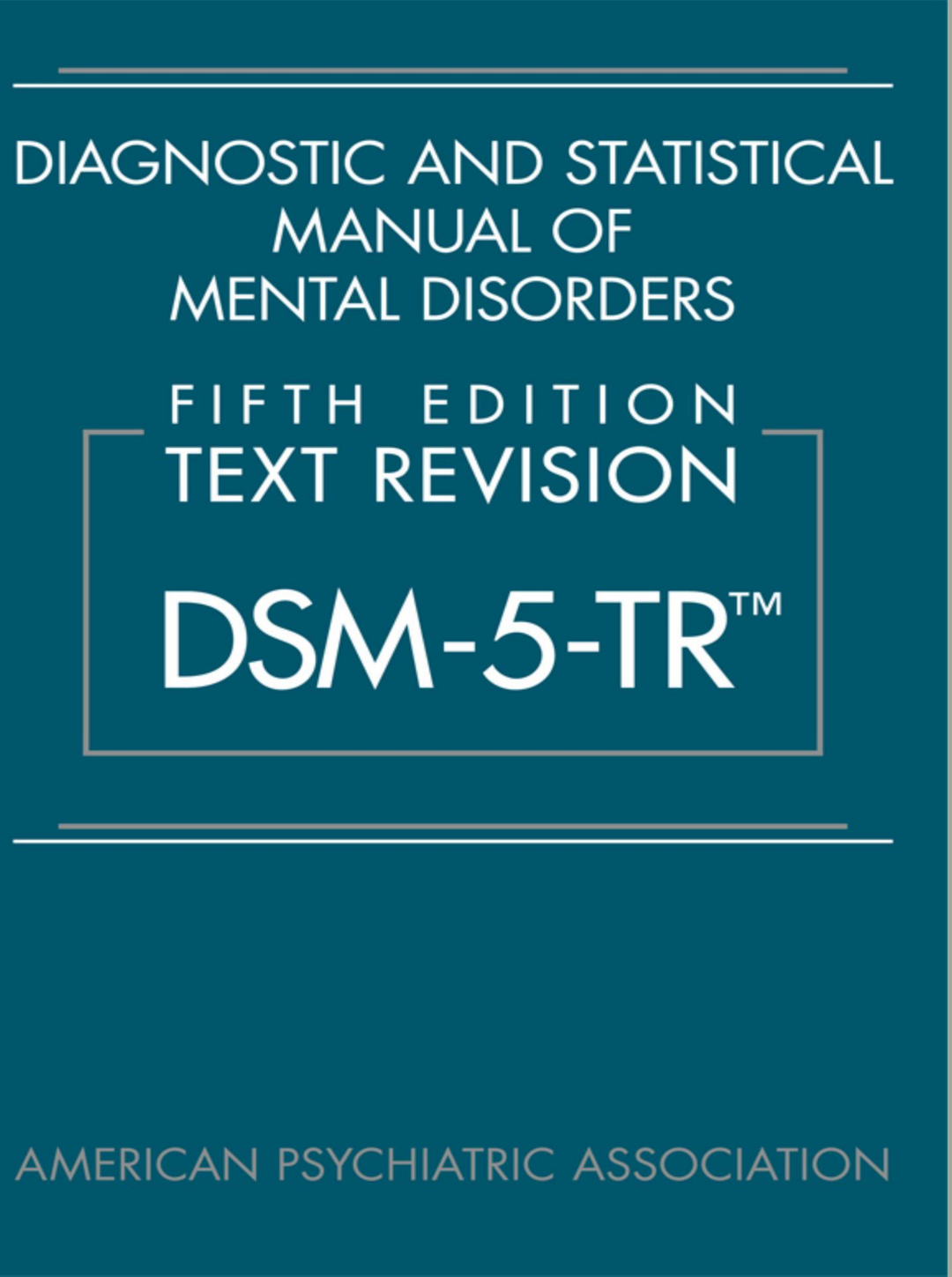
Fall 2025 SOWK 581

WEEK 05

The #AMA - DSM-5

JACOB CAMPBELL, PH.D., LICSW



Week 05 Plan

Agenda

Week Five Content

AMA - DMS-5-TR Edition

LEARNING OBJECTIVES

- Stronger understanding of the DSM

DSM

Jacob Campbell, Ph.D. LICSW
Heritage University

READ

Chapter 4 *Multicultural Practice* with Reading Quiz

Indicators for Cultural Competence in Social Work Practice

Using the *Culturagram* to Assess and Empower Culturally Diverse Families

LISTEN InSocialWork Podcast about Diversity/Cultural Competence

WRITE SIX REPLIES

- Chapter 04 Reflection Questions
- Using the Culturagram or ADDRESSING
- Reviewing the DMS-5 CFI
- The NASW Indicators for Cultural Competence in Social Work Practice

Week Five Content

DSM Jacob Campbell, Ph.D. LICSW
Heritage University

When should providers draw the line when recognizing if their clients' symptoms are behaviors normal to their culture or just psychiatric symptoms?

Jacob Campbell, Ph.D. LICSW
Heritage University

In the introduction to the DSM-5 video, the professor states that gambling is now considered only a process addiction. What does he mean by this? Also, in the past, DSMs' explanations and courses have discussed the potential incorporation of gaming and sex addiction as a part of the DSM. Even in my SUD courses, they have discussed these addictions as actual diagnosable mental health issues that should be addressed and corrected. So why haven't these been added?

My question is regarding diagnosing; how can we differentiate between similar conditions, for example, generalized anxiety disorder and panic disorder? I know we have to carefully examine the symptoms, but I think it can become very confusing at the beginning as we begin diagnosing.

How we can differentiate diagnoses between similar conditions. I'm sure people have been misdiagnosed before, and I'm wondering how we can tell two apart if they are teetering between the conditions.

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There are people that face into trauma and able to trust, according to the DSM-5 and talks about two different types of stressors. How can we define the different types of stressors to client they are facing? For example, there is posttraumatic stress disorder ana acute stress disorder.

How do you decide between two possible diagnoses that share symptoms? Another question I have is How do you handle situations where a client disagrees with their diagnosis?

If the client sees another clinician for a second opinion, how should one go about it when the diagnosis may be different between clinicians (the other clinician and me)? Or the opposite occurs, where they come to me for a second opinion, and I believe their diagnosis is different from their first clinician?

Where’s the line between normal distress and a diagnosable disorder? For example, people can feel anxious, but how much do they have to have that normal distress to be diagnosed with an anxiety disorder?

Towards the end of the video, Professor Kinter showed an old list of the frequency of diagnoses where he was employed. Given your experience and immense knowledge, do you think there is a correlation between schizoaffective disorder, schizophrenia, bipolar disorders, and addictive disorders, mainly alcohol, cannabis, and other substances?

They are all, in one way or another, involve psychoses - they all affect the mind and lose touch with reality.

If an individual regularly goes into an alcohol related psychosis, which is normally not permanent, but heavy alcohol use damages the brain, resulting in permanent brain damage, and elements of schizophrenia are now present, what would your diagnosis look like?

The two mirror each other so well, in my eyes, that if there's no known or disclosed alcohol or substance use, then one could easily mistake one for the other.

Is there anything missing in the DSM that could be beneficial to diagnosing individuals?

Jacob Campbell, Ph.D. LICSW
Heritage University

My question is regarding treatment. What are evidence-based treatments for borderline personality disorder? Also, what does a treatment plan look like for a person with schizophrenia?

When conducting a diagnostic interview, how do you balance being thorough without overwhelming the client? What are some common mistakes you see new clinicians make during the diagnostic process? How can we avoid them?

How do clinicians make sure they aren’t just focusing on the diagnosis but also the whole person?