more than the individual with the illness. Siblings' friends may no longer feel comfortable visiting their home, and parents may struggle to find supportive networks in their community. Individuals with schizophrenia spectrum disorders experience more than just the negative thought patterns of someone in a low mood, with self-doubts, worrisome burdens, or the lingering voice of an authoritarian parent in their head. These individuals may hear commands to commit violent acts, experience sensory hallucinations, realize delusions of grandeur or persecution and believe in these paranoid cognitions, which can be quite terrifying for individuals, family, friends, and coworkers. Homelessness, substance misuse, and incarceration (although typically for misdemeanors and nonviolent crimes) can be issues for individuals with schizophrenia that do not receive proper treatment (Gonzalez & Rosenheck, 2002; Mowbray, 1985). Extreme depression and hopelessness indicate that suicide is one of the most dangerous complications of these disorders (Kilgus et al., 2016). Enhancing one's quality of life through adequate support systems, ability to cope with stress, social and functional improvement, vocational rehabilitation, and medication management for symptoms are critical. It should be noted, this classification of mental health disorders can be managed (not cured) with medication, but relapse is quite common when individuals fail to maintain a consistent regimen.

BIPOLAR AND RELATED DISORDERS

This classification of mood disorders includes bipolar I, bipolar II, and cyclothymic disorders. While distinguishable by the level of severity and duration of symptoms, all three disorders share the common characteristics of extreme highs and extreme lows—in energy, affect, cognition, and behavior. Bipolar I disorder involves a manic episode, where the period of elevated mood and increased activity is so severe it causes clinically significant distress and may require hospitalization. Though not required for diagnosis, bipolar I disorder commonly includes episodes of hypomania and major depression, once the manic period subsides (APA, 2013). A diagnosis of bipolar II disorder is warranted when one experiences both hypomanic and major depressive episodes. Individuals with bipolar II disorder do not experience mania and instead experience hypomania. The two differences between a manic and a hypomanic are related to the duration and severity of the episode. A manic episode lasts for at least 1 week, impairs social and occupational functioning, and may include psychotic symptoms, which can lead to hospitalization. Conversely, a hypomanic episode lasts for at least 4 consecutive days, leads to a disruption in functioning, but typically does not lead to severe impairments or require hospitalization. Despite the absence of clinically significant distress or hospitalization characteristic of mania, bipolar II should not be considered a less serious disorder than bipolar I. Individuals with bipolar II disorder still must contend with the substantial impact of mood fluctuations and frequently experience longer phases of debilitating depression (APA, 2013). Cyclothymic disorder differs from the two types of bipolar disorder in the duration, severity, and pervasiveness of symptoms. Individuals with

Table 14.3 Bipolar and Related Disorders

Category	Prevalence	Description
Bipolar I	0.6%	Bipolar I is characterized as elevated, expansive, or irritable and abnormal and persistently increased goal-directed activity or energy and will constitute as being either manic (lasting 1 week), hypomanic (lasting 4 days). Major depressive episode is also common although not required for a diagnosis of bipolar I.
Bipolar II	0.8% within U.S.	Bipolar II consists of having one or more major depressive episodes, and at least one hypomanic episode.
Cyclothymic disorder	0.4%–1% of U.S.	Cyclothymic disorder manifests as frequent and constant fluctuating mood consisting of hypomanic and depressive symptoms.
Substance/medication-induced bipolar and related disorder	Unknown	Substance-induced disorder results in raised, extensive, or agitated mood with or without depressive symptoms, or decreased pleasure in most activities.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

cyclothymia experience numerous, distinct periods of hypomanic symptoms (that do not meet the criteria for a hypomanic episode) and depressive symptoms (that do not meet the symptom or duration criteria for a major depressive episode). These fluctuations in mood last for at least 2 years (APA, 2013). For more information on each of these and related disorders, view Table 14.3.

PSYCHOSOCIAL ISSUES

Individuals with bipolar and related disorders may experience unique impairment in the realms of occupational, educational, interpersonal, familial, financial, and overall psychosocial functioning. Not only must they and those around them manage episodes of extreme lows, which carry with them all the complications seen in those with depressive disorders, they must also contend with periods of mania and/or hypomania, as well as distinct challenges related to mood instability. The unpredictability in presentation of these disorders makes the creation and implementation of proactive coping mechanisms extremely difficult. A widespread lack of understanding, inconsistent symptomology, denial, and stigmatization can cause individuals with bipolar disorders to be misdiagnosed, undiagnosed, or improperly treated, which may prolong and exacerbate symptoms (Falvo & Holland, 2018). Social supports are critical in helping to adequately identify and manage the disorder (Weinstock & Miller, 2010).

When one is in the throes of a manic or hypomanic episode, they may experience feelings of grandiosity, racing thoughts, decreased ability to distinguish between important and irrelevant tasks, a rise in physical energy with a corresponding decline in need for sleep, and increased activities directed toward accomplishing goals or involving potentially damaging repercussions (APA, 2013). When individuals are experiencing a manic episode, they often do not perceive that they need treatment and may resist efforts from others to help them receive treatment. During these episodes, they are susceptible to poor judgment and impulsivity; what may seem like a perfect idea at the time may cause an individual to squander finances, lead to relationship trouble, result in job loss, physical injury, or legal ramifications (Hammen & Cohen, 2005). People in their orbit may assume the individual is merely productive, bold,

ambitious, or creative, causing a lack of understanding or support when the episode subsides. Individuals experiencing mania or hypomania may become angry and irritable when others question their behavior, further pushing away those who may try to help.

The consequences related to the extreme highs of bipolar disorder may be compounded by depressive episodes, which may lead to further educational, occupational, financial, and relational complications. Symptoms of bipolar depression may be more pronounced than those associated with unipolar depression. Individuals are likely to experience lower levels of physical, emotional, and mental energy; longer, more severe, and a greater number of symptoms; and related psychosis, resulting in a higher incidence of hospitalizations and suicide (Kilgus et al., 2016). The common feature of up and down cycles of mood and symptomology can be incredibly challenging to medicate and manage, causing a great deal of burden on significant others and caregivers (Hammen & Cohen, 2005). Without knowing what to anticipate, loved ones may be unable to adequately modify their environment and adapt behaviors to support the individual's changing needs. A study conducted by Targum et al. (1981) examined the impact of bipolar disorder on families and found that over half the nonbipolar spouses they surveyed would not have chosen to have children with their bipolar spouse had they better understood the illness. With a limited capacity to consider others' perspectives and a heightened focus on one's own experience, interpersonal difficulties with parents, siblings, friends, colleagues, bosses, and teachers are prevalent.

DEPRESSIVE DISORDERS

Included in this class of disorders are major depressive disorder, disruptive mood dysregulation disorder, and dysthymia. Though differing in duration and accompanying physical and cognitive symptoms, common to all of these disorders is a prolonged negative, sad, or vacant mood (APA, 2013). Also known as "persistent depressive disorder," dysthymia manifests similarly to major depressive disorder; however, the depressive mood lasts for at least 2 years (APA, 2013). Disruptive mood dysregulation disorder is more commonly seen in children and involves severe outbursts and irritable, angry temperament that cause impairment in school, home, and relationships. For a brief description of disorders listed under the category of dissociative disorders, please see Table 14.4.

Table 14.4 Depressive Disorders		
Category	Prevalence	Description
Major depressive disorder	7% (18–29 years-old); threefold (60+ years)	Occurring for most of the day, there is a loss of interest in pleasurable activity lasting at least 2 weeks. Common symptoms include but are not limited to increase and/or decrease towards appetite, sleep, concentrating, thinking, substance abuse, and suicidal ideation.
Persistent depressive disorder (dysthymia)	0.5%	This is similar to major depressive disorder but occurs for at least 2 years.
Premenstrual dysphoric disorder	1%–5.8%	Feelings of irritability, anxiety, and dysphoria occur during menstruation.
Substance/medication-induced depressive disorder	0.26%	Symptoms are similar to major depressive disorder but occur as a result of inducing medication or a substance.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

PSYCHOSOCIAL ISSUES

Depressive disorders can cause severe limitations in an individual's ability to function in all areas of life. Lack of energy, trouble sleeping or waking, feelings of worthlessness, difficulty concentrating, memory loss, and exceedingly negative thoughts are symptoms experienced by those with depressive disorders. Simple daily tasks, such as taking a shower or walking the dog, can seem insurmountable, and social interactions and occupational performance frequently decline. Challenges can be compounded by the fact that the interventions that may help someone's condition improve are the very things that can appear almost overwhelming. Exercise, time spent outdoors, connection to others, finding meaning, spirituality, and a purpose for living may encourage one to seek help; however, depending on the length and severity of their disorder, motivation and willpower reserves may be depleted. Others may not be able to comprehend the impact and gravity of one's depressive disorder, and well-meaning friends may remark, "Things aren't so bad! Be grateful for what you have! Snap out of it!" These reactions may only add to feelings of aloneness, hopelessness, and guilt at one's inability to cheer up. Most people find it laborious to be around those who are chronically gloomy and pessimistic, so social invitations may decrease, and isolation may perpetuate. Many individuals with a depressive disorder may go undiagnosed or untreated, as symptoms may appear to be related to other medical conditions (Whooley & Simon, 2000). The disorder may progress if untreated, and lapses in memory and problems focusing may result in vocational complications, unemployment, and financial strain.

Children with disruptive mood dysregulation disorder have trouble managing frustrations and keeping their temper in check, which presents complications at both school and home. Patience and tolerance are required to participate in normal activities, but for an individual with disruptive mood dysregulation disorder, inhibitions are limited. Teachers may not be able to provide the support these individuals need while maintaining order throughout the classroom. Academics, athletics, family, and peer relationships may suffer, which can have lasting complications for developing youth. Parents may struggle with discipline, and their patience may wear thin. Siblings may be unable to relate, feel resentment, anger, or fear, and the family system may deteriorate. Establishing and maintaining friendships may be extremely challenging for these individuals, and they may experience reduced self-esteem and poor self-concept. Early intervention and treatment are of utmost concern to ensure children meet critical developmental milestones and are able to flourish.

ANXIETY DISORDERS

Anxiety disorders are the most frequently diagnosed conditions in the United States and commonly co-occur with other illnesses (Kilgus et al., 2016). Generally, low to moderate levels of anxiety are a normal reaction to stress, and the physiological response such as increased heart rate, breathing, and increased blood flow to the brain can improve one's ability to focus, enhance motivation to complete work deadlines, or school assignments. However, anxiety disorders may manifest as psychological symptoms, which include excessive worry, fear, and avoidance of certain people, places, or things. For instance, individuals with a social anxiety disorder or selective mutism may be reluctant to work on a group project outside of school that requires active discussion and social communication, because they may fear social embarrassment or potential scrutiny by others. For persons with a generalized anxiety disorder and panic disorders, there may be disinclination towards socializing with others, or they may completely withdraw and isolate themselves from social participation. Behavioral

Table 14.5 Anxiety Disorders		
Category	Prevalence	Description
Separation anxiety disorder	0.9%–1.9%	Excessive fear and/or anxiety towards being separated from attachment figures
Selective mutism	0.03%–1%	Aside from close family members (e.g., mother and father), children with selective mutism not engaging or initiating in speech when spoken to
Specific phobia	7%–9%	Intense fear, anxiety, and avoidance over a specific object or situation (e.g., underground tunnels, elevators, insects, dogs, heights, storms)
Social anxiety disorder	7%	Experiencing feelings of being scrutinized by others in a social setting (social gathering, public speaking, etc.), which illicit intense fear or anxiety
Panic disorder	11.2% among adults	Intense fear and discomfort reaching a peak within minutes following an anxiety-provoking situation. (Physical and psychological symptoms range from chest pain, accelerated heart rate, sweating, trembling, feelings of choking, chills or heat sensation, etc.)
Agoraphobia	1.7%	Fear or anxiety triggered by real or anticipated exposure which can include enclosed spaces, using public transportation, large crowds, being home alone, etc.
Generalized anxiety disorder	0.9% adolescents; 2.9% adults	Excessive anxiety and worry for at least 6 months over a number of events or activities

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

and somatic symptoms including head and stomach aches, dizziness, shaking, sweating, chest pain, heart palpitations, insomnia, restlessness, and muscle tension are common and generally quite debilitating.

For anxiety disorders, some symptoms may result from trepidation surrounding social settings, as in social anxiety disorder or selective mutism; may involve distress created by a variety of situations, as seen in those with generalized anxiety disorder, agoraphobia, or panic disorders; may be prompted by separation from attachment figures (separation anxiety disorder); or may be related to a particular object, as in specific phobias (APA, 2013). While individuals may experience differing severities of these disorders, all produce disproportionate emotional, psychological, and behavioral responses in either time or degree compared to others in the same situation. Because the measures of anxiety are subjective and manifestations of the disorders may be odd, clinicians must remain vigilant to seemingly unrelated client complaints in order to produce an accurate diagnosis. For a brief description of disorders listed under the category of dissociative disorders, please see Table 14.5.

PSYCHOSOCIAL ISSUES

Anxiety disorders can have a profoundly limiting effect on one’s enjoyment of life and can become debilitating if not adequately addressed and treated. One may learn to avoid situations, people, or things that produce feelings of fear and panic caused by these disorders. Though lifestyle modifications may lead to a reduction in certain symptoms, they may also negatively impact relationships, families, career, academic achievement, and overall vitality. Someone with severe agoraphobia may be unable to work, use transportation, or even leave the house. An individual with a separation anxiety disorder may cling excessively to

loved ones and shun any activity that must be done alone. A child with selective mutism, who refuses to speak at school or with peers, may become cognitively stunted, academically impaired, or socially withdrawn. A mild specific phobia may merely create an inconvenience, while severe phobias can cause individuals to retreat from life out of fear of having to confront the item or situation. The unpredictable threat of panic attacks may make simple activities like running errands or meeting appointments unbearable for those with panic disorder. Generalized anxiety disorder can create such an ominous, persistent feeling of dread and unease that individuals are unable to focus on work, manage relationships, or even get out of bed. For those with social anxiety disorder, the symptoms are prompted by situations in which one has to be in the presence of others, causing an overwhelming worry that they will do something deplorable or be judged negatively. A diagnostic feature of this disorder is that social situations nearly always arouse these thoughts and feelings, making employment, school, and human connection incredibly challenging.

Because we all experience varying degrees of anxiety at one point or another, individuals with pathological levels may be misunderstood, stigmatized, or have their concerns diminished. Hearing, “Don’t fret”; “you really need to relax”; “everything is fine”; “you’re such a worrywart,” or “you’re just an introvert”; can negatively impact one’s view of self. Decreased self-esteem leading to co-occurring depression is a common trajectory for individuals with anxiety disorders. They may question the validity of their concerns, thinking they just have to toughen it out and learn to manage their symptoms by limiting their lives. However, persistent stress can have long-term, harmful effects on the body, so it is critical that clinically significant distress is appropriately diagnosed and treated.

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

The category of obsessive-compulsive and related disorders is included in Table 14.6 with a description of each. The category’s overarching theme consists of a group of disorders that cause significant distress and impairment in functioning due to excessive rituals and pre-occupations. Some of the disorders are characterized as having obsessions and/or compulsions. Obsessions can be described as having unwanted, persistent thoughts, desires, and images. In contrast, compulsions are repetitive type behaviors in an effort to reduce the anxiety and distress brought upon by the obsessions (APA, 2013). For instance, a person with an obsessive-compulsive disorder (OCD) may have unwanted and persistent thoughts about leaving their home’s front door unlocked, and thus to ease their anxiety, drive back to ensure the door is indeed locked. Although this may seem like a normal response for most, a person with OCD could go back four, five, or more times even after checking and knowing the door is secure. Some may use others to assist and alleviate the distress by asking for assurance or being a witness to what they are doing (e.g., witnessing to ensure the door is locked). Other obsessive-compulsive disorders and related disorders are focused on repetitive behaviors, which can include skin picking and hair pulling (APA, 2013). For a brief description of disorders listed under the category of dissociative disorders, please see Table 14.6.

PSYCHOSOCIAL ISSUES

Life requires a level of acceptance that things will occur that one cannot control; however, for individuals with obsessive-compulsive and related disorders, relaxing into that reality can be unbearable. Giving up the rigidity of routine or repetition can be so unnerving that one chooses to retreat from life in favor of maintaining their coping behaviors. Relationships demand

Table 14.6 Obsessive-Compulsive and Related Disorders		
Category	Prevalence	Description
Obsessive compulsive disorder	1.2%	Individuals with this disorder experience obsessive or recurrent and persistent thoughts causing anxiety and stress and compulsive or repetitive behavior such as washing hands, checking doors, etc. which impact quality of life and living.
Body dysmorphic disorder	2.5% females; 2.2% males	Persons are obsessed with thoughts and perceptions of having defects or flaws over their physical appearance.
Hoarding disorder	2%–6%	Persons are unable to discard or part with personal possessions, regardless of whether they hold any value.
Trichotillomania (hair pulling disorder)	1%–2%	Individuals persistently pull out their own hair.
Excoriation (skin-picking) disorder	1.4%	Individuals persistently pick at their skin (generally around the face, arms, and hands, but can include areas with skin irregularities, pimples, scabs, etc.) for a significant portion of the day.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

a degree of give and take, but individuals with an obsessive-compulsive disorder (OCD) may genuinely be unable to concede or compromise, leading to social isolation. Though some may simply see an individual with mild trichotillomania as quirky or odd, others may bully or torment them. Working with others on the job or at school may be unmanageable for those with OCD and related disorders; teachers and bosses may not understand one’s overwhelming necessity to manage their environment, and their livelihood may suffer. Authority figures may refuse to accommodate the demands of an individual with OCD, and legal trouble may ensue. Shame and embarrassment about one’s obsessions and compulsions are common. However, individuals with OCD cannot simply ignore their obsessive thoughts or turn off their compulsive behaviors, and any attempt at doing so may cause even more psychological or physiological distress.

Body dysmorphic disorder (BDD) can result in significant impairment in one’s interpersonal, familial, occupational, and educational realms. Romantic relationships may be unsustainable, as individuals with BDD see their appearance in such a negative light and cannot comprehend how someone would choose to be with them. Partners may become disillusioned at the prospect of having to validate their loved ones continuously and dispute their concerns. Friends and colleagues may dismiss those with BDD as self-centered and egomaniacal, leading to social withdrawal. One may engage in dangerous behaviors, including unnecessary surgeries, risky medications, and unhealthy eating habits, due to the dysfunctional belief that one is severely unattractive and must modify their appearance to be acceptable or pleasing. The overwhelming thoughts that they are repulsive may consume mental and emotional energy and can lead to job loss, compromised academic achievement, and a diminished experience of life itself.

Individuals with a hoarding disorder may experience social stigmatization, neighbor disputes, and family distress, as others cannot comprehend why the individual will not throw away what they consider garbage. For those with an excessive acquisition specifier, financial and legal complications may result if they are unable to resist the temptation to accumulate

possessions which they cannot afford, racking up credit card debt or charges of fraud and shoplifting. Job loss may add to their money troubles if their employer refuses to accommodate time off for court dates or has a policy restricting legal convictions. Their physical health may also become negatively impacted if they are living in squalor. Eviction from a property, fire hazards, and broken bones from falling over piles of belongings are common concerns that must be addressed, as well as an overall reduction in joy and fulfillment (APA, 2013).

TRAUMA AND STRESSOR-RELATED DISORDERS

Reactive attachment disorder (RAD), disinhibited social engagement disorder (DSED), post-traumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders are all considered trauma and stressor-related disorders. The diagnostic criterion common for trauma and stressor-related disorders is a clear indicator that the disorder was caused by a traumatic or stressful event. Psychological symptoms following an incident of this magnitude can take many internalized and externalized forms, including anxiety and fear-based symptoms, anger and aggressive symptoms, anhedonia and dysphoric symptoms, dissociative symptoms, or a combination of these manifestations (APA, 2013).

RAD, DSED, and PTSD often result from early childhood trauma. Children exposed to trauma have a higher risk of developing learning disabilities and difficulties with executive functioning (attention and focus, organization, emotional regulation) due to brain changes from long-term stress. The most consistent finding is of stress-causing ongoing excessive activation of the amygdala, the part of the brain that perceives threats. Excessive activation of the amygdala causes normal medial prefrontal cortex restraint to be less active, resulting in impairments in adaptation, cognition, and behavioral flexibility. Specifically, the prefrontal cortex regulates executive function, working memory, reasoning, and decision-making, all of which are negatively impacted by the overactivation of the amygdala. Long-term stress can lead to many abnormalities, including chronic lower baseline levels of cortisol affecting the stress response, leading the body to remain in a state of chronic stress. The volume and function of the hippocampus are also impacted, effecting memory processing. Due to the varying ways individuals are impacted by trauma and stress, trauma and stressor-related disorders are challenging to research (Suvak & Barrett, 2011; Zilberstein, 2014). For a brief description of disorders listed under the category of trauma and stressor-related disorders, please see Table 14.7.

Table 14.7 Trauma and Stressor-Related Disorders		
Category	Prevalence	Description
Reactive attachment disorder	Rare	A disorder in which a child is unable to establish healthy attachment with their parent or primary caretaker
Disinhibited social engagement disorder	Rare	A disorder in which a child lacks the appropriate nurturing and affection from parent or caregiver for any number of reasons, and as a result does not closely bond to parents and is as comfortable with strangers as with their primary caregivers
Posttraumatic stress disorder	3.5%	A disorder that may manifest a range of psychological symptoms in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/ combat, rape, or other violent personal assault
Acute stress disorder	<20%	A disorder that can occur immediately after a traumatic event and can cause a range of psychological symptoms and, without recognition or treatment, may lead to posttraumatic stress disorder

(continued)

Table 14.7 Trauma and Stressor-Related Disorders (continued)		
Category	Prevalence	Description
Adjustment disorder	5%–20%	A disorder characterized by a group of symptoms, such as stress, feeling sad or hopeless, and physical symptoms that can occur after going through a stressful life event
Other specified trauma and stressor-related disorder	Unknown	A disorder in which symptoms characteristic of a trauma and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functions predominate but do not meet the full criteria for any of the disorders in the trauma and stressor-related disorders diagnostic class
Unspecified trauma and stressor-related disorder	Unknown	A disorder in which symptoms characteristic of a trauma and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functions predominate but do not meet the full criteria for any of the disorders in the trauma and stressor-related disorders diagnostic class and includes presentations for which there is insignificant information for a specific diagnosis

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

PSYCHOSOCIAL ISSUES

Because trauma and stressor-related disorders typically result from incidents involving another individual and may be triggered by seemingly innocuous everyday events, psychosocial issues that result from these disorders are numerous and can have debilitating effects on one’s quality of life. Disorders that develop due to the actions of another human being, such as sexual assault, physical attack, or emotional abuse, can cause an individual to experience extreme distress in relationships. They may be unable to cope with normal daily life effectively after a traumatic event. They may avoid intimacy by withdrawing from social activities or self-medicating through substance use, disordered eating, or other maladaptive behaviors.

As previously noted, a common diagnostic feature of trauma and stress-related disorders is recurrent, intrusive symptoms, including frequent flashbacks to the incident, where one feels as if it were happening all over again (APA, 2013). Something as benign as a car backfiring could cause someone with trauma from gun violence to dissociate or become angry and combative. An individual who has experienced sexual abuse may become hypervigilant or irritable if they pass someone wearing the cologne of their assailant. The symptoms associated within this category may pose to be challenging for family, friends, and coworkers due to (a) symptoms persisting for an extended period of time; (b) empathy may be short-lived due to inadequate information provided; (c) a lack of understanding of the disorder. Companions may be left dumbfounded, unable or unwilling to relate or to square their response with what is occurring in the present moment. One may begin to isolate out of fear of future attacks or because of negative responses from others.

Regressive behaviors, including thumb-sucking and bedwetting, are frequently seen in children with trauma and stressor-related disorders (Kilgus et al., 2016). Familial conflicts may develop, as parents struggle to adapt their disciplinary responses to a child who was previously developmentally typical. The family may have to expend additional attention and resources toward the affected individual, which may cause siblings to experience jealousy or resentment. A decreased ability to concentrate and conduct problems may create a negative

school environment, and parents may find themselves facing challenging questions as they decide on appropriate treatment plans for their child.

Depression, anxiety, anhedonia, and aggression are commonly experienced by individuals with trauma and stressor-related disorders (APA, 2013). Compounding these emotional presentations are other symptoms, such as disruptions in sleep caused by recurrent nightmares or the body's inability to deactivate its stress response. An already exhausted immune system may become depleted, leading to a reduction in physical health (Friedman et al., 1995). Increased cognitive difficulties and decreased ability to self-regulate are also associated with inadequate sleep, which may cause an individual to experience intensified complications at work and home.

One may find themselves making extreme modifications in the way they go through daily life in order to avoid potentially triggering people, places, and things. Physical relocation, career, or school transition may be necessary, which are not easy tasks for anyone. Feelings of hopelessness, leading to suicidal thoughts and behaviors, may manifest, especially if one experiences job loss, underemployment, or relational distress. Employers may need to provide time off from work for regular counseling appointments while one learns to cope with their symptoms. Family therapy may help individuals develop a greater understanding of their loved one's experience and acquire skills to support them throughout the healing process.

DISSOCIATIVE DISORDERS

Dissociative disorders include dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder. This class of disorders has the potential to disrupt all areas of psychological functioning as they involve problems with identity, sense of self, emotion, memory, perception, and behavior. Dissociative disorders are listed in the *DSM-5* next to trauma and stressor-related disorders to reflect the close relationship between these diagnostic classes. Both dissociative disorders and trauma and stressor-related disorders are commonly associated with past experiences of trauma. The core symptoms of dissociative disorders include amnesia, depersonalization, derealization, identity confusion, and identity alteration. Amnesia refers to significant reoccurring gaps in memory. Depersonalization refers to feelings of detachment or disconnection from one's emotions or physical body. Derealization is the experience of disconnection from familiar people and places. Identity confusion denotes internal struggle and conflict regarding one's sense of self. Identity alteration refers to the experience of feeling and acting like a different person or persons at different times. Identity alteration is characterized by personality changes that do not feel under one's control (APA, 2013). For a brief description of disorders listed under the category of dissociative disorders, please see Table 14.8.

Table 14.8 Dissociative Disorders		
Category	Prevalence	Description
Dissociative identity disorder	1.5%	It is characterized as the continuance of two or more personality states resulting in a change in behavior, recollection, perception, awareness of one's surroundings, reduced levels of cognitive and sensory ability.
Dissociative amnesia	1.8%	As a result of distress, the individual experiences difficulty remembering standard everyday personal information.

(continued)

Table 14.8 Dissociative Disorders (continued)		
Category	Prevalence	Description
Depersonalization/derealization disorder	2%	It is characterized as being detached or removed from one's self (e.g., physically, emotionally, and cognitively).
Other specified dissociative disorder	Unknown	It is similar to Dissociative Identity Disorder (DID) as individuals are affected psychosocially, but has less distinct aspects (i.e., loss of memory) and thus, does not meet the diagnosis of DID. Diagnosis is given when the individual has been subjected to prolonged and severe coercive tactics and/or trauma exposure resulting in unhealthy and abnormal reactions.
Unspecified dissociative disorder	Unknown	Diagnosis is given when individuals are affected psychosocially (e.g., family, friends, employment), but due to a lack of information, a specific diagnosis is unable to be given.

Source: Adapted from American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

PSYCHOSOCIAL ISSUES

The human experience necessitates a process of creating and establishing one's sense of self; therefore, dissociative disorders may be particularly unnerving for individuals directly and indirectly affected by these conditions. According to Erik Erikson's (1980) influential theory of psychosocial development, identity formation is one of life's critical tasks; healthy maturation grows out of "confidence that one's ability to maintain inner sameness and continuity ... is matched by the sameness and continuity of one's meaning for others" (p. 94). An individual with a dissociative disorder lacks this feeling of cohesion and integration that is so crucial for proper development and fulfillment. Individuals with dissociative disorders may forget important facts, like where they live and work or how to take care of themselves, making employment, social functioning, and activities of daily living extremely challenging. One can imagine the stress of realizing one has lost this information, for the person with the disorder as well as loved ones and associates. Families and friends may lack adequate knowledge, skills, and finances to provide proper resources to care for them. While dissociative identity disorder may appear in highly functioning individuals, it carries with it a startling statistic, "over 70% of outpatients with dissociative identity disorder have attempted suicide" (APA, 2013, p. 295). Because these disorders are highly complex, only clinicians with specialized experience and training can treat these individuals, making successful management of symptoms increasingly challenging and critical (Kilgus et al., 2016).

SOMATIC SYMPTOM AND RELATED DISORDERS

Somatic symptom and related disorders include somatic symptom disorder, illness anxiety disorder, conversion disorder, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder. These disorders are all associated with somatic symptoms, which cause significant distress and impairment for longer than 6 months. Somatic symptom and related disorders are also often chronic and difficult to assess, diagnose, and treat. Due to the adverse somatic symptoms characteristic of these disorders, individuals with somatic symptom and related disorders usually present

Table 14.9 Somatic Symptom and Related Disorders

Category	Prevalence	Description
Somatic symptom disorder	5%–7%	One or more physical symptoms are manifested (e.g., pain) affecting daily living.
Illness anxiety disorder	1.3%–10%	Overall daily living is affected due to excessive and intense worrying of having a chronic illness.
Conversion disorder	Unknown	Diagnosis is given when an individual presents with having physical or neurological symptoms (e.g., blindness), but there is no indication the person has such a disease or disability.
Factitious disorder	Unknown	Physical and/or psychological complaints are feigned to purposely deceive others.
Unspecified somatic symptom and related disorder	Unknown	This is characteristic of Somatic Symptom Disorder but does not meet the full criteria for a diagnosis among any of the aforementioned disorders within this category.

Source: Adapted from American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

first in medical rather than psychiatric settings. Somatic symptom and related disorders can be comorbid with defined medical conditions, as diagnoses also focus on how an individual perceives and interprets their symptoms. The behaviors, thoughts, and feelings in response to distressing somatic symptoms are all taken into consideration in assessing an individual's perception and interpretation of their symptoms. Factors which predispose individuals to somatic symptom and related disorders include genetic, biological, environmental, and cultural factors. Experiences of chronic illness, exposure to abuse or neglect, and learned behavior from family members are also factors which predispose individuals to somatic symptom and related disorders (APA, 2013; Holster et al., 2017). For a brief description of disorders listed under the category of somatic symptom and related disorders, please see Table 14.9.

PSYCHOSOCIAL ISSUES

Degree of visibility of a health condition's presence and its corresponding impact on one's life is correlated with stigmatization and discrimination (Livneh & Wilson, 2003). Individuals whose disorders are not readily observable to those around them may be slow to acknowledge diagnosis and accept treatment. The lack of consistent reaction from those in the environment may cause them to downplay the disorder's effects, which may serve to exacerbate the disorder's negative influence on their lives (Falvo & Holland, 2018). Individuals with somatic symptom disorders may seem to outsiders to be perfectly healthy, but their inner experiences may be extremely distressing. "Medically unexplained symptoms" is a fundamental characteristic of these disorders, which can leave patients and providers frustrated, struggling for answers and viable treatment options (APA, 2013, p. 310). Though the physical manifestations of their disorders may not be apparent to others, the psychosocial limitations these individuals experience are real and may be profound. Unresolved physical pain and impaired function may lead to unemployment, if an individual is unable to manage their symptoms well enough to get through the workday. For those without a robust and empathetic support system or whose symptoms lack resolutions, hopelessness, depression, and reliance on drugs or alcohol may result.

FEEDING AND EATING DISORDERS

Feeding and eating disorders are a class of mental and behavioral dysfunctions that can result in major disruptions in physical, psychological, social, and spiritual well-being. Included in this section are pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge-eating disorder, other specified and unspecified feeding or eating disorders. Pica involves the ingestion of nonnutritive substances, which may include chalk, paper, coal, soap, paint, hair, clay, plastic, cloth, or any number of other nonfood items. More than just the peculiar eating habits of a teething child, or the culturally relevant practice of consuming soil, pica is characterized by persistent, developmentally inappropriate behavior that is typically unrelated to biological abnormalities, although some cases do indicate vitamin or mineral deficiencies (APA, 2013). Pica is the only disorder within this class which may present in combination with another feeding or eating disorder.

Rumination disorder is characterized by the repeated regurgitation of food, independent of gastrointestinal illness. More commonly seen in infants and adolescents, the regurgitated food may be rechewed, reswallowed, or spit out. Avoidant/restrictive food intake disorder is seen in individuals who fail to meet sufficient weight or nutritional requirements due to extreme avoidance, lack of interest, or distress over possible consequences of eating, such as a fear of choking or repulsion to sensory characteristics of foods. This disorder exists beyond inadequate access to nourishment, cultural practices, or simply picky or selective habits.

While the eating disturbances of avoidant/restrictive food intake disorder and rumination disorder are typically unrelated to concerns regarding body image, anorexia nervosa and bulimia nervosa are associated with an intense fear of weight gain. Anorexia nervosa involves extreme restriction of food caused by an overwhelming desire to be thin, despite existing emaciation or adverse consequences, and in conjunction with distorted thoughts about one's appearance and self-worth. Usually seen in young adults, this disorder may develop after a stressful or traumatic event, as one attempts to regain a sense of control by managing food intake and body size. Anorexia nervosa is specified by severity according to body mass index (BMI) and behavioral expressions. Restricting type indicates one engages in excessive dieting, fasting, or exercising to lose weight, while binge-eating/purging type involves vomiting or laxatives to rid oneself of any consumed substances. Bulimia nervosa, however, is characterized by eating abnormally large quantities of food, within a specified period of time, while feeling as though one lacks the ability to restrain one's intake. Following a bingeing episode, an individual with bulimia nervosa will engage in compensatory behaviors, including forced vomiting, over exercising, extreme dieting, or the inappropriate use of laxatives, to prevent weight gain. As seen in individuals with anorexia nervosa, those with bulimia nervosa place undue self-evaluation on their physical appearance; however, many may be over or within the healthy weight range. Significantly more prevalent in females than males, the onset of the disorder is typically between puberty and age 40 and may occur following a failed diet plan (APA, 2013).

Binge-eating disorder involves extreme, rapid, recurrent episodes of food consumption; however, the compensatory behaviors characteristic of bulimia nervosa are not present. Individuals with binge-eating disorder commonly experience distress and discomfort around their eating habits but lack a sense of control during these occurrences. Observed in individuals with varying weights and body compositions, this disorder is distinct from obesity. See Table 14.10 for additional information and prevalence rates among these and unspecified and other specified feeding and eating disorders.

Table 14.10 **Feeding and Eating Disorders**

Category	Prevalence	Description
Pica	4% adults	Consuming things not considered of nutritional value (e.g., dirt, mothballs, etc.) causing severe digestive issues
Rumination disorder	0.9% adults	Disorder commonly occurring among infants and young children in which they regurgitate undigested food and then spit out or reswallow it
Avoidant/restrictive food intake disorder		Characterized by regulating the type or quantity of food consumed; however, not associated with a disorder in which distress in body shape or size occurs.
Anorexia nervosa	0.6% adults	Distress in body shape and/or size followed by a need to restrict or starve oneself to avoid weight gain
Bulimia nervosa	1.5% adults	Disorder characterized as the need to control body weight due to distorted body image; occurs by consuming large quantities of food over a short period of time, and then resorting to methods to control weight gain (e.g., vomiting)
Binge-eating disorder	1.2% adults	Recurrent episodes of eating excessive quantities of food over a short period of time; generally, occurring during times of stress and excessive worry

Source: Adapted from American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

PSYCHOSOCIAL ISSUES

Physical health complications due to the behaviors of feeding and eating disorders may compound the psychosocial impacts on individuals with these disorders and their loved ones. Pica can cause intestinal obstruction, perforations, infections, or poisoning due to consuming damaging or toxic nonfood substances, such as lead-based paint chips, stones, or wool. Malnutrition and delayed growth are frequently seen in individuals and children with rumination and avoidant/restrictive food intake disorders, as their bodies fail to receive proper nourishment. Women with anorexia nervosa may experience amenorrhea, insomnia, possibly irreversible bone loss, and in extreme circumstances, early mortality. Increased risk of suicide is a serious concern for those with untreated bulimia nervosa, and binge-eating disorders may lead to challenges caused by excessive caloric intake. Because these disorders are all potentially life-threatening, early detection, proper support, and adequate resources are critical. False information and social stigmatization are experienced by many individuals with eating disorders, which is an unfortunate reality that may not only hinder treatment progress but may also add to the episodic tendencies of these disorders. Those with the abnormal habits of pica may be cast aside by insensitive peers, which may lead to low self-esteem and isolation. Children with rumination disorder may experience conflicts with well-meaning parents and schoolteachers, who cannot understand why they will not simply cease their odd behavior. Those with avoidant/restrictive food intake disorder may be unable to participate in normal social functioning, as many experience extreme sensitivity to the sounds of another eating or aversion to food smells.

Individuals with anorexia nervosa and bulimia nervosa are frequently obsessed with worries about their body, weight, size, and others' perceptions of their appearance (Kilgus et al., 2016). Cognitive distortions, including inflexible and catastrophic thoughts, such as, "I can only eat six almonds and eight grapes today," or "I will instantly gain 50 pounds if I eat

this sandwich,” may cause individuals to develop a rigid and overwhelming need to manage their environment. This desire for control may lead to withdrawal, as activities which detract from extreme exercise regimens, or where food may be present, may make social interactions quite challenging. Commonly seen in those with anorexia nervosa, low sex drive, anhedonia, depressive mood, anxiety, and negative affect are features that may damage relationships. The binge-eating episodes characteristic of bulimia nervosa and binge-eating disorder frequently encourage feelings of guilt, shame, and embarrassment, as well as financial strain caused by excessive food consumption. Individuals with feeding and eating disorders are most commonly brought to treatment by concerned loved ones, as their reduced confidence, limiting beliefs, and distorted thoughts may not allow them to grasp that anything other than their weight, body, size, or inability to control their compulsions is a problem. An antidote to the harmful mental and behavioral patterns associated with feeding and eating disorders is compassion and connection, therefore healing frequently occurs in conjunction with another.

ELIMINATION DISORDERS

Elimination disorders all involve the inappropriate elimination of urine or feces and are usually first diagnosed in childhood or adolescence. This group of disorders includes enuresis, the repeated voiding of urine into inappropriate places, and encopresis, the repeated passage of feces into inappropriate places. Subtypes are provided to differentiate nocturnal from diurnal (i.e., during waking hours) voiding for enuresis and the presence or absence of constipation and overflow incontinence for encopresis. Although there are minimum age requirements for diagnosis of both disorders, these are based on developmental age and not solely on chronological age. Both disorders may be voluntary or involuntary. Although these disorders typically occur separately, co-occurrence may also be observed. Refer to Table 14.11 for a description of the elimination disorder categories.

PSYCHOSOCIAL ISSUES

While not uncommon, elimination disorders can cause significant problems for children and adults at school and work, within families, with peers, and for one’s own self-concept. Whether voluntary or involuntary, nocturnal or diurnal, inappropriate elimination can feel embarrassing for individuals and their loved ones. Children with an elimination disorder may be socially ostracized or bullied, leading to complications in cognitive, emotional, and social development. Some schools may not accommodate children without proper elimination capacities, which may impact the quality of academics a child receives. Parents and siblings may not understand the disorder and may experience frustration with the child’s inability or unwillingness to eliminate urine and feces in a developmentally appropriate way.

Table 14.11 Elimination Disorders		
Category	Prevalence	Description
Enuresis	5%–10% among 5-year-olds; 3%–5% among 10-year-olds; 1% among adults	Children who are potty-trained, but regress and are unable to control the need to urinate; can be voluntary or involuntary
Encopresis	1% adults	Involuntary or voluntary action of soiling one’s clothing; occurs after toilet training

Source: Adapted from American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

Frequent bedwetting can cause sleep disturbances, exacerbating distress, and already tense familial and personal relationships may be further impacted by financial strain as the family manages symptoms and treats the disorder.

SLEEP-WAKE DISORDERS

The use and classification of sleep-wake disorders are intended for general mental health and medical clinicians (including those caring for adult, geriatric, and pediatric patients). Sleep-wake disorders encompass 10 disorders or disorder groups which are outlined in Table 14.12. Individuals with these disorders typically present with sleep-wake complaints of dissatisfaction regarding the quality, timing, and amount of sleep. Resulting daytime distress and impairment are core features shared by these sleep-wake disorders. Sleep disorders are usually accompanied by depression, anxiety, and cognitive changes that must be addressed in treatment planning and management. Persistent sleep disturbances are established risk factors for the subsequent development of mental illnesses and substance use disorders.

Table 14.12 Sleep-Wake Disorders		
Category	Prevalence	Description
Insomnia disorder	33%	Disorder causing marked impairment and reduced quality of life due to the inability to fall asleep and/or stay asleep
Hypersomnolence disorder	0.9%	Disorder characterized by having excessive episodes of sleepiness despite acquiring a minimum of 7 hours of quality sleep
Narcolepsy	0.02%–0.04%	Similar to hypersomnolence disorder, but involving recurring hallucinations, cataplexy, and sudden sleep episodes whereby the person falls asleep during an activity (e.g., talking)
Obstructive sleep apnea hypopnea	0.6% adults	Disorder marked by difficulty breathing during sleep due to the recurrent relaxing of throat muscles, resulting in the blockage of airway
Central sleep apnea	1.5%	Disorder in which breathing repeatedly stops and starts during sleep
Sleep-related hypoventilation	1.2%	Disorder in which breathing is restricted and thus leads to reduced levels of oxygen or increased levels of carbon monoxide
Circadian rhythm sleep-wake disorders	0.17%	When a body's circadian rhythm (or one's internal clock) is not well regulated and results in sleep disturbances; overall mental health functioning significantly affected
Non-rapid eye movement (NREM) sleep arousal disorders	Very common	Frequent episodes of being partially awake and performing complex tasks without any knowledge of the occurrence
Nightmare disorder	1%–2%	Disorder characterized by recurring nightmares; generally in which the individual's life is in jeopardy
Restless legs syndrome	2%–7.2%	Disorder causing an uncontrollable urge to move one's leg during sleep and may result or lead to insomnia or a lack of quality sleep

Source: Adapted from American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

PSYCHOSOCIAL ISSUES

Sleep is a critically important state, when the body and mind are able to relax and rejuvenate on a deep, cellular level. A healthy amount of sleep must be achieved in order for maximum productivity, effectiveness, and fulfillment to be reached during wake time. When the quality of this function is impacted by a sleep–wake disorder, an individual’s psychosocial experience may be negatively impacted. Anyone who has experienced a rough night’s sleep can recognize the next day drowsiness, fogginess, short-temperedness, and lack of motivation this deficiency can cause. A situation or conversation that may seem like no big deal on 7 or 8 hours of replenishing sleep may feel catastrophic or insurmountable when one struggles with a sleep–wake disorder. Grades may plummet, work performance may be hindered, and one’s relationships may suffer. Automotive accidents, poor judgment leading to physical injuries, cognitive impairment, exacerbated mental and emotional health disorders, reliance on substances, relationship issues, and decreased quality of life are all side effects of disturbed sleep.

SEXUAL DYSFUNCTION DISORDER

Sexual dysfunction disorder (SDD) encompasses a group of disorders affecting a person’s ability to engage in sexual activity or experience pleasure (APA, 2013). The prevalence of this disorder is oftentimes found among the aging population and a person may have more than one present at the same time. For instance, men and women entering middle adulthood will either experience a natural decline in testosterone and estrogen levels which ultimately affect one’s ability to obtain an erection, have a desire to engage in sexual activity, or both. Additionally, careful consideration is taken when providing a diagnosis for this disorder as cultural factors may influence expectations or suppress feelings about the experience of sexual pleasure. Moreover, if another mental disorder is the primary cause for sexual dysfunction (e.g., depressive disorder, posttraumatic stress disorder, anxiety disorder), then a diagnosis of SDD is not made. Refer to Table 14.13 for a description of the sexual dysfunction categories.

Table 14.13 Sexual Dysfunctions		
Category	Prevalence	Description
Delayed ejaculation	<1%	Distinct delay or inability to achieve ejaculation
Erectile disorder	13%–21% of men ages 40–80.	Continued inability or failure to obtain and/or maintain an erection while engaging in sexual activities
Female orgasmic disorder	10%–40%	Difficulty experiencing orgasm and/or decreased ability to experience orgasmic sensation
Female sexual interest/arousal disorder	Unknown	Decreased sexual interest towards engaging in sexual activity and absence of sexual thoughts or desire to engage in sexual activity with partner
Genito-pelvic pain/penetration disorder	15%	Difficulties in having vaginal intercourse, fear, and/or anxiety of experiencing pain as a result of intercourse
Male hypoactive sexual desire disorder	6% of men ages 18–24; 41% of men ages 66–74	Absent or deficient sexual thoughts and desire to engage in sexual activity
Premature ejaculation	20%–30% of men ages 18–70	Inability to refrain from ejaculating; generally, occurring within 1 minute following vaginal penetration.
Substance/medication-induced sexual dysfunction	Varies upon class of drug	Difficulty towards obtaining sexual arousal, erection, lubrication, orgasm, etc.

Source: Adapted from American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

PSYCHOSOCIAL ISSUES

Although each mental health disorder plays a significant role in perceived quality of life, sexual dysfunction disorder presents a unique set of challenges (e.g., lack of sexual desire, pain as a result of vaginal penetration, impotence, feelings of shame and embarrassment). Let us consider the following: When thinking of an ideal partner, what are some characteristics you and others generally consider as an important quality? Do they include physical attractiveness, being financially independent, well-educated, having a good moral compass, and honesty? Now, of the various causes for marital dissatisfaction and divorce, three include incompatibility, infidelity, and a lack of intimacy. SDD is often reported as an embarrassing and challenging situation for some to overcome (e.g., Genito-Pelvic Pain/Penetration Disorder) unless medication is an option (e.g., Erectile Disorder). Overall however, intimacy is considered a valuable and important component for most relationships and studies have indicated the results of one partner having a diagnosis of SDD tends to lead to break-up, familial discord, divorce, and affects reproduction (Kadri et al., 2002). Although some of the disorders falling under this category are easily treatable through the use of medication and psychotherapy, others can present an array of challenges regardless of whether treatment is available.

CASE MANAGEMENT, STANDARDS, AND MODELS

Case management has become a vital intervention and approach used in various healthcare fields to help individuals with mental health disorders access the treatment and resources necessary to manage their conditions. Case management is defined as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy” (Noonan, 2019). The purpose of case managers is to help clients and their families to meet the client’s specific healthcare needs. A case manager assists with the promotion of client safety, facilitation of quality care, and helps to ensure cost-effective outcomes for clients (Noonan, 2019).

Building trusting relationships, using evidence-based practices, and empowering the client are a few of the roles of a case manager. A case manager can be the liaison between the clients and their healthcare team, acting as an advocate for the client. When clients believe that their healthcare team is not meeting their needs, the case manager can work with the clients and their families to ensure the clients’ needs are met. The case manager can confirm that clients understand their treatment plan and ensure there is an open line of communication between the client and the healthcare team (Noonan, 2019).

Continuity of care is focused on recognizing that a client needs support and care over an extended period. Establishing rapport and relationships with clients can help in their treatment and transition into long-term care. Case managers form collaborative relationships with their clients, families, and caregivers. By creating this relationship, the case manager can intervene more effectively and prevent crises from occurring. For example, a relapse may be avoided if the client, their family, or caregiver notices changes in the client and contacts the case manager. Without a strong relationship, the client, family, or caregiver may be hesitant to contact the case manager and therefore cause more harm to the client. Case managers also provide structure and support for clients who may need to be titrated overtime. Structure and support can be titrated similar to how psychiatrists and physicians adjust medication dosages. A case manager may collaborate with the patient to “titrate the levels of

environmental support and structure needed to facilitate survival, personal development, and adaptation to mental illness” (Kanter, 1989, p. 362). This titration can be accomplished by gradually reducing or increasing the structure and support provided to the client based on the client’s specific needs. As the client’s world changes, the case manager needs to be able to be flexible in their intervention strategies to accommodate the changing needs of the client. Along with being flexible with the client and titrating their support and structure, the case manager also needs to facilitate client resourcefulness and autonomy. The clients need to be in charge of their own lives, and the case manager can help.

INTENSIVE CASE MANAGEMENT

Intensive case management (ICM) was created based on two community models of care, Assertive Community Treatment (ACT) and Case Management (CM; Dieterich et al., 2017). The emphasis in ICM is on smaller caseloads (<20) and high intensity input (Dieterich et al., 2017). Smaller caseloads allow case managers to better serve clients with severe mental health disorders, who could not be engaged in usual case management practices due to the severity of their condition (Surles & McGurrin, 1987).

In the ICM model, the clients are provided with outreach, services, and practical assistance in daily living skills within the clients’ natural environments (Mueser et al., 1998, p. 39). The interventions are specific to addressing specific population subgroups. These subgroups include individuals who are homeless with severe mental illness (Coldwell & Bender, 2007), persons with primarily a substance abuse (Kirk et al., 2013), and who are diagnosed with alcohol dependence (Gilbert et al., 2012), severe mental illness and substance abuse (Pettersen et al., 2014), or first-episode psychosis (Brewer et al., 2015). Due to the size of the group and the unshared caseload, the ICM model can be effective with working with various populations.

STRENGTH-BASED MODEL

The strength-based model (SBM) has gained much popularity over the years due to the emphasis on focusing on a client’s strengths rather than their weaknesses (Sullivan, 1992; Weick et al., 1989). Generally, most models focus solely on the mental health disorder and “limitations” (e.g., Intensive Care Model), but the SBM aims at identifying the client’s assets for the primary purpose of helping them achieve their goals (Mueser et al., 1998). A strengths-based approach to working with clients is assisting with empowerment and confidence building to enhance their abilities for the purpose of overcoming adversity. Focusing on an individual’s strengths can help increase self-assurance, promote growth, and strengthen the rapport developed between the client and the case manager.

In the strength-based model, case managers work with clients to help identify their strengths and to begin building self-confidence. Individuals who have chronic mental health disorders may lack the resources necessary to meet their basic needs and may not have access to the resources that will enable them to live and be successful in their community (Rapp & Chamberlain, 1985). The emphasis of the interventions should be related to areas that the client deems important to their daily life. Rapp and Chamberlain (1985) identified focus areas for interventions; those areas include, “education, housing, recreation and leisure time, health, and social and family supports” (p. 419).

Rapp and Chamberlain (1985) identified the primary principles of the strength-based model. The key elements include: “(1) the dual focus on client and environment, (2) the use

of preprofessional personnel (students as case managers), (3) the particular training program employed, (4) assessment procedures that focused on strengths rather than deficits, (5) the specific approach to generating alternative interventions using group supervision, (6) the outreach model of service delivery, and (7) the high degree of responsibility given to the client in directing and influencing the interventions" (Rapp & Chamberlain, 1985, p. 419).

CLINICAL CASE MANAGEMENT

Clinical case management recognizes the importance of case managers having specialized training and skills as clinicians to provide effective direct services to clients in addition to their general case management function (Deitchman, 1980; Harris & Bergman, 1987; Lamb, 1980). Clinical case managers must balance their role as a clinician, in which their primary focus is on the biological and psychological functioning of clients, and their role as a case manager, in which their primary focus is on addressing the overall maintenance of the client's physical and social environment (Kanter, 1989). The goal of the interventions should be on helping the individual to learn basic skills for survival, personal growth, community participation, and recovery from or adaption to mental illness (Kanter, 1989, p. 361).

REHABILITATION MODEL

The rehabilitation model is similar to the strengths model because the rehabilitation model emphasizes the importance of providing services based on the individual's goals and interests (Mueser et al., 1998). The focus is not on the goals set by the treatment team, but instead, the treatment team's goals are based on the goals and interests of the client. The focus of the rehabilitation model is on helping the client to identify and remediate skills necessary for community reintegration and achievement of personal goals.

ASSERTIVE COMMUNITY TREATMENT MODEL

The assertive community treatment (ACT) model was designed by Stein and Test (1980) to be a community-based, comprehensive treatment approach. The approach is multidisciplinary, consisting of a team of a psychiatrist, nurse, and at least two case managers (Mueser et al., 1998). Like the ICM model, the ACT model consists of a low patient to staff ratio (10:1). Unlike the ICM, ACT consists of a shared caseload between clinicians with the majority of the services provided by the ACT team. ACT is also provided in the community, such as in the patients' homes or restaurants (Mueser et al., 1998). ACT also has 24-hour coverage and time-unlimited services, so the client is receiving the best care possible throughout the day (Mueser et al., 1998). The main goal of the ACT model is to provide practical supports in daily living, such as shopping for the client, doing laundry, or providing transportation.

INTERDISCIPLINARY CASE MANAGEMENT

According to the Case Management Society of America (CMSA) Standards of Practice for Case Management (2016), there are 15 Standards of Professional Case Management Services. The Standards of Professional Case Management Services cut across disciplines such as counseling, social work, allied health, and nursing. Listed in Table 14.14 are some of the standards of case management as well as a brief description for each. More information about the standards can be found in the CMSA Standards of Practice for Case Management (2016).

Table 14.14 Interdisciplinary Case Management Approaches	
Client selection process for case management	Evaluation of clients should ensure that clients who receive services are appropriate for case management services.
Client assessment	Assessments should be “individualized and client centered” taking into account the client’s cultural, linguistic, and family needs.
Care needs and opportunities identification	Identify the needs of your client as well as areas where case management interventions would be appropriate.
Planning	In collaboration with the healthcare team, patient, and the client’s family, the case manager will create a plan tailored toward the client’s goals, interests, and care needs.
Monitoring	Throughout the course of the client’s treatment, the case manager should continue to employ assessments of the client to ensure the patient’s treatment goals are being met.
Outcomes	The case manager’s focus when developing outcomes should be on optimizing the client’s “health, wellness, safety, physical functioning, adapting, health knowledge, coping with chronic illness, engagement, and self-management abilities.”
Closure of professional case management services	The case manager should ensure that all services are closed based upon closure guidelines.
Facilitation, coordination, and collaboration	Case managers should facilitate communication, coordination, and collaboration between the patient, client’s family, caregiver, healthcare team, and other stakeholders. The purpose of the open communication, coordination, and collaboration is to ensure that the clients’ goals are being met and maximizing positive outcomes.
Qualifications for professional case managers	Competency in areas of practice should be maintained during practice. These include having a “current, active, and unrestricted licensure or certification” or a bachelors or graduate degree in social work or related health and human services.
Legal	Adhere to all local, state, and federal laws and regulations. These can include, but are not limited to, the patient’s privacy and confidentiality.
Ethics	Case managers should be knowledgeable of their respective code of ethics (e.g., nursing, social work, and rehabilitation counseling). Main ethical principle areas include beneficence (do good), nonmaleficence (do no harm), autonomy (respect the individual’s right to make their own decisions), justice (fair treatment), and fidelity (keep promises).
Cultural competency	A key role of the case manager is as an advocate for the patient, family, and caregiver. As a care coordinator and advocate, the case manager should advocate for policy changes that improve the quality, safety, and cost-effectiveness of services for the client.

Source: Data from Case Management Society of America. (2016). CMSA standards of practice for case management. <https://www.miccsi.org/wp-content/uploads/2017/03/CMSA-Standards-2016.pdf>

SUMMARY

Individuals with mental health disorders often experience medical and psychosocial challenges associated with their conditions. Additionally, stigma, prejudice, and discrimination can create unique obstacles for individuals with mental health disorders. These obstacles can influence family relationships, feelings of self-worth, community engagement, and participation in the workforce. Living with a mental health disorder can affect not only the individual but also the family and support system of that individual. Mental health disorders often require an interdisciplinary approach to treatment and care. This

approach may include pharmaceutical and therapeutic interventions, vocational training, enhancing social supports, and building on client strengths and autonomy. Effective case management can help clients to access the resources and services necessary to manage their mental health disorders and flourish in their environments. Case management can coordinate comprehensive and holistic treatment based on the client's needs, strengths, and assets.

There are several types of case management practices described in this chapter which can be employed when working with clients with mental health conditions. Intensive case management is generally provided to clients with severe mental health disorders who may benefit from more focused and personalized care. The strength-based model of case management described in this chapter focuses on the inherent strengths of the client, client empowerment, and interventions focused on the client's preferences. In clinical case management, a clinical care provider (e.g., counselor or social worker) provides the services and combines case management practices with clinical or therapeutic interventions. Another model described in this chapter; the rehabilitation model, focuses on helping clients to determine individual goals and develop skills necessary to achieve these personal goals. The assertive community treatment (ACT) model, which uses an interdisciplinary team to provide practical supports to clients in their natural environment, was also outlined in this chapter. The case management section concludes with the interdisciplinary case management approach and includes the Case Management Society of America's standards of practice. The information provided in this chapter was intended for the reader to become familiar and knowledgeable with each mental health category listed, understand the psychosocial implications for each, and be able to recognize case management approaches to provide effective treatment for clients with a mental health disorder.

CASE STUDY 14.1 The Case of John

Denise, a case manager at Morehead Company, has had John referred to her for case management services. John has been diagnosed with severe depression and has had difficulty maintaining employment. He had an associate's degree in mechanics and experience working as a mechanic at a local car dealership. He has previously worked at an auto parts store and as a truck driver. His marriage of 5 years is over, and his wife moved back to her home state. He is currently living in an apartment and drives a 10-year-old Ford truck. John's doctor recommends he seek counseling and medication for his depression. At this point John has not been going into work and is at risk for losing his job. He has no other income to support himself. His mother and sister live nearby but are at a loss of how to help him. John has been self-medicating with alcohol and has had difficulty getting up and going to work on time. He has already been given a reprimand at work and is on the verge of losing his job.

Questions

1. As a case manager, what would be the strategies Denise would need to deploy to help John with his disability?
2. Which case management model would you use in working with John and why?
3. What are the five key principles of Clinical Case Management?
4. What are the similarities of the rehabilitation and strength-based models?
5. List the CMSA Standards of Practice for Case Management that apply to John's case scenario.

Field-Based Experiential Exercises

1. Work with a local counseling agency and develop a summary over the psychosocial aspects of having a mental disorder and the differences found based on the specific diagnoses of the clients.
2. Randomly select three mental health disorders from the *DSM-V* and write a summary/report on how you might be affected personally and professionally if you had a diagnosis from the mental health disorders selected.
3. Develop three case studies involving randomly selected mental health disorders from the *DSM-V*. Then create a case management plan consisting of a treatment strategy. When designing your plan, consider age, gender, ethnicity, and educational level to address the client's personal and professional needs.

REFERENCES

Only key references appear in the print edition. The full reference list appears in the digital product found on <http://connect.springerpub.com/content/book/978-0-8261-6284-7/part/part04/chapter/ch14>

- Addington, J., Piskulic, D., & Marshall, C. (2010). Psychosocial treatments for schizophrenia. *Current Directions in Psychological Science*, 19(4), 260–263. <https://doi.org/10.1177/0963721410377743>
- Brewer, W. J., Lambert, T. J., Witt, K., Dileo, J., Duff, C., Crlenjak, C., McGorry, P. D., & Murphy, B. P. (2015). Intensive case management for high-risk patients with first-episode psychosis: Service model and outcomes. *Lancet Psychiatry*, 2(1), 29–37. [https://doi.org/10.1016/S2215-0366\(14\)00127-8](https://doi.org/10.1016/S2215-0366(14)00127-8)
- Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry*, 164(3), 393–399. <https://doi.org/10.1176/ajp.2007.164.3.393>
- Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. *Cochrane Database of Systematic Reviews*, (1), CD007906. <https://doi.org/10.1002/14651858.CD007906.pub3>
- Gilbert, H., Burns, T., Copello, A., Coulton, S., Crawford, M., Day, E., Deluca, P., Godfrey, C., Parrott, S., Rose, A. K., Sinclair, J. M. A., Wright, C., & Drummond, C. (2012). Assertive Community Treatment for Alcohol Dependence (ACTAD): Study protocol for a randomized controlled trial. *Trials*, 13, 19. <https://doi.org/10.1186/1745-6215-13-19>
- Holster, J. L., Hawks, E. M., & Ostermeyer, B. (2017). Somatic symptom and related disorders. *Psychiatric Annals*, 47, 184–191.
- Kirk, T. A., Leo, P., Rehmer, P., Moy, S., & Davidson, L. (2013). A case and care management program to reduce use of acute care by clients with substance use disorders. *Psychiatric Services*, 64(5), 491–493. <https://doi.org/10.1176/appi.ps.201200258>
- Noonan, P. (2019). *Supporting the ACO population: What is the case manager's role?* Case Management Society of America. https://www.cmsatoday-digital.com/cmsq/0319_issue_8_2019/MobilePagedArticle.action?articleId=1538268#articleId1538268

- Pettersen, H., Ruud, T., Ravndal, E., Havnes, I., & Landheim, A. (2014). Engagement in assertive community treatment as experienced by recovering clients with severe mental illness and concurrent substance use. *International Journal of Mental Health Systems*, 8(1), 40. <https://doi.org/10.1186/1752-4458-8-40>
- Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of general psychiatry*, 37(4), 392–397. <https://doi.org/10.1001/archpsyc.1980.01780170034003>
- Suvak, M. K., & Barrett, L. F. (2011). Considering PTSD from the perspective of brain processes: A psychological construction approach. *Journal of Traumatic Stress*, 24(1), 3–24. <https://doi.org/10.1002/jts.20618>
- Zilberstein, K. (2014). Neurocognitive considerations in the treatment of attachment and complex trauma in children. *Clinical Child Psychology and Psychiatry*, 19(3), 336–354. <https://doi.org/10.1177/1359104513486998>

ADDITIONAL RESOURCES

- American Society of Addiction Medicine criteria: <https://www.asam.org/resources/the-asam-criteria>
- Case Management from Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/case-management>
- Case Management Society of America: <http://www.cmsa.org>
- The Community Guide from Community Preventive Services Task Force: <https://www.thecommunityguide.org>
- Disability-related counseling competencies from American Rehabilitation Counseling Association, a division of ACA: https://www.counseling.org/docs/default-source/competencies/arca-disability-related-counseling-competencies-final-version-5-15-19.pdf?sfvrsn=c376562c_6
- Integrated Care Models from Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions: <https://www.thenationalcouncil.org/integrated-health-coe/>