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Post-DSM: Social Work Values and Decolonizing Assessment

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Peter Sobota [00:00:10] From the University at Buffalo School of Social Work, welcome to the InSocialWork podcast. I'm Peter Sobota, and it's good as always to have you along, everyone. Among providers of mental health services, including social workers, psychiatrists, and psychologists, the DSM-5 is the most utilized resource for assessing and diagnosing mental health problems in the United States, and actually much of the world. That said, the DSM is not without its share of controversy and concern. Especially for social workers. On today's show, our guests, Sharyn DeZelar and Lisa Borneman will engage us in some critical thinking about the DSM, decolonizing assessment and diagnosis and reconciling its medical model orientation with social work values, mission, education and practice. Doctors DeZelar and Borneman will offer alternatives and provide examples of a collaborative orientation characteristic of social work values, a decolonized framework for assessment and conceptualization, as well as the importance of a trauma-informed care perspective. They'll also offer suggestions for social workers attempting to navigate a world in settings where the DSM is the driving force in assessment, treatment, and reimbursement. Lisa Borneman, DSW-LICSW, is assistant professor at the St. Catherine University Master of Social Work program. And Sharyn DeZelar, PhD, LICSW, is also assistant professor at St. Catharines University in the Master of Social Work program. Hi, Lisa and Sharyn, welcome to In Social Work.

Sharyn [00:01:50] Hello!

Lisa [00:01:50] Hello!

Peter Sobota [00:01:52] Hello, thank you again, publicly, for your patience in trying to schedule this. All props to both of you. Thank you. So today, I'm going to invite the two of you to do some, well, you've already done it, critical thinking about the DSM, decolonizing assessment and diagnosis, especially in social work practice. Maybe even think critically about social work in general, including our values, mission, and practice. You know, simple stuff. You know it's just stuff that's just easy to figure out. So to get to it straight away, especially when it comes to assessment and as a diagnostic tool for social workers, what is not to love? About the wonderful and beautiful diagnostic and statistical manual of mental disorders.

Sharyn DeZelar [00:02:57] Uh, so much, Peter, there's so much to talk about. Um, what, uh, this is Sharyn speaking. Um, Lisa and I can talk about this for a while. The reliability is bad. It's, um, the, for some of the diagnoses, um... Including major depressive disorder and generalized anxiety disorder, which we know are two of the biggest diagnoses that we are often engaging with. Reliability hovers around like 30%. Now, none of us would ever,

would be able to get research studies published with those numbers. And yet, this is what we're told is our, you know, kind of our guidebook, right? For like how to determine the best diagnosis for folks.

Peter Sobota [00:03:58] Yes, I've heard it referred to as the Bible of mental health care practice. Yeah, that's a bad Bible. All right. Would you like to, would you like to chime in Lisa?

Lisa Borneman [00:04:09] Yes, yeah, this is Lisa. So, I think the other, well, there's so many things about it. But, yeah. One other thing that comes to mind quickly is it, the DSM has a tendency, because it's based in the medical model, it pathologizes, you know, like responses to trauma, it pathologizes and it doesn't incorporate the trauma that we see. So like PTSD is really our only way of identifying trauma and that doesn't fit everyone, right? It was normed. So, and so many of our diagnoses are normed on a very specific population, typically white, often male, you know, specific age groups, right. So it's not normed on. And yet it's used universally, right? And so it misses so much when we think about folks from the BIPOC community, when we're looking at, you know, like anyone that is not white, right, white, predominantly male, it really, it's not speaking to that group. And so, and PTSD was mostly normed on veterans. Very helpful. And... Not everyone who has you know most people who have trauma are not having trauma from that so it's um yeah and and then it pathologizes responses like normal responses to not you know unusual experiences.

Peter Sobota [00:05:54] Yeah, and that's kind of, at least my understanding, that's how the medical model works, is that you conduct a certain kind of assessment to arrive at a diagnosis, and then the diagnosis dictates how you respond to that problem. So it's this kind of... Like baking a cake recipe approach to the medical model doesn't seem like the best fit for human beings who tend to be a lot more interesting than most cake recipes, yeah.

Lisa Borneman [00:06:27] Right, we're far more complicated.

Sharyn DeZelar [00:06:29] Right. And, and I think related to that piece, this is Sharyn again, related to that is, you know, like the idea of the original purpose of the DSM, I think was much more one that we can get behind in terms of aligning with social work values, right? The original idea was more just, you know, help clinicians understand. Different diagnoses and mental health conditions as well as potentially for the purpose of guiding, then what are we gonna do about it, right? However, over the multiple evolutions and revisions of the DSM, it has been co-opted in a way. In fact, in DSM three, I actually pulled up the quote because Lisa and I have talked about this. There was at the beginning of the DSM, in the DSM 3, there's actually a caution on page 12. If you've got an old copy, you can go look it up, but there's a caution at the beginning of it that specifically states that the use of this manual for non-clinical purposes such as determination of legal responsibility. Competency or insanity or justification for third-party payment must be critically examined. Excuse me. Must be critically examine. And it actually says that at the beginning of the DSM. And then, but for DSM4, they took that out. Yep. So now, so they used to caution us saying, this isn't supposed to be used for insurance billing. This isn't suppose to be used for determining sanity in court hearings. Like it's meant to be a clinical guide, right? But clearly, we have swayed from that original purpose. And there is a lot of money behind the DSM. And there are a lot people that are making an awful lot of money based on this book getting used and used for billing purposes. And so when we think about our social work

values, we're unfortunately in a situation where we're having to use this system because our insurance providers require it, and yet ethically it doesn't line up with our values.

Peter Sobota [00:09:04] Yeah, later on, I hope, yeah, I don't want to do it now, but later on please remind me, I want to get back to how do social workers navigate this tension between acting in accordance with our values and ethics, but also perhaps working in settings where this is driving practice and maybe walking that kind of tight rope. So I don't want to go there now, but I. It's just the light bulb went off while you were talking, and I don't want to lose it. Yeah, we can do that. In DSM II, which I learned when I was in graduate school, I was very surprised to learn that homosexuality was a mental disorder. I think they had it down as, I think, I remember words like egocentonic or egodistonc or something, but I also remember it being fascinating that members of the APA itself started sending letters to the team saying, by the way, I'm a gay or lesbian person, professional, a psychiatrist, and there's a whole bunch of people like me in this field. And it kind of disappeared over time. So it's obviously a work in progress.

Sharyn DeZelar [00:10:23] Yeah, that's a good example of some really great advocacy that has happened by communities to get that removed. There's a great documentary called Cured, and we actually have all of our students watch that documentary as like a very, an opening. So this is in the course in which we teach students about clinical assessments and diagnosing. Bye. And we watched this documentary at the beginning, which is about how homosexuality was in the DSM and the advocacy efforts that got that changed. And it really shows how we do have some ability to make some changes if we work together.

Peter Sobota [00:11:08] Yeah, and you bake that in early as your students are learning about assessment. See, that's...

Sharyn DeZelar [00:11:14] We start critical, we start critical and we don't ever stop.

Lisa Borneman [00:11:20] Yeah, and that's that's like their first one of their first clinical classes that we have is that so that they're they all start with that sort of view.

Peter Sobota [00:11:31] Yeah, I mean, and also talking, I think, I'm not a fan of the DSM, if that's not already obvious, but we've kind of covered in some ways that I think the easy part about our conversation today, maybe more well-worn. But how about talking about the DSN in terms of its kind of inadequacies from a decolonized. Approach to the world that we live in and our existing structures. Where does it fall short from a decolonization point of view?

Lisa Borneman [00:12:13] But I, this is, they said again, I think, you know, I touched on that a bit earlier, just that, you know, we're who, who the, it's normed on and the universality, the way that we treat it as a universally applicable to all. And the fact that like, even though it has added sort of a cultural find quotes and air quotes cultural aspect to it. It's not like it's being generous and the sort of cultural pieces that they put in there are, they're not useful. It's, and it's sort of this, these extreme examples of like a cultural difference in how something might show up. So it really doesn't allow for, for that piece of it. Like it doesn't it allow for difference within a human and how they show up. Whatever symptoms they have. And it's symptom based, right? It's based on what's wrong with you versus what happened to you or what strengths you have. And so it's only cataloging symptoms and not looking at, you know, I think about specific things like oppositional defiant disorder or borderline personality disorder, right. Those are two that are often folks

who receive those diagnoses are often folks who've experienced trauma and fairly extreme trauma. And so the behaviors, and it's based on behaviors versus actual symptomology. So like if we're thinking about depression where you're not eating as much or you're eating more or your sleep is impacted or your mood is impacted, right, it's all, it's based on those things. Oppositional Defiant Disorder and Personality Disorder specifically are more behaviorally focused. And they're, but they're not couched in a way of like, trauma is not included or considered as a part of that diagnosis. And so again, we're pathologizing a behavioral response to something. And then once you get these diagnoses, like you're really, there's such a stigma.

Speaker 5 [00:14:32] They're yours too, right? They go with you.

Lisa Borneman [00:14:34] They go with you forever. And it's so hard to get that removed. And if you're given that diagnosis sort of erroneously without real, you know, this is the other thing. I'm going to toss this in really quick. Back in the day, when I first started looking at diagnoses and stuff, I got the little mini, you can get a little mini companion book that talks about like, How do I diagnose? And one of the statements that was stated in there is, you should be able to make a diagnosis, a full diagnosis in 15 minutes. I was shocked. I was like, you have got to be kidding me right now. Like 15 minutes?

Peter Sobota [00:15:18] Do you get to talk to your client for a while?

Lisa Borneman [00:15:20] Longer than 15 minutes or? That is insane. The fact that many of us have to make diagnoses to 90 minutes is too fast. People aren't even opening up to you yet. So you can get these erroneous diagnoses based on behavior, based on things that have been reported to you and not even know the full story from a client because who is able to, even in 90 minutes, really get the full story of what is going on for someone.

Sharyn DeZelar [00:15:52] And then I would like to add, because you asked Peter about decolonizing, I think that then even taking everything that Lisa said and looking at it collectively for groups of people who systemically are oppressed, then. So now we're not we're not just talking about an individual who's had some things happen to them. But when we get large groups of. You know, particular, you know, folks from particular racial and ethnic groups, folks, you know that are have specific common experiences in the United States that are extremely oppressive and prejudiced and racialized, right? And then so we have these huge societal issues. And then we use the DSM. To give people individual labels that are heavily stigmatized because of society's problems. So like these are society's problems and then they are individually, we are individually pathologizing people for society's problems.

Peter Sobota [00:17:05] 100. Yeah, gee, I can't imagine why people who aren't white are reluctant to seek mental health services or arrive at the door with general distrust. I have no idea how that happens.. it's very, very confusing... You know, while the two of you were talking, I was kind of just going through my memory banks about things that I just haven't questioned, like the 50-minute therapeutic hour, for example, or the fact that we value insight and cognitive processing of ideas to solve problems. I had the good fortune of spending some time in Hawaii and living in a Hawaiian neighborhood with native, where I was the minority, the Haole, without soul. And their approach to therapy was fascinating. It was storytelling. It was experiential. It was family, a troubled family member going to live with another, not even a family member, but a neighborhood. Trusted group. And I just thought. Talk therapy's not the only place where it's at, but that's really what we have come to accept without questioning. Which I think fits all of the points you were making just really

perfectly. All right, so we've done, well, you've done a very good job at doing the critical thinking about the status quo. And now always comes kind of like the hard part, right? So what do we do about it? So You've laid out some of the limitations. Do you have some ideas about what the alternatives are? Yes, we do get the magic wand laying around here somewhere. Okay.

Lisa Borneman [00:19:14] I mean, I think one of the things that we one of the the models that we talk a lot or frameworks that we talked a lot about in our courses is power threat meaning framework. And that is a framework that focuses in on what has happened to a person and how power has impacted them in their lives. And so it's there are six pieces to it and help me out because I probably won't get them all. So it's power, threat, meaning response, skills, thank you, and story. And story. Story. Interesting. Yeah. And so there are, there's sort of a way of talking about each of those with the person. So, it's sort like, you know, what, how has power impacted you in your life? And then the threat is you know, what did you, what, what did you do about it? I should have my slides up to remember, like I get a mixed up.

Sharyn DeZelar [00:20:18] How did it affect you? The threat is yeah how did it affect you

Lisa Borneman [00:20:23] And then the meaning is what did you make of that? Like what meaning did you ascribe to that? And then, the response is like, how did you get through? Like what did we do to survive? And then skills are, what are your strengths? And then story is, what is the story that you wanna tell about this? And so it's a way of opening up and deepening the conversation. And we teach this to all of our students and it was so great in our clinical methods class, one of the students that I had in that class said to me, you know, I tried the power threat meaning with a client and she said, I could not believe how much it opened up the conversation and where we were able to get versus this sort of prescribed you know, assessment, biopsychosocial assessment of like, where did you grow up? How was your birth? You know, all of those things, like actually allowing the person to tell their story, right? Storytelling is so important and so key to most of us. Like, I think that it's effective with many, many groups of people. But for communities where storytelling is... Key to their health and their tradition, it's even more important that we're able to open this up in a way that is not medical model, not this sort of very clinical way of looking at it.

Peter Sobota [00:22:12] Sharyn, would you like to add anything to that?

Sharyn DeZelar [00:22:14] Yeah, yeah. So the way that we use this, again, this power threat meaning framework, you know, they're doing some great, great things. And it's from the British Psychological Society. And, and all of their stuff is free, right? Like, you can just see the difference in the model of a for-profit system like we have in the United States, where it's, we have to a lot of money. To have this book that we're supposed to use and that people have to pay a lot of money to get the diagnosis and then for the treatment, right? Whereas you've got different perspectives that are much more about community level healing in their values and they develop a framework and then they just give it away and say, please use this. So just even that foundation and those values is very different. So, yeah. Any of you can go look this up and get the resources and use it. So what we really are trying to do like with our students in our class, but also we've done some workshops with social workers in the community as well. What we're really trying to have folks do is like really de-center the DSM in terms of its importance. You might have to use it. Like, you might have to use it if you're billing insurance. They might require it.

Peter Sobota [00:23:48] You know, yeah, I'm sorry for interrupting, but that was the one thing that I think we left out of the critical thinking, or at least I did, is how much that thing drives insurance reimbursement. Right. And I think that's a point you're making, but I want to make it explicit. Go ahead. Sorry.

Sharyn DeZelar [00:24:07] No, yeah, no, that's absolutely it. So we might have to use it. But let's demystify it by, one, recognizing it for what it is. It is a very imperfect book. And what it is, it's a tool or it's a process that we have to use because the insurance company requires it for billing. So let's set it to the side. And instead, we're going to focus our assessment using this model that Lisa so wonderfully described of really focusing on someone's lived experience and their very understandable reactions and responses to things that happen to them and helping them really craft their story. That's where we center things. Then maybe as professionals, after the fact, we can look at that book, we can look at the DSM and say- Well, have you noticed-

Peter Sobota [00:25:15] Have you noticed we're not naming it anymore? It's like three and a half.

Sharyn DeZelar [00:25:18] Right, right, the book. The book that shall not be named. Should we say that? So maybe if we just see it as a billing tool. Then that's part of it. I mean, and I think that relates to another one of the critiques that we may be indirectly talked about, but didn't specifically name yet, but is important to name is like, if one of the purposes of the DSM is to give us clinical guidance, right? So like, I know the person I'm working with is sort of in this depressive category. Okay, then that supposed to help give me some clinical guidance for like what we might do. There's been no, like there isn't really research evidence that backs that like whether a person got a diagnosis of major depressive disorder moderate or major depressive disorder severe that you would necessarily do anything differently or if they had PTSD with depressive symptoms, right? Because what we're treating is the symptoms. When we're working with folks, for treating their symptoms, not their diagnosis. So the fact that the DSM has all of these clinical cutoffs, that the clinical cut-offs are another really big critique and problem. Because if you got, let's say you've got four of these symptoms instead of five and you needed five to get the diagnosis, does this mean that the person couldn't benefit from the help, right? And so... In that sense, whether we get exact diagnosis in terms of what we do for our work with people, it doesn't really matter. It matters for billing. And because if you have an adjustment disorder diagnosis, you can only bill for these certain number of sessions. But if you had major depressive disorder, you can have more. There's the recipe of them. Yeah, those are really the only reasons why it matters which diagnosis you give is so that you can get people the services that they need. In terms of how we respond to people, it's based on their symptoms.

Lisa Borneman [00:27:43] What they want to focus on also. I mean somebody who comes in with complex trauma is not necessarily ready to like work specifically on their trauma yet like there may be other things or because we don't have a complex trauma diagnosis we may have to diagnose with whatever symptoms are most prevalent right and so but we may not work on that so maybe like anxiety is the that is showing up. But so we that's the diagnosis that we have to go with because there's not a complex but we know there's a trauma history so then maybe we are focusing on the trauma because that will alleviate the anxiety right so it isn't necessarily telling us what to focus on it is just saying like here i need to get like i need sessions because this person was dealing with some stuff right so it is really um well i i just want to toss in one thing about like like how do like the process of diagnosing and like how we can like because we still have to do this right

we still. Have to use this DSM one thing that I do with clients is that I talk them through I've done it on both sides like one side they come to me and they're like I have these diagnoses but I don't know what they mean okay well let's talk about them let's see if they're even relevant for you and on the other side okay so. You know, I'm up front in the beginning like we will have to date like we have to have a diagnosis at some point, you know, we have this minute this much time until we can and then I have to have a Diagnosis because that's that's the system that we're working under. So we talked through it. It's like you know here's kind of where I'm heading. I want to talk with you about like how does that feel to you. What do you think about that like here's here are the reasons why I think that we can head in that direction. But you know, I I want to be transparent with the person as much as I can be There are times when maybe you feel that out as a clinician. But in all cases where I am able, I want to be able to be really transparent about that process and what it looks like and what that means and how it's used beyond just this billing practice.

Sharyn DeZelar [00:29:54] Yeah, and that's really a decolonizing approach, right? We involve the person, we kind of arrive at a diagnosis in partnership and we discuss the implications, right, of certain diagnoses and like what could be some of the downsides to having this label. And we can, that's one way to work within a system. That is problematic, but implements some decolonizing strategies, right? Like to just be more collaborative, be more collaborative in the diagnostic process and informing people of things, right. And here's the thing, like we're kind of like laughing and making faces here on this Zoom call about this. Yeah. I wish people could see this. Yeah. No, I know. Right? Like... We're social workers. Of course we should be collaborative, right? And of course we be informing people about the consequences of certain things. But historically, if you're super entrenched in a medical model system, that's not happening. I'm sure there's some clinicians out there that are doing it and are doing a great job. But just in terms of collectively, this isn't how we're taught to practice.

Lisa Borneman [00:31:14] Right, yes, it's not, we're not rewarded for that, right? We're not, that isn't something we're encouraged to do. I think people are doing it, and I love that people are going it. And I think that we're always encouraged to that.

Peter Sobota [00:31:25] Yeah, this is this is what I especially, you know, we're all educators. So I think this is one of the things that I think students need to hear is that here's the the reality of the playing field. Now, you are a social worker. We have a unique value system. We have way of looking at the world that is uniquely ours. How are we gonna navigate that if we wanna be clinical social workers, which so many, at least of our students, want to be? And helping them navigate that slippery slope, I think is super wise, for sure. Um, to, you know, to go back to your, um, your, uh, Lisa, I think it was your comments about how, you know, you use your explanation of how assessment and diagnosis was done, sounded very convoluted and it sounded like you were almost, it was ripe for. Not doing the right thing, but doing what works to meet the right thing in terms of like, not giving somebody the the most accurate quote diagnosis. But but when the diagnosis is linked to length of treatment, it's almost invites you to play around with the so called classification system. It's it just seems backwards to me.

Lisa Borneman [00:32:57] I agree. I think it is backwards. And it is, you know, it's not like you're sort of fishing for a diagnosis, like, okay, what can we make up? You know, like it, they need to meet it, right? I mean, that is, that's what we're looking at. And I mean I think I have students sometimes who will say, well, I'm just going to give everybody adjustment disorder. I'm like, well you're going to do them a disservice, right? You're going do them a

disservice because you get six sessions for that. And if you have somebody who's really dealing with some serious trauma and it's showing up as you know Maybe it's shown up mostly as depression, right? Like that's kind of where because again complex are if they don't meet PTSD. Yes, we can do they don not otherwise specified blah blah blah all those things but like we want to we want get out what is actually the the most troublesome piece of this and You know what? Criteria does that meet related to the DSM, but yeah, we're not, yeah, I don't want to give everybody adjustment disorder because it's doing them a disservice, like service-wise it's them a disservice.

Peter Sobota [00:34:08] Um, years ago in my practitioner days, I was a clinical supervisor at an outpatient clinic and I had social workers, we, we had social workers on the staff who I think were proud to be social workers and wanted to be as true to those values as humanly possible, despite the fact that we were in a heavy, we were a hospital base, so you can imagine the medical model was, was worshiped. Um, and as their supervisor, I had to review the treatment plans. It was an avalanche of adjustment disorder. It was like they got together and decided this is the least damaging diagnosis, but they they did not understand the piece that you talked about. That it's also the least amount of coverage that you're going to get. So it was like you couldn't win. You know, we've been focusing a lot about like on clinical work and preparing social workers in terms of their own kind of individual assessments, and maybe intervention plans. But, you know, because we're social workers, you know we kind of dig the macro piece as well. You know I'm just wondering, do you two have thoughts about what kind of systemic and political activities that social workers who care about what we're talking about right now could advocate for or get involved with because, you know, these things go on on levels that just filter down to individual social workers and practitioners. Do you have any thoughts about political or systemic changes that we might get involved with.

Lisa Borneman [00:36:00] We need more social workers on the APA, the people who are working on the DSM. And we do have opportunities to comment.

Peter Sobota [00:36:11] And that's a great idea though, right? I mean if you think about it how many of us do Maybe academics do but I'm I don't know if a whole ton of practitioners do that and they're the people doing the work

Lisa Borneman [00:36:24] yeah and I really believe like social workers make up like we do the most diagnosing and so really we have collectively and this is I think the issue is that we get and we talk about I talk about this in class I'm sure Sharyn does too you know like it's really easy when you get into your professional work to get so micro-focused. That you forget about that bigger picture and you forget to stand up and look around every once in a while and go wait a minute like I'm seeing things here that on a larger level really need intervention and so that being collective because right as one person it feels daunting it's like I don't know what I can do as one here in this but as a collective of people so getting You know, joining groups that are trying to affect change, like they're out there, there's all kinds of groups out there that are working on different aspects of social work and trying to make changes to our profession, but also to the places where we intersect, right? And so getting involved in those can give you a sense of, you know, oh, we're all in this together. Like we do all want this change to happen.

Peter Sobota [00:37:57] Thanks. Do you want to chime in on this at all, sir?

Sharyn DeZelar [00:38:00] Yeah, I mean, and I think some of the good places for that work could be like getting involved in your local chapter of NASW or maybe, or like in

Minnesota we have like a clinical mental health. Clinical social work, set society, right? And so like being involved with those groups and encouraging those groups to be taking action, taking a stand, you know, push back for, you know in the, I think I'm thinking of like at the legislature, right, like with insurance companies, let's try to argue for more than six sessions for adjustment disorder, right? I mean, there's lots of places where we can and should be getting involved. And again, sometimes that does feel overwhelming when we're out there doing the work. And so that's why I think joining in on some of those other professional organizations makes it easier to be a part of some collective work because you got your numbers behind you there.

Peter Sobota [00:39:15] Yeah, while the two of you were talking, what drove my question that I just posed to the two of you was this thought of, wouldn't it be a great start, one of many interventions, if we could decouple reimbursement from diagnostic labeling? And that reimbursement would be, coupled more directly with the story, for example, that you were, you know, you're just going to be all sorts of pushback on that. But it's not like what we have in place right now is the greatest thing since ice cream, right? It's just like, you know, let's let's give something different a try. And it might even be more accountable.

Sharyn DeZelar [00:40:01] And there are examples of that happening out in the community, too, right? Like, I mean, in our in our community, you know, we're in the Twin Cities area in Minnesota. You know, post the murder of George Floyd, there were. Were some collective efforts to respond to community mental health right like right in our backyard of where this tragedy occurred and there is um a lot of unrest and um just real hurt and community level trauma and and there were groups of people that came together to look at Hey, how do we, how would we? Support the community's mental health as a community, right? And there are some really cool, like, grassroots-based mental health providers that are still in operation, that kind of developed post the murder of George Floyd in the Twin Cities that don't use insurance. And so they've kind of collectively come together to find alternative funding streams to support the mental health work. And so therefore they do not bill insurance. They do provide services to community members on sliding fee basis, and then they have some alternative funding streams. And because of that, they're not bound to those, we must come up with a DSM diagnosis after the first session, and they don't do it. And they assess, they absolutely still assess, right? Cause that's good practice. But their assessment isn't based on the DSM and they don't even use it.

Peter Sobota [00:41:56] Interesting.

Lisa Borneman [00:41:58] It exists. It exists!

Peter Sobota [00:42:01] What's up, Lisa?

Lisa Borneman [00:42:01] Can just say the assessment take can take longer like the person gets time to actually open up and oh develop trust with the clinician before having to you know show show their whole hand like I just it just doesn't even make sense to me like it's it's so I used to do work on with a drop-in center for young people who were houseless and we talked about that all the time, like we had this assessment that we wanted to go through but we we always said like you will learn all that you need to know over time as the person is ready to open up to you and that is how it should be allowing the person time to build trust and recognize like oh you are a person who I can reveal things to and be honest with and then we can figure out where you know like that's how we figure out how to move together and we. But you can't do that in 90 minutes like i just it's

so it's such a false narrative like it's such a false way of thinking about about the work it just makes them crazy

Peter Sobota [00:43:11] Absolutely. Yeah. And it actually takes me back to when you were talking about the power threat meaning approach. A lot of what you, I wasn't familiar with that. And when you were talking it, it reminded me a lot of narrative therapy. You identify the limited story, you help a client expand the story and then re-author it. That takes a little bit, right? And actually the evidence around narrative therapy is pretty good.

Lisa Borneman [00:43:48] Okay, I just I have to just tell you something really quick because it made me laugh so much. So I started with a new company doing some I do private practice on the side and when I'm not teaching and the person I was interviewed to become part of this sort of larger group and the percent said well what evidence based practices do you use and I said and all like first off I'm like oh packles up hate that word hate that words so much And, and I said, well, I'm, you know, overarching. I'm a narrative. You know, I use narrative. We need like really evidence-based. I'm like, lady, there's a journal on narrative theory. You guys are lost. Like that is evidence-base practice. I was just floored that it was like-

Peter Sobota [00:44:34] They weren't into the postmodern movement that is driving psychotherapy nowadays.

Lisa Borneman [00:44:37] I said, well, what do you mean by evidence based? She goes, well CBT and I'm like, okay, those are not the only things. And I will tell you those don't work with everybody. Not universal, not universal. So, you know, then it's like, okay, so now I'm working with someone. I have to like, do I use some, you know, elements of CBT? Of course I do because, you know, it's about thinking and like, how our thoughts and our, you know, intervention, whatever, blah, blah. But it's just so ridiculous to me that it's like, oh, narrative's not what narrative's not. So yeah, I mean, narrative, which has been around forever, is not, it's not considered evidence-based everywhere. And yet it is. If you mean evidence-base, well.

Peter Sobota [00:45:20] Sharyn looks like she's dying to say something, sorry.

Sharyn DeZelar [00:45:24] No, it's okay.

Peter Sobota [00:45:26] So, all right, we're starting to get in the neighborhood of our time limit here. And, um, You know, I was actually thinking, you folks are from, you know, Minneapolis, and I was thinking about George Floyd and that period afterwards where we kind of, there was that moment where like understanding and actually contextualizing, at least in the national discussion seemed to, and Black Lives Matter movements and all that. And then it kind of. Away, I think. And you know, here in Buffalo, you know a young man drove from the middle, and this is a large state to drive across, drove like three hours from the middle of the state to western New York, specifically to shoot black people in one of our supermarkets and ended up killing 10 people. And it was pretty much the same, You know, everybody came together. There was this. Brief interlude of understanding. And then we kind of went back to being who we are, a very segregated city in many ways. So I think what I what I see currently are Even many social workers and people who are like-minded, they seem almost immobilized and kind of almost resigned to the fact that cynical, much less, you know, transformative change related, for example, to decolonizing frameworks isn't even possible. Forget it. We don't live in that climate. You've said a lot

today, but would you like... Do you have any kind of encouraging words to keep people moving forward beyond all the things you've said so far or how you do it, quite frankly?

Sharyn DeZelar [00:47:34] I think one thing is that we need to be talking about it, like with each other, we need give our students space to talk about it. But you know that demoralized feeling, right? We see that a lot, we're seeing that a a lot. I'm seeing that, a lot more lately, especially given that we're in the middle of a shutdown and nobody knows what's gonna happen with. With food support and all sorts of things. And so we have lots of students that of course are coming to school and they've just left their practicum placement and they're demoralized. And they say, why do this work? Or like, I'm not gonna be able to practice in the way that I wanna practice. Why are we even reading this book? So we read we all of our students read Decolonizing Therapy by Jennifer Mulan and they read it and then they discuss it in like a book club format and so we you know we make space for them to talk about it and really having those conversations I think during these these tight times or the tight isn't the right word, but our current, our current. Times of opposition to progress, right? To making any real major systemic change for the good. Like that's why we need to be on the inside of those systems more than ever. Being that safe voice within the problematic system and that safe space. Doing we can there's lots of little micro level things that we can do during these times right like how we do our our assessments how how we engage as a how we practice as a team we actually have a lot of control over that and so we can continue to really try to practice in these values and we need to talk to each other and give um space for people to talk to each other and form community and so that we can like you know community can take care of each other. That's how we're gonna get through.

Peter Sobota [00:50:08] Yeah, I think we're at the point where it seems like the political systems are not gonna do that. So we're gonna have to do it

Sharyn DeZelar [00:50:15] Right

Peter Sobota [00:50:16] Yeah, here at our school in Buffalo, we're really struggling with, we feel that we are not as engaged with the community as we could be. You know, we're like this campus stuff. So, but to your point, bringing together students, faculty, practitioners, and community leaders, that's the way to do it. And we should be good at that. That's like our mojo. So, yeah. Thank you. So we are now up against our barrier, our self-imposed barrier for time, but I want to leave you with parting thoughts. If there's anything that we didn't get to that you really want to lay out or if there's a summary statement that you'd like to make, Here's your chance.

Lisa Borneman [00:51:06] I think just the only thing I really wanted to say is just try something, like one thing, it doesn't have to be huge. How you set up your office to make it inviting to multiple people, like anything. Just try something. And as Sharyn said, get involved, be with other people. And that we affect change by working together and being collective.

Peter Sobota [00:51:36] And yeah, if I could, I'm sorry, Sharyn, if we don't have to reinvent the wheel, I mean, I don't know if we need to remind people that there's a big difference between treating complex trauma and trauma-informed service delivery, and a trauma-informed service delivery system would be ideal to promote the ideas that the two of you have been talking about. So we don't have to invent it. In many ways, it's right there for the taking. Sorry, Sharyn. Thank you for being patient.

Sharyn DeZelar [00:52:06] No, no, that's okay. The only thing that I wanted to add was that and and this is Yeah, just adding to the other piece that we've been talking about is really to lean into our professional identity as social workers. Like we are about systemic change. We are about social justice. And so that's why being together, right? Like having some peer consultation groups, talking about how we're doing this practice in these times, right. Like this is, that's how, that's what's gonna hold us accountable to our professional values and our practice standards, right? If we, you know, we can hold each other accountable and as Lisa said, it can be something really small that you do. You can do small things to make a big difference so that someone feels safe and heard.

Peter Sobota [00:53:03] Yeah, and a lot of us, including me, we need to get, we have to reconcile that often the pace of change is glacial and we have to be in it for the long haul. It's not just going to a march and then saying, whoa, that was fun, I'm jazzed by that. But okay, what do you do after?

Sharyn DeZelar [00:53:24] Right.

Peter Sobota [00:53:26] Well, you know what, thanks to both of you. Thanks for joining us. Thanks for spending the time. It was an absolute pleasure.

Lisa Borneman [00:53:36] Thank you, Peter. It was really fun.

Sharyn DeZelar [00:53:38] Thank you

Peter Sobota [00:53:41] The inSocialWork podcast team is Steve Sturman, our tech guru and web and media director. Ryan Tropf is our graduate production assistant, recording editor, and content contributor. Say hi, Ryan. (**Ryan:** Hello!). And I'm Peter Saboda. We'll see you next month, everybody.