California State University, San Bernardino

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2019

Syllabus and Lecture Slides for a Revised Social Work Practice Course on Diagnosing with the DSM-5 Using Case Studies and Active Learning Techniques to Enhance Student Engagement.

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I. SCHOOL OF SOCIAL WORK MISSION

CSUSB’s School of Social Work offers accessible, dynamic, and rigorous academic programs that prepare students with the professional values, knowledge and practice skills to effectively enhance the well-being of the diverse populations and communities of our region, state, and world.

II. CATALOG DESCRIPTION

Introduction to the generalist model of practice with individuals, families, and groups, comparative theories of micro practice, introductory intervention skills. Prerequisites; SW602B.

III. COURSE OVERVIEW AND RATIONALE

This is the third course in social work foundation micro practice sequence. This course builds upon content presented in SW602A and SW602B. There is continuity in the presentation of theoretical frameworks and practice models. Content also includes integration of models and application with different client systems (individuals, families, and groups).

IV. COURSE GOALS/STUDENT LEARNING OBJECTIVES

Upon completion of the course students will be expected to demonstrate:
<table>
<thead>
<tr>
<th>Number</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review from prior coursework the political, economic and historical backgrounds of the DSM emphasizing its application in clinical social work practice.</td>
</tr>
<tr>
<td>2</td>
<td>Describe objectively the strengths and limitations of the DSM system, and develop an awareness of other classification systems.</td>
</tr>
<tr>
<td>3</td>
<td>Connect social work principles to the assessment and diagnostic process, utilizing a strengths based process.</td>
</tr>
<tr>
<td>4</td>
<td>Demonstrate cultural competence in identifying adaptive and maladaptive behaviors in diverse clinical settings.</td>
</tr>
<tr>
<td>5</td>
<td>Develop accurate DSM diagnoses in an ethical manner.</td>
</tr>
<tr>
<td>6</td>
<td>Communicate with clients, family members and other professionals regarding major mental disorders and their applicable criteria.</td>
</tr>
<tr>
<td>7</td>
<td>Incorporate the DSM diagnostic process into the Generalist Intervention Model.</td>
</tr>
</tbody>
</table>

V. REQUIRED TEXTS/READINGS


Additional Readings, typically peer-reviewed journal articles, as listed in the syllabus and weekly course guides on Blackboard.

VI. ASSIGNMENTS AND GRADING POLICY

Course assignments are given the following value towards your final grade:

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Percentage of final grade</th>
<th>Due dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homework Assignments (2)</td>
<td>20%</td>
<td>04/22 &amp; 05/27</td>
</tr>
<tr>
<td>Hot Topic Paper</td>
<td>25%</td>
<td>05/20</td>
</tr>
<tr>
<td>Poster Presentation (Final)</td>
<td>15%</td>
<td>06/10</td>
</tr>
<tr>
<td>Final Exam</td>
<td>30%</td>
<td>06/14</td>
</tr>
<tr>
<td>Attendance &amp; Participation</td>
<td>10%</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Homework Assignments (April 22 & May 27)**
The purpose of the homework assignments is to supplement your understanding of psychological disorders through the use of interactive activities and videos. You will be required to reflect on the activity or video by answering several questions. The homework assignments should be approximately to four to five pages maximum, double-spaced. Additional details are listed at the end of the syllabus.

**Hot Topic Paper (May 20)**
The purpose of this paper is to familiarize you with critical issues and ethical concerns in the mental health field especially as those pertain to social work, social justice, equity, human rights and diagnoses using the DSM-5. You will work with a partner for this research assignment (Note: I will accept persons writing this paper solo, but pairs are preferred). Write 8 - 10 page paper on a new, controversial, or otherwise “cutting edge” approved topic concerning a particular diagnosis and relevant “Hot Topic” issues surrounding that diagnosis. Minimize any overlap with information already covered in this course through the books, articles, activities or lectures. The paper must be based on at least eight recent (in the past 10 years), relevant sources; four sources must be scholarly, peer-reviewed journal articles (not just abstracts).

A “Hot Topic” is any new or controversial issue that social workers, psychologists, counselors, etc. are currently discussing and/or debating and, in this case, related to a specific diagnosis or diagnostic category. A potential list of such topics is given below though you are not limited by the list. Additional details are listed at the end of the syllabus.

**Poster Presentation (To be presented on June 10 from 1 p.m. – 2:00 p.m.)**
Along with the Hot Topic Paper, you will complete a poster presentation highlighting the most important information for your classmates about this topic in understanding this diagnosis and relevant “Hot Topic.” Do not include a simple list of the symptoms that are needed for this diagnosis, as those can be easily accessed by your classmates in the DSM-5. Instead, include the highlights of the diagnosis and highlights of the “Hot Topic” issue to serve as informational purposes for your colleagues. Please include your reference page/s along with your poster so your classmates can access these resources.

**Final Exam (Due June 14)**
The final exam will cover the material learned in class and will consist of case studies. I will expect you to provide a diagnosis (including the ICD 10 codes) based on the information provided, plus answer other related questions. You can use your DSM-5 and notes during these exams.
In the School of Social Work, M.S.W. grades are assigned as follows:

<table>
<thead>
<tr>
<th>Percent</th>
<th>Letter grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-96</td>
<td>A  Excellent</td>
</tr>
<tr>
<td>95-90</td>
<td>A- Very good</td>
</tr>
<tr>
<td>89-86</td>
<td>B+ Good</td>
</tr>
<tr>
<td>85-83</td>
<td>B  Satisfactory</td>
</tr>
<tr>
<td>82-80</td>
<td>B- Poor</td>
</tr>
<tr>
<td>79-76</td>
<td>C+ Below course expectations</td>
</tr>
<tr>
<td>75-73</td>
<td>C  Seriously below expectations</td>
</tr>
<tr>
<td>≤ 72</td>
<td>F  Failed course</td>
</tr>
</tbody>
</table>

**Meaning of Grading Scale Descriptions**

This section explains how the instructor evaluates your assignments and how your overall grade is determined.

(A) **Excellent**
- Far above expected performance or criteria.
- Extensive use, understanding and appropriate integration of a number of required, optional and other relevant readings.
- Clear evidence of the use of the student’s own creative ideas and not just a repetition of ideas presented in class or in readings. There is evidence of the student’s own critical thought.
- Special insights that go beyond what the authors had in mind. Able to analyze and apply ideas.
- Assignment is well organized, logical and well written.

(A-) **Very Good**
- Well above expected performance.
- The student used and incorporated relevant required course readings, as well as optional relevant readings in an appropriate fashion.
- Demonstrated critical thinking, logical progression of ideas and good, clear linkages between various readings and the ideas presented.
- Evidence of the use of the student’s own ideas.
• Shows a beginning ability to analyze ideas. Also a conceptual understanding of the issues under discussion.
• Assignment is well organized, logical and well written.

(B+) Good
• Assignment is within expected performance.
• Generally used required readings only.
• Demonstrated some evidence of own thinking.
• Some evidence of ability to integrate readings with ideas under discussion.
• For the most part the paper is well organized, logical and well written.

(B) Fair
• A low pass.
• Little use of readings.
• Little use of imagination and creative thinking.
• Little evidence of ability to integrate course materials.
• Writing, clarity and organization minimal.

(B-) Poor
• Failure at the graduate level. You will pass this course with this grade, but must get a high grade in another course to maintain 3.0 GPA.
• No use of readings.
• Lack of critical thinking.
• Marked lack of originality.
• Writing and organization not acceptable at graduate level.

(C+/C) Below and Seriously Below Expectations
• Does not come close to addressing the criteria listed above.

VII. COURSE REQUIREMENTS AND EXPECTATIONS

Course objectives will be met through lectures, class presentation by students, discussion, assigned readings, in-class activities, and exams. **Students are expected to read assigned readings prior to class and to be prepared for graduate level discussion. These are listed as Pre-lecture Activities in the course calendar.**

Credit Hour Policy (The hours you owe yourself)

All CSU degree programs and courses bearing academic credit must comply with the federal law regarding the “credit hour,” which is defined as “the amount of work
represented in intended learning outcomes and verified by evidence of student achievement that is an institutionally established equivalency that reasonably approximates not less than:

1. **One hour of classroom or direct faculty instruction and a minimum of two hours of out-of-class student work each week** for approximately 15 weeks for one semester or trimester hour of credit...

Please see the following link for additional information:
[http://bulletin.csusb.edu/academic-support/academic-support.pdf](http://bulletin.csusb.edu/academic-support/academic-support.pdf)

**Cell Phones/Laptops**
Cell phones should be silent during class time and not used for communication purposes. If you need to use your cell phone, please step out of the room to briefly take a call or send a message if important. **Laptops (and similar devices) may be used for educational purposes only (such as writing notes, accessing material related to this class).** They are not to be used during lectures and class presentations unless it is for an educational purpose. If you use your phone and/or laptop for reasons other than educational purpose, you will be given a verbal warning in person or via e-mail. After that, you will lose all attendance/participation points for the day.

**Class Attendance**
This class is scheduled to meet once per week, so attendance in class is crucial and absences from scheduled class sessions will adversely affect the course grade. **Attendance in class is expected and absences from scheduled class sessions will adversely affect the course grade.** Every student gets one courtesy absence and late arrival but each absence and/or late arrival thereafter will result in a partial reduction of participation points. Three absences will result in a full letter grade reduction. Four absences will result in a fail. Three tardies will result in an absence. Leaving class before it is over will be considered an absence. As a professional courtesy, please advise me via email if you are going to miss class or arrive late.

**Class Participation**
An MSW is a professional degree that leads to providing services to individuals, families, groups, organizations, and communities. Communication is vital in this profession because social workers must be able to speak in front of groups, as well as within group settings and with individuals. Furthermore, the use of self is important to develop. These skills will be practiced in this class by participating. Half of your participation comes from you attendance and the other half will be done based on your participation in class
discussions and activities. If you are going to be absent, you still have to complete the pre-lecture material and send this to me to not lose participation points.

**Late Assignments**
Assignments must be turned in prior to or on the date listed in the course syllabus unless it is announced otherwise in class. Please contact the instructor if you are going to submit an assignment late. Late assignments will only be accepted if prior arrangements have been made with the instructor. Please note, there will be a 10% grade reduction per each day late.

**Presentation of Written Assignments**
Papers must be typed using size 12 font of Arial or Times New Roman font, with one inch margins at top, bottom, and sides of the page – this is generally the default settings in Microsoft Word. Page numbers and cover page are required. Where appropriate, heading and sub-headings should follow the assignment format and instructions. Please be sure to check your written work for proper tense, spelling, grammar, punctuation, formatting, and current APA style is expected. Points will be deducted if your submissions do not follow these instructions.

**Tips to Maximize your Learning Experience**

- Plan ahead and do not try to do all of the readings the night before the lecture. It helps to download all of the readings a few days beforehand and to visit the lecture slides the morning of the lecture. This also ensure you have access to the materials once you graduate and can easily find them when needed.

- Put away your cell phone, electronics, and other media distractions while doing your readings and assignments. Even the sight of your cell phone can be distracting and affect how much you learn. Practicing this will improve your learning and improve your life overall. Try it!

- Visit the various links I provide at the end of the lecture material, which consist of podcasts, websites, YouTube Videos, and additional readings. They complement the lecture material and are usually engaging (and sometimes funny). I particularly recommend subscribing to the Social Work Podcast and In Social Work Podcast and listening to various episodes for those of you with long commutes.

- Come prepared with questions from the readings and ask questions during lectures. It is likely that you are not the only one with the question. Also, posing the question
during class gives others a chance to comment and/or learn from the question and response.

- Last, contact me early if any issues arise. It is important that you let me know if you are struggling with the course material or the course format. The earlier you let me know, the sooner I can try to make adjustments.

VIII. WRITING RESOURCES

- Purdue University: [http://owl.english.purdue.edu/owl/resource/560/01/](http://owl.english.purdue.edu/owl/resource/560/01/)
- APA Site: [http://www.apastyle.org/](http://www.apastyle.org/)
- Kent State University: [https://libguides.library.kent.edu/ld.php?content_id=41871474](https://libguides.library.kent.edu/ld.php?content_id=41871474)

Writing Coach: The School of Social Work has a writing coach especially for its students. Our coach, Francesca Astiazaran, will help you identify problems you might have with your writing and assist you in finding solutions. You can visit the writing coach at any stage in your writing: from as early as brainstorming and/or understanding your prompt to the final stages of your paper (and, of course, everything in between). While she is not an editor and cannot simply go through your paper and "fix" things, she can help you with issues such as grammar, sentence structure, and word choice as well. Francesca can meet with you on campus, online (Via Zoom), or by email. Whichever type of appointment you choose will require an appointment in advance. You can visit the calendar and find instructions for booking an appointment at [https://csbs.csusb.edu/social-work/coach](https://csbs.csusb.edu/social-work/coach).

IX. INTERNET ACCESS TO COURSE MATERIAL

All of readings and lecture slides will be available on Blackboard organized by the weekly topics, and I will also use Blackboard to make announcements. I recommend that you download the material on a weekly basis prior to the lecture so you come to class prepared and so that you have an electronic copy for future reference.

X. UNIVERSITY POLICIES

**Plagiarism and Cheating**

Students are expected to be familiar with the University’s definition of and consequences for plagiarism and cheating (Under “Academic Regulations” in the Bulletin of Courses, [http://bulletin.csusb.edu/academic-regulations/](http://bulletin.csusb.edu/academic-regulations/)). Among the possible consequences for plagiarism and/or cheating is expulsion.
Support for Students with Disabilities

The School of Social Work supports the University’s commitment to diversity and the Americans with Disabilities Act (ADA). Faculty will provide reasonable accommodations to any student with a disability who is registered with the Office of Services to Students with Disabilities that needs and requests accommodations as recommended by that office. If you are in need of an accommodation for a disability in order to participate in class, please see the instructor and contact Services to Students with Disabilities (SSD) located at University Hall, Room 183. You could also call them at (909) 537-5238, e-mail them at ssd@csusb.edu or visit the SSD website for more information at http://ssd.csusb.edu/index.html.

Cal State San Bernardino Statement of Commitment to Diversity Excerpt

“In our commitment to the furthering of knowledge and fulfilling our educational mission, California State University, San Bernardino seeks a campus climate that welcomes, celebrates, and promotes respect for the entire variety of human experience. In our commitment to diversity, we welcome people from all backgrounds and we seek to include knowledge and values from many cultures in the curriculum and extra-curricular life of the campus community... Dimensions of diversity shall include, but are not limited to, the following: race, ethnicity, religious belief, sexual orientation, sex/gender, disability, socioeconomic status, cultural orientation, national origin, and age.” (From the CSU San Bernardino University Diversity Committee Statement of Commitment to Diversity, http://diversity.csusb.edu/, 2010)

Dropping and Adding

It is the student’s responsibility to ensure that they have enrolled in their classes, or officially dropped them if they do not intend to attend, by Census Date (usually two weeks after the start of the quarter). There are increasing penalties for not dropping or being properly enrolled by the Census Date (refer to “Academic Regulations” in the Bulletin of Courses, http://catalog.csusb.edu/)

Emergency Evacuation Procedures

Please make sure you have familiarized yourself with the campus evacuation site noted on the map posted closest to your classroom and that you know where the nearest exit is. Should there be an emergency, please proceed to the nearest evacuation site. Make sure a member of evacuation team has checked off your name before you leave campus, so that we so not spend time searching for you unnecessarily. The phone number for public safety is (909) 537-5165. On a campus phone the number is 75165.

Emergency Event Procedures
The CSUSB campus is typically a very safe place. However, unforeseen events can happen anywhere. The purpose of this section of the syllabus to review different types of emergencies together to have a plan in mind. 911 can be called any time there is a need for an emergency response. The non-emergency phone number for campus police is 537-5165. (On campus phone the number is 75165). The campus escort service for company walking to your car is 909-537-5165.

If a class is canceled due to campus closing, please go to your course Blackboard site to see if there is an alternative assignment for that class session or for other updates. The list below cannot cover every aspect of every possible situation, but it should cover some basics and provide some initial preparedness.

**Emergency Preparedness Checklist for First Class Session Discussion**

- Building Alarm goes off (fire or other). Evacuate building calmly. Only use stairs. Proceed as a group to the grass area beyond Parking Lot M (in front of Visual Arts Building). Stay there until building Marshall (wearing reflective vest) indicates all clear. There may be no Marshall in the evening, so go to the grassy area beyond parking lot M and wait for instructions. If someone in your class cannot use the stairs, assist the person to the safest place in the building and inform the police/fire department of their whereabouts so they can be safely evacuated.

Please make sure you have familiarized yourself with where the nearest exit is, how to use stairs to get to the ground floor, and where Parking Lot M is.

- Earthquake. Building phones should sound alarm and give instructions, generally to duck under a desk, table, doorway to up against a wall. It is ok to hold on to a secure object. Make sure the door is open to your classroom if possible. Cover the back of your neck with your hands. Stay away from unsecured furniture. Once the shaking has stopped, proceed as quickly as possible to the stairs and evacuate. Do not use the elevators.

- Medical Emergency: Call 911 and report. Use any first aid available if trained.

- Dangerous person: Leave the area as soon as possible and let others know there is a dangerous person in the area. Call 911 and report.

- Shots fired/active shooter: Move away from the immediate path of danger. If possible, exit the building. Otherwise, SHELTER IN PLACE (definition below). Notify anyone you may encounter to avoid the location of gunshots. After evacuating the area of the shooting, seek shelter and stay there until emergency responders arrive and advise you what to do.
Identify who in the class has training in the following areas: CPR, other first aid, shots fired/active shooter training.

Definition of “Shelter in Place” and alternative safe locations. Go to the nearest room or office, close and lock the door. If the door has an interior lock, please lock. Turn off the lights. Seek protective cover. Stay away from doors and windows. Keep quiet and act as if no one is in the room. Do not answer the door. Wait for police to assist you out of the building. Call 911 from an on-campus phone. Faculty may suggest alternative safe locations.

Discuss helping mobility, hearing, or sight impaired classmates.

Look at the following websites and bookmark on phone:

http://riskmanagement.csusb.edu/emergencymanagement/preparednessReferenceGuide.html

https://www.fema.gov/media-library-data/1472672897352-d28bb197db5389e4dcedef335d3d867/FEMA_ActiveShooter_OnePagev1d15_508_FINAL.pdf

http://www.bucks.edu/resources/security/activeshooterprotocol/
https://www.dhs.gov/options-consideration-active-shooter-preparedness-video

XI. COVERAGE OF ETHICS, DIVERSITY, HUMAN RIGHTS AND SOCIAL AND ECONOMIC JUSTICE IN THIS COURSE

Social workers have an obligation to conduct themselves ethically and to engage in ethical decision making. Social workers are knowledgeable about the value base of the profession, its ethical standards, and relevant law. Social workers:

- Recognize and manage personal values in a way that allows professional values to guide practice;
- Make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles;
- Tolerate ambiguity in resolving ethical conflicts; and
- Apply strategies of ethical reasoning to arrive at principled decisions.

(CSWE Educational Policy 2.1.2, 2008).
This course addresses ethical principles that guide professional practice in the following manner. Several class sessions will focus on ethics in working with clients, including weeks 1, 2 and 4. The readings in the text and articles for those weeks are applicable. The quizzes will assess students' knowledge and skills. The assessment paper and the subsequent discussion address ethical situations and dilemmas and application of appropriate models.

Engage Diversity and Difference in Social Work Practice

Social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. Social workers appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim. Social workers:

- Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power;
- Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups;
- Recognize and communicate their understanding of the importance of difference in shaping life experiences; and
- View themselves as learners and engage those with whom they work as informants.

(CSWE Educational Policy 2.1.4, 2008).

This course addresses diversity in the following manner. Week 4 specifically addresses multicultural awareness and human diversity, in the lectures, readings and discussion. The assessment paper requires attention to these issues. In weeks 3 and 5-10, diversity will be integrated as appropriate to the topic.

Advance Human Rights and Social and Economic Justice

Each person, regardless of position in society, has basic human rights, such as freedom, safety, privacy, an adequate standard of living, health care, and education. Social workers recognize the global interconnections of oppression and are knowledgeable about theories of justice and strategies to promote human and civil rights. Social work incorporates social justice practices in organizations, institutions, and society to ensure...
that these basic human rights are distributed equitably and without prejudice. Social workers:

- Understand the forms and mechanisms of oppression and discrimination;
- Advocate for human rights and social and economic justice; and
- Engage in practices that advance social and economic justice.
- (CSWE Educational Policy 2.1.5, 2008).

**Spring 2019 Course Calendar**
*(Note: subject to change with fair notice)*

<table>
<thead>
<tr>
<th>Week / Date</th>
<th>Topics, Assignment, Due Dates, &amp; Readings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Week 1</strong></td>
<td><strong>Holiday</strong></td>
</tr>
<tr>
<td>Mon., 4/1</td>
<td>Cesar E. Chávez holiday observed on 4/1/19. No class. This is not an April Fools’ joke.</td>
</tr>
<tr>
<td><strong>Week 2</strong></td>
<td><strong>Introduction to the Course, syllabus review, and review of the assessment process. Discussion of adaptive and maladaptive behaviors and major systems of classification: DSM, ICD, ICF.</strong></td>
</tr>
<tr>
<td>Mon., 4/8</td>
<td><em>Pomeroy Reading</em> Chapter 1: Introduction, pp. 1-15 (<em>Focus on this reading</em>).</td>
</tr>
</tbody>
</table>

*Other Reading*


<table>
<thead>
<tr>
<th>Week / Date</th>
<th>Topics, Assignment, Due Dates, &amp; Readings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-lecture activities</strong></td>
<td></td>
</tr>
<tr>
<td>Listen to the following podcast in addition to doing the aforementioned readings.</td>
<td></td>
</tr>
<tr>
<td><strong>Recommended Reading</strong></td>
<td></td>
</tr>
<tr>
<td>DSM-5 Classification pp. xiii-xl; Introduction, Use of the Manual, and Cautionary Statement pp. 5-25; Assessment Measures, pp.733-748; Cultural Formulation, pp. 749-760 <em>in case you forgot this from SW 602A</em></td>
<td></td>
</tr>
<tr>
<td><strong>Site to Explore (Also recommended)</strong></td>
<td></td>
</tr>
<tr>
<td>Please review “What are Mental Health medications?” “How are medications used to treat mental health disorders?” and “Which groups have special needs when taking psychiatric medications?” <em>I strongly recommend you use this website throughout this course to learn more about the medications used for each major category of disorders.</em></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Week 3</th>
<th>Neurodevelopmental Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon., 4/15</td>
<td><strong>Last Day to identify paper topic and partner</strong></td>
</tr>
<tr>
<td><strong>DSM-5 Reading</strong></td>
<td></td>
</tr>
<tr>
<td>Neurodevelopmental Disorders, pp. 31-86.</td>
<td></td>
</tr>
<tr>
<td><strong>Pomeroy Reading</strong></td>
<td></td>
</tr>
<tr>
<td>Chapter 2: Neurodevelopmental Disorders, pp. 16-25.</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-lecture activities:</strong></td>
<td></td>
</tr>
<tr>
<td>Complete aforementioned readings, read Carlos Vasquez vignette on page 29, and answer the questions on page 32.</td>
<td></td>
</tr>
<tr>
<td><strong>Recommended Reading</strong></td>
<td></td>
</tr>
<tr>
<td>Week / Date</td>
<td>Topics, Assignment, Due Dates, &amp; Readings</td>
</tr>
<tr>
<td>------------</td>
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</tr>
</tbody>
</table>
| Week 4     | **Disruptive, Impulse-Control, and Conduct Disorders**  
**HOMEWORK 1 DUE Monday 4/22** |
| Mon., 4/22 | DSM-5 Reading  
Disruptive, Impulse-Control, and Conduct Disorders pp. 461-480.  
Pomeroy Reading  
Chapter 15: Disruptive, Impulse-Control, and Conduct Disorders, pp. 327-333.  
**Pre-lecture activities**  
Complete aforementioned readings, read Bobby Jones vignette on page 334, and answer the questions on pages 335-336.  
Recommended Reading  
| Week 5     | Depressive Disorders  
DSM-5 Reading  
Depressive Disorder pp. 155-188.  
Pomeroy Reading  
Chapter 5, Depressive Disorders, pp. 101-112.  
**Pre-lecture activities** |


<table>
<thead>
<tr>
<th>Week / Date</th>
<th>Topics, Assignment, Due Dates, &amp; Readings</th>
</tr>
</thead>
</table>
| **Complete aforementioned readings, read Maggie Weinzafpel vignette on page 113, and answer the questions on page 115.**  
  **Recommended Reading**  
| **Week 6**  
**Mon., 5/6** | **Bipolar and Related Disorders**  
**DSM-5 Reading**  
Bipolar and Related Disorders, pp. 123-154  
  **Pomeroy Reading**  
Chapter 4, Bipolar and Related Disorders, pp. 79-88.  
  **Pre-lecture activities**  
Complete aforementioned readings, read Helen Stonewall vignette on page 89, and answer the questions on page 91.  
  **Recommended Reading**  
| **Week 7**  
**Mon., 5/13** | **Anxiety Disorders (Required) and Obsessive-Compulsive and Related Disorders (Recommended)**  
**DSM-5 Reading**  
Anxiety Disorders pp. 189-233  
  **Pomeroy Reading**  
Chapter 6, Anxiety Disorders, pp. 132-140.  
  **Pre-lecture activities** |
<table>
<thead>
<tr>
<th>Week / Date</th>
<th>Topics, Assignment, Due Dates, &amp; Readings</th>
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<tbody>
<tr>
<td></td>
<td>Complete aforementioned readings, read Sam Barnes vignette on page 148, and answer the questions on page 149.</td>
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<td><strong>Recommended Reading</strong></td>
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<td><strong>DSM-5 Reading</strong></td>
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<td></td>
<td>Obsessive-Compulsive and Related Disorders pp. 235-264</td>
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<td><strong>Pomeroy Reading</strong></td>
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<td>Chapter 7, Obsessive-Compulsive and Related Disorders, pp. 158-178.</td>
</tr>
<tr>
<td>Week 8 Mon., 5/20</td>
<td>Trauma- &amp; Stressor-Related Disorders (Required); Dissociative and Somatic Symptom Disorders (Recommended) <strong>Hot Topic Paper Due</strong></td>
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<tr>
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<td><strong>DSM-5 Reading</strong></td>
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<td></td>
<td>pp. 265-290: <em>Trauma- and Stressor-Related Disorders</em></td>
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<td><strong>Pomeroy Reading</strong></td>
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<td></td>
<td>Chapter 8, Trauma and Stressor-Related Disorders, pp. 180-197.</td>
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<td><strong>Pre-lecture activities</strong></td>
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<tr>
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<td>Complete aforementioned readings, read Nancy Kauffman vignette on page 205, and answer the questions on pages 207-208.</td>
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<td><strong>Recommended Reading</strong></td>
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<td>DSM-5 Reading</td>
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<td>pp. 291-307: <em>Dissociative Disorders</em></td>
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<td></td>
<td>pp. 309-327: <em>Somatic Symptom and Related Disorders</em></td>
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<td><strong>Pomeroy Reading</strong></td>
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<tr>
<td></td>
<td>Chapter 9, Dissociative Disorders, pp. 232-244.</td>
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<tr>
<td></td>
<td>Chapter 10, Somatic Symptom and Related Disorders, pp. 246-266.</td>
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<tr>
<td>Week / Date</td>
<td>Topics, Assignment, Due Dates, &amp; Readings</td>
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<tr>
<td><strong>Week 9</strong>&lt;br&gt;Mon., 5/27</td>
<td><strong>Memorial Day Holiday No Class. Substance Related and Addictive Disorders.</strong>&lt;br&gt;<strong>HOMEWORK 2 DUE Monday 5/27/19 at 11:59 p.m.</strong>&lt;br&gt;&lt;br&gt;<strong>DSM-5 Reading</strong>&lt;br&gt;Substance-Related and Addictive Disorders, pp. 481-589&lt;br&gt;&lt;br&gt;<strong>Pomeroy Reading</strong>&lt;br&gt;Chapter 16: Substance-Related and Addictive Disorders, pp. 347-357.</td>
</tr>
<tr>
<td><strong>Finals Week</strong></td>
<td><strong>Personality Disorders lecture the first half of class.</strong>&lt;br&gt;<strong>Poster Presentations (1 p.m. – 2 p.m.)</strong></td>
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<tr>
<th>Week / Date</th>
<th>Topics, Assignment, Due Dates, &amp; Readings</th>
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<tbody>
<tr>
<td>Mon., 6/10</td>
<td><strong>FINAL EXAM DUE Friday 6/14 at 11:59 p.m.</strong></td>
</tr>
</tbody>
</table>
|            | *DSM-5 Reading*  
Personality Disorders pp. 645-684 |
|            | *Pomeroy Reading*  
Chapter 18, Personality Disorders, pp. 392-397. |
|            | **Pre-lecture activities**  
Complete aforementioned readings, read Jack Keller vignette on page 401, and answer the questions on page 403. |
|            | *Recommended Reading*  
doi:10.1016/S0140-6736(14)61995-4 |
Assignment Guidelines

*****

Homework 1 (10 points)
Due Date: April 22, 2019 at 11:59 p.m.

Watch the three videos listed below and answer the questions that follow:

*Six Core Strengths for Healthy Child Development – An Overview:*
https://www.youtube.com/watch?v=skaYWKC6iD4

*Dr. Bruce Perry The Impact of Stress On the Body:*
https://www.youtube.com/watch?v=TIUdALXnPiQ

*Trauma, Brain and Relationship: Helping Children Heal:*
https://www.youtube.com/watch?v=RYj7YYHmbQs

(1) Describe the six core strengths for healthy child development. How do they build off one another?

(2) What is the importance of emotional regulation in children? How does it relate to the development of psychological disorders (this question is not necessarily covered in the videos)?

(3) Describe one way that adversity/stress can affect the brain’s functioning. How is this relevant to your future work?

(4) Is every child negatively impacted if they experience trauma? What does Dr. Perry recommend to help children heal who have experienced trauma?

(5) Why does Dr. Perry argue that 95% of public funds are being misspent to address the effects of trauma? What is the logic behind his argument?

(6) Last, find a relevant video or podcast related to toxic stress or trauma on the brain from the sites listed below. Watch it and write two paragraphs on what you learned. You have to indicate the website you obtained the information from and where in the video you found the information (i.e., 2:45 into the video, the speaker talks about…). Here are a few sites that you could explore to help you answer this last question:

- https://developingchild.harvard.edu/resources/
- https://www.nctsn.org/resources/training

*Note:* When you answer the aforementioned questions, please indicate, which video you obtained your answer from. It is expected that you write 4 – 5 pages maximum (double-spaced).
Homework 2 (10 points)

Due Date: May 27 at 11:59 p.m.
Watch at least two of the following video clips regarding Addiction from HBO (they will be posted on Blackboard as well) and then answer the questions listed below.

- The Adolescent Addict:  
- The Science of Relapse:  
- Steamfitters Local Union 638:  
- Insurance Woes:  

Please answer the following questions and indicate what video clip helped you answer the question.
1. Discuss three things new to you or that stood out to you from watching the two clips.
2. Identify at least two biases you may have regarding persons with a substance use disorder and how this may affect your work/treatment. (Note if your biases changed after reviewing this week’s material).
3. How important is substance/addiction education for your MSW/future career?
4. What is one specific thing that you can do to increase your knowledge of substances use disorders?
5. Find one online video or podcast that discusses the effects of drugs on the brain. Choose one type of drug (i.e. stimulants) and describe how it affects the brain succinctly.
Diagnosis & Hot Topics in Mental Health Research + Poster Presentation
(40% of final grade)

1 of 2: Hot Topic Paper (25% of final grade)

Due Date: Monday May 20, 2019 at 11:59 p.m.
The purpose of this assignment is to familiarize you with critical issues and ethical concerns in the mental health field especially as those pertain to social work, social justice, equity, human rights and diagnoses using the DSM-5. You will work in teams of two for this research assignment (Note: You could also write the paper on your own). Write an 8 -10-page paper (APA format, title page, double-spaced, size 12 font, etc.) on a new, controversial, or otherwise innovative approved topic concerning a particular diagnosis and relevant “Hot Topic” issues surrounding that diagnosis. Minimize any overlap with information already covered in this course through the books, articles, activities or lectures. The paper must be based on at least ten (10) recent (in the past 10 years) relevant sources; five (5) sources must be scholarly, peer-reviewed journal articles (not just abstracts).

A "Hot Topic" is any new or controversial issue that social workers, psychologists, counselors, etc. are currently discussing and/or debating and, in this case, related to a specific diagnosis or diagnostic category. A potential list of such topics is given below though you are not limited by the list.

Make sure that you identify your partner and have your chosen topic approved by the instructor by April 15. Only two (2) papers per specific diagnosis are allowed, so if two pairs have already signed up, for example, to write a paper on Veterans and PTSD, you and your partner should choose another topic.

Past “Hot Topics” have included
- Military Sexual Trauma Among Female Veterans
- Disruptive Mood Dysregulation Disorder: Temper tantrum or mental illness?
- Alcohol Use Disorder Diagnostic Criteria Changes From the DSM-IV-TR to DSM-5
- Eating Disorders and Men
- Anorexia Nervosa and Suicide
- Pros and cons of the alternative DSM-5 Model for Personality Disorders.
- Stimulant Use Disorder: Harm reduction versus abstinence only
- Off label use of medications related to a specific diagnosis
- Medicalization of normality controversy (Gender Dysphoria, Sexual Dysfunction, etc.)
- Life choices or mental disorders (substances, gambling, gaming)?
• Dissociative Identity Disorder: Real or imagined?
• Mental health diagnosis and violent crimes: Myth versus reality
• Neurocognitive Disorders and competence
• Depressive Disorders and grief
• Bipolar Disorder and children
• Psychotropic medication with children (Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Conduct Disorder, etc.)
• Post-Traumatic Stress Disorder and children (or veterans)
• Personality Disorders in children and adolescents
• Reactive Attachment Disorder in child welfare

The Research Paper should include the following (Note: you can use each numbered point as the headings – you may need to reword it than how it is presented – in your paper):

1. Definition and description of chosen diagnosis: This section should make up no more than half of the paper. The remainder of the paper should be devoted to the “hot topic”.
   a. Definition: How does the DSM-5 describe the particular diagnosis? Has this changed from previous versions of the DSM? Are there alternative definitions in the literature or in the DSM-5 (see page 761 if applicable)?
   b. Characteristics of Presenting Behavior/ Primary Symptoms: What are the major features of this diagnosis?
   c. Etiology: What is the cause of this illness/disorder?
   d. Prevalence: What are the prevalence rates? Are there differences based on particular characteristics (culture, gender, age, etc.)?
   e. Age of onset
   f. Treatment options: Briefly describe major treatment options that are most commonly used to treat this disorder.
   g. Outcome: What is life like for a person living with this diagnosis? What challenges will they encounter?

2. Clear description of the “Hot Topic” related to this diagnosis.

3. Discussion of the chosen diagnosis in light of the “Hot Topic” research information.

4. Include a discussion on the implication of your findings in terms of social work practice.

5. A conclusion/summary of the paper.

6. Reference page/s
Due Date: June 10, 2019

Along with the Hot Topic Paper, you will complete a poster presentation highlighting the information that you feel will be useful for your classmates about this topic in understanding this diagnosis and relevant “Hot Topic.” Do not include a simple list of the symptoms that are needed for this diagnosis, as those can be easily accessed by your classmates in the DSM-5. Instead, include the highlights of the diagnosis and highlights of the “Hot Topic” issue to serve as informational purposes for your colleagues. Please include your reference page/s along with your poster so your classmates can access the resources you found.

**Diagnosis & Hot Topics in Mental Health Research Paper + Poster Presentation Grading Rubric**

<table>
<thead>
<tr>
<th>Area of evaluation</th>
<th>Feedback</th>
<th>Points Possible</th>
<th>Points Earned</th>
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<tbody>
<tr>
<td>Definition and Description of Chosen Diagnosis: Your paper includes the following topics: Definition; Characteristics of Presenting Behavior/ Primary Symptoms; Etiology; Prevalence; Age of onset; Treatment Options; Outcome</td>
<td>8</td>
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<tr>
<td>Hot Topic: Description and discussion of the diagnosis from the perspective of the particular hot topic</td>
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<td>Social Work Implications/ Summary: You have discussed the implications of this information on SW practice and summarized the paper</td>
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<td>Resources: The paper includes at least 10 resources, 5 peer-reviewed, and these resources are used throughout the paper</td>
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<td>Grammar/APA: Paper is well organized, APA guidelines are followed</td>
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<tr>
<td><strong>Hot Topic Paper TOTAL</strong></td>
<td><strong>25</strong></td>
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<td><em>Poster:</em> Clarity and creativeness.</td>
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<tr>
<td><em>Poster:</em> Reference included (either on poster or separately)</td>
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<tr>
<td><em>Poster:</em> Highlights of the diagnosis and of the “hot topic”</td>
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<td><strong>Poster Presentation TOTAL</strong></td>
<td><strong>15</strong></td>
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Disruptive, Impulse-Control, and Conduct Disorders

ODD

Externalizing Behaviors, Impulsive Behaviors, and Lack of Control

CD

IED
Today’s goals:

- Differentiate between Neurodevelopmental Disorders & Disruptive, Impulse-Control, and Conduct Disorders
- Learn the symptoms of the most common Disruptive, Impulse-Control, and Conduct Disorders.
- Understand their general prevalence and some assessment tools.
- Practice diagnosing Disruptive, Impulse-Control, and Conduct Disorders as well as differential diagnosis.
What are Disruptive, Impulse-Control, and Conduct Disorders?

Characterized by **externalizing behaviors and poor impulse control**. There is a loss of restraint in controlling emotions and behaviors, which affects others and violates social norms.

- **ODD** is evenly distributed between behaviors (argumentativeness & defiance) and emotions (anger & irritation)
- Outbursts of anger disproportionate to provocation (e.g., IED)
- Behaviors that violate rights of others or societal norms (e.g., CD)
Disruptive, Impulse-Control, and Conduct Disorders & Prevalence

- Oppositional Defiant Disorder (ODD) – 6%
- Conduct Disorder (CD) – 6%
- Intermittent Explosive Disorder (IED) – 2.7%
- Pyromania – 1%
- Antisocial Personality Disorder (dual listing) -.2% to 3.3% (although higher in some settings)
- Kleptomania – 1%
- Other/Unspecified Specified Disruptive, Impulse-Control, and Conduct Disorder
Assessment Tools

Generally, we gather information from parent/guardian and/or teacher. Always important to check with multiple sources!

Assessment instruments are helpful. These include:

– Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001)

– Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997)

– Eyberg Child Behavior Inventory (ECBI; Eyberg & Robinson, 1983)
Oppositional Defiant Disorder (ODD)

Traits and Characteristics (4)
Frequent & persistent pattern of (≥ 6 months):

- **Angry/Irritable mood** (i.e. loses temper, easily annoyed, often angry and resentful)

- **Argumentative/Defiant behavior** (argues with authority figures, refuses to follow rules or requests)

- **Vindictiveness** (spiteful/vindictive)
To be diagnosed with ODD, the aforementioned symptoms should be exhibited during interaction with at least one individual.

However, if that person is a sibling, then it’s not a disorder.

“Oh it’s your sister! No problem.”
ODD - Development & Course

- Begins in childhood, rarely after early adolescence.
- ODD often precedes the development of Conduct Disorder (CD), especially those with childhood-onset CD. **However, most children don’t.**
- ODD with mood related symptoms: Risk for affective disorders
- ODD with defiant/argumentative & vindictive: Risk for CD
- Other potential problems later in life: impulse-control problems, substance use, anxiety, depression, antisocial behavior.
Oppositional Defiant Disorder Example

John Henry is five years old. He was a fussy baby who was difficult to soothe. Now attending his third pre-school, he is in jeopardy of being dismissed again for his refusal to follow rules and for his angry outbursts. He argues with his peers on a weekly basis and refuses to cooperate with his teacher's requests. He is disobedient at home as well and seems to deliberately annoy others.

**F91.3: Moderate Oppositional Defiant Disorder**

**Key symptoms:** disobedience, anger, annoys/argues others  
**Assessment/further info needed:** Additional historical information as well as more data on his home situation.  
**Treatment options:** social skills training, individual and family therapy, parent child interaction therapy (PCIT), problem solving therapy, and/or school-based interventions  
**Prognosis:** Guarded if family history and parenting is positive for risk factors. Good if family completes evidence based practice.
**Conduct Disorder (CD)**

**Traits and Characteristics (3)**
*Repetitive & persistent pattern of behavior that violates the rights of others or major social norms in past 12 months (1 criterion in past 6 months):*

- Aggression to people and animals (Bullying, initiating fights, using weapons on others, rape/sexual assault, fire setting, cruelty)
- Destruction of property
- Deceitfulness, theft, manipulation
- Serious violations of rules (truancy, running away, curfew)

Two Subtypes
1. Childhood onset (< 10 y.o.)
2. Adolescent onset (10 – 18)

Specify if with limited prosocial relations (at least 2 of the following for 12 months):
- Lacking remorse or guilt
- Callous—lack of empathy
- Unconcerned about their performance.
- Shallow or deficient affect
Symptom behaviors increase in severity over time (lying, shoplifting, burglary, assault, or worse). However, it can vary by individual.

Unfortunately, those with childhood-onset have a worse prognosis, with increased risk for criminal behavior and substance-related disorders.

For the majority, CD remits by adulthood. Especially true for those with adolescent-onset and those with mild symptoms who achieve adequate social and occupational adjustment as adults.

CD into adulthood could then lead to a much more entrenched and far more difficult treat disorder. Can you name it?
Mary Rose is nine years old. She is adopted. Her biological mother suffered from depression and her biological father was abusive. Mary Rose was removed from the home at age three, but not before witnessing excessive arguing between her parents including physical fighting. Mary Rose spent time in foster care before being adopted three years ago. She has had difficulty adjusting to her new family and school. She initiates fights with her classmates and seems to enjoy intimidating them. She takes other’s possessions and destroys them just for the fun of it. Last week she rode her bicycle outside of her neighborhood and was gone for three hours. She lied to her parents about where she had been and couldn’t understand why they were worried about her.

**F91.1: Mild/Moderate Childhood-onset, Conduct Disorder**

**Key symptoms:** annoys others, initiates fights, derives pleasure from intimidating others, destroys property, lacks empathy, disregards rules, lying.

**Assessment/further info needed:** assess for co-occurring diagnosis (depression, learning disorders) and treat these if warranted.

**Treatment options:** PCIT, Multisystemic therapy.

**Prognosis:** Guarded given the positive biological risk factors, history of trauma and early age of onset.
Possible Trajectory for ODD & CD

Oppositional Defiant Disorder

- Defiant, argumentative, vindictive
- Angry-irritable

Conduct Disorder

Other emotional disorders

- Childhood-onset & Severe

Antisocial Personality Disorder
Possible causes for ODD & CD

Biological
- Parent diagnosed with: ADHD, Alcohol Dependence, CD, Antisocial Personality Disorder, Schizophrenia, Mood Disorder
- Sibling with a Disruptive/Impulse-Control Disorder

Environmental
- Harsh discipline
- Parental rejection/neglect
- Inconsistent parenting/multiple caregivers
- Large family size
- Single parent status
- Abuse: sexual, physical, emotional
- Parental criminality
- Familial psychopathology
Differential Diagnosis: Other diagnosis that share the symptoms

**ODD**
- Conduct disorder: a more extreme presentation of the symptoms beyond those seen in ODD.
- ADHD: important to know that failure to obey is not solely in situations that demand sustained effort and attention or demand to sit still.
- ...and several others. Refer to DSM-5.

**CD**
- ADHD: impulsive behavior is disruptive, but does not violate rights of others or societal norms.
- ...and several others. Refer to DSM-5.

*Note: ADHD is a very common disorder for both CD and ODD. Can be diagnosed in addition to CD or ODD.*
Intermittent Explosive Disorder- (IED) Criteria

Traits and Characteristics (Minimum age of at least 6 years) and must display either

- Recurrent episodes of failing to resist aggressive impulses that manifest as either verbal and/or physical aggression, **twice weekly** for a 3 month period (that do not result in actual assault and/or property destruction)

- Three physically aggressive behavioral outbursts involving damage or destruction of property and/or injurious to a person or animal over the course of 12 months

Important to note that outbursts are not premeditated and out of proportion to triggering event.
Intermittent Explosive Disorder - Other Criteria

- Other criteria stipulate that the destructive outbursts are impulsive (not intentional), and not to achieve some tangible objective (e.g. money)
- The degree of aggressiveness is deemed an excessive response to the provocation
- Symptoms must cause significant suffering, psychosocial impairment, or negative consequences (e.g. financial fees or legal consequences)
- Not better explained by another mental disorder or medical condition
- https://www.youtube.com/watch?v=9uQgyn0DQJs
In Brief: Pyromania, Kleptomania, Other Specified, Unspecified

- Both Pyromania and Kleptomania are related to building and relieving tensions by performing the respective behaviors (fire-setting or theft)
- Both Other Specified and Unspecified have symptoms that cause significant distress and impairment but don’t meet full criteria

**Key Features of Each Disorder**

- Pyromania- premeditated fire setting more than once, general fascination with fire
- Kleptomania- continuous inability to resist urge to steal
- Other Specified Disruptive, Impulse-Control, and Conduct Disorder- specify why criteria were not met
- Unspecified Disruptive, Impulse-Control, and Conduct Disorder– there is a lack of information to determine diagnosis
Treatment for Disruptive, Impulse Control & Conduct Disorders

- Focuses on Behavior
- Cognitive Behavioral Therapy
- Social Skills Training
- Anger Management
- Parent Management Training (teaching parents how to respond)

Not Pharmaceuticals
Take ten minutes to share your answers to the Bobby Jones Vignette and then answer the following questions:

1. What is your diagnosis for Bobby Jones?
2. What differential diagnoses did you consider and why?
3. What is your treatment recommendation and why?

313.81 (F91.3) Oppositional Defiant Disorder, severe severity
V15.41 Personal history (past history) of physical abuse in children
V62.3 Academic or Educational Problem
References and Resources


What Are Disruptive, Impulse-Control and Conduct Disorders?

**Disruptive, Impulse-Control, and Conduct Disorders (**Highly recommended**)**
https://www.youtube.com/watch?v=XH46Nm1QOcq

**Conduct Disorder Examples**
https://www.youtube.com/watch?v=THslP7pM9Oc&nohtml5=False
http://mstservices.com/resources/videos (Conduct Disorder Treatment)
https://www.cebc4cw.org/program/multisystemic-therapy/detailed (Conduct Disorder Treatment)

**Chris Brown After GMA Appearance (IED Example)**
https://www.youtube.com/watch?v=9uQqyn0DQJs

Video Link to help you understand the DSM-5:
https://www.youtube.com/watch?v=9OhVshzYvn8 (*Highly recommended*)
https://www.youtube.com/watch?v=D-vOGwN0-dI

Social Work Podcast and excellent critique of DSM-5:
http://socialworkpodcast.blogspot.com/2016/01/DSM5critique.html
Today’s goals:

- Review most important points from Homework 1
- Differentiate between Neurodevelopmental Disorders & Disruptive, Impulse-Control, and Conduct Disorders, & Depressive Disorders
- Understand their general prevalence and some assessment tools.
- Learn the symptoms of the most common Depressive Disorders.
- Practice diagnosing Disruptive, Impulse-Control, and Conduct Disorders as well as differential diagnosis.
Homework 1 Review
DSM-5 Disorders Revisited

Disruptive, Impulse Control & Conduct Disorders (DIC)
- Oppositional defiant disorder
- Conduct disorder
- Antisocial personality disorder
- Intermittent explosive disorder
- Impulse control disorder
  - Pyromania
  - Kleptomania

Impulsive Behaviors
- Lack of self control

BEGIN in Childhood
PERSIST in Adulthood

Neurodevelopmental Disorder
- Social: Autism, ADHD
- Motor: Cerebral palsy, Tourette syndrome
- Cognitive: Down syndrome, FASD

- Milestones = age *delay* ranges

First word
- 1st word

Smile
- No eye contact

Walking

Mamma! Dadda!
Depressive Disorders: Commonalities and Differences

**Commonalities**
- Emotional state (sad, empty, or irritable mood)
- Somatic symptoms/changes (aches, insomnia)
- Cognitive disturbances/changes (negative thinking, poor concentration)

**Differences**
- Duration
- Timing
- Presumed etiology
Depressive Disorders and Prevalence

- Disruptive Mood Dysregulation Disorder: 2-5%
- Major Depressive Disorder: 7%
- Persistent Depressive Disorder (Dysthymia): .5% - 1.5%
- Premenstrual Dysphoric Disorder: 2-6%
- Substance/Medication-Induced Depressive Disorder: .26%
- Depressive Disorder due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder
Assessment of Depressive Disorders

Assessment Tools
- Beck Depression Inventory II (BDI-II)
- Center for Epidemiologic Studies-Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Self-Harm Behavior Questionnaire (SHBQ)
- State-Trait Anger Expression Inventory-2 for Children and Adolescents (STAXI-2 CA)
- State-Trait Anger Scale (STAS)
- Anger Expression Scale for Children (AESC)

*ALWAYS assess for suicide risk (prior attempts at highest risk)
Reminder: Mood vs. Affect

- Mood is internalized, it is an emotional state that influences one’s thinking and behaviors.
- Affect is the external representation of a mood or emotion.
- This distinction is important, and the two may differ or be congruent (when affect and mood match i.e. smiling when happy).
Beware of Cognitive Tunnel Vision

What happens when you are in a sad mood?
– Negative thoughts-lead to negative feelings and reactions.
– Positive thoughts-result in positive feelings and behaviors.
Etiology of Depressive Disorders

There is no one attribute that causes depressive disorders. Some are:

- Temperament
- Stress level / life experiences
- Genetics
- Hormones
- Substance use
- Medical condition
The history of Disruptive Mood Dysregulation Disorder (DMDD)

CULTURE

U.S. CHILDREN MISDIAGNOSED WITH BIPOLAR DISORDER

BY STUART L. KAPLAN, M.D. ON 6/19/11 AT 1:00 AM
What makes children with DMDD from others?

The severity and regularity of their temper outbursts, which tend to be inconsistent with the situation.

- Parents would view this as the child “losing control”
- Not consistent with child’s developmental level (e.g., outside the range of the “terrible twos”)

Between outbursts, child’s mood is persistently irritable or angry, and the symptoms are not just a passing phase.
Diagnostic criteria for DMDD

1) Child must be at least six years old but not older than 18

2) Severe recurrent temper outbursts begin before age ten and inconsistent with developmental level

3) Mood between outbursts is persistently irritable and angry most of the day nearly every day

4) Temper outbursts occur 3 or more times per week for at least a year
   – Should not be symptom free for longer than 3 months

5) Temper and outbursts must be present in two of three settings (e.g., home, school, and/or with friends)
Bella is 9 years old and in the 4th grade. Bella’s mother sought treatment due to increasing disruptive behaviors over the past year, including non-compliance, physical aggression toward peers, and frequent behavioral meltdowns which resembled the temper tantrums of a much younger child. Tantrums included screaming, yelling, slamming doors, and crying. Bella and her mother both noted that it was difficult for Bella to “move on” when something angered her. She also noted that Bella had an underlying irritable mood, manifesting as Bella appearing “cranky” the majority of the time and the family feeling they needed to “walk on eggshells” to avoid upset. At school, at least one phone call home per week was being placed due to Bella’s refusal to comply or sometimes to even speak to her teacher for days at a time. Bella and her mother noted that Bella was generally well liked by peers and teachers, given that she was hardworking and funny, yet her current disruptive behaviors were causing significant interference in making new friends and meeting academic goals.

**F34.8: Disruptive Mood Dysregulation Disorder**

**Key symptoms:** Recurrent tantrums and irritable/angry mood  
**Differential diagnosis:** Why isn’t this bipolar disorder, ODD, or IED?  
**Treatment options:** CBT focusing on anger management & social skills with parent sessions. Psychiatric assessment for medication if CBT does not improve symptoms.  
**Prognosis:** Guarded if family history and parenting is positive for risk factors. Good if family completes evidence based practice.
Major Depressive Disorder (MDD)

- The most common psychiatric illness in mental health and medicine.

- So much so, it is worthwhile to commit the nine characteristic symptoms to memory.

“Depression Is Worth Studiously Memorizing Extremely Grueling Criteria. Sorry!” Initials stand for:

- Compare to page 161
  1) Depressed mood 4) Sleep change 7) Guilt
  2) Interests diminish 5) Motor Activity 8) Concentration
  3) Weight change 6) Energy 9) Suicide
Major Depressive Disorder (MDD)

Characteristics (5)
(5 symptoms during same 2 week period AKA episode)

- One symptom must be either depressed mood or loss of interest or pleasure.
- Not due to substance use or medical condition.

What if there is a significant loss (p. 161)?
How is MDD different from grief (p. 161)?
MDD Diagnostic Process

There are a number of specifiers for depressive disorders in order to help us focus on diagnosis and treatment. Refer to pages 162 & 184-188 in DSM-5:

- Single Episode or Recurrent Episode
- Severity/psychotic/remission

Descriptive specifiers:
- Psychotic features
- Anxious distress
- Mixed features
- Melancholic features
- Atypical features
- Mood-congruent psychotic features
- Mood-incongruent psychotic features
- Catatonia
- Peripartum onset (during pregnancy)
- Seasonal pattern
Persistent Depressive Disorder (Dysthymia)

Characteristics (2) *(2 or more symptoms for 2 years)*

- A mild, albeit chronic and persistent, depressed mood occurring most of the day for more days than not for at least two years.

- During periods of depressed mood, *at least two of the six symptoms must be present.*
  1. Poor appetite or overeating
  2. Insomnia or hypersomnia
  3. Low energy or fatigue
  4. Low self-esteem
  5. Poor concentration or difficulty making decisions
  6. Feelings of hopelessness

- Can’t be without symptoms for more than 2 months and can’t have manic episodes.
Dysthymia and the Diagnostic Process

Like MDD, there are a multitude of specifiers for this dx. Refer to page 169 & 184-188 of DSM-5:

- anxious distress
- mixed features
- melancholic features
- atypical features
- mood-congruent psychotic features
- mood-incongruent psychotic features
- peripartum onset

- Remission: in partial remission or full remission
- Onset: early onset or late onset
- 4 specifiers regarding major depressive episode criteria
- Severity: mild/moderate/severe
Treatment

Psychotherapy (individual, family, group)
- Cognitive Behavioral Therapy (CBT)
- Interpersonal Therapy (IPT)

Medication
- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Norepinephrine and dopamine reuptake inhibitors (NDRIs)
- Atypical antidepressants
- Tricyclic antidepressants
- Monoamine oxidase inhibitors (MAOIs)
- Other Medications
Maggie Weinzafpel Vignette (p. 113)

Take ten minutes to share your answers to the Maggie Weinzafpel Vignette and then answer the following questions:

1. **What is your diagnosis for Maggie Weinzafpel?**
2. **What differential diagnoses did you consider and why?**
3. **What is your treatment recommendation and why?**

- **296.22 (F32.1) Major Depressive Disorder, single episode, moderate severity**
- **V61.10 (Z63.0) Relationship Distress with Spouse or Intimate Partner**
- **V61.20 (Z62.820) Parent-Child Relational Problem**
- **V62.29 (Z56.9) Other Problem Related to Employment**
- **V.62.89 (Z60.0) Phase of Life Problem**
Questions to ask to assess Depressive Disorders

- Do you have trouble sleeping (falling asleep, waking up in the night, waking up too early, sleeping too much, nightmares)?
- How is your appetite (loss of appetite, overeating)?
- Are you having any trouble concentrating?
- How is your mood, in general? Are there times when you feel down, sad, angry, irritable?
- When you feel this way, do you know what is causing it? How long does it last? What do you do to feel better?
- Have you lost interest in things that you used to enjoy?
- Do you feel like things will get better?
- Do you have any thoughts of wanting to hurt yourself? (If so, have you ever done so? If so, when and how?)
- Have you ever thought that you didn’t want to live anymore or wanted to end your life? If so, how recently have you felt that way?
References and Resources


**Depressive Disorders from APA Website**
https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.dsm04

**What causes anxiety and Depression - Inside Out**
https://www.youtube.com/watch?v=tNsTy-j_sQs

**Inside Out: Emotional Theory Comes Alive**
https://www.youtube.com/watch?v=xXYhua4IwoE&feature=youtu.be

**Bella DMDD Case Study:**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5658126/

**Types of depression and bipolar disorder in the DSM5 | Khan Academy**
https://www.youtube.com/watch?v=eSXZwk8axmI

**Major Depressive Disorder | Clinical Presentation**
https://www.youtube.com/watch?v=3IUkw23paUk

**5 Types of Depressive Disorders**
https://www.youtube.com/watch?v=PbJB0ZIh4w

**Dr Bruce Perry - Early Brain Development: Reducing the Effects of Trauma**
Trauma- and Stressor-Related Disorders
Today’s goals:

- Continue building onto our DSM-5 Diagnosis Map
- Understand the general prevalence and etiology of Trauma- and Stressor-Related Disorders.
- Learn the symptoms Trauma- and Stressor-Related Disorders and how they differ from what we have covered thus far.
- Practice diagnosing Trauma- and Stressor-Related Disorders as well as differential diagnosis.
DSM-5 Disorders Revisited

Disruptive, Impulse Control & Conduct Disorders (DIC)
- Oppositional defiant disorder
- Conduct disorder
- Antisocial personality disorder
- Intermittent explosive disorder
- Impulse control disorder
  - Pyromania
  - Kleptomania

Impulsive Behaviors
- Lack of self control

Neurodevelopmental Disorder

- Social:
  1. Autism
  2. ADHD

- Motor:
  1. Cerebral palsy
  2. Tourette syndrome

- Cognitive:
  1. Down syndrome
  2. FASD

- Milestones = age delay ranges
- First word

- No eye contact
- Mamma, dadda!

BEGIN in childhood
PERSIST in adulthood

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Internalizing Disorders

Depression
- Depressed Mood
- Loss of Interest
- Motor Retardation
- Hopelessness
- Low Self-Esteem

Anxiety
- Fatigue
- Weight Loss/Gain
- Sleep Disturbance
- Agitation/Irritability
- Difficulty Concentrating
- Thoughts of Death
- Muscle Tension
- Shortness of Breath
- Chronic Worry
- Heart Palpitations
- Feeling On Edge
- Nausea
- Numbness
- Fear of Losing Control
Bipolar Disorders Review

- Mania
- Hypomania
- Normal Mood
- Cyclothymic Disorder (for the last 2 yrs)
- Sub-syndromal Depression
- Major Depression

Time (In weeks)

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Trauma- and Stressor-Related Disorders

The following disorders all require exposure to some trauma or stressful event.

- Reactive Attachment Disorder (Unknown but Rare <10% in clinical populations)
- Disinhibited Social Engagement Disorder (Unknown but Rare <20% in clinical populations)
- Post-Traumatic Stress Disorder (3.5% to 8.7%)
- Acute Stress Disorder (Depends on trauma: <20% for non-interpersonal trauma)
- Adjustment Disorders (5-20% in MH settings)
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder
Assessment of Trauma- and Stressor-Related Disorders

- Should include multiple sources of information: self-report, collaterals, medical/military hx, family hx.
- Should always do a risk assessment

Assessment Instruments
- Adults: Clinician-Administered PTSD Scale (CAPS), The PTSD Checklist (PCL)
- Children: Child Behavior Checklist (CBCL), The Disturbances of Attachment Interview (DAI), Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
RAD versus DSED

Both require neglect and a developmental age of 9 months.

**Reactive Attachment Disorder (2)**
- When distressed, rarely seeks comfort, protection, nurturance or support & does not respond to it when received.
- Symptoms prior to age 5.

**Two of the following:**
- Minimal social & emotional responsiveness to others.
- Limited positive affect.
- Periods of unexplained irritability, sadness, or fearfulness with caregivers.

**Disinhibited Social Engagement Disorder (2)**
- Approaches unfamiliar adults
- Willingness to go with an unfamiliar adults with little/no hesitation
- “Overly familiar verbal or physical behavior”
- Fails to check back with caregiver when venturing away
Differential Diagnosis

**RAD vs. DSED**
- Internalizing behavior versus externalizing behaviors.
- A child with DSED may be securely attached to caregiver.
- RAD symptoms *must be present before age 5.*

**ADHD**
- Not social impulsivity like ADHD, but social disinhibition
- Children with RAD/DSED do not exhibit inattention or hyperactivity.

**Autism Spectrum Disorder**
- Deficits in social communicative functioning i.e. intentional communication
- Presence of restricted interests and ritualized behaviors
RAD: Treatments

First, take the child out of abusive home and identify a family that will care for him/her. **Best practice treatments not yet established, but the combination of therapy, counseling and psychoeducation should be considered:**

- Family therapy: activities involving the caretaker(s) and the child, aimed at enhancing attachment bond as well as helping both the caretaker(s) and other members in the household understand the symptoms.

- Interaction Guidance: a strengths-based intervention in which the focus is on observable interactions, communication and relationship between caregiver and child, rather than either alone.

- **Avoid attachment therapies called “rebirthing”, “corrective attachment treatment”, or “holding.”** Has lead to several deaths and rejected as a treatment by APA and APSAC.
Responding to trauma is normal

- *Trauma* comes from the Greek word, ‘wound’

- When damaging events occur, it’s natural to feel powerful emotions. Although unpleasant, these emotions are normal and healthy.

- In fact, not getting this profound change from a traumatic experience is actually abnormal.
What makes an event traumatic?

1. It’s an overwhelming event. The level of distress an event causes and a person’s response, not the scale of the event.

2. Exposure involves actual or threatened death, serious injury or sexual violence to self or to a loved one (family or friend). Exception: secondary trauma (e.g., first responders).

3. The trauma results in persistent emotional reactions: fear, hopelessness, dissociation, anhedonia or dysphoria, among many others.
PTSD versus ASD Symptoms

Both require exposure to a traumatic event.

PTSD (≥6 symptoms for more than a month)

1. Intrusive re-experience: nightmares, flashbacks, upsetting memories.

3. Alterations in cognitions and mood.

“I felt so much, that I started to feel nothing.”

ASD (≥9 symptoms for 3 to 30 days)

2. Avoidance of stimuli associated with the traumatic event

4. Increased arousal and reactivity including:
   - Hypervigilance
   - Exaggerated startled response
   - Problems with concentration
   - Irritable behavior & angry outburst (w/ little or no provocation)

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PTSD & Acute Stress Disorder among children (6 years and younger) p. 272

- Learning or witnessing the traumatic loss of a parent or caregiving figure.

- Trauma-specific reenactment in play and/or drawings.

- All other characteristics similar to adults, as previously mentioned.
Factors that affect prognosis

Pre-traumatic factors
- Social support
- Experienced a previous trauma or major stressor (especially in childhood)
- Level of education
- Level of functioning
- Diagnosed with a mental illness
- Severity of traumatic event

Posttraumatic factors
- Inadequate coping strategies
- Social support
Treatment: Psychotherapy

- **Cognitive therapy:** Recognize the ways of thinking (cognitive patterns) that are keeping the client “stuck”—for example, negative or inaccurate ways of perceiving normal situations. For PTSD, cognitive therapy often is used along with exposure therapy.

- **Exposure therapy:** Safely face the frightening stimulus so that person can start implement effective coping strategies. Use of "virtual reality" programs that allow you to re-enter the setting in which you experienced trauma.

- **Eye movement desensitization and reprocessing (EMDR):** EMDR combines exposure therapy with a series of guided eye movements that help you process traumatic memories and change how you react to traumatic memories.

- **Group psychotherapy:** foster a community of support among other survivors such as Seeking Safety.
Treatment: Medication

- **Antidepressants:** Selective serotonin reuptake inhibitor (SSRI) medications sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration (FDA) for PTSD treatment.

- **Benzodiazepine:** Reduce feelings of anxiety and stress for a short time to relieve severe anxiety and related problems. Have the potential for abuse.

- **Prazosin.** If symptoms include insomnia or recurrent nightmares, a drug called prazosin (Minipress) may help. Although not specifically FDA-approved for PTSD treatment, prazosin may reduce or suppress nightmares in many people with PTSD.
Adjustment Disorders

Examples of everyday stressful events that most people can adjust to and cope with.

- An engineer discovers her husband has been unfaithful.
- A student learns he has failed an important exam and may lose a scholarship.
- The breakup of a seven year relationship with one’s first love.
- A store owner must deal with an impending bankruptcy and staff layoffs.
Adjustment Disorders

Symptoms may require outpatient help & involve difficulty adjusting to a stressful, non-life-threatening situation.

Must occur within 3 months of stressor and not last longer than 6 months. There are six types (specifiers):

- Depressed mood: dysphoria, tearfulness, hopelessness
- Anxiety: nervousness, jitteriness, hyperventilation
- Mixed anxiety & depressed mood
- Disturbance of conduct: violating rights of others, breaking societal norms
- Mixed disturbance of emotions & conduct
- Unspecified: for example, a person who has developed difficulty functioning at work
Common stressors associated w/ Adjustment Disorders

**Adolescents**
- School problems (60%)
- Parental rejection (27%)
- Alcohol and/or substance (26%)
- Parental separation/divorce (25%)

**Adults**
- Marital problems (25%)
- Separation/divorce (23%)
- Moving (17%)
- Financial problems (14%)

Should Adjustment Disorder persist after six months, the clinician should reconsider diagnosis.

- Example: Adjustment disorder w/ depressed mood may develop into major depressive disorder.
Treatment Options

Most adjustment disorders are transient. Therefore...

- **Supportive psychotherapy**: the therapist can help the client adapt to the stressor or gain insight of the stressor and the self.

- **Group Psychotherapy**: can provide a supportive social atmosphere.

- **Medications**: short-term (i.e., days to weeks) targeted at the predominant symptoms.
Differential Diagnosis

If criteria for ASD is not met, AD sx may occur immediately after traumatic event.

If criteria for ASD or PTSD is no longer met (and last no more than 6 months since trauma)

Initial stress reaction
Trauma-created symptoms last 3 - 30 days

Acute Stress Disorder
Symptoms persist for more than a month

Posttraumatic Stress Disorder

Adjustment Disorder
Nancy Kauffman Vignette (p. 205)

Take ten minutes to review the Nancy Kauffman Vignette in groups. Please do or answer the following:

1. Share your answer to the questions on pp. 207 – 208?
2. What is Nancy’s prognosis and why?
3. What is your treatment recommendation and what symptoms would you target?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
Nancy Kauffman Vignette (p. 205)

Take ten minutes to review the Nancy Kauffman Vignette in groups. Please do or answer the following:

1. Share your answer to the questions on pp. 207 – 208?
2. What is Nancy’s prognosis and why?
3. What is your treatment recommendation and what symptoms would you target?

_________________________________________________________________

309.0 (F43.21) Adjustment Disorder with depressed mood
V60.3 (Z60.2) Problem Related to Living Alone
V61.03 (Z63.5) Disruption of Family by Separation or Divorce
References and Resources


Short clips depicting PTSD:
https://www.youtube.com/watch?v=_O9HIQyUtx8
https://www.youtube.com/watch?v=D7L-Er1bZCo
https://www.youtube.com/watch?v=IOeQUwdAjE0

Social Work Podcast and excellent critique of DSM-5:
http://socialworkpodcast.blogspot.com/2016/01/DSM5critique.html

This American Life Podcast (Kid in gang neighborhood-32:30)
http://www.thisamericanlife.org/radio-archives/episode/484/doppelgangers

Transition to DSM 5: Anxiety, OCD and Stress related Disorders:
https://www.youtube.com/watch?v=zkLZD8bVe2o

PTSD Case Examples: