

**Dawn Apgar**

# Social Work Licensing Clinical Exam Guide

Fully  
Updated

**Comprehensive ASWB LCSW Exam Review**

Full Content Review, 500+ Total  
Questions, and Practice Exams

- **Based on the latest ASWB content outline**
- **2 full-length practice exams**
- **All-new glossary of key social work terms**



The following guides by Dawn Apgar are available from Springer Publishing to assist social workers with studying for and passing the ASWB® examinations necessary for licensure.

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Test focuses on knowledge acquired while obtaining a Baccalaureate degree in Social Work (BSW). A small number of jurisdictions license social workers in the Associate category and require the ASWB Associate examination. The Associate examination is identical to the ASWB Bachelors examination, but the Associate examination requires a lower score to pass.

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**Dawn Apgar, PhD, LSW, ACSW**, has helped thousands of social workers across the country pass the ASWB® examinations associated with all levels of licensure. She has consulted with many universities and professional organizations to assist with establishing licensure test preparation programs.<sup>ii</sup>

Dr. Apgar has done research on licensure funded by the American Foundation for Research and Consumer Education in Social Work Regulation and has served as chairperson of her state's social work licensing board. She is a past President of the New Jersey Chapter of NASW and has been on its National Board of Directors. In 2014, the Chapter presented her with a Lifetime Achievement Award. Dr. Apgar has taught in both undergraduate and graduate social work programs and has extensive direct practice, policy, and management experience in the social work field.



# **Social Work Licensing Clinical Exam Guide**

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## **Comprehensive ASWB LCSW Exam Review**

Fourth Edition

Dawn Apgar, PhD, LSW, ACSW



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*To Bill, Ryan, and Alex*

*You remind me what is important, support me so I can do it all, and always inspire me to be  
a better person.*

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# Preface

Congratulations on getting to this point in your social work career. The decision to become licensed is significant, and passing the licensing examination demonstrates that you have the basic knowledge necessary to safely practice. Social workers are employed in all kinds of settings including hospitals, correctional facilities, mental health and addictions agencies, government offices, and private practices. It is essential that those served have some assurance that these practitioners are competent to provide the services that they are charged with delivering. Regulation through certification and licensure helps to assure that social workers will interact in an ethical and safe manner, and there is oversight to address actions that are not consistent with this standard.

Passing the licensing exam is only one step in becoming certified or licensed, but it is usually the most difficult challenge faced after graduating with your degree.

What does it take to pass the licensure exam?

- A.** Keeping calm when studying and taking the test
- B.** Analyzing the questions correctly
- C.** Knowing the social work content areas

Getting the correct answer to this question is easy as success requires them all! You have acquired skills in all these areas during your educational preparation for professional social work practice. Remember what has worked for you in the past to manage anxiety

and learn new concepts. Passing the licensure examination requires critical thinking and social workers are great at problem-solving or coming up with logical solutions to problems.

Although there are other test preparation materials produced, this guide provides all these essential elements in a single, manageable, easy-to-use format.

Individuals who are studying for the social work licensing examination have a primary concern and request. They are worried that they do not know important information about the tests that will prove to be a barrier to passing, and they want a “place” to go that will have all the necessary materials in a single location. They want to focus their efforts on studying for the exam—not hunting around for what needs to be studied!

This guide was created based on this important information, and it <sup>xx</sup> has been gathered from thousands of social workers just like you. Although it is not produced by or affiliated with ASWB in any way, and does not guarantee a passing score on the examinations, the test-taking techniques have been developed and used successfully by others who were faced with the same challenge that you are—others who are now certified and licensed social workers! They found this information so helpful in passing because the skills that it takes to be a good social worker in practice can be very different than the skills that it takes to pass the examination.

This edition of the guide has greatly expanded content on study and test-taking strategies, including effective ways to prepare for and pass the licensing examination. Material on methods for analysing questions correctly has been added, along with examples to illustrate the strategies presented. Often social workers find this information most helpful when preparing for and taking the licensing test.

Best wishes as you study. And remember that there is never only one way to achieve a goal, so use this guide in a way that works for you as you prepare. In choosing this guide as your roadmap, you have taken an important first step on the journey of passing the examination for certification and licensure

# How to Use This Guide

This guide has been carefully constructed to provide social workers with information on the licensure examination and how to properly prepare in order to pass it; test-taking strategies and methods for analysing the questions correctly; and the content areas which comprise the test.

**The first section** of the guide contains essential material to understand the best way to study, the logistics associated with taking the examination, and help with identifying what is being asked in test questions so that correct answers can be selected. Understanding how the licensing exam is constructed is valuable as it helps to identify priority areas for study. Anxiety is also reduced as there are no surprises when showing up to testing centers or when taking the licensure exams.

There are no “tricks” or “secrets” to help with passing licensure tests, but there are mistakes that social workers commonly make when studying and analyzing questions that lead to difficulties in performance. This first section provides guidance that is invaluable if taking the test for the first time or again due to not passing.

**The second section** of the guide has summary material on all the content areas, competencies, and Knowledge, Skills, and Abilities statements (KSAs) which are used by test developers to formulate actual questions. Some test takers have referred to this section as a “MSW Program in a Box,” as it contains a summary of relevant concepts learned in a graduate social work program that may be assessed on the test. The format of this section is identical to the outline or “blueprint” for the examination with all four content areas covered. Each chapter within a content area represents a

competency which has been identified as essential for testing. Lastly, within each chapter is summary information on each of the KSAs that can be tested on the exam. It is important to be familiar with all the possible topics that can be assessed. Simply looking over the table of contents for this section can be a helpful orientation to the material that needs to be studied. This section ends with a full-length practice test that can be used to simulate the actual examination experience. Taking this “mock” test is a great way to culminate a study plan and so is best done just before a scheduled test date.

# Pass Guarantee

If you use this resource to prepare for your exam and do not pass, you may return it for a refund of your full purchase price, excluding tax, shipping, and handling. To receive a refund, return your product along with a copy of your exam score report and original receipt showing purchase of new product (not used). Product must be returned and received within 180 days of the original purchase date. Refunds will be issued within 8 weeks from acceptance and approval. One offer per person and address. This offer is valid for U.S. residents only. Void where prohibited. To initiate a refund, please contact Customer Service at [csexamprep@springerpub.com](mailto:csexamprep@springerpub.com).

## **Section I**

# **About the Examination, Study Strategies, and Test-Taking Tips**

2 1

# The Licensure Examination

Generally, when social workers are getting ready to take the Association of Social Work Boards (ASWB®) tests, they are anxious not only about knowing the content, but also about the examinations themselves. They have many questions about the number of questions that are asked and the number of correct answers required to pass. Becoming familiar with the examination basics assists in increasing comfort with the examination conditions and structure, thereby reducing anxiety about the unknown.<sup>3</sup>

## TEST CONSTRUCTION

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The foundation of licensure examination construction is an ASWB practice analysis. The results of the practice analysis provide the content outlines for the tests. The structure of this guide and the material contained in it are based on the most recent content outline or “blueprint” developed by ASWB for licensure tests.

While the methodology used to guide the practice analysis process is complex, it is useful to understand some of the basics. In brief, ASWB surveys licensees nationally about the extent to which they use discrete knowledge items (known as the KSAs) in their current work and the extent to which they are important in their jobs. Using these survey results, as well as

subject matter experts to group and weight the items, ASWB constructs content outlines or “blueprints” for their licensure tests. Each category of examination—Bachelors, Masters, Clinical, and Advanced Generalist—has a different content outline. However, these outlines have the same basic structure:



**Four content areas** which are broad areas assessed on the exams

- **Competencies** which are meaningful sets of knowledge, skills and abilities that are important within each content area
- **Knowledge, Skills, and Abilities statements (KSA)** which describes a discrete knowledge component that is the basis for individual exam questions that may be used to measure the competency

The structure of ASWB's content outlines can be conceptualized as a funnel with content areas representing the broad domains on the test, competencies consisting of more narrowly identified groupings of topics, and KSAs as specific subjects which appear on the tests. There are separate content outlines for each of the four ASWB examinations. While there is some overlap, there are also discrete KSAs. The focus of testing is to determine if social workers have the theoretical, procedural, and factual information needed to practice. Becoming familiar with the content areas, competencies, and KSAs (which are described in the second section of the guide and are listed as its table of contents) is a helpful study tip as test takers are required to remember the requisite knowledge related to these topics to guide them to the correct answers.

## **TYPES OF QUESTIONS**

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There are three types of questions—recall, application, and reasoning—on the ASWB examinations. While each exam contains a mix of these types, the composition varies depending upon the category, with the Bachelors examination having more recall and application questions and the Clinical and Advanced Generalist having more application and reasoning questions. The Masters test has an equal distribution of all three question types.

**Recall questions** require selection of answers based on remembering learned material. **Application questions** require using information in a straightforward, specific way, such as identifying how knowledge would be used in specific settings, with target client

groups, and/or in various social work roles. **Reasoning questions** require using knowledge to make judgments using theories, ethical principles, or other social work content to drive decisions. Reasoning questions are often scenarios or vignettes, which tend to be longer and more complex. The content needed to answer each of the question types is identical, but the degree to which the topics are easily identifiable is not. Often test takers are not able to recognize that knowledge related to certain KSAs must be applied or used in their reasoning to get the correct answers as these KSAs are not explicitly mentioned.

The following illustrates how information on common psychotropic medications can be asked using all three question types.

### **Recall**

Which medication is a mood stabilizer?

- A. Haldol
- B. Prozac
- C. Lithium

### **Application**

A client with bipolar disorder is being hospitalized. The client is experiencing episodes of mania and depression. The client is MOST likely going to be prescribed?

- A. Haldol
- B. Prozac
- C. Lithium

### **Reasoning**

A client is hospitalized due to feelings of severe<sup>5</sup> hopelessness and withdrawal. Upon intake, the client cries uncontrollably throughout the interview. The family reports periods of sleeplessness, excitement, and elevated energy by the client weeks earlier. The primary intervention is the

prescription of a psychotropic medication. The drug will likely aim to:

- A. Ensure that the client does not experience delusions or hallucinations
- B. Alleviate the client's depression
- C. Stabilize the client's mood swings

The answer to all three of these questions is the same—C. The recall question simply requires identifying lithium as a mood stabilizer whereas understanding that lithium, as a mood stabilizer, is used for the treatment of bipolar disorder is needed to correctly answer the application question. The reasoning question, which is the most complex of the three types, provides the symptoms of bipolar disorder, requiring first the diagnosis and then the identification of a medication that aims to stabilize the mood swings as the primary aim of the intervention.

## **EXAMINATION STRUCTURE AND CONDITIONS**

ASWB offers valuable information about its licensure tests on its website—[www.aswb.org](http://www.aswb.org). It may be useful to look at the *ASWB Examination Guidebook*, which is free and located there. It is not a test preparation resource, but it does contain descriptions of how to register for the exams, security protocols, monitoring of results, and other testing logistics. All the information needed by most test takers is summarized below.

***All the ASWB examinations (Bachelors, Masters, Clinical, and Advanced Generalist) have the same format.***

Tests in all categories consist of 170 multiple-choice questions which must be answered in

4 hours from the time that the first question is seen. The examination is computerized but requires no specialized computer knowledge. There is a brief computer tutorial that assists with orientation to the software program. Spending time getting comfortable with the device is a good

idea, since it does not count toward the 4-hour time limit. Brief restroom breaks are allowed, but the clock does not stop so these activities must be included in the 4-hour limit. It is important to be judicious with the time taken for breaks.

***Only 150 of the 170 questions answered are used to determine whether a passing score is achieved.***

Although 170 questions are answered, 20 of these questions are not scored as they are being piloted for possible inclusion as scored questions on future ASWB examinations. Thus, only 150 questions are used to determine a passing score. The 20 pilot items are never identified (even after the test is over) and are dispersed among scored items, so it is important to treat all 170 questions as critical.

No questions should be left blank; it is important to answer all 170 questions in the 4 hours.

***The licensure test is a national examination that can be used for licensure in multiple states.***

It is possible to take the examination in any state/jurisdiction, even if it is not the one in which licensure is sought. In addition, a social worker does not need to live in a state/jurisdiction to be licensed there. Social workers can hold licenses in multiple states/jurisdictions and often do as they may be required when doing telehealth or providing other services to clients who live in states/jurisdictions that are different from those in which social workers live.

Licensure examinations are administered at a variety of times, but appointments are needed. Select a time when personal performance is at its peak. The exam is lengthy, so avoid taking it in the afternoon if you are a morning person or early in the morning if you are “a night owl.” There are rules about scheduling and cancelling appointments which need to be closely followed. This information is available on ASWB’s website ([www.aswb.org](http://www.aswb.org)).

Testing is closely monitored so it is important to be familiar with what’s allowed and not allowed. Details can be found on the ASWB website.

***Non-standard testing arrangements (accommodations) for the licensure test must be approved in advance.***

All testing accommodations related to documented disabilities must be approved by the licensing board and arranged in advance with ASWB. Extra time is the most common accommodation granted. Some states allow for these accommodations for those for whom English is not a first language; others do not. When registering for the examination with ASWB, there is a form that must be completed with appropriate supporting documentation. ASWB works with states/jurisdictions to review and grant requests as appropriate. It is important that non-standard testing arrangements be approved prior to arrival at testing centers, as there are strict rules which must be followed by site personnel who do not have the authority to change them without approved accommodations.

***Examinations are scored immediately, and unofficial results are provided.***

After completing the examination, there is a brief survey given about the testing experience. The computer then scores the test and the results (pass/not pass) are provided immediately. When passing, a brief report is provided with the test taker's name, test category (Bachelors, Masters, Clinical, or Advanced Generalist), test date, state/jurisdiction, and test performance (number of questions correct with the number needed to pass). These results are "unofficial" as they still must be securely transmitted electronically to the licensing board of any designated state/jurisdiction. The results do not change but must be securely transmitted to be "official."

When not passing, a brief summary is also provided. It lists the four content areas and the number of questions asked in each of the four domains. It also lists the number of questions answered correctly in each of these areas. However, which specific questions are answered correctly or incorrectly is never known. The exam is pass/fail, and a passing score can be used for certification or licensure in any state.

If there are questions about the process for sending passing exam scores to other states/jurisdictions for licensure, the ASWB website ([www.aswb.org](http://www.aswb.org)) must be consulted as it has the necessary forms and fees.

***Questions to test the four content areas are in random order.***

Although the KSAs are in four broad content areas which may be used to structure studying, the questions on the examination are in <sup>7</sup> random order and skip across topics. There are not separate sections for human development, ethics, and so on. In fact, the specific KSA being tested by each question is not listed. Being successful requires test takers to identify the specific knowledge areas and the requisite content to get the questions correct.

It is important not to skip around and be prepared for having questions on different content areas intermixed with one another. Each question stands alone to assess knowledge related to a distinct KSA. Avoid relating questions to one another and be prepared to shift focus for each question asked. The good news is that this structure allows questions on topics which are more familiar to be intermixed with those in areas which may be more challenging. If the answer to a question is not known, be assured that the next one will likely be on a topic that is more familiar.

***The number of questions needed to get correct to pass varies.***

Social workers always want to know how many questions of the 150 scored items they need to answer correctly to pass the exam. Although this sounds like an easy question, it is not! Not all questions on the ASWB examinations are the same level of difficulty as determined by the pilot process, so individuals who are randomly assigned harder versions of the exams need to answer fewer questions correctly than those who were lucky enough to have easier questions. This method ensures that the examination is fair for all those who are taking it, regardless of which questions were chosen. The number of questions needed to get correct generally varies from 90 to 107 of the 150 scored items. The pass point for the version of the examination taken is only revealed after the test is finished and scored electronically. On the unofficial score report, the exam score and pass point are listed.

It is possible to use this report to gauge the difficulty of the examination taken compared with other test versions available within a category (Bachelors, Masters, Clinical, and Advanced Generalist). The version is randomly selected and cannot be requested. If the pass point needed is closer to 90, the version had harder questions, and if it is closer to 107, it had easier ones. On average, most test takers have pass points which are close to 100 questions.

***Repeat test takers do not have the same questions when retaking the examination.***

Many people do not pass licensure examinations the first time and need to retake them, which is allowable after 90 days. Unfortunately, test takers need to pay for the examination each time that it is taken. Often those retaking the tests go home and look up information on topics with which they struggled. While it is always good to fill in knowledge gaps, the same questions will not appear on examinations taken in the future. Other questions in the four areas are selected. As the four domains are so broad, the foci of the questions may be quite different. To be adequately prepared, it is best to go back and study all the KSAs listed in content areas associated with poor performance. Do not exclusively focus on only those which appeared previously on the tests. The 90-day wait period allows for additional studying and gives ASWB time to ensure that different versions of the examinations, with new questions, are available for repeat test takers.

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# Studying for the Examination

Social workers studying for the ASWB examinations always want <sup>9</sup> techniques that assist them in answering questions correctly. While test-taking tips can be helpful, they are no replacements for good old-fashioned studying of content. Test-taking tips are not enough on their own to eliminate all the incorrect response choices. It is knowledge of the content area that is needed to select the correct answer from response choices that are incorrect. Thus, a study strategy aims to ensure that the content on the examination is familiar and can be applied to the scenarios which appear on the test.

Study strategies appear before test-taking tips in this guide as knowledge of the content areas must be attained before applying certain techniques to eliminate incorrect response choices. Test takers usually have their own methods for studying based upon their learning styles and the time till their test dates. There is no set number of hours that is required since some test takers are well-versed in the content areas and others need more time as they have forgotten or not learned key concepts. Regardless of the study period, it is essential to have a defined study plan which includes time set aside to review the content. This chapter provides useful information that can help guide this process, including picking a study style based on learning style and managing test anxiety.

## **STUDY MATERIALS AND TIME FRAME**

Social workers who are studying for the ASWB tests have lots of questions about the value of study materials and the time needed to prepare. They are often overwhelmed with advertisements from exam preparation companies and do not have methods for evaluating their worth. In addition, there are pressures to take the licensing exams, but

uncertainty about whether taking them too quickly will have negative outcomes. The answers to the following frequently asked questions provide critical guidance in identifying appropriate study materials and the length of time needed to pass.

***Q: What material must be studied for the licensure examination?***

The licensure tests assess knowledge of social work content, so it is imperative to focus on scholarly material to help fill in the gaps and make sure that there is adequate knowledge of the key concepts and terms related to the KSAs. Readiness to take the examinations can be assessed by the extent to which content on each of the KSAs can be briefly explained to someone who does not have any prior knowledge of them. The difference between passing and not passing the examinations almost always is a result of gaps in knowledge, not application of test-taking strategies, so the bulk of studying must be aimed at filling in knowledge gaps or refreshing information already learned.

The good news is that studying for the licensure examinations really begins the first day of any social work program as the KSAs represent information that is taught in any accredited institution. The topics look familiar as they are the focus of many social work courses.

As there are many KSAs that may be assessed, it is necessary to know a little bit about a lot of topics. Limiting studying to this guide or other key resources that summarize material is the best method. This is not the time to go back and read textbooks! There are so many topics assessed that it is not possible or practical to know everything related to them. This guide is geared to provide important information on these areas “under one roof.” Those who pass state that they are only tested on a small portion of the content contained in this guide. Remember that not all the KSAs are on any one examination.

It is hard enough to read through all the material in this guide. Using outside resources must be done on a limited basis. If used, supplemental study materials must be *scholarly* (written by social workers with education and training—do not rely on content from websites/companies where authors’ degrees are unknown), *free* (there is no need to pay for academic content as there are many scholarly resources available free online), and *brief* (quick summaries and overviews which are less than a page on a given topic are best as they

highlight the most salient information). In addition, it is important not to fall prey to solicitations for “secrets” to pass the test. Study materials must reflect that which is taught in social work programs. Unfortunately, many other licensure preparation materials are not written by social workers so their content does not reflect that which is important and unique to the profession.

The content in this guide assumes that test takers have learned about these KSAs previously in their social work programs. If material is unclear or it was never learned, some supplemental information may be needed to fill in knowledge gaps. In these instances, it is best to use free resources on the internet or any other documents that have no more than a paragraph summarizing key points. Remember, it is not necessary to read a book on Freud to understand his work and its importance in explaining human development.

In addition, there is always a time lag between the generation of new social work content and when it appears on the ASWB examinations. It takes time to write and pretest questions on new material. Thus, there is no need to worry about recent innovations appearing on the licensing test. The bulk of the content focuses on theoretical underpinnings of the social work profession that do not change dramatically or quickly over time.

The exam content outlines, with the accompanying content areas, competencies, and KSAs, change very little over time. This consistency is good and bad. The good news is that there is no need to know the “latest and greatest” in all content areas. It is hard to keep completely up to date in a profession that is changing so rapidly. Now for the bad news! For many, especially if they are working in specialty areas, some of the content or answers may appear to be dated. This is often the case related to psychopharmacology because new medications are being approved and used rapidly. Remember the time lapse when studying, and do not rely on breaking news or even agency practices which may be using more current protocols.

***Q: How much time must be spent studying as I want to pick a test date?***

This question is impossible to answer as some test takers know the <sup>11</sup> content and are ready to take examinations once they are familiar with exam format and structure, as well as the test-taking strategies.

Others need to spend time studying content that was forgotten or not learned.

However, most test takers never feel “ready” to take the ASWB examinations. Not unlike other standardized examinations, such as the Scholastic Aptitude Test (SAT) or Graduate Record Examination (GRE), readiness cannot be judged by knowing everything about the content areas. The ASWB examinations are not designed for test takers to “know it all” to pass. Often, picking a test date is the hardest task; as with the SAT or GRE, a deadline for admission to college or graduate school forces individuals to select dates even when they do not feel ready. For the ASWB examination, it will be necessary to select dates in the next few weeks or months, perhaps dictated by job opportunities or promotions predicated on being licensed. It is typical that test takers walk into the ASWB examinations without feeling totally ready or satisfied with the amount of time that they had to prepare.

Often confidence is boosted by picking test dates and developing detailed study goals to be accomplished before those dates. Some fit their studying into shorter time frames in which they spend a lot of time over several days or weeks reviewing the material and others complete these reviews more slowly. Whatever strategy chosen, it is great to take the tests knowing that study plans were actually followed and time allotted for studying was actually spent.

***Q: How do I get access to sample questions as I want to use them for studying?***

Although individuals like to study from sample questions, this is not advisable to only rely on questions as study materials. There are many reasons for this recommendation, but here are just a few.

1. Although it makes test takers feel better when they get answers correct on sample questions, getting correct answers is not a valid indicator of really knowing all the requisite content about the KSA. Studying information on the KSAs directly increases the ability to answer all questions on these topics, not just particular sample questions.
2. Answers to sample questions inappropriately influence decisions made on the actual examinations when asked about similar topics.

For example, seeing answers that are similar to ones that we correct or incorrect for sample questions increases or decreases the likelihood of selecting or eliminating them based upon this prior experience. However, questions in the “real” examination are not exactly the same as the ones seen during studying and it is essential to evaluate all response choices independently, without any undue bias that may be caused by use of prior sample questions.

3. The sample questions studied are not going to be on actual examinations and probably are not even written by those who developed the licensure tests. Thus, the idea that many social workers have of wanting to “get into the head” of the individual writing the exam or understand their logic is not valid—though it might make them good clinicians in real life! Unfortunately, many of the sample question apps and resources for purchase for the ASWB examinations are not even written by social workers! Thus, trying to figure out why answers are correct which were not selected may be futile as the questions may not be actually testing social work content.

It is a good idea to take a “mock” examination which mimics the <sup>12</sup> actual licensure test in length, composition, and question format. There is such an examination in the back of this guide. Additionally, ASWB sells full-length practice tests to those who are registered to take their exams. The best way to use a full-length practice test is as follows.

1. After studying is completed and readiness to take the actual ASWB examination has been assessed, select a 4-hour period where the mock examination can be completed in a quiet environment without interruptions.
2. Answer the questions as if it were the actual examination—using time strategies and having to pick one answer—even if you are not completely sure that it is correct.
3. Keep track of the time even if short bathroom breaks are taken. Finishing the full-length practice test demonstrates the ability to get through 170 questions in the 4 hours allotted. This experience

should relieve some anxiety about the timed nature of the examination. Most people complete the actual examinations in 3-3.5 hours so there is no need to worry about finishing as long problem solving is continuing and answers are selected even when there may not be complete certainty that they are correct.

4. Score the full-length practice test *after* completing it. Resist the urge to look at the answer key to see if questions are correct immediately after answering them. A “mock” examination is not to be used to determine readiness to take the actual test. Instead, it provides an idea of the length of the examination and how much focus is needed, in addition to boosting confidence that all questions can be answered in the time allotted.

## **CONSIDERATIONS WHEN STUDYING**

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Good study skills are essential when preparing for the ASWB licensure examinations. It can seem overwhelming to get ready for these high-stakes tests. Studying requires discipline and motivation. There are a few strategies that increase the likelihood of passing. Studying that builds focus and stamina, prioritizes content that is likely to be on the tests, and increases understanding results in better outcomes and leads to greater success.

### ***Build Focus and Stamina***

Most test takers have not taken standardized multiple-choice 4-hour examinations for a long time—if ever! Social workers’ lives are hectic, and they rarely get a chance to really focus on a single task or have the luxury of thinking about a single topic in a deep, critical manner. Thus, many people find it helpful to study in 4-hour blocks of time rather than for a few minutes here and there. Carving out this time may be difficult, but it is beneficial because it also helps with building up concentration and focus. Remember, runners do not start with marathons; they need to build their strength and endurance over time before they can tackle 26.2 miles.

Many social workers who have passed the ASWB examinations complain about how hard it was to stay focused and how exhausting they were after finishing their tests. Preparation needs to include

building up focus and stamina. The first time that test takers are engaged in critical thinking related to the content areas for 4 hours should not be during their actual examinations!

### **Prioritize Content**

Think about the vast amount of information that is available on each <sup>13</sup> of the KSAs listed in the content areas. Often social workers have trouble prioritizing the content that is important and determining how much depth of knowledge is needed in each of the topics contained in this guide. It is important to recognize that social workers who have attended social work programs at different schools, as well as courses within these programs taught by various faculty, have passed the examinations. Thus, it cannot be about specific details or stories told by one professor, but instead the “core” elements included in any overview or lecture on a topic, regardless of school or professor. These elements are the ones that must be learned and remembered because they are the basic concepts related to the knowledge being tested.

In addition, there are also “core” or essential areas seen as critical to competent practice. Can you imagine social workers leaving undergraduate or graduate programs without reviewing the signs of child abuse and neglect and the duty of mandatory reporting? Of course not! Child abuse and neglect are “core” topics that often are the basis of examination questions. The list of these areas is not fixed but includes confidentiality, assessment of danger to self and others, professional boundaries, self-determination, cultural awareness, and so on. When studying, prioritize areas that every social worker needs to know, regardless of setting or specialization. These topics are likely to be asked about on the examinations.

### **Concentrate on Understanding Over Memorization**

When studying, it is not necessary to memorize content because terms or definitions need not be recalled from memory. ASWB examinations do not require memorization. Instead, test takers need to distinguish one answer, from several, that most directly relates to a topic or is essential based on knowledge of the content area. Thus, understanding is critical as most questions relate to application or reasoning. Test takers must be able to explain the importance of each KSA, rather than memorizing fancy terms or facts. Memorizing can lead

to superficial understanding of concepts, which is not useful for the ASWB examinations.

Often, social workers are focused on using the clinical and other jargon that they learned in their social work programs; however, they may be unable to explain what these concepts mean in plain and understandable terms. For example, when asked what should happen when meeting with clients for the first time, social workers often use phrases such as, “You need to build rapport,” “It is essential that you start where a client is,” or “Social workers should show empathy as to what a client is going through.” Though all true, these statements give little insight into any real actions that social workers must take in these first meetings. What should a social worker do to “build rapport”? How would a client know if a social worker is being “empathetic”? What would a social worker be doing or saying? Having to explain KSAs to those who know little about social work practice and ask lots of questions about the content area is far better than studying with social work colleagues who do not challenge the use of jargon or technical terms which can be confusing and do not include essential basics.

The following questions can serve as a quick assessment of whether requisite knowledge and understanding have been obtained.

What are the most relevant points 1.  
related to this KSA that would be  
contained in a 5-minute “lecture” on the topic? If they cannot be  
easily identified, then more studying is needed!

2. What is the relevancy of this KSA to social work practice and how social workers use this information to make decisions while interacting with clients? Most questions require information to be applied in specific scenarios.
3. How does this KSA relate to the assessment and treatment of clients? Does it in any way impact problems or issues that they may be experiencing? More than half of the examination focuses on assessment, planning, and intervention (the second and third content areas), so using knowledge for reasoning in these areas is essential.

In order to get correct answers, exam questions require broad application of key concepts related to theories (e.g., the understanding

that what happens to a client early in life can influence later functioning) or specific terms associated with these areas, even if the constructs are not mentioned (e.g., picking a response that best represents “family homeostasis”). For those areas in which requisite knowledge is possessed, only a quick review by reading through the content outlined in the subsequent pages of this guide is needed. If there are gaps in knowledge, more detailed studying may be needed.

### ***Respect Learning Style***

There are different learning styles that dictate methods that are most effective when having to fill in gaps in knowledge. Determining which one best fits can help ensure that studying results in learning and expedite the study process.

#### ***Visual Learners***

Visual learners learn best through what they see. Although lectures can be boring for visual learners, they benefit from the use of diagrams, PowerPoint slides, and charts.

- Use colored highlighters in this guide to draw attention to key terms.
- Develop outlines or take notes on the concepts in this guide.
- Write talking points for each of the KSAs on separate white index cards.
- Create a coding schema of symbols and write them in this guide next to material and terms that require further study.
- Study in an environment that is away from visual distractions such as television, people moving around, or clutter.

#### ***Auditory Learners***

Auditory learners learn best through what they hear. They may have difficulty remembering material that they read in this guide but can easily recall it if it is read to them.

- Tape-record yourself summarizing the material –listen back reinforce what was read.

- Have a study partner explain the relevant concepts and terms related to the KSAs.
- Read the text from this guide aloud to assist with remembering content.  
Find free, short online podcasts or YouTube videos on the content areas to assist with learning.
- Talk to yourself about the content when studying—emphasizing what is important to remember related to each KSA.

### ***Kinesthetic or Hands-On Learners***

Kinesthetic learners learn through tactile approaches aimed at experiencing or doing. They need activities and physical activities as a foundation for instruction.

- Make flashcards on material because writing it down assists with remembering the content.
- Use as many different senses as possible when studying—read material when on the treadmill, use highlighters, talk aloud about content, and/or listen to a study partner.
- Develop mnemonic devices to aid in information retention (e.g., EAPIET or Eat PIE Today is a great way to remember the social work problem-solving process—Engaging, Assessing, Planning, Intervening, Evaluating, and Terminating).
- Write notes and important terms in the margins of this guide.
- Find a study partner and quiz each other on material—turn it into a game and compare the length of time that a KSA can be discussed before running out of material.

## **MANAGE TEST ANXIETY**

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Perhaps one of the biggest issues that social workers need to address when preparing for and actually taking the examinations is anxiety. Although not designed to be an exhaustive resource on how to address test anxiety, this guide would be incomplete if it did not provide some

guidance to assist with anxiety during this stressful time in professional development.

It is important to acknowledge that anxiety can be useful during this process because it helps prioritize studying above other demands in everyday life. There are no methods to acquire the needed knowledge besides good old-fashioned studying. Anxiety can be a motivator to keep going over the material even when there are more interesting things to do!

Remember, everyone who is studying for the examinations is feeling the same way. Stress and anxiousness are typical so do not feel alone.

However, it is essential to manage this anxiety, and there are several strategies that can help.

### *1. Make a Study Plan and Work the Plan*

A great way to instill confidence is being able to walk into the testing center having followed a structured study plan. A study plan helps break the material into smaller manageable segments and avoid last-minute cramming.

### *2. Do Not Forget the Basics*

It is important not to neglect biological, emotional, and social needs leading up to and on the day of the examination. Get plenty of rest, build in relaxation time, and eat well to avoid exhaustion during this preparation process.

### *3. Be Familiar With the Test Environment*

Before the day of the examination, be familiar with the testing conditions. On the day of the test, be prepared early to avoid feeling rushed. Take time to carefully review the tutorial on the computer before starting to answer questions to avoid wasting time during the exam.

#### *Use Relaxation Techniques*

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Breathe and remember to relax during the examination. Simply shutting your eyes or stretching your neck several times during the 4-hour exam can help with refocusing.

### *5. Put the Examination Into Perspective*

Rarely do people get the score they want the first time taking any standardized test. Taking the SAT or GRE more than once is the rule rather than the exception. Social workers often attach too much meaning to whether they pass the ASWB examination the first or second time. They feel their entire career rests on the results. This is not true. There are many outstanding social workers who have had to take the test multiple times. The test can be retaken so remember that this is not the only chance to pass. Do not let the test define self-worth and avoid thinking in “all or nothing” terms.

#### *6. Expect Setbacks*

The road to licensure is not different than other journeys in life and not usually without unexpected delays or even disappointments. It is important to see these as typical parts of the process and not ends in themselves. Try to figure out why these setbacks in studying or passing occurred and how they can be used as feedback for making improvements. The hard work associated with getting a social work degree certainly causes some disappointments and challenges. Studying for and passing the examination is also not easy, but success is possible with keeping focused and learning from challenges encountered.

#### *7. Reward Yourself*

Do not wait until passing to celebrate. Build some enjoyment into the test-taking experience by creating little incentives or rewards along the way. Go out to dinner after having studied for 4 hours on a Saturday afternoon. Get up early and study before work to enjoy a movie when arriving home. Making the study process more fun can result in studying more and improve performance on the examination.

#### *8. Acknowledge and Address the Anxiety*

Ignoring the anxiety that accompanies this process does not help as it is not possible to completely eliminate it through the techniques mentioned. However, assessment is needed to determine whether it is manageable and can be addressed by some of these suggestions or it is interfering so significantly with

the learning process that it results in “blanking out” or problems in other life areas. If the latter is the case, more intensive anxiety-reduction interventions are needed. Repeatedly studying the content over and over does not reduce anxiety. Although most people can develop their own strategies for anxiety management, others need outside help. Usually, individuals who need the assistance of others are those who have experienced anxiety in their lives prior to this experience. No matter what the severity—anxiety management is a critical part of every study plan!

# Tips for Answering Questions Correctly

In addition to the development of a sound study plan, it is important to <sup>17</sup> use strategies to help distinguish correct answers from incorrect response choices. These are not “secrets” or “tricks”—they are approaches that assist with reading the questions, understanding what is being asked, and applying critical social work content. There are common mistakes that social workers initially make when trying to answer ASWB exam questions as they test content in a standardized way. The following tips assist with using a thoughtful approach to question analysis, as well as provide important principles to remember when answering questions on the exam.

## **USING THE BEST OVERALL APPROACH**

***The KSA being assessed must be identified before looking at the response choices.***

It is essential that questions are thoroughly understood before looking at the response choices. The most difficult part of selecting the correct answer is identifying the knowledge area and KSA that is being tested. To ensure that proper attention is given to understanding the question, a multistep process must be undertaken.

1. Read the question exactly as it is written, paying attention to key words and those in quotes. Do not look at the response choices yet!
2. Ask “What is this question about?” to determine which of the KSAs being tested.

3. Think about the important concepts related to the KSA; they are essential in distinguishing the correct answers from the incorrect ones.
4. Examine the question again to confirm that any assumption about which KSA is being tested is correct and to determine how the important concepts related to the KSA are relevant to the question.
5. Now look at the response choices for the first time! Read each carefully.
6. Eliminate any that do not appear to be correct. If more than one response choice appears to be viable, go back and read the question again-looking only at the remaining response choices left.

It is sometimes difficult to eliminate incorrect response choices immediately, so this process may involve multiple iterations. Each time a response choice is eliminated, read the question and the response choices that are left. Going back to the question each time that a response choice is eliminated helps with keeping focused on critical content which is contained in the question.<sup>18</sup>

Often test takers spend more time reading and debating between the response choices than critically analyzing questions, which is a big mistake!

***When response choices are proper names, read and think about them before looking at questions.***

While many questions have response choices which are long, there are others that consist of proper names, such as those of clinical terms, diagnoses, theories, or medications. When asked to select between listed terms, diagnoses, theories, or medications, it is best to read the response choices first and think about their usage, meanings, and/or applications before looking at the questions. This approach allows the use of evidence in the questions to support or help eliminate response choices based on actual knowledge about these concepts, without being biased by question wording.

If terms, diagnoses, theories, or medications listed as response choices are unknown before reading the questions, they must be eliminated and only those with which there is some textbook familiarity should be considered. There is a natural tendency to gravitate toward selecting proper names that sound good or like they “fit” without really

understanding their meaning. This mistake can be avoided by making sure that only response choices which are understood with 100% certainty are considered. If those which are known can be eliminated, “mystery” terms, diagnoses, theories, or medications can then be considered.

Increasing your familiarity with key social work terms will help increase your success as it will make it easier to distinguish between the response choices provided. This study guide has an important section that defines key social work terms to assist you in your studying.

***Answers must be selected for all questions—avoid skipping around or leaving answers blank.***

There is plenty of time to answer the questions in the 4-hour period allotted for the test. Although the examination is timed, most people have no issue with test completion, but are very nervous about the time and feel rushed due to anxiety. Often that anxiety can fuel the desire to leave questions blank if answers are unknown or to skip around to find questions that are more familiar. Such an approach is a mistake. The questions should be answered in the order in which they are listed. Skipping around wastes time. The most time spent must be on identifying the KSA being tested or what the question is asking. Not answering a question after this analysis has occurred serves no purpose because no more information will be available later in the examination. An answer needs to be selected before moving on. Also, an answer must be selected after reading the question a few times and applying the strategies. Individuals who run out of time are “stuck” because they are waiting for the feeling of certainty in their answers that does not come in these types of standardized examinations.

Lastly, the computer can be used to “flag” questions for which correct answers are uncertain. Flagging must be avoided and only used for a few questions throughout the examination. There is really no reason to flag as, again, there will be no more information to help with selecting correct answers or eliminating incorrect response choices later in the examination. Flagging can cause increased unnecessary anxiety. Even when passing, test takers get a lot of questions incorrect. There is no reason to keep identifying uncertainty about whether questions are correct through flagging.

***The “best” response choice is not always the correct answer.***

Standardized examinations are often difficult and test takers find themselves struggling to identify the correct answer from several listed response choices.<sup>19</sup> In these instances, social workers can make a common mistake such as selecting the response choice that has catchy social work phrases, such as “from a client’s perspective” or “focus on a client’s strengths and skills.” Although these are important social work concepts, they need to relate to the KSA being tested. If response choices are judged solely based on the inclusion of important social work terms—Independent of what the question is really asking—it is easy to be drawn to the “best” ones (judged solely based on the inclusion of social work jargon) even when they are not correct.

One way to avoid making this mistake is to go back and reread the question when debating between response choices. Often test takers struggle with choosing between response choices without going back to questions to reconfirm the KSAs being tested. Simply debating between response choices, without reviewing questions again, may lead to picking the “best” ones based on compelling social work content or terms—rather than their connection to the content areas.

***Do not “fight” the standardized approach to testing of social work knowledge!***

ASWB examinations assess knowledge of social work content in a standardized way. Often, what is learned in the classroom is very different than practice in the field. Knowledge is only one factor that drives actual behavior. Textbook knowledge also differs from practice wisdom and clinical judgments. Answers must be based upon content studied from this guide and what was learned in the classroom. Questions are written to make sure that all social workers provide uniform responses. Answers cannot depend on individualized practice experiences or diverse agency protocols and policies.

When viewing questions, ask “What did I study in the guide that relates to this question?” or “Which KSA is being tested and what do I know about this content area?” Avoid inappropriately asking, “What would I do in this instance?” or “How should I handle this situation?” as these questions lead to picking response choices that draw upon practice experience, which varies across test-takers, rather than the existing knowledge base in a given area.

There is only one correct answer for each question. Since everyone has different practice experience, basing answers on what is seen or

done in the field can lead to many different approaches which does not work when taking standardized tests. However, the knowledge base of the profession, as taught in social work programs, is universal, regardless of setting or practice experience. Basing responses on information that is taught in the classroom and outlined in social work textbooks ensures getting consistent answers with others—even if there are factors that make it impossible to implement them in certain work settings.

## **REMEMBERING IMPORTANT QUESTION FEATURES**

***The importance of social justice and macro practice is paramount.***

The ASWB examinations assess social work knowledge, which emphasizes the importance of three practice methods—micro, mezzo (also known as meso), and macro. Even when doing clinical work, social workers differ in their intervention from others doing counseling or therapy as they recognize that many problems stem from the larger <sup>20</sup> environment, including marginalization and oppression. Social workers are mandated to address the root causes of these systemic issues, rather than blaming those impacted by them. All social workers, even those specializing in clinical or micro practice methods, have these responsibilities. Thus, scenarios on the examinations that appear to be testing direct practice with individuals can actually be situations in which social workers must change policies or advocate for clients' rights in order to address issues causing distress such as discrimination and lack of adequate services.

Often test takers preparing for the examinations question whether administration/  
management or policy practice will be tested. Of course! Mezzo and macro social work practice are equally as important as micro practice. All ASWB exams are going to include questions aimed at ensuring social workers are change agents and fight for social justice. The profession is rooted in serving those who are poor and disenfranchised.

A strong commitment to reform can be seen in questions that involve agency policies as well. For example, supervisors are there to ensure that clients receive the most effective and efficient services possible—not to make things easier for social workers or enforce agency mandates.

It is essential to make sure the root causes of problems are addressed. There may be barriers to properly serving clients. Social workers must look at response choices through the lens of what is best for clients. The self-determination of clients must only be limited in situations that could harm clients or others. The correct answers are always the ones that put clients first.

Questions often focus on conflicts between meeting clients' needs versus adhering to practices or policies created by agencies. When there is a barrier to meeting clients' needs, social workers must take responsibility for trying to remove the barriers. Social workers must fight to change rules which do not maximize client functioning. Having clients comply is blaming victims and not getting at the root causes of issues. Answers which reflect these changes are correct even when such changes seem unrealistic and lengthy. Whether or not social workers are successful does not change the mandate to challenge unjust practices. Response choices should not be dismissed just because they seem too difficult to achieve. If test takers do not challenge injustice through policy practice on their examinations, it is likely that they have answered incorrectly!

***Do not get distracted by settings or scenarios.***

Although there are some questions that require simple "recall" of content, many ask for the "application" of information to particular situations or scenarios. These questions come in the form of vignettes and are often the ones in which social workers make mistakes. In practice, social workers often alter their actions based on many contextual variables. However, remember that the questions on the examination are about the application of social work knowledge within the KSAs, and this knowledge does not change regardless of the setting in the vignette. In addition, any of the KSAs can be implemented in a wide variety of settings. Thus, it is important not to get "lost" in the scenario.

For example, the core components of a discharge plan are the same if it is prepared for a client leaving the hospital, a drug treatment facility, or an inpatient psychiatric treatment setting. The content (i.e., history/assessment, treatment provided, follow-up needed) may be different, but each discharge plan must contain information in these critical areas. Thus, it is essential to stay focused on the content being tested and remember that it is not necessary to have worked in the <sup>21</sup> settings mentioned in the vignettes (schools, hospitals, drug treatment

centers, nursing homes, etc.) to pass the examination; the KSAs or core social work content being tested is universal, regardless of venue.

Test takers often relate scenarios to the type of social work services that they have provided in the past or in their practice settings. Unless specified, social workers in scenarios could be providing a wide variety of interventions including, but not limited to, information and referral, case management, advocacy, skills training, and so on. Psychotherapeutic counseling is just one of many treatments delivered by social workers. Most scenarios are applicable to any social worker in any practice situation delivering any service as they are testing important professional content that are applied generally.

Lastly, when answering questions which involve scenarios, it is critical that response choices selected relate to the KSAs and are not just focused on “fixing” the situations. Often there are one or two response choices that may be helpful to clients in the specific circumstances described, but do not represent important social work concepts that can be applied universally to other situations or scenarios. The exam does not aim to test what social workers do in every instance, but rather knowledge that must be applied more broadly. Make sure to see the forest through the trees by not narrowly focusing on the specific client situation and missing the important broader intent of the question.

***Client feelings and behaviors should not be pathologized as they may be typical reactions.***

Social workers often view licensure examinations as a means to assess their clinical knowledge. They view all client behaviors through a psychotherapeutic lens and are inappropriately quick to attribute client feelings and behaviors to symptomology of disorders or dysfunction. Using this approach, social workers are apt to wrongly view clinical attributes as the focus of treatment or intervention.

For example, if clients have experienced unsuccessful infertility treatments, they are likely to feel depressed, frustrated, and hopeless. These are typical reactions which may result from not achieving desired results from medical interventions. The presence of these feelings does not mean that they must be the focus of social work treatment or clinically analyzed and diagnosed. Perhaps such clients simply need support for pursuing alternative methods for becoming parents, such as through adoption or surrogacy.

Examination questions often focus on making sure test takers do not diagnose clients with disorders unless *all* required clinical criteria are present. Feelings and emotions can be appropriate manifestations of underlying problems. Interventions or treatments must aim to address the underlying root causes of issues, not their symptoms. Anxiety, sadness, and anger are typical feelings and do not need to be addressed unless they are causing problems for clients or interfering with functioning. The mention of client emotions in questions does not mean that they are the foci of treatment or even problems.

ASWB examinations, including those focused on clinical methods, are taken by social workers employed in all types of settings and roles. Clinical work is not restricted to the provision of psychotherapy, but also includes case management and even advocacy. Most questions on the ASWB examinations are not focused on psychopathology, but instead test the broad and diverse knowledge base used by those in the profession. There are many appropriate interventions to address client problems, not just counseling. It is important not to solely focus on the treatment of client emotions as the goal of services.

***There are no specific state or jurisdictional laws that should influence response selections.***

The ASWB exams are used in every U.S. state, as well as the District <sup>22</sup> of Columbia, the U.S. Virgin Islands, and several Canadian provinces. Correct answers are the same for all social workers taking the examinations. However, the systems of care and laws in each state/jurisdiction differ; thus, responses to situations may be varied in real-life, everyday work. This is not the case on the licensing tests, as there is only one correct answer to each question. Thus, it is essential not to consider “rules” or laws that apply or resources that may be available in only one state/jurisdiction.

A simple way to avoid unconsciously using state/jurisdiction-specific information when answering questions is to think of a different state/jurisdiction and ask, “What would a social worker living in [insert name of another state/jurisdiction here] pick as the correct answer?” If the answer is, “I don’t know because I am not sure how things are done there,” the response choice is mistakenly being selected based on practice systems and rules that may differ between states/jurisdictions and not universal social work content that is always applicable. If the answer chosen is the same regardless of state/jurisdiction, the selection

is based on core social work content that is essential to know. Professional ethical standards apply regardless of state/jurisdiction so using them to help identify correct answers can be very helpful.

***The hierarchy of clients' needs must be respected, with safety prioritized.***

Questions on the examinations often require social workers to order their actions with clients or identify issues or problems that are most important in given scenarios. In practice, such decisions are often somewhat subjective and driven by practice wisdom that accounts for many clinical and contextual factors. However, on the examination, all social workers must select the same correct answers. A useful framework for prioritizing client needs and addressing them sequentially is Maslow's hierarchy of needs.

Although it is unlikely that Maslow's hierarchy of needs would ever be explicitly asked about on the examination, it is a tool that can be used repeatedly to help prioritize problems or order actions based on client need. Social workers must always address health and safety issues before moving on to those that relate to psychological functioning such as self-esteem. Thus, when questions include response choices that screen for or attend to the health and safety of clients, test takers must examine them carefully to see if there is explicit wording that indicates clients are in danger or at risk of harming others. If so, this concern must be addressed before other actions are taken.

Social workers must also provide concrete services to meet basic needs, such as housing, employment, and transportation, before moving up the hierarchy. Social workers often must drive and accompany clients to doctor's appointments or food shopping to ensure that they receive needed care and have access to fundamental resources. Maslow's framework indicates that without health, safety, and basic needs being met first, clients cannot meet their higher-level needs.

***Steps in processes must not be skipped because they take too long or will not "solve" problems.***

Most questions do not ask test takers to "solve" problems or even take actions that directly lead to resolving issues or situations. For example, a question may ask what a social worker should do FIRST when having an issue with a colleague. Although speaking directly to the colleague <sup>23</sup>

may not seem as expedient as going to a supervisor, it is appropriate to address the issue with the colleague before going up the chain of command. In addition, putting requests in writing after not getting responses to phone calls are also needed to ensure proper documentation. In practice, social workers often have deadlines and need to act quickly, requiring skipping of critical steps in processes. However, these pressures do not exist in test scenarios.

There are not long waiting lists, scarce resources, or delays in referrals that exist in scenarios unless they are explicitly stated. In actual practice, social workers encounter these realities daily and often base their decisions and actions to ensure results despite these constraints. These factors must not influence selecting a response choice unless they are explicitly stated in the question.

Often knowledge about the processes themselves are being assessed, rather than the outcomes. Unless there is a compelling reason, such as safety, which is explicitly stated in scenarios, test takers should adhere to the sequencing in established protocols, such as chains of command or documentation procedures. Actions can be taken immediately after one another so skipping any of them is not needed. Desired results will eventually be achieved, even when all steps in processes are respected.

***Determining phases of the problem-solving process within scenarios is critical.***

Another critical tool to assist with selecting the correct answer is the problem-solving process (i.e., engagement, assessment, planning, intervention, evaluation, and termination). Understanding the goal of each phase and the tasks to be completed therein is critical because many questions on the examination focus on making sure that things are happening in the correct order.

For example, if questions are about first meetings with clients, the activities of social workers must focus on engagement. Engagement includes finding out why clients are there and why they are seeking services now, explaining the role of social workers and what to expect in treatment, listening to clients as they explain their situations, and explaining the limits of confidentiality. Including references to specific meetings or activities completed are clues for determining what phase of the problem-solving process social workers and clients are in and what activities are appropriate next.

Actions by social workers are quite different in engagement than they are in termination. Although questions rarely explicitly state the phase, it can be identified by what has occurred, such as “when gathering information on the problem” to indicate assessment or “when developing the contract” to indicate planning. Also, it may be useful to classify answers into the phases in which they would occur in order to select what comes FIRST or NEXT.

## **Focusing on Question Formatting and Wording**

In addition to using the best approach and remembering important question features, it is necessary to make sure to attend to question formatting and wording. Missing critical words in questions results in making avoidable mistakes. There are some basic, but essential, tips that heighten awareness and must be used to make sure that the most salient wording in questions is considered and key words are not missed. The <sup>24</sup> following questions help guide critical analysis of test questions to improve performance and avoid common errors.

### ***Q: Is there a qualifying word in the question?***

Many questions contain key words that are extremely important and distinguish the correct answer from the incorrect response choices. These words are capitalized, and bolded. In addition, they can usually be seen near the end of questions. Examples of qualifying words are BEST, NEXT, MOST, and FIRST. Whenever a qualifying word is contained in a question, it is the key to selecting the correct answer from the incorrect responses and is directly related to the concept being assessed. Put the qualifying word in front of each response choice when reading it to ensure that the focus on this key word is maintained. Repeat the qualifying word before reading each response choice. By inserting the qualifying word before each response choice, you are less likely to get distracted by words that may not be salient. Qualifying words, when present, are the most important factors to consider when selecting between the response choices provided.

### ***Q: Is demographic information about the client mentioned in the question?***

If the ages of clients are included in the vignette, they must be considered as age often provides relevant information for selecting correct response

choices. For example, having imaginary friends at age 4 is very different than having them at age 34. Imaginary friends in childhood are an extension of pretend play and part of Piaget's preoperational stage. However, having them in later life can be an indicator of psychosis resulting from a hallucination or delusion. Thus, in the former instance, this behavior is typical, which would require no special intervention, whereas in the latter, it is necessary to do a mental status examination or refer for psychiatric evaluation. Additionally, confidentiality and consent are handled differently for young children, as compared with adults. If questions refer to clients generally, answers are not age dependent.

When studying, social workers do not need to memorize the exact ages at which individuals leave one stage of development or reach another. However, when mentioned in questions, age can be useful to indicate where clients are in the life course and what may be expected.

Questions may also contain other important demographic information such as race/ethnicity, religious affiliation, sexual orientation, gender identity, etc. There is always a reason that this information was included in the question so it must be considered when discerning between response choices.

***Q: Is this question testing the application of a specific theory, perspective, or practice model?***

The ASWB examinations require basic knowledge about many theories, practice models, and perspectives related to social work practice. Whether on the undergraduate or graduate level, social workers take courses on theory and practice, learning different models of intervention. A theory is a set of interrelated concepts that are organized in a way that explains aspects of everyday life. A practice model is a way in which a theory is operationalized. And a perspective is a point of view that is usually broader and at a higher level of abstraction (i.e., strengths perspective). Having a basic understanding of various theories, practice models, and perspectives, as well as the terms that are rooted in them, is necessary.

Sometimes there are recall questions about theories, practice models,<sup>25</sup> or perspectives, but knowledge in these areas is often tested through application to vignettes. For example, the last sentence before the response choices may state, "Using a systems approach, a social worker can expect this recent medical diagnosis to ..." Examining the response choices through the "lens" of systems theory is essential to selecting the

correct answer. Systems theory states that individuals are in continual interaction with their environment and that parts within a system are interrelated. Thus, when one subsystem is affected, they are all affected. Having this knowledge is essential as the correct answer must reflect the medical diagnosis affects others in the family or aspects of the client's life beyond health.

It is not necessary to be an expert in all theories, practice models, or perspectives. Instead, knowledge must be "an inch deep, but a mile wide" with test takers knowing multiple theories, practice models, or perspectives—not just the ones that they use in their daily work. The ones that need to be applied to scenarios may not even be best practices for the problems presented. Questions requiring application of theories, practice models, or perspectives are not asking for test takers to pick the modalities to be used, but instead which response choices represent the theories, practice models, or perspectives chosen by the question writers.

When studying, it is good to know the focus of each modality—for example, understanding the fundamental difference between structural and strategic family therapies. In addition, questions often contain terms or techniques associated with various interventions, even when the names of the treatment approaches are not mentioned. Sometimes questions do not specify paradigms but use related terms that would only be known if they were studied.

When examining questions, make sure to determine whether questions require the use of particular theories, practice models, or perspectives. If so, the answers must directly relate to these approaches, whether or not they are the best means to address the problems.

### ***Q: Are conclusions about scenarios supported by explicit wording?***

Perhaps the biggest mistake that social workers make when reading vignettes is adding material to these questions. This is done unconsciously when social workers mistakenly think of clients or situations in their own practices that are similar to those described in the question. Social workers often view scenarios through a "micro practice lens," as most social workers work directly with individuals and families. However, a client in a scenario does not need to be an individual. It can be a family, organization, group, or community so an assumption should not be made that the term "client" refers to a single individual.

Unfortunately, as social workers are in the field longer, they are more likely to make this mistake as there are more instances in which

scenarios resemble their own practice experiences. For example, if clients are described as psychotic or threatening, they may be inappropriately judged as a danger to themselves or others because of social workers' past experiences with clients who were such. However, being psychotic or threatening does not necessarily imply danger. Clients can be threatening, but verbalizations could focus on not paying bills or refusing to continue with services. Threats do not necessarily involve physical harm unless it is explicitly stated in the vignettes.

To determine whether material is added to questions, ask what social workers doing macro practice might do as often the material that is added to questions involves clinical content. Social workers doing micro, mezzo, and macro social work draw from the same theoretical base and rely <sup>26</sup> on the same professional knowledge. Social workers must be able to competently apply all three practice methods in their work. Often when asking whether a social worker in a scenario could be providing macro services, test takers see the situation in a new light as many vignettes do not specify the practice method used. Social workers tend to assume that micro-level or clinical services were being delivered, but these are implicit biases. It is essential to recognize that all test takers tend to read and interpret questions based upon their own practice experiences. These experiences mean that information gets unconsciously added. It is always advisable to reread questions to ensure that conclusions are supported by empirical evidence and not just assumptions which are not sustained by question wording.

***Q: Are there quotation marks in the questions or response choices?***

Some questions include words or phrases in quotation marks that directly relate to identifying the KSAs and/or getting the correct answers. For example, a vignette may describe a client who walks into the first therapy session and states, "I don't have to tell you anything and I don't want to be here," followed by a question asking about a social worker's BEST response. Although this question does not explicitly state that it is asking how to best address resistance, it is doing so as evidenced by the client's statement. Words in quotation marks are there for a reason and usually have information that is essential for selecting correct answers.

Quotation marks can also be in response choices. Sometimes entire response choices are quoted statements, such as those which represent social workers' most appropriate reactions to clients' concerns or

behaviors in scenarios. Test takers must evaluate words or phrases in answers with the same diligence that they do so in questions.

***Q: Do response choices begin with verbs that can provide some assistance?***

Many of the response choices to questions on the examination begin with verbs. The verbs can provide valuable assistance, especially if you are debating between multiple response choices. For example, some response choices describe social workers taking action (“tell” or “arrange”) without mentioning any roles for clients. These response choices do not use an empowerment approach, which may help rule them out.

“Explore” and “engage” are verbs that usually indicate that social workers are working with clients to arrive at solutions. “Ignore” or “wait” may indicate that social workers are not helping clients address critical problems when needed.

Verbs can also be associated with phases of the problem-solving process. “Assure” is often associated with engagement, while “assess,” “ask,” and “determine” best describe assessment. If actions are supposed to occur at certain phases of the helping process, verbs must be examined to see if they are consistent with the requisite phase. In addition, test takers are often asked to order actions of social workers. If response choices represent different actions, examining the verbs to assist with ordering is helpful. “Acknowledge” is usually done before “explore” or “explain.”

Examining verbs which begin response choices is a helpful tool to use when two or more response choices appear equally viable. As not all response choices begin with verbs, it can only be used for some question formats. However, close attention must be paid to verb choice in some instances as it provides a concise way to determine if an action by a social worker is appropriate given material in the question, as well as where it is to occur within the problem-solving process.

***Q: Does the answer explicitly or implicitly involve the client?***

Social workers view clients as experts on their own situations and they <sup>27</sup> should be regarded as such. Often response choices on the examinations are not correct as they only mention social workers acting and do not involve collaboration with clients. Even when actions may

seem appropriate, they may be incorrect as they do not mention roles for the client. Test takers must view response choices carefully, asking whether clients are mentioned explicitly or implicitly. Response choices based on social workers making decisions about tasks in the problem-solving process, such as appropriate interventions, are not as good as those that base these decisions on discussions with clients. Even when social workers have sound advice or can take actions to assist clients, these answers are not preferred over those which mention working *with* clients to determine the reasons for the problems or intervene. The involvement of the client is often a crucial factor in answer selection.

***Q: Is a response choice being selected solely because it contains social work jargon or buzz words?***

ASWB examinations aim to determine whether social workers really understand the concepts being tested or are just selecting response choices because they sound correct or have answers that have social work “buzz words” such as “rapport,” “empathy,” “support system,” “joining with a client,” “strengths perspective,” “from a client’s perspective,” and so on. Often, social workers have a hard time eliminating response choices that contain jargon that is important to effective practice. These are key concepts that are the cornerstone of competent social work services. However, a word or catch phrase does not make a response choice correct. A response choice may not be correct because the other parts of it are inadequate, false, or simply do not address the problem needing attention.

When seeing social work “buzz words” in response choices, it is essential to read the response choices critically. Perhaps they will not be as appealing if synonyms for these “buzz words” are used in their place. Often incorrect response choices are made more appealing by adding social work jargon to see if test takers will be lured by their inclusion. Most of the time jargon is in the incorrect response choices, serving as distractors. Test takers should not be influenced by the inclusion of fancy social work terms in response choices and need to select response choices based on their substantive merits, ensuring that they directly relate to the assessment of the chosen KSAs.

***Q: Has the question format been examined and broken down into its requisite components?***

On the ASWB examinations, social workers often struggle with application and reasoning questions that require them to take what has been learned and use it to identify correct answers given hypothetical contexts. These items require test takers are frustrated as they do not know what is being asked in questions and how to choose between response choices which seem similar. Becoming more familiar with the construction of multiple-choice tests, as well as remembering concepts that are hallmarks within the social work profession, can greatly assist.

Many social workers do not have experience taking multiple-choice tests and are unfamiliar with the format of questions. Application and reasoning questions are like funnels with several important parts.

**Background**—Often a question starts with background information <sup>28</sup> such as why the client is receiving services, what type of services are being received, and/or demographic information about the client (such as age, gender identity, religion, sexual orientation, or other relevant data). The background, if present, is typically the first sentence of the question. If no background information is provided then it is not relevant to addressing the presenting problem or answering the question correctly.

**Presenting Problem or Issue**—Most questions ask test-takers to evaluate a variety of responses or actions to appropriately address identified concerns. Presenting problems can be briefly described in a sentence or two but are sometimes lengthier, such as in reasoning questions that are assessed using vignettes or scenarios. If there is background information provided in the question, the presenting problem or issue is described in the sentence or sentences between the background and the last sentence before the response choices. If there is no background information provided, the question begins with the problem or issue which commences with the last sentence before the response choice.

**Question Stem**—The last sentence or portion of a sentence before the response choices helps the test-taker understand the focus or intent of the question. The question stem often includes qualifying words or the lens that needs to be considered when evaluating the response choices, such as “using a task centered approach” or “a social justice perspective.” This last sentence or question stem is often very specific and points the test taker in the correct direction, establishing the criterion to be used when evaluating the response choices.

The following example identifies the key components of a question.

A client states that he has received services in the past and "it did not work out."	<i>Background</i>
He appears tense and angry, telling the social worker that he does not want the social worker to speak with his prior provider. In order to best assist the client, the social worker should FIRST:	<i>Presenting Problem or Issue</i>
	<i>Question Stem</i>
A. Assure the client that the prior provider will not be contacted without his permission	<i>Key</i>
B. Tell the client that services will only be focused on current problems	<i>Distractor</i>
C. Explain that effective treatment requires knowing what has been done in the past	<i>Distractor</i>

***Q: Has the question been read or referred to more than once to distinguish the correct answer (known as the key) from the incorrect response choices (known as distractors)?***

A key is the correct answer to the question which is based on content learned in social work educational programs. The ASWB tests assess knowledge so the key is superior to the alternatives based on conceptual information that was learned in school that is not contained in the other response choices.

Distractors are plausible, but incorrect response choices to a question. Rarely will response choices appear that can be easily eliminated. ASWB does not use "all of the above" or "none of the above" response choices. Distractors are similar in length and language to the keys or correct answer. Often distractors represent common mistakes made by social workers. Test takers often inappropriately select incorrect response <sup>29</sup> choices or distractors as they feel that they incorporate or overlap correct ones. Each response choice must be assessed based on the explicit wording used and social workers must not assume redundancy between them.

Often selecting the correct answer requires rereading or referring back to the question. A good strategy is eliminating incorrect response choices in an iterative process. After eliminating the first incorrect response choice, a test taker should reread the question so its intent is clear before selecting the correct answer from the remaining alternate choice.

These are principles that must be considered when distinguishing the key from distractors. While not exhaustive, these themes are consistent across questions and can be used to assist with identifying correct answers. However, the degree to which each is relevant to a particular question varies. A question to help with test-taking is listed after each relevant concept.

- Social workers have groups, organizations, and communities

clients.

- *Does the question specifically identify an individual or family as client or could the level of intervention be bigger (the client is a group, an organization, and/or a community)?*
- Social workers do all types of intervention including provision of concrete services, case management, policy practice, and community organization.
  - *Does the question explicitly state the type of service being provided or not, the KSA is universal across intervention types*
- Social workers respect client self-determination.
  - *Are any of the response choices more respectful of the client's right to make decisions?*
- Social workers are trained to identify the root causes of problems.
  - *Do any of the response choices address the underlying system issues rather than just those impacted?*
- Social workers engage collaboratively with clients.
  - *Do any of the response choices mention the client implicitly or explicitly as opposed to just the social worker?*
- Social workers use a systems approach to understanding functioning
  - *Do any of the response choices consider the interplay between biopsychosocial-cultural-spiritual functioning or the micro, mezzo, macro levels of intervention?*
- Social workers apply their knowledge in diverse settings and with many populations.
  - *Do any of the response choices reflect knowledge that can be generalized to all agencies, methods of practice, and client groups?*
- Social workers are committed to social justice and working with those who are oppressed.

- *Do any of the response choices ensure equal rights, especially for those who are poor and/or marginalized?*

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## **Section II**

# **Content and Practice Test for the ASWB Clinical Examination**

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# Self-Assessment

There is a separate content outline for each of the four ASWB<sup>33</sup> examinations (Bachelors, Masters, Clinical, and Advanced Generalist). However, there is tremendous overlap in content across these tests. Sometimes a KSA is not listed in the same content area or is described slightly differently (e.g., “theories of human development” versus “developmental theories”). However, the knowledge needed to competently answer questions in this area is the same.

The good news is that doing well on one ASWB examination often means performing well on another. It is always easier to remember material that has been already learned than to learn it for the first time!

It is very helpful to review the content outline to concentrate studying in areas in which more preparation is needed. Many of these topics look familiar as they are the basis of social work educational programs. Topics in which basic content and/or key terms cannot be remembered or recalled must be foci for studying and indicated by circling “1.” If some basic information and/or key terms is known about topics, there may be a need to fill in some gaps and “2” must be circled. Lastly, if all key concepts and terms of the topics, as well as their applicability to social work practice and impacts on client functioning, can be summarized, no additional preparation is needed and “3” can be circled. Adequate preparation means synthesizing material from multiple content areas and discussing all aspects of the KSAs easily and fluidly.





**Association of Social Work Boards'  
Content Outline for Clinical Examination**

	3 Well Prepared	2 Somewhat Prepared	1 Not Prepared
I. Human Development, Diversity, and Behavior in the Environment (24%)			
<i>Human Growth and Development</i>			
Theories of human development throughout the lifespan (e.g., physical, social, emotional, cognitive, behavioral)			
The indicators of normal and abnormal physical, cognitive, emotional, and sexual development throughout the lifespan	3	2	1
Theories of sexual development throughout the lifespan	3	2	1
Theories of spiritual development throughout the lifespan	3	2	1
Theories of racial, ethnic, and cultural development throughout the lifespan	3	2	1
The effects of physical, mental, and cognitive disabilities throughout the lifespan	3	2	1
The interplay of biological, psychological, social, and spiritual factors	3	2	1
Basic human needs	3	2	1
The principles of attachment and bonding	3	2	1
The effect of aging on biopsychosocial functioning	3	2	1
Gerontology	3	2	1
Personality theories	3	2	1
Factors influencing self-image (e.g., culture, race, religion/spirituality, age, disability, trauma)	3	2	1
Body image and its impact (e.g., identity, self-esteem, relationships, habits)	3	2	1
Parenting skills and capacities	3	2	1
Basic principles of human genetics	3	2	1
The family life cycle	3	2	1
Models of family life education in social work practice	3	2	1
The impact of aging parents on adult children	3	2	1
Systems and ecological perspectives and theories	3	2	1
Strengths-based and resilience theories	3	2	1
The dynamics and effects of loss, separation, and grief	3	2	1
<i>Human Behavior in the Social Environment</i>			
Person-in-environment (PIE) theory	3	2	1
Family dynamics and functioning and the effects on individuals, families, groups, organizations, and communities	3	2	1

The dynamics of interpersonal relationships	3	2	1
		35	
Indicators and dynamics of abuse and neglect throughout the lifespan	3	2	1
The effects of physical, sexual, and psychological abuse on individuals, families, groups, organizations, and communities	3	2	1
The characteristics of perpetrators of abuse, neglect, and exploitation	3	2	1
The effects of life events, stressors, and crises on individuals, families, groups, organizations, and communities	3	2	1
The impact of stress, trauma, and violence	3	2	1
Crisis intervention theories	3	2	1
The effect of poverty on individuals, families, groups, organizations, and communities	3	2	1
The impact of the environment (e.g., social, physical, cultural, political, economic) on individuals, families, groups, organizations, and communities	3	2	1
Social and economic justice	3	2	1
Theories of social change and community development	3	2	1
The impact of social institutions on society	3	2	1
The impact of globalization on clients/client systems (e.g., interrelatedness of systems, international integration, technology, environmental or financial crises, epidemics)	3	2	1
Criminal justice systems	3	2	1
The impact of out-of-home placement (e.g., hospitalization, foster care, residential care, criminal justice system) on clients/client systems	3	2	1
Theories of couples development	3	2	1
The impact of physical and mental illness on family dynamics	3	2	1
Co-occurring disorders and conditions	3	2	1
The impact of caregiving on families	3	2	1
Psychological defense mechanisms and their effects on behavior and relationships	3	2	1
Addiction theories and concepts	3	2	1
The effects of addiction and substance abuse on individuals, families, groups, organizations, and communities	3	2	1
The indicators of addiction and substance abuse	3	2	1
Role theories	3	2	1
Feminist theory	3	2	1
Theories of group development and functioning	3	2	1
Communication theories and styles	3	2	1
Theories of conflict	3	2	1
<i>Diversity and Discrimination</i>			
The effect of disability on biopsychosocial functioning throughout the lifespan	3	2	1

The effect of culture, race, and ethnicity on behaviors, attitudes, and identity	3	2	1
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The effects of discrimination and stereotypes on behaviors, attitudes, and identity	3	2	1
The influence of sexual orientation on behaviors, attitudes, and identity	3	2	1
The impact of transgender and transitioning process on behaviors, attitudes, identity, and relationships	3	2	1
Systemic (institutionalized) discrimination (e.g., racism, sexism, ageism)	3	2	1
The principles of culturally competent social work practice	3	2	1
Sexual orientation concepts	3	2	1
Gender and gender identity concepts	3	2	1
II. Assessment, Diagnosis, and Treatment Planning (30%)			
<i>Biopsychosocial History and Collateral Data</i>			
The components of a biopsychosocial assessment	3	2	1
Techniques and instruments used to assess clients/client systems	3	2	1
The types of information available from other sources (e.g., agency, employment, medical, psychological, legal, or school records)	3	2	1
Methods to obtain sensitive information (e.g., substance abuse, sexual abuse)	3	2	1
The principles of active listening and observation	3	2	1
The indicators of sexual dysfunction	3	2	1
Symptoms of neurologic and organic disorders	3	2	1
<i>Assessment and Diagnosis</i>			
The factors and processes used in problem formulation	3	2	1
Methods of involving clients/client systems in problem identification (e.g., gathering collateral information)	3	2	1
The components and function of the mental status examination	3	2	1
Methods to incorporate the results of psychological and educational tests into assessment	3	2	1
The indicators of psychosocial stress	3	2	1
The indicators, dynamics, and impact of exploitation across the lifespan (e.g., financial, immigration status, sexual trafficking)	3	2	1
The indicators of traumatic stress and violence	3	2	1
Methods used to assess trauma	3	2	1
Risk assessment methods	3	2	1
The indicators and risk factors of the client's/client system's danger	3	2	1

to self and others

Methods to assess the client's/client system's strengths, resources,  
and challenges (e.g., individual, family, group, organization,  
community)

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The indicators of motivation, resistance, and readiness to change	3	2	1
Methods to assess motivation, resistance, and readiness to change	3	2	1
Methods to assess the client's/client system's communication skills	3	2	1
Methods to assess the client's/client system's coping abilities	3	2	1
The indicators of the client's/client system's strengths and challenges	3	2	1
Methods to assess ego strengths	3	2	1
The use of the Diagnostic and Statistical Manual of the American Psychiatric Association	3	2	1
The indicators of mental and emotional illness throughout the lifespan	3	2	1
Biopsychosocial factors related to mental health	3	2	1
Biopsychosocial responses to illness and disability	3	2	1
Common psychotropic and non-psychotropic prescriptions and over-the-counter medications and their side effects	3	2	1
The indicators of somatization	3	2	1
The indicators of feigning illness	3	2	1
Basic medical terminology	3	2	1
The indicators of behavioral dysfunction	3	2	1
Placement options based on assessed level of care	3	2	1
Methods to assess organizational functioning (e.g., agency assessments)	3	2	1
Data collection and analysis methods	3	2	1

#### *Treatment Planning*

Methods to involve clients/client systems in intervention planning	3	2	1
Cultural considerations in the creation of an intervention plan	3	2	1
The criteria used in the selection of intervention/treatment modalities (e.g., client/client system abilities, culture, life stage)	3	2	1
The components of intervention, treatment, and service plans	3	2	1
Theories of trauma-informed care	3	2	1
Methods and approaches to trauma-informed care	3	2	1
The impact of immigration, refugee, or undocumented status on service delivery	3	2	1
Methods to develop, review, and implement crisis plans	3	2	1
Discharge, aftercare, and follow-up planning	3	2	1
Techniques used to evaluate a client's/client system's progress	3	2	1
Methods, techniques, and instruments used to evaluate social work practice	3	2	1
The principles and features of objective and subjective data	3	2	1
Basic and applied research design and methods	3	2	1
Methods to assess reliability and validity in social work research	3	2	1

### III. Psychotherapy, Clinical Interventions, and Case Management (27%)

#### *Therapeutic Relationship*

The components of the social worker-client/client system relationship	3	2	1
The principles and techniques for building and maintaining a helping relationship	3	2	1
The dynamics of power and transparency in the social worker-client/client system relationship	3	2	1
The social worker's role in the problem-solving process	3	2	1
Methods to clarify the roles and responsibilities of the social worker and client/client system in the intervention process	3	2	1
The concept of acceptance and empathy in the social worker-client/client system relationship	3	2	1
The dynamics of diversity in the social worker-client/client system relationship	3	2	1
The effect of the client's developmental level on the social worker-client relationship	3	2	1
The impact of domestic, intimate partner, and other violence on the helping relationship	3	2	1
Verbal and nonverbal communication techniques	3	2	1
The concept of congruence in communication	3	2	1
Methods to obtain and provide feedback	3	2	1

#### *The Intervention Process*

The principles and techniques of interviewing (e.g., supporting, clarifying, focusing, confronting, validating, feedback, reflecting, language differences, use of interpreters, redirecting)	3	2	1
The phases of intervention and treatment	3	2	1
Problem-solving models and approaches (e.g., brief, solution-focused methods or techniques)	3	2	1
The client's/client system's role in the problem-solving process	3	2	1
Methods to engage and motivate clients/client systems	3	2	1
Methods to engage and work with involuntary clients/client systems	3	2	1
Limit setting techniques	3	2	1
The technique of role play	3	2	1
Role modeling techniques	3	2	1
Techniques for harm reduction for self and others	3	2	1
Methods to teach coping and other self-care skills to clients/client systems	3	2	1
Client/client system self-monitoring techniques	3	2	1
Methods of conflict resolution	3	2	1
Crisis intervention and treatment approaches	3	2	1
Anger management techniques	3	2	1
Stress management techniques	3	2	1

The impact of out-of-home displacement (e.g., natural disaster, homelessness, immigration) on clients/client systems	3	2	1
Methods to create, implement, and evaluate policies and procedures that minimize risk for individuals, families, groups, organizations, and communities	3	2	1
Psychotherapies	3	2	1
Psychoanalytic and psychodynamic approaches	3	2	1
Cognitive and behavioral interventions	3	2	1
Strengths-based and empowerment strategies and interventions	3	2	1
Client/client system contracting and goal-setting techniques	3	2	1
Partializing techniques	3	2	1
Assertiveness training	3	2	1
Task-centered approaches	3	2	1
Psychoeducation methods (e.g., acknowledging, supporting, normalizing)	3	2	1
Group work techniques and approaches (e.g., developing and managing group processes and cohesion)	3	2	1
Family therapy models, interventions, and approaches	3	2	1
Couples interventions and treatment approaches	3	2	1
Permanency planning	3	2	1
Mindfulness and complementary therapeutic approaches	3	2	1
Techniques used for follow-up	3	2	1
Time management approaches	3	2	1
Community organizing and social planning methods	3	2	1
Methods to develop and evaluate measurable objectives for client/client system intervention, treatment, and/or service plans	3	2	1
Primary, secondary, and tertiary prevention strategies	3	2	1
The indicators of client/client system readiness for termination	3	2	1
<i>Service Delivery and Management of Cases</i>			
The effects of policies, procedures, regulations, and legislation on social work practice and service delivery	3	2	1
The impact of the political environment on policy-making	3	2	1
Theories and methods of advocacy for policies, services, and resources to meet clients'/client systems' needs	3	2	1
Methods of service delivery	3	2	1
The components of case management	3	2	1
The principles of case recording, documentation, and management of practice records	3	2	1
Methods to establish service networks or community resources	3	2	1
Employee recruitment, training, retention, performance appraisal, evaluation, and discipline	3	2	1

Case recording for practice evaluation or supervision	3	2	1
			40
Methods to evaluate agency programs (e.g., needs assessment, formative/summative assessment, cost effectiveness, cost-benefit analysis, outcomes assessment)	3	2	1
The effects of program evaluation findings on services	3	2	1
Quality assurance, including program reviews and audits by external sources	3	2	1
<i>Consultation and Interdisciplinary Collaboration</i>			
Leadership and management techniques	3	2	1
Models of supervision and consultation (e.g., individual, peer, group)	3	2	1
Educational components, techniques, and methods of supervision	3	2	1
The supervisee's role in supervision (e.g., identifying learning needs, self-assessment, prioritizing, etc.)	3	2	1
Methods to identify learning needs and develop learning objectives for supervisees	3	2	1
The elements of client/client system reports	3	2	1
The elements of a case presentation	3	2	1
The principles and processes for developing formal documents (e.g., proposals, letters, brochures, pamphlets, reports, evaluations)	3	2	1
Consultation approaches (e.g., referrals to specialists)	3	2	1
Methods of networking	3	2	1
The process of interdisciplinary and intradisciplinary team collaboration	3	2	1
The basic terminology of professions other than social work (e.g., legal, educational)	3	2	1
Techniques to inform and influence organizational and social policy	3	2	1
Methods to assess the availability of community resources	3	2	1
Techniques for mobilizing community participation	3	2	1
Methods to establish program objectives and outcomes	3	2	1
Governance structures	3	2	1
The relationship between formal and informal power structures in the decision-making process	3	2	1
Accreditation and/or licensing requirements	3	2	1

#### IV. Professional Values and Ethics (19%)

##### *Professional Values and Ethical Issues*

Legal and/or ethical issues related to the practice of social work, including responsibility to clients/client systems, colleagues, the profession, and society	3	2	1
Techniques to identify and resolve ethical dilemmas	3	2	1

The client's/client system's right to refuse services (e.g., medication, medical treatment, counseling, placement, etc.)	3	2	1
Professional boundaries in the social worker-client/client system relationship (e.g., power differences conflicts of interest, etc.)	3	2	1

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Ethical issues related to dual relationships	3	2	1
Self-disclosure principles and applications	3	2	1
The principles and processes of obtaining informed consent	3	2	1
Legal and/or ethical issues regarding documentation	3	2	1
Legal and/or ethical issues regarding termination	3	2	1
Legal and/or ethical issues related to death and dying	3	2	1
Research ethics (e.g., institutional review boards, use of human subjects, informed consent)	3	2	1
Ethical issues in supervision and management	3	2	1
Methods to create, implement, and evaluate policies and procedures for social worker safety	3	2	1

#### *Confidentiality*

The use of client/client system records	3	2	1
Legal and/or ethical issues regarding confidentiality, including electronic information security	3	2	1
Legal and/or ethical issues regarding mandatory reporting (e.g., abuse, threat of harm, impaired professionals, etc.)	3	2	1

#### *Professional Development and Use of Self*

Professional values and principles (e.g., competence, social justice, integrity, and dignity and worth of the person)	3	2	1
Professional objectivity in the social worker-client/client system relationship	3	2	1
Techniques for protecting and enhancing client/client system self-determination	3	2	1
Client/client system competence and self-determination (e.g., financial decisions, treatment decisions, emancipation, age of consent, permanency planning)	3	2	1
The influence of the social worker's own values and beliefs on the social worker-client/client system relationship	3	2	1
The influence of the social worker's own values and beliefs on interdisciplinary collaboration	3	2	1
The impact of transference and countertransference in the social worker-client/client system relationship	3	2	1
The impact of transference and countertransference within supervisory relationships	3	2	1
The components of a safe and positive work environment	3	2	1

Social worker self-care principles and techniques	3	2	1
Burnout, secondary trauma, and compassion fatigue	3	2	1
Evidence-based practice	3	2	1
Professional development activities to improve practice and maintain current professional knowledge (e.g., in-service training, licensing requirements, reviews of literature, workshops)	3	2	1

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# Key Social Work Terms

## **SOME IMPORTANT SOCIAL WORK TERMS**

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In addition to terms defined in other parts of this study guide, these 300 words or concepts are important for social workers to know as they relate to one or more of the content areas on the social work licensing exam. Studying words that may be unfamiliar will help with performance on recall or application questions. These words could also appear in reasoning questions that contain scenarios or vignettes. Sometimes the actual terms do not appear, but questions ask about key concepts that are related to these terms.

**aberrant:** markedly different from an accepted norm; deviant, atypical or nonconforming

**abstinence:** practice of not doing something; often used to describe an activity which may be enjoyable such as drinking alcohol or engaging in sexual activity

**act of commission:** engaging in an act of malfeasance when knowing the action or omission is illegal

**act of omission:** failure to perform a legal duty; social work task that is not done despite the need to do so according to established standard of care

**acuity:** sharpness or ability, particularly of the mind, vision, or hearing

**acute:** short or episodic; often characterized by high intensity and unanticipated (sudden onset); not chronic

**ad hoc:** created or done for a particular needed purpose; occurs temporarily to fulfil a given need

**advance directive:** written statement of wishes regarding medical treatment to ensure those wishes are honored in the event that they cannot be communicated to doctors; types of advance directives, include, but are not limited to, living wills, medical powers of attorney and do-not-resuscitate (DNR) orders

**adverse event:** a harmful or negative occurrence which is often unanticipated; sometimes resulting from a medication or other intervention, such as surgery

**age of consent:** legal age at which a minor can legally engage in a behavior without parental consent; varies by jurisdiction and type of activity; minors are granted right to confidentiality if they are over the age of consent as they are regarded in same manner as adults

**agranulocytosis:** decline in the number of white blood cells,<sup>44</sup> typically due to a medication reaction; can be caused by clozapine and certain antipsychotics

**altruistic:** genuinely interested in or committed to the well-being of others

**amelioration:** aimed at improving or making better; lessening of symptoms or severity of disease, illness, or disorder; eradicating a social problem

**antecedents:** things or events that existed before or logically precede others; often identified as causes of maladaptive behaviors

**antianxiety medication:** drug used to reduce or alleviate symptoms of anxiety disorders; known as anxiolytics or tranquilizers, work by targeting certain neurotransmitters in the brain to promote relaxation, reduce excessive worry, and alleviate feelings of anxiety

**antidepressant medication:** drug used to treat depression by targeting neurotransmitters in the brain, such as serotonin, norepinephrine, or dopamine

**antipsychotic medication:** drug used to manage symptoms of psychosis, such as hallucinations, delusions, and disorganized thinking

**antisocial behavior:** actions that deviates from social norms and violates the rights of others such as crime, delinquency, and aggression

**apathy:** lack of interest, motivation, or emotion; often seen in conditions like depression

**assent:** agreement or approval by someone not able to give legal consent due to age or cognitive ability

**assisted suicide:** life-ending actions done with the help of others, especially the taking of lethal drugs provided by doctors to those with terminal illnesses or incurable conditions

**attachment theory:** psychological framework that explores the emotional bonds and connections individuals form with primary caregivers in early childhood and their impact on development

**atrophy:** decreasing in size and function; shrinkage of muscle or nerve tissue; can be caused by aging, inactivity, malnutrition, and other injuries, illnesses, and conditions

**authoritarian parenting:** children expected to follow strict rules established by the parents; failure to do results in punishment

**authoritative parenting:** caregivers establish rules and guidelines that children are expected to follow; more democratic than authoritarian as nurturing and forgiving if rules are not followed

**aversion therapy:** behavior therapy designed to make clients give up undesirable habits by causing them to associate these habits with unpleasant effects

**avolition:** total lack of motivation that makes it hard to get anything done

**barbiturates:** group of drugs known as sedative-hypnotics; derived from barbituric acid; addictive and life-threatening withdrawal symptoms; declining use in recent years

**bartering:** acceptance of services, goods or other non-monetary payments from clients in return for services; creates the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients; only permissible in very limited cultural contexts

**beneficence:** to act for the benefit of others; moral obligation of <sup>45</sup> helping professionals to do no harm and act in the best interest of others

**benign:** not damaging or threatening to life; often used to describe growths that are not cancerous

**benzodiazepines:** drugs that depress central nervous system activity and relax muscles; used in the treatment of generalized anxiety, panic disorder, and insomnia; can help with withdrawal from alcohol; replaced the use of barbiturates due to fewer risks associated with overdose

**bereavement:** period of mourning or grief; often occurs after the death of a family member or close friend

**biofeedback:** techniques to psychologically lower physiological processes such as heart rate, muscle tension, and blood pressure; used for tension relief

**biopsychosocial assessment:** integrated evaluation that considers biological, psychological, and social factors to understand health and well-being

**boundary crossing:** intentionally or unintentionally deviating from established professional standards dictated by professional relationships; harmless, non-exploitative

**boundary violation:** harmful or potentially harmful deviation from established professional standards dictated by professional relationships; often involves exploitation

**broker:** social work role that focuses on identification of, location of, and linkage to community resources

**callous:** showing no emotion toward or concern for others; lacking empathy for the feelings or experiences of others

**capitation:** payment structure used with insurance companies; provider or facility is paid a fixed amount for each person; risk is taken by entity to deliver services under cost of contract; incentive to provider or facility to promote wellness

**case advocacy:** mediating, negotiating and navigating systems on behalf of and in collaboration with an individual or family in need of change

**catastrophizing:** assuming the worse when faced with the unknown; can lead to excessive worry or increased anxiety

**catalyst:** social work role that focuses on promoting change to eradicate inequities or promote social justice; achieved through developing humane service delivery, advocating for just social and environmental policy, and supporting a worldview that acknowledges global interdependence

**catatonia:** disturbance of motor functioning which can include muscular rigidity or adoption of bizarre postures; associated with some psychological disorders; commonly referred to as “catatonic state”

**catharsis:** the release of repressed emotions due to trauma that are brought back into consciousness; expression of strong emotions which have been “pent up”; needed for healing

**cause advocacy:** working to change how organizations and institutions operate, as well as how they affect governmental policy decisions and guidelines; often called class advocacy

**chaining:** operant conditioning technique to learn complex tasks <sup>46</sup> by reinforcing steps in a series; forward chaining involves reinforcing first step until it is learned and then doing same for next step until entire task is learned

**chronic:** long standing; persisting for a long time or reoccurring; continual

**cisgender:** having gender identity that corresponds to the gender roles for one's birth sex

**civil commitment:** court-ordered hospitalization or institutionalization due to danger to self or others; also called “involuntary commitment” or “involuntary hospitalization”

**client-centered therapy:** self-discovery and actualization occur in response to consistent empathic understanding of and respect for

views; growth results from reflection and clarification that includes resolving conflicts, reorganizing values and approaches to life, and learning how to interpret thoughts and feelings

**client self-monitoring:** form of data-gathering in which clients are asked to systematically observe and record specific targets such as their own thoughts, emotions, body feelings, and behaviors; often used in cognitive behavioral therapy

**close-ended questioning:** soliciting information which requires choice from a limited number of options (such as yes/no); used to structure assessment; beneficial when time is limited or specific information required

**codependency:** being emotionally reliant on another; used to describe two people who are emotionally dependent on one another; used to describe a dysfunctional relationship in which one person engages in behaviors that enable dysfunction by another

**cognitive dissonance:** holding two beliefs, values, or attitudes that contradict each other; can cause mental discomfort and psychological stress

**cognitive distortions:** inaccurate, irrational views of reality which may serve to assist with coping from adverse events; unhealthy thoughts which are often addressed in cognitive behavioral therapy

**cognitive restructuring:** therapeutic process of assisting clients to see errors in thinking and self-defeating beliefs so that they can be replaced with more positive and productive thought patterns

**collateral contact:** a third party who has firsthand knowledge client's circumstances and can be used to verify or supplement information

**collateral information:** records or documents associated with the client that are used in the problem-solving process; may be used to corroborate information provided by the client

**color blindness:** disregard of racial differences and structural inequities within institutions

**comorbidity:** occurring at the same time, such as having a psychological and medical problem simultaneously; often referred to as co-occurring

**compassion fatigue:** stress resulting from working with those who have experienced trauma; symptoms include apathy, feeling overwhelmed, exhaustion, pessimism, and feeling powerlessness; sometimes referred to as the “cost of caring”

**complementarity:** supplementing or enhancing the qualities of <sup>47</sup> another; a balance within a relationship due to feeling that another compliments or adds to the union

**complementary medicine:** encompasses treatments that fall outside of the scope of scientific medicine, but can be used as an ancillary interventions; examples include acupuncture, massage, chiropractic, and osteopathy (manipulation and massage of the joints, bones, and muscles)

**compulsion:** behavior that must be performed to avoid distressing situations or adverse outcomes; behavior for which person is driven or compelled to prevent psychic stress or distress

**compulsory:** required or mandated; must be done due to rule or law

**confabulation:** unconsciously compensating for gaps in memory by making up stories or details; causes include memory disorders, injuries, and mental health disorders

**confirmation bias:** tendency to select information that confirms existing beliefs; impacts gathering and recalling of information

**conflict resolution:** informal or formal process that two or more parties use to find an acceptable solution to a dispute or disagreement

**confrontation:** therapeutic technique of calling attention to distorted thinking, behavioral patterns, or ineffective communication so that it can be addressed

**congenital:** medical or physical characteristic present since birth; also used to describe a habit that is firmly established such as lying

**congruent communication:** verbal and nonverbal language and actions provide consistent messages; important for intimacy and emotional connection

**conjunctive therapy:** partners in a relationship or members of a family are treated together in joint sessions, instead of being treated separately; also called conjunctive counseling

**consent:** legal permission for something to happen or agreement to do something; cannot be obtained from those not legally authorized to make decisions

**consultation:** usually time-limited work or guidance provided due to specialized expertise; advice does not have to be followed (non-binding)

**continuity of care:** ensuring that there are no gaps or duplication in service; often a focus when moving from one provider to another, or being discharged from a hospital or other inpatient setting

**continuum of care:** range of services geared to address varying levels of need from most to least severe; needed to appropriately

address problems as they get better and/or worse

**contraindication:** reason for a person not to receive a medication, treatment, or intervention as it not appropriate and/or could be harmful

**convalescence:** time spent recovering from an illness, injury, or other medical condition; often referred to a “recuperation”

**conversion therapy:** process that aims to change those attracted to others of the same gender to become solely heterosexual; considered unethical by NASW, as well as the professional organizations of psychologists and psychiatrists; supported by some religious groups; also called “reparative therapy”

**cooptation:** strategy for reducing resistance by including <sup>48</sup> opponents in decision making; aims to change viewpoints of those who are oppositional

**corroboration:** independent evidence that confirms or supports something

**countertransference:** emotional reaction of helper which can be used to identify the reaction of others to the one being assisted; based on the helper’s own psychological needs which are revealed through conscious responses; historically seen as a hinderance, but now viewed as helpful to the therapeutic process

**court-appointed examiner:** professional sanctioned by the court to evaluate and generate a report to be used in legal proceedings; must report all relevant information back to the court

**cultural humility:** lifelong commitment to self-reflection, learning, and respectful engagement with diverse cultures, recognizing the limitations of one’s own knowledge and experiences

**cultural pluralism:** recognition and accommodation of those from various racial, religious, ethnic, and other diverse groups; willingness and commitment to work together despite freedom to practice own traditions

**decompensation:** loss of typical functioning; can relate to coherent thought, emotional regulation, activities of daily living, and/or cognitive functioning

**defense mechanism:** mental process, typically unconsciously, to avoid conscious conflict or anxiety

**deleterious:** harmful, hazardous, or detrimental

**delirious:** incoherence of thought or speech; incoherent; also been used to describe someone who is wildly excited

**delirium:** disordered thought that can include changes in cognition (disorientation, memory impairment, or language disturbance), hallucinations, restlessness, and misinterpretation of sounds or sights; acute state which develops quickly; can fluctuate over a short period; multiple etiologies; usually temporary and treatable

**delusion:** false, fixed belief despite evidence to the contrary; believing something that is not true

**delusion of grandeur:** false sense of great ability, knowledge, worth, and so forth

**dementia:** general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life; primarily impacts those over the age of 65; likelihood of developing dementia significantly increases with age

**depersonalization:** feeling estranged from oneself and usually from the external world; often occurs as a result of a traumatic

experience; characteristic of some mental disorders

**desensitization:** gradual reduction in adverse reaction to stimuli due to exposure or as a result of behavioral techniques aimed at reducing anxiety or fear

**detoxification:** process which aims to remove drugs or other harmful substances from the body; must be closely monitored as can have life threatening consequences associated with withdrawal

**developmental disability:** condition occurring before <sup>49</sup> adulthood that results in life-long functional impairment; may be due to genetic or other disorder present at birth or an accident during childhood that causes significant difficulties with cognition, mobility, and/or other functional domains

**deviance:** actions that are considered inappropriate or a typical; data that varies significantly from the norm

**diagnostic-related groups:** classification system that standardizes payment to hospitals based on the care given to and resources used by a “typical” patient with similar characteristics and diagnosis/treatment needs; covers all charges from the time of inpatient admission to discharge

**diagnostic overshadowing:** tendency to attribute clients’ symptoms or difficulties solely to their mental health diagnosis, overlooking other factors or underlying issues

**dialectic:** uncovering the truth through debate of contradicting viewpoints; rooted in a type of cognitive behavioral therapy found effective with suicidal behavior and borderline personality disorder; therapy using this approach focuses on regulating emotions, being mindful, and learning to accept pain

**differential diagnosis:** process of distinguishing between mental, physical, or other problems that result in similar symptoms or might be causes for behavior

**discounting the positive:** explaining the positive as luck or an isolated instance; like mental filtering, but do not overlook the negative (just choose to minimize its importance)

**double bind:** contradictory messages or requests in which affirmatively responding to one negates the other; situation in which any choice results in unpleasant outcome

**dual relationship:** having another association with a client, such as friend, family member, intimate partner, coworker, and so forth; should be avoided due to boundary violations

**dysphoria:** general sense of dissatisfaction

**dysthymia:** persistent depressive disorder; chronic, but mild so easily treatable

**eco-map:** graphical representation that shows all of the systems at play in a client's life

**echolalia:** non-voluntary, unsolicited repetition of words or sounds associated with a mental condition; may also be used to describe children repeating words or sounds when learning to talk

**eclectic therapy:** use of multiple clinical approaches in order to select the best treatment for each individual client

**ecological perspective:** focuses on the interrelationship between individuals and their environment; emphasis on the interactions between people and the larger contexts in which they exist

**ego:** part of the personality that mediates between the desires of the id (unconscious instincts) and the constraints of the superego (internalized rules and values)

**egocentric:** little to no regard for others' interests, beliefs, or attitudes

**ego dystonic:** thoughts, impulses, or wishes that are repugnant or unacceptable to one's sense of self; sometimes referred to as "ego alien"

**ego psychology:** emphasizes the capacity for logical thinking<sup>50</sup> in controlling impulses, planning, and dealing with the external environment

**ego syntonic:** thoughts, impulses, or wishes that are acceptable to self as they are compatible with one's views and ways of thinking

**elimination disorder:** condition which involves defecation or urination; usually occurs in children or adults with intellectual disabilities; not due to the use of substances or medical problems

**emancipated minor:** youth who has not reached the age of adulthood (18 in most states) but may claim legal rights as an adult

**enabler:** social work role which focuses on increasing coping skills or alleviating stress; conveying hope, reducing resistance, helping to manage feelings, and partializing problems are central; family role which focuses on protecting those who are dysfunctional by making excuses or remedying the consequences of harmful actions

**encopresis:** passage of feces which is involuntary; may be due to emotional or psychological problems; often treated with behavioral intervention; medical causes should be ruled out

**endogenous depression:** depression that cannot be linked to an external psychological stressor so it is assumed to be caused by a biological or genetic factor

**enmeshed family:** members have little to no autonomy or personal boundaries

**entitlement:** feeling that special consideration is deserved; right or benefit of a person or group; benefit program for which one has the legal right to receive

**entropy:** degree of chaos, randomness, disorganization, and disorder in a system or family

**enuresis:** urination that is involuntary; may be caused by medical problem, which should first be ruled out, or psychological distress

**equifinality:** concept that similar outcomes can stem from different experiences

**equilibrium:** state of balance or stability

**equity:** approach to resource allocation in which individuals receive their fair share of the goods and services in society; distinct from equality which provides each resources to all as equity sometimes required treating people differently from others to compensate to lack of opportunities

**ethnocentrism:** judging one's own social, cultural, or racial group as superior to others; tendency to view and/or judge others' ethnicity in light of one's own

**etiology:** cause of a behavior, disorder, or disease; root of the problem

**euphoria:** elevated mood; excessive state not due to external events can be associated with mania, a characteristic of bipolar disorder

**euthanasia:** practice of intentionally ending life to eliminate pain and suffering; usually distinguished from assisted suicide as action is done by another

**evidence-based practice:** use of best scientific knowledge, based on explanatory studies using experimental designs, to guide professional interventions

**existential therapy:** focuses on free will, personal choice, and <sup>51</sup> the search for meaning; aims to enhance self-awareness and understanding; stresses personal responsibility for existence and meaning of life

**exogenous depression:** depression caused by a distressing event or situation; also called “reactive depression”

**expressive communication:** ability to communicate thoughts and feelings through words, gestures, signs, and/or symbols; communication “output”

**extinction:** fading and disappearance of behavior that was previously learned by association with another event; behavior eventually becomes extinct if reward no longer follows the behavior

**external locus of control:** belief that outcomes are not under one's control, but rather due to environmental factors, luck, chance, or randomness

**external validity:** extent to which results are generalizable

**expressive therapies:** therapeutic approaches that incorporate creative and expressive mediums, such as art, music, or dance, to

promote self-expression, healing, and personal growth

**factitious disorder:** serious mental disorder in which someone deceives others by appearing sick (imposed on self), by getting sick or by self-injury; caregivers can falsely present others, such as children, as being ill, injured, or impaired (imposed on another); formerly called Munchausen or Munchausen by proxy syndrome

**false memory syndrome:** condition in which a person has an apparent recollection of an event that did not actually occur, especially one of childhood sexual abuse

**false positive:** inaccurate test results indicating positive findings (or presence of a condition) when they are really negative (or condition is not present)

**feasibility study:** assessment to determine whether goals, objectives, or plans are achievable given available resources

**feces:** excrement (stool) discharged from the intestines

**fee splitting:** receiving compensation for referrals made to other professionals; unethical in social work practice

**fee-for-service:** payment method for services, in which providers set their own fees, that are paid in part or full by recipients and/or insurance companies

**fetish:** object or nonsexual part of the body that causes sexual excitement; object, idea, or behavior that is the focus of irrational devotion or excessive attention

**fixation:** obsessive preoccupation with an idea, impulse, or aim

**flashbacks:** vivid and intrusive re-experiences of traumatic events, often associated with post-traumatic stress disorder (PTSD)

**flooding:** behavioral technique in which stimuli that cause anxiety are presented with regularity and intensity so that they no longer produce the adverse response

**folie à deux:** identical or similar mental disorder affecting two or more individuals, usually the members of a close family; while not restricted to can often involve paranoid delusions

**formative evaluation:** gathering and analyzing feedback <sup>52</sup> during the development or implementation of a program, project, or product; often used to help improve processes

**formulary:** listing of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits

**free association:** process used in psychoanalysis which encourages client to verbalize whatever thoughts come to mind, no matter how embarrassing, illogical, or irrelevant; allows unconscious ideas and feelings to be revealed so they can be interpreted

**generativity:** orientation towards making the world a better place for others; benevolence; most commonly occurs during middle adulthood according to Erickson

**genogram:** diagram illustrating a client's family members, how they are related, and their medical history; used to see hereditary patterns of behavior and medical and psychological factors that are shared or influential

**gestalt therapy:** focuses on becoming more aware of and taking responsibility for one's own actions, as well as recognizing distortions in thinking; emphasis on "here and now"; encourages reenactments and role plays to better understand behavior

**ghost sickness:** nightmares, weakness, loss of appetite, fear, anxiety, hallucinations, confusion, and so forth that are attributed to the deceased or supernatural; cultural belief

**grandiosity:** exaggerated sense of self, importance, or ability; may be regarded as a delusion of grandeur when extreme

**groupthink:** when a group of individuals reaches a consensus without critical evaluation of the consequences or alternatives

**guided imagery:** using calming mental images to achieve a relaxed, focused state to manage stress/pain, promote healing, or enhance performance. also called “visualization”

**gustatory hallucinations:** tasting something that is not present; can be of an inedible object, such as metal

**hallucination:** false sensory perception that is believed to be real though it is not; most common are auditory and visual; typically a symptom of a psychotic disorder, but can be caused by substance use, medical problem, or another condition

**health care proxy:** document that designates a person to make health care decisions in situations in which the designee is unable to do so; differs from living will which identifies what life-saving measures are desired; both are considered advanced directives

**hematuria:** presence of blood in a person's urine; characterized as “gross” when blood can be easily seen or “micro” when it cannot but it is visible under a microscope

**hero:** family role which attempts to draw attention away from the dysfunction by excelling and performing well

**histrionic behavior:** manipulative behavior that is dramatic, demanding, self-indulgent, and attention seeking

**homeopathy:** based on the belief that the body can cure itself <sup>53</sup> through the use of natural substances like plants and minerals; use of natural elements trigger body's natural responses; sometimes referred to as "alternative medicine"

**homeostasis:** maintenance of a stable balance, evenness, or symmetry within a system

**humanistic psychology:** focus on humans as individuals; concerned with the fullest growth in the areas of love, fulfillment, self-worth, and autonomy; take issue with deterministic approach which posits that people's behavior is predominantly driven by behavioral stimuli and early childhood experiences

**hypochondriasis:** abnormal preoccupation with health and a fear of having or getting a disease despite physical evidence to the contrary; known as illness anxiety disorder

**hypomania:** milder version of mania that lasts for a short period (usually a few days); characterized by elevated mood, enhanced irritability, higher energy level, being more talkative, and/or feeling more confident; does not cause significant distress or greatly impair functioning related to work, family or social life like mania

**id:** part of the personality that contains the instinctual, biological drives; most primitive component of the personality; located in the unconscious; desire for immediate gratification begins in infancy, until the ego begins to develop

**ideas of reference:** belief that irrelevant or benign things directly refer to oneself or have special personal significance; often referred to as "delusions of reference"

**ideation:** formation of ideas or beliefs; suicidal ideation requires social workers to assess for harm

**identification with the aggressor:** survivors of kidnapping, assault, rape, and so forth develop sympathy for their perpetrators and may even justify their actions; also called “Stockholm syndrome”

**idiopathic:** disease or condition that has an uncertain or unknown origin

**illusion:** incorrectly perceiving or interpreted; common in people with schizophrenia

**imaginary friend:** fictitious person, animal, or other entity with which one has a friendship or interpersonal relationship; a companion that is constructed in the psyche; having one in childhood is developmentally appropriate and not indicator of mental disorder

**impaired colleague:** coworker whose functioning has deteriorated because of a physical or mental problem, including substance use, disability, death of family or friend, burnout/stress, illness, and so forth; address by bringing to the attention of the person, when feasible, so accommodations can be made to eliminate impact on service delivery

**impotence:** consistent inability to sustain an erection for sexual intercourse; cause can be erectile dysfunction; can be caused by emotional factors, but most often due to physical problem

**in vivo:** conditions that approximate real-life; often used to describe face-to-face encounters, such as in-vivo supervision

**incoherent:** unclear; expressed in an incomprehensible or confusing way; not making sense

**insomnia:** difficulty falling asleep, staying asleep, or having non-<sup>54</sup> restorative sleep, often associated with various mental health conditions

**interdisciplinary:** analyzes, synthesizes and harmonizes links between disciplines into a coordinated and coherent whole; distinct from multidisciplinary

**intermittent reinforcement:** when only some responses are rewarded; operant behavioral technique; difficult to extinguish behaviors that have been intermittently reinforced

**internal locus of control:** belief that things that happen are greatly influenced by own abilities, actions, or mistakes

**internal validity:** confidence that independent variable causes the dependent variable (cause-effect)

**intersectionality:** interconnected nature of social categorizations such as race, gender, and class; often refers to overlapping systems of discrimination and disadvantage

**involuntary commitment:** legal process that results in a person who is deemed a danger to self or others being confined to a hospital or facility without consent; length of stay varies depending on continued presence of dangerous behavior; reevaluation occurs regularly

**learned helplessness:** feeling that have no control over a situation which results in behaving in a dependent or powerless manner; leads to failure to engage in opportunities to change; prevents activity or action

**least restrictive environment:** conditions which have the fewest controls or those which approximate the settings which would naturally occur; often with people with disabilities to ensure inclusion in greater society or avoid segregation in education

**lethality:** ability to cause death or serious harm

**lethargy:** low energy level and/or lack of motivated behavior; often associated with depression and other conditions

**locus of control:** influence over life conditions; external locus of control regards outcomes as arising from external or situational factors that cannot be influenced while internal locus of control regards outcomes as due to one's own actions and abilities

**lost child:** family role focused on removing oneself from the dysfunction; often perceived as the "good" child because time is spent alone or involved in isolated activities

**magical thinking:** belief that one's own actions influence external events in the environment; often referred to as "superstitious thinking"

**malaise:** feeling of discomfort or that something is not right

**maleficence:** act of committing harm or evil; prevented by using evidence-based interventions and adhering to accepted standards of care

**malingering:** exaggerate or feign illness in order to escape duty or work; motivation to engage in behavior is intentional with external (secondary) gain

**managed care:** coordination of benefits by a third-party (usually payers) to reduce the cost of providing health care and ensuring continuity of treatment

**mania:** extreme state of excitement and overactivity; often <sup>55</sup> accompanied by overoptimism, grandiosity, and/or impaired judgment; preoccupation with an activity or idea when used as a suffix, such as with the impulse control disorders of kleptomania and pyromania

**mascot:** family role focused on using humor to ease tension and distract from dysfunctional situations

**mediator:** social work role that focuses on resolving conflicts

**medical model:** model of health that suggests that disease is detected and identified through a systematic process of observation, description, and differentiation, such as medical examinations, tests, or symptom descriptions

**medical necessity:** services or supplies that are deemed essential to diagnose or treat medical or behavioral conditions according to accepted standards of care

**medication-assisted treatment:** use of prescribed medications to relieve the withdrawal symptoms and psychological cravings associated with substance use disorders; evidence-based treatment option used in combination with counseling and behavioral therapies

**mental status exam:** assessment of current mental capacity through evaluation of general appearance, behavior, beliefs, mood, and cognition (attention, orientation, memory, and so forth)

**mood stabilizer:** medication used to manage mood swings and stabilize symptoms in individuals with mood disorders like bipolar disorder

**morbidity:** rate of disease in a group or population; presence of unhealthiness or psychological state

**motivational interviewing:** counseling approach aimed at helping make changes; techniques focus on resolving ambivalence, eliciting change talk and behavior, and helping utilize internal motivation to make needed changes

**multidisciplinary:** drawing on knowledge from different disciplines but staying within their boundaries; distinct from interdisciplinary

**narrative therapy:** aims to separate clients from their problems, allowing them to externalize their issues rather than internalize them; involves adjusting the life stories through writings

**narcolepsy:** disorder consisting of excessive daytime sleepiness accompanied by brief episodes of sleep during waking hours; can occur in dangerous situations such as while driving a car; chronic condition with no cure, but symptoms can be managed with medication and lifestyle changes

**negative entropy:** system becoming less disordered or more ordered; growing or developing

**negligence:** failure to use reasonable care or caution

**neurotransmitter:** chemical messenger in the brain that transmits signals between neurons, influencing various brain functions and behaviors

**object permanence:** understanding that something exists even if it cannot be seen due to the ability to form a mental representation of the object or person

**object relations theory:** describes how the inability to form <sup>56</sup> and develop positive and enduring attachments are based on early life experiences of separation or lack of connection with significant caregivers

**ombudsman:** an official who investigate, settles, and reports on complaints which can involve violations of human rights or systemic issues; often referred to as a “public advocate” when working for a government authority

**olfactory hallucinations:** smelling something that is not present; can be either pleasant or non-pleasant odors

**organic brain syndrome:** persistent mental impairment associated with a disturbance in consciousness, cognition, mood, affect, and behavior caused by dementia, delirium, infection, injury, or substance-induced psychosis

**palliative care:** medical care that focuses on comfort rather than providing a cure; goal is to reduce the severity of a disease or slow its progress

**paradoxical directive:** prescribing the symptoms or behaviors that are targeted for change; often referred to as “reverse psychology”

**paranoia:** unwarranted or delusional belief that one is being persecuted, harassed, or betrayed by others; can occur as a symptom of a mental disorder or condition

**paraphrasing:** therapeutic technique of using different words to re-state assertions to improve understanding and help with analyzing meaning

**parasomnia:** disorder in which odd or dangerous events occur during sleep; can include sleep talking, sleepwalking, sleep terrors, and so forth

**parity:** equality between two or more constructs or policies; social workers often advocate that mental health care should be treated with same care and funding as physical care

**partialization:** breaking down issues or processes into incremental steps or actions

**permanency planning:** assessing and preparing children for long-term care when in out-of-home placements such as with family, resource families, or residential facilities

**permissive parenting:** caregivers take on a friendship role, preferring to avoid conflict; mostly allowing children to do what they want and offering limited guidance or direction

**polarized thinking:** often referred to as “black and white” or “all or nothing” thinking; assessing reality and situations in the extremes without considering that the presence of more moderate or tempered alternatives

**positive regard:** unconditional acceptance of others without judgment

**prescribing the symptom:** treatment technique in which social worker directs the continuation of the undesired behavior or action; paradoxical directive which demonstrates that behavior or action can be controlled

**privileged communication:** legal right to keep professional interactions private; applies to doctor–patient and lawyer–client discussions; a psychotherapist-patient privilege was established in the Federal Rules of Evidence in 1996 with the *Jaffee v. Redmond* case

**prognosis:** prediction of the course, duration, severity, and <sup>57</sup> outcome of a condition, disease, or disorder; helps a client weigh the benefits of different treatment options

**pro bono:** provision of services free-of-charge, typically for individuals who cannot afford them

**projection bias:** thinking others have the same priority, attitude or belief

**projective testing:** eliciting responses to ambiguous scenes, words, or images to uncover hidden conflicts or emotions that can be addressed through psychotherapy or other treatments

**prosocial behavior:** action intended to benefit others such as helping, sharing, donating, and/or volunteering

**proxy:** someone who is authorized to act on behalf of another; used to describe a decision or vote made for another

**psychodrama:** therapeutic technique in which clients play their antagonists or themselves in stressful roles; provides opportunity to act out inner feelings and relieve anxiety

**psychodynamic theory:** therapeutic approach that explores unconscious thoughts, emotions, and past experiences to gain insight and facilitate personal growth and change

**psychopharmacology:** use of medication to treat mental disorders; some disorders, such as those characterized by psychosis, require this approach

**psychosis:** incapacitating mental functioning characterized by impaired thinking, reasoning, and reality testing; distorted perceptions; inappropriate affect or emotional reactions; ideas of reference; hallucinations; and/or delusions

**psychosomatic:** physical ailments that are caused by psychological factors; connection between mind and body

**psychotherapy notes:** documentation taken during a therapy session by a mental health professional that is separated from the rest of the client file; not meant to be shared with others

**psychotic break:** sudden onset or worsening of psychotic symptoms, often accompanied by a loss of contact with reality

**power of attorney:** legal document that gives an individual authority to make decisions for another person as needed

**rapid cycling:** pattern in bipolar disorder where an individual experiences frequent shifts between manic, hypomanic, depressive, or mixed states

**rapprochement:** part of a development process in which children differentiate themselves from their caregivers (develop awareness of separate identity); occurs at about 18 months in which there is a renewed interest in dependency on caregivers

**reality testing:** assessing limitations in light of biological, physiological, social, or environmental actualities; distinguish between fantasy and real life

**receptive communication:** ability to understand and comprehend spoken language heard or read; understanding of language “input”

**redaction:** hiding or removing confidential information for legal <sup>58</sup> or security purposes

**reflection:** therapeutic technique to mirror or expand upon statements to help with recognizing issues and making connections for deeper understanding

**reframing:** technique used to help see a behavior or problem in a different way, including the positive aspects which result; also called “cognitive reframing”

**residual:** something left behind; physical or psychological symptom which remains treatment; residual model of policy posits that the government should only be involved as a last resort as other interventions have failed

**respite care:** temporary assistance to persons who need ongoing help to provide relief for regular caregivers; essential to avoid caregiving burnout

**role complementarity:** acting in an expected manner; performing appropriately in assumed roles; opposite of “role discomplementarity”

**role reversal:** exchanging their duties and/or positions; can be used as a therapeutic technique in psychodrama to help increase understanding of others’ feelings and experiences

**ruminination:** regurgitating food and then swallowing it; being preoccupied with certain obsessive thoughts

**scapegoat:** person blamed for the wrongdoings, mistakes, or faults of others; family role focused on creating other problems and concerns, often through misbehavior, to deflect attention away from the real family issue(s)

**secondary prevention:** screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing

**secondary trauma:** emotional distress which occurs from being exposed to those who have been traumatized; similar symptoms to post traumatic stress disorder; also called “vicarious trauma”

**self-actualization:** full realization of creative, intellectual, and social potential; results from internal drive and external reward

**self-efficacy:** how capable individuals feel about achieving their goals

**serotonin:** a neurotransmitter in the brain that is the key to mood regulation

**shaping:** reinforcing progressively closer approximations to the desired behaviors; behavior management technique

**sliding scale:** amount to be paid increases or decreases based on level of income

**social work interview:** purposeful conversations between practitioners and clients, involving verbal and nonverbal communication; purpose includes gathering information about the client's history, needs and strengths

**somatization:** psychological distress that is unconsciously expressed as physical ailments; counseling can help to address; motivation is unconscious with no apparent gain for the illness or condition

**splitting:** failure to recognize positive and negative qualities as <sup>59</sup> a cohesive whole; symptom of borderline personality disorder; cognitive distortion characterized by "all or nothing" thinking

**standard of care:** level and type of service that a reasonably competent and skilled professional, with similar education and experience, would have provided under the circumstances

**strategic family therapy:** focus is on identifying and applying novel interventions to produce behavioral change rather than on helping to gain insight into the sources of problems

**structural family therapy:** focus is on helping improve functioning through examining structure, rules, roles, and boundaries

**stupor:** state of lethargy and impaired consciousness, marked by disorientation, unresponsiveness, and immobility

**suicidal ideation:** having ideas or ruminations about the possibility of ending one's own life

**superego:** part of the personality that represents internalized societal rules, morals, and values

**symbiotic relationship:** interdependence between two or more people (or organisms in biology); an infant is dependent on a parent physically and emotionally initially, but dependence should subside over time; can be either functional or dysfunctional (co-dependency)

**systematic desensitization:** behavior management technique which provides incremental exposure to anxiety-provoking stimuli or conditions with the aim of eventually reducing fear

**tactile hallucinations:** feeling touch or movement in or on one's body which cannot be explained by any tangible evidence

**Tarasoff decision:** landmark California court decision that stipulates that those engaged in psychotherapy have a duty to protect or warn third parties if client poses an imminent and foreseeable threats to them; established "duty to warn" mandate

**tardive dyskinesia:** neurological syndrome that results in repetitive, involuntary, purposeless movements; caused by the long-term use of certain drugs which are used for the treatment of psychiatric and other conditions; usually treated by stopping or minimizing use of the offending drug

**task-centered treatment:** short-term intervention in which problems and goals/activities needed to address them are identified with clear timeframes for completion; highly structured; client responsible and highly involved in the change effort

**task group:** group formed to solve a problem, provide a service, or create a product

**tertiary prevention:** intervention with those who are already affected; goals focused on improving quality of life by reducing

limitations or delaying complications

**third party payers:** monetary reimbursement by insurance companies or government agencies for services provided to clients

**toxic stress:** strong, frequent and/or prolonged activation of the body's stress response system without adequate protective relationships and other mediating factors; often results in poor health outcomes

**transference:** emotional reactions by clients in the therapeutic <sup>60</sup> process due to unresolved experiences and/or unconscious thoughts; usually focused on the helper as a result of displacement or projection

**trauma bonding:** unhealthy attachment by survivor to an abuser

**triage:** identifying treatment urgency during disaster or mass tragedy; focused on meeting the needs of those with more serious injuries or problems first

**triangulation:** use of exclusion or threats in a three-person relationship to maintain control; adding a third person to a two-person interaction or relationship to ease tension; often seen in dysfunctional families; use of different data sources in research to increase credibility and confidence in findings

**unconditional positive regard:** involves showing complete support and acceptance of a person no matter what that person says or does

**uninvolved parenting:** overall sense of indifference by caregivers; limited engagement with their children and rarely implement rules; not always intentional, as caregivers are often struggling with their own issues; referred to as uninvolved parenting

**unspecified mental disorder:** symptoms cause clinically significant distress or impairment in functioning but do not meet the full criteria for the mental disorder; used in situations in which person diagnosing chooses not to specify the reason that criteria are not met

**utilization review:** process to determine the level of care needed and whether services being delivered are justified; part of quality assurance process; often conducted by third-party payers or insurers

**vicarious liability:** legal premise that not only is a defendant liable for actions but the person's employer, supervisor, or instructor may also be seen as culpable

**vicarious trauma:** psychological and other distress based on interactions with those who have been traumatized; usually develops over time

# **Content Area I: Human Development, Diversity, and Behavior in the Environment (24%)**

# CHAPTER

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1

# Human Growth and Development

## **THEORIES OF HUMAN DEVELOPMENT THROUGHOUT THE LIFESPAN (E.G., PHYSICAL, SOCIAL, EMOTIONAL, COGNITIVE, BEHAVIORAL)**

Social work theories are general explanations that are supported by evidence obtained through the scientific method. A theory may explain human behavior by describing how humans interact with each other or react to certain stimuli. Because human behavior is so complex, numerous theories are utilized to guide practice.

Many factors influence people and their behaviors. The first influence is *individual characteristics* or differences that are unique to each client, such as knowledge, attitudes, beliefs, general personality style, and disposition. There are also *interpersonal factors* that impact how clients behave and feel. These may include social support, social cohesion, work relationships, friendships, and/or religious belonging. A third influence comes from *institutional factors*. These are the rules, regulations, and informal structures in the organizations where clients live and work. Institutional rules may include prohibition of certain behaviors (i.e., smoking), dress expectations, and/or rules about social interaction. A fourth influence is *community factors*, which come from the social environment in which clients live, including social resources/networks and community norms. The last influence is *public policy*, which may mandate regulations and laws such as wearing seat belts, not using drugs, and/or limits on physical aggression. These hierarchical factors are the basis of the ecological perspective or model.

In social work, there are many theoretical perspectives that help to explain the human behavior of clients, including, but not limited to,

systems, conflict, rational choice, social constructionist, psychodynamic, developmental, social behavioral, and humanistic perspectives.

**Systems:** Systems are made up of interrelated parts; each part impacts all other parts, as well as the system as a whole. The dynamic interactions within, between, and among systems produce both stability and change.

**Conflict:** Clients try to advance their own interests over the interests of others as they compete for scarce resources. Power is unequally divided and some social groups dominate others. Members of nondominant groups become alienated from society. Social change is driven by conflict.

**Rational Choice:** Clients are rational and goal directed and <sup>64</sup> human interaction involves exchange of social resources such as love, approval, information, money, and physical labor. Clients have self-interest and try to maximize rewards and minimize costs. Power comes from unequal resources in exchanges.

**Social Constructionist:** Social reality is created when clients, in social interaction, develop a common understanding of their world. Clients are influenced by social processes that are grounded in customs, as well as cultural and historical contexts.

**Psychodynamic:** Unconscious, as well as conscious, mental activity serves as the motivating force in human behavior. Early childhood experiences are central and clients may become overwhelmed by internal or external demands. Defense mechanisms are used to avoid becoming overwhelmed.

**Developmental:** Human development occurs in defined, age-related stages that build upon one another and are distinct. Human development is a complex interaction of biological, psychological, and social factors.

**Social Behavioral:** Human behavior is learned when clients interact with the environment through association, reinforcement, and imitation. All human problems can be formulated as undesirable behavior and can be changed through techniques such as classical and operant conditioning.

**Humanistic Perspective:** Each client is unique and is responsible for choices made. Clients have the capacity to change themselves because human behavior is driven by a desire for growth, personal meaning, and competence. Behaving in ways that are not consistent with the true self causes clients anxiety.

## Social Development

Human beings are inherently social. Developing competencies in this domain enhances a person's mental health, success in work, and ability to achieve in life tasks.

Erik Erikson was interested in how children socialize and how this affects their sense of self. He saw personality as developing throughout the life course and looked at identity crises as the focal point for each stage of human development.

According to Erikson, there are eight distinct stages, with two possible outcomes. Successful completion of each stage results in a healthy personality and successful interactions with others. Failure to successfully complete a stage can result in a reduced ability to complete further stages and, therefore, a more unhealthy personality and sense of self. These stages, however, can be resolved successfully at a later time.

### Trust Versus Mistrust

From birth to 1 year of age, children begin to learn the ability to trust others based upon the consistency of their caregiver(s). If trust develops successfully, the child gains confidence and security in the world and is able to feel secure even when threatened. Unsuccessful completion of this stage can result in an inability to trust, and therefore a sense of fear about the inconsistent world. It may result in anxiety, heightened insecurities, and feelings of mistrust in the world around them.

### Autonomy Versus Shame and Doubt

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Between the ages of 1 and 3, children begin to assert their independence by walking away from their mother, picking which toy to play with, and making choices about what they like to wear, to eat, and so on. If children in this stage are encouraged and supported in their increased independence, they become more confident and secure in their own ability to survive in the world. If children are criticized, overly controlled, or not given the opportunity to assert themselves, they begin to feel

inadequate in their ability to survive, and may then become overly dependent upon others while lacking self-esteem and feeling a sense of shame or doubt in their own abilities.

### ***Initiative Versus Guilt***

Around age 3 and continuing to age 6, children assert themselves more frequently. They begin to plan activities, make up games, and initiate activities with others. If given this opportunity, children develop a sense of initiative, and feel secure in their ability to lead others and make decisions. Conversely, if this tendency is squelched, either through criticism or control, children develop a sense of guilt. They may feel like nuisances to others and will therefore remain followers, lacking self-initiative.

### ***Industry Versus Inferiority***

From age 6 to puberty, children begin to develop a sense of pride in their accomplishments. They initiate projects, see them through to completion, and feel good about what they have achieved. If children are encouraged and reinforced for their initiative, they begin to feel industrious and feel confident in their ability to achieve goals. If this initiative is not encouraged but instead restricted, children begin to feel inferior, doubting their abilities, and failing to reach their potential.

### ***Identity Versus Role Confusion***

During adolescence, the transition from childhood to adulthood is most important. Children are becoming more independent, and begin to look at the future in terms of career, relationships, families, housing, and so on. During this period, they explore possibilities and begin to form their own identities based upon the outcome of their explorations. This sense of who they are can be hindered, which results in a sense of confusion ("I don't know what I want to be when I grow up") about themselves and their role in the world.

### ***Intimacy Versus Isolation***

In young adulthood, individuals begin to share themselves more intimately with others and explore relationships leading toward longer term commitments with others outside the family. Successful completion can lead to comfortable relationships and a sense of commitment, safety,

and care within a relationship. Avoiding intimacy and fearing commitment and relationships can lead to isolation, loneliness, and sometimes depression.

### ***Generativity Versus Stagnation***

During middle adulthood, individuals establish careers, settle down within relationships, begin families, and develop a sense of being a part of the bigger picture. They give back to society through raising children, being productive at work, and becoming involved in community activities and organizations. By failing to achieve these objectives, individuals become stagnant and feel unproductive.<sup>66</sup>

### ***Ego Integrity Versus Despair***

As individuals grow older and become senior citizens, they tend to slow down and explore life as retired people. It is during this time that they contemplate accomplishments and are able to develop a sense of integrity if they are satisfied with the progression of their lives. If they see their lives as being unproductive and failing to accomplish life goals, they become dissatisfied with life and develop despair, often leading to depression and hopelessness.

On a micro level, social development is learning how to behave and interact well with others. Social development relies on emotional development or learning how to manage feelings so they are productive and not counterproductive.

On a macro level, social development is about a commitment that development processes need to benefit people, particularly, but not only, the poor. It also recognizes the way people interact in groups and society, and the norms that facilitate such interaction.

Social development implies a change in social institutions. Progress toward an inclusive society, for example, implies that individuals treat each other fairly in their daily lives, whether in the family, workplace, or public office. Social cohesion is enhanced when peaceful and safe environments within neighborhoods and communities are created. Social accountability exists to the extent that individuals' voices are expressed and heard. Reforms aimed at improving rights and more participatory governance are part of the process by which institutional change is achieved.

## **Emotional Development**

Emotional milestones are often harder to pinpoint than signs of physical development. This area emphasizes many skills that increase self-awareness and self-regulation. Social skills and emotional development are reflected in the ability to pay attention, make transitions from one activity to another, and cooperate with others.

During childhood, there is a lot happening during playtime. Children are lifting, dropping, looking, pouring, bouncing, hiding, building, knocking down, and more. Children are busy learning when they are playing. Play is the true work of childhood.

During play, children are also learning that they are liked and fun to be around. These experiences give them the self-confidence they need to build loving and supportive relationships all their lives.

## Cognitive Development

Cognitive development focuses on development in terms of information processing, conceptual resources, perceptual skill, language learning, and other aspects of brain development. It is the emergence of the ability to think and understand.

A major controversy in cognitive development has been “nature and nurture,” that is, the question of whether cognitive development is mainly determined by a client’s innate qualities (“nature”), or by a client’s personal experiences (“nurture”). However, it is now recognized by most experts that this is a false dichotomy: There is overwhelming evidence from biological and behavioral sciences that, from the earliest points in <sup>67</sup> development, gene activity interacts with events and experiences in the environment.

There are six levels of cognition:

1. *Knowledge*: rote memorization, recognition, or recall of facts
2. *Comprehension*: understanding what the facts mean
3. *Application*: correct use of the facts, rules, or ideas
4. *Analysis*: breaking down information into component parts
5. *Synthesis*: combination of facts, ideas, or information to make a new whole
6. *Evaluation*: judging or forming an opinion about the information situation

Ideally, in order for a client to learn, there should be objectives at each of these levels. Clients may have goals to learn in any of three domains of development:

1. *Cognitive*: mental skills (knowledge)
2. *Affective*: growth in feelings or emotional areas (attitude or self)
3. *Psychomotor*: manual or physical skills (skills)

Jean Piaget was a developmental psychologist best known for his theory of cognitive development. His stages address the acquisition of knowledge and how humans come to gradually acquire it. Piaget's theory holds that children learn through interaction with the environment and others.

Piaget also developed a theory of moral development, but the work by Lawrence Kohlberg is best known in this area. He agreed with Piaget's theory of moral development in principle, but wanted to develop the ideas further.

Stage	Age	Characteristics
1. Sensorimotor	0–2 years	<ul style="list-style-type: none"><li>1. Retains image of objects</li><li>2. Develops primitive logic in manipulating objects</li><li>3. Begins intentional actions</li><li>4. Play is imitative</li><li>5. Signals meaning—infant invests meaning in event (i.e., babysitter arriving means mother is leaving)</li><li>6. Symbol meaning (language) begins in last part of stage</li></ul>
2. Preoperational	2–7 years	<ul style="list-style-type: none"><li>1. Progress from concrete to abstract thinking</li><li>2. Can comprehend past, present, and future</li><li>3. Night terrors</li><li>4. Acquires words and symbols</li><li>5. Magical thinking</li><li>6. Thinking is not generalized</li><li>7. Thinking is concrete, irreversible, and egocentric</li></ul> <p>h.</p> <p>68</p> <p>Cannot see another point of view</p>

		<p>i. Thinking is centered on one detail or event      Imaginary friends often emerge during this stage and may last into elementary school. Although children do interact with them, most know that their friends are not real and only pretend they are real.      Thus, having an imaginary friend in childhood does not indicate the presence of a disorder. It is a normal part of development and social workers should normalize behavior with parents who are distressed about this activity during this developmental stage.</p>
3. Concrete Operations	7–11 years	<ol style="list-style-type: none"> <li>1. Beginnings of abstract thought</li> <li>2. Plays games with rules</li> <li>3. Cause and effect relationship understood</li> <li>4. Logical implications are understood</li> <li>5. Thinking is independent of experience</li> <li>6. Thinking is reversible</li> <li>7. Rules of logic are developed</li> </ol>
4. Formal Operations	11 through maturity	<ol style="list-style-type: none"> <li>1. Higher level of abstraction</li> <li>2. Planning for future</li> <li>3. Thinks hypothetically</li> <li>4. Assumes adult roles and responsibilities</li> </ol>

Kohlberg believed that moral development parallels cognitive development. Kohlberg's theory holds that moral reasoning, which is the basis for ethical behavior, has six identifiable developmental constructive stages—each more adequate at responding to moral dilemmas than the last. Kohlberg suggested that the higher stages of moral development provide the person with greater capacities or abilities in terms of decision making and that these stages allow people to handle increasingly complex dilemmas. He grouped his six stages of moral reasoning into three major levels. A person must pass through each successive stage of moral development without skipping a stage.

Level	Age	Stage	Orientation
Preconventional	Elementary school level (before age 9)	1	Child obeys an authority figure out of fear of punishment. Obedience/punishment.
		2	Child acts acceptably as it is in her or his best interests. Conforms to rules to receive rewards.
Conventional (follow stereotypic norms of morality)	Early adolescence	3	Person acts to gain approval from others. "Good boy/good girl" orientation.

Level	Age	Stage	Orientation
		4	Obeys laws and fulfills obligations and duties to maintain social system. Rules are rules. Avoids censure and guilt.
Postconventional (this level is not reached by most adults)	Adult	5	Genuine interest in welfare of others; concerned with individual rights and being morally right.
		6	Guided by individual principles based on broad, universal ethical principles. Concern for larger universal issues of morality.

Learning theory is a conceptual framework describing how information is absorbed, processed, and retained during learning. Cognitive, emotional, and environmental influences, as well as prior experience, all play a part in how understanding, or a worldview, is acquired or changed, as well as how knowledge and skills are retained.

There are many learning theories but all can be conceptualized as fitting into four distinct orientations:

1. Behaviorist (Pavlov, Skinner)—learning is viewed through change behavior and the stimuli in the external environment are the focus of learning. Social workers aim to change the external environment in order to bring about desired change.
2. Cognitive (Piaget)—learning is viewed through internal mental processes (including insight, information processing, memory, and perception) and the focus of learning is internal cognitive structures. Social workers aim to develop opportunities to foster capacity and skills to improve learning.

3. Humanistic (Maslow)—learning is viewed as a person's activities aimed at reaching the person's full potential, and the focus of learning is in meeting cognitive and other needs. Social workers aim to develop the whole person.
4. Social/Situational (Bandura)—learning is obtained between people and their environment and their interactions and observations in social contexts. Social workers establish opportunities for conversation and participation to occur.

## Behavioral Development

Behavioral theories suggest that personality is a result of interaction between the individual and the environment. Behavioral theorists study observable and measurable behaviors, rejecting theories that take internal thoughts and feelings into account.

These theories represent the systematic application of principles of learning to the analysis and treatment of behaviors. Behaviors determine feelings. Thus, changing behaviors will also change or eliminate undesired feelings. The goal is to modify behavior.

The focus is on observable behavior—a target symptom, a problem behavior, or an environmental condition, rather than on the personality of a client.

There are two fundamental classes of behavior: respondent and <sup>70</sup> operant.

1. Respondent: involuntary behavior (anxiety, sexual response) that automatically elicited by certain behavior. A stimulus elicits a response.
2. Operant: voluntary behavior (walking, talking) that is controlled by consequences in the environment

Best-known applications of behavior modification are sexual dysfunctions, phobic disorders, compulsive behaviors (i.e., overeating, smoking), and training of persons with intellectual disabilities and/or autism spectrum disorder.

It is impractical for those using behavior modification to observe behavior when clients are not in residential inpatient settings offering 24-hour care. Thus, social workers train clients to observe and monitor their own behaviors. For example, clients can monitor their food intake or how many cigarettes they smoke. Client self-monitoring has advantages (i.e.,

inexpensive, practical, and therapeutic) and disadvantages (i.e., clients can collect inadequate and inaccurate information or can resist collecting any at all).

There are several behavioral paradigms.

- A. RESPONDENT OR CLASSICAL CONDITIONING (Pavlov): Learning occurs as a result of pairing previously neutral (conditioned) stimulus with an unconditioned (involuntary) stimulus so that the conditioned stimulus eventually elicits the response normally elicited by the unconditioned stimulus.

Unconditioned Stimulus → Unconditioned Response

Unconditioned Stimulus + Conditioned Stimulus → Unconditioned Response

Conditioned Stimulus → Conditioned Response

- B. OPERANT CONDITIONING (B. F. Skinner): Antecedent events or stimuli precede behaviors, which, in turn, are followed by consequences. Consequences that increase the occurrence of the behavior are referred to as reinforcing consequences; consequences that decrease the occurrence of the behavior are referred to as punishing consequences. Reinforcement aims to increase behavior frequency, whereas punishment aims to decrease it.

Antecedent → Response/Behavior → Consequence

*Operant Techniques:*

1. **Positive reinforcement:** Increases probability that behavior occur—praising, giving tokens, or otherwise rewarding positive behavior
2. **Negative reinforcement:** Behavior increases because a negative (aversive) stimulus is removed (i.e., remove shock)
3. **Positive punishment:** Presentation of undesirable stimulus following a behavior for the purpose of decreasing or eliminating behavior (i.e., hitting, shocking)
4. **Negative punishment:** Removal of a desirable stimulus following a behavior for the purpose of decreasing or eliminating that behavior (i.e., removing something positive, such as a token or dessert)

1. **Aversion therapy:** Any treatment aimed at reducing attractiveness of a stimulus or a behavior by repeated pairing of it an aversive stimulus. **An example of this is treating alcoholism with antabuse.**
2. **Biofeedback:** Behavior training program that teaches a person to control certain functions such as heart rate, blood pressure, temperature, and muscular tension. Biofeedback is often used in attention-deficit/hyperactivity disorder (ADHD) and anxiety disorders.
3. **Extinction:** Withholding a reinforcer that normally follows a behavior. Behavior that fails to produce reinforcement will eventually cease.
4. **Flooding:** A treatment procedure in which a client's anxiety is extinguished by prolonged real or imagined exposure to high-intensity feared stimuli.
5. **In vivo desensitization:** Pairing and movement through a hierarchy of anxiety, from least to most anxiety-provoking situations takes place in "real" setting.
6. **Modeling:** Method of instruction that involves an individual (model) demonstrating the behavior to be acquired by a client.
7. **Rational emotive therapy (RET):** A cognitively oriented therapy in which a social worker seeks to change a client's irrational beliefs through argument, persuasion, and rational reevaluation and by teaching the client to counter self-defeating thinking with new, nondistressing statements.
8. **Shaping:** Method used to train a new behavior by prompting and reinforcing successive approximations of the desired behavior.
9. **Systematic desensitization:** An anxiety-inhibiting response cannot occur at the same time as the anxiety response. An anxiety-producing stimulus is paired with relaxation-producing responses until eventually an anxiety-producing stimulus produces a relaxation response. At each step a client's reaction of fear or dread is overcomes.

by pleasant feelings engendered as the new behavior is reinforced by receiving a reward. The reward could be a compliment, a gift, or relaxation.

10. **Time out:** Removal of something desirable—negative punishment technique.
11. **Token economy:** A client receives tokens as reinforcement for performing specified behaviors. The tokens function as currency within the environment and can be exchanged for desired goods, services, or privileges.

## THE INDICATORS OF NORMAL AND ABNORMAL PHYSICAL, COGNITIVE, EMOTIONAL, AND SEXUAL DEVELOPMENT THROUGHOUT THE LIFESPAN

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Human growth, development, and learning become progressively more complex over time and are influenced through a variety of experiences and interactions. Growth, development, and learning proceed in predictable patterns reflecting increasingly complex levels of organization across the life course. Each developmental stage has distinctive characteristics; however, each builds from the experiences of earlier stages.<sup>72</sup> The domains of development are integrated within the child, so when one area is affected, other areas are also affected. Development proceeds at varying rates from child to child, as well as across developmental domains for individual children, reflecting the unique nature of each. Because growth and development are generally predictable, social workers should know the milestones of healthy development and the signs of potential delay or disability.

### Child Development

Child development refers to the physical, mental, and socioemotional changes that occur between birth and the end of adolescence, as a child progresses from dependency to increasing autonomy. It is a continuous process with a predictable sequence, yet having a unique course. Individuals do not progress at the same rate, and each stage is affected by the preceding types of development. Because these developmental changes may be strongly influenced by genetic factors and events during

prenatal life, genetics and prenatal development are usually included as part of the study of child development.

## ***Infants and Toddlers (Age 0–3)***

### **Healthy Growth and Development**

- Physical—grows at a rapid rate, especially brain size
- Mental—learns through senses, exploring, playing, communicates crying, babbling, then “baby talk,” simple sentences
- Social–Emotional—seeks to build trust in others, dependent, beginning to develop a sense of self

### ***Key Health Care Issues***

- Communication—provide security, physical closeness; promote healthy parent–child bonds
- Health—keep immunizations/checkups on schedule; provide proper nutrition, sleep, skin care, oral health, and routine screenings
- Safety—ensure a safe environment for exploring, playing, and sleeping

### ***Examples of Age-Specific Care for Infants and Toddlers***

- Involve child and parent(s) in care during feeding, diapering, and bathing
- Provide safe toys and opportunities for play
- Encourage child to communicate—smile, talk softly
- Help parent(s) learn about proper child care

## ***Young Children (Age 4–6)***

### **Healthy Growth and Development**

- Physical—grows at a slower rate; improving motor skills; dresses self; toilet trained

- Mental—begins to use symbols; improving memory; vivid imagination, fears; likes stories
- Social–Emotional—identifies with parent(s); becomes independent; sensitive to others' feelings

## ***Key Health Care Issues***

- Communication—give praise, rewards, clear rules
- Health—keep immunizations/checkups on schedule; promote health habits (good nutrition, personal hygiene, etc.)
- Safety—promote safety habits (use bike helmets, safety belts, etc.)

## ***Examples of Age-Specific Care for Young Children***

- Involve parent(s) and child in care—let child make some food choices
- Use toys and games to teach child and reduce fear
- Encourage child to ask questions, play with others, and talk about feelings
- Help parent(s) teach child safety rules

## ***Older Children (Age 7–12)***

### ***Healthy Growth and Development***

- Physical—grows slowly until a “spurt” at puberty
- Mental—understands cause and effect, can read, write, do math; active, eager learner
- Social–Emotional—develops greater sense of self; focuses on school activities, negotiates for greater independence

## ***Key Health Care Issues***

- Communication—help child to feel competent, useful
- Health—keep immunizations/checkups on schedule; give information

on alcohol, tobacco, other drugs, and sexuality

- Safety—promote safety habits (playground safety, resolving conflicts peacefully, etc.)

### ***Examples of Age-Specific Care for Older Children***

- Allow child to make some care decisions (in which arm do you want vaccination?)
- Build self-esteem—ask child to help you do a task, recognize achievements, and so on
- Guide child in making healthy, safe lifestyle choices
- Help parent(s) talk with child about peer pressure, sexuality, alcohol, tobacco, and other drugs

### ***Adolescent Development***

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The development of children ages 13 through 18 years old is a critical time as children develop the ability to understand abstract ideas, such as higher math concepts, and develop moral philosophies, including rights and privileges, and move toward a more mature sense of themselves and their purpose.

### ***Healthy Growth and Development***

- Physical—grows in spurts; matures physically; able to reproduce
- Mental—becomes an abstract thinker (goes beyond simple solutions; can consider many options, etc.); chooses own values
- Social-Emotional—develops own identity; builds close relationships; tries to balance peer group with family interests; concerned about appearances, challenges authority

### ***Key Health Care Issues***

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- Communication—provide acceptance, privacy; build teamwork, respect
- Health—encourage regular checkups; promote sexual responsibility

- advise against substance abuse; update immunizations
- Safety—discourage risk-taking (promote safe driving, violence prevention, etc.)

### ***Examples of Age-Specific Care for Adolescents***

- Treat more as an adult than child—avoid authoritarian approaches
- Show respect—be considerate of how treatment may affect relationships
- Guide teen in making positive lifestyle choices (i.e., correct misinformation from teen's peers)
- Encourage open communication between parent(s), teen, and peers

### ***Adult Development***

Adult development refers to the changes that occur in biological, psychological, and interpersonal domains of human life from the end of adolescence until the end of life. These changes may be gradual or rapid, and can reflect positive, negative, or no change from previous levels of functioning.

### ***Young Adults (Age 18–35)***

#### ***Healthy Growth and Development***

- Physical—reaches physical and sexual maturity, nutritional needs are for maintenance, not growth
- Mental—acquires new skills, information; uses these to solve problems
- Social-Emotional—seeks closeness with others; sets career goals; chooses lifestyle, community; starts own family

#### ***Key Health Care Issues***

- Communication—be supportive and honest; respect personal values
- Health—encourage regular checkups; promote healthy lifestyle (proper nutrition, exercise, weight, etc.); inform about health risks (heart disease, cancer, etc.)

- disease, cancer, etc.); update immunizations
- Safety—provide information on hazards at home, and work

## Examples of Age-Specific Care for Young Adults

- Support the person in making health care decisions
- Encourage healthy and safe habits at work and home
- Recognize commitments to family, career, and community (time, money, etc.)

## Middle Age Adults (Age 36–64)

### Healthy Growth and Development

- Physical—begins to age; experiences menopause (women); may develop chronic health problems
- Mental—uses life experiences to learn, create, solve problems
- Social-Emotional—hopes to contribute to future generations; stays productive, avoids feeling “stuck” in life; balances dreams with reality; plans retirement; may care for children and parents

### Key Health Care Issues

- Communication—keep a hopeful attitude; focus on strengths, rather than limitations
- Health—encourage regular checkups and preventive exams; address age-related changes; monitor health risks; update immunizations
- Safety—address age-related changes (effects on sense, reflexes, etc.)

## Examples of Age-Specific Care for Middle Adults

- Address worries about future—encourage talking about feelings, plans, and so on
- Recognize the person’s physical, mental, and social abilities/contributions

- Help with plans for a healthy active retirement

## ***Older Adults (Age 65–79)***

### **Healthy Growth and Development**

- Physical—ages gradually; natural decline in some physical abilities and senses
- Mental—continues to be an active learner, thinker; memory skills may start to decline
- Social-Emotional—takes on new roles (grandparent, widow or widower, etc.); balances independence, dependence; reviews life

### **Key Health Care Issues**

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- Communication—give respect; prevent isolation; encourage acceptance of aging
- Health—monitor health closely; promote physical, mental, and social activity; guard against depression, apathy; update immunizations
- Safety—promote home safety; especially preventing falls

### **Examples of Age-Specific Care for Older Adults**

- Encourage the person to talk about feelings of loss, grief, and achievements
- Provide information, materials, and so on, to make medication use at home safe
- Provide support for coping with any impairments (avoid making assumptions about loss of abilities)
- Encourage social activity with peers, as a volunteer, and so on

## ***Elders (Age 80 and Older)***

### **Healthy Growth and Development**

- Physical—continues to decline in physical abilities; at increasing risk for falls

for chronic illness, major health problems

- Mental—continues to learn; memory skills and/or speed of learning may decline; confusion often signals illness or medication problem
- Social-Emotional—accepts end of life and personal losses; lives independently as possible

### Key Health Care Issues

- Communication—encourage the person to express feelings, though avoid despair; use humor, stay positive
- Health—monitor health closely, promote self-care; ensure proper nutrition, activity level, rest; reduce stress, update immunizations
- Safety—prevent injury, ensure safe living environment

### Examples of Age-Specific Care for Adults Ages 80 and Older

- Encourage independence—provide physical, mental, and social activities
- Support end-of-life decisions—provide information, resources, and on
- Assist the person in self-care—promote medication safety; provide safety grips, ramps, and so on

## THEORIES OF SEXUAL DEVELOPMENT THROUGHOUT THE LIFESPAN

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Many people cannot imagine that everyone—babies, children, teens, adults, and older adults—are sexual beings. Some inappropriately believe that sexual activity is reserved for early and middle adulthood. Teens <sup>77</sup> often feel that adults are too old for sexual intercourse. Sexuality, though, is much more than sexual intercourse. Humans are sexual beings throughout life.

*Sexuality in infants and toddlers*—Children are sexual even before birth. Males can have erections while still in the uterus, and some boys are born with an erection. Infants touch and rub their genitals because it provides pleasure. Little boys and girls can experience orgasm from

masturbation, although boys will not ejaculate until puberty. By about age 2, children know their own gender. They are aware of differences in the genitals of males and females and in how males and females urinate.

*Sexuality in children (age 3–7)*—Preschool children are interested in everything about their world, including sexuality. They may practice urinating in different positions. They are highly affectionate and enjoy hugging other children and adults. They begin to be more social and may imitate adult social and sexual behaviors, such as holding hands and kissing. Many young children play “doctor” during this stage, looking at other children’s genitals and showing theirs. This is normal curiosity. By age 5 or 6, most children become more modest and private about dressing and bathing.

Children of this age are aware of marriage and understand living together, based on their family experience. They may role play about being married or having a partner while they “play house.” Most young children talk about marrying and/or living with a person they love when they get older. Most sex play at this age happens because of curiosity.

*Sexuality in preadolescent youth (age 8–12)*—Puberty, the time when the body matures, begins between the ages of 9 and 12 for most children. Girls begin to grow breast buds and pubic hair as early as 9 or 10. Boys’ development of the penis and testicles usually begins between 10 and 11. Children become more self-conscious about their bodies at this age and often feel uncomfortable undressing in front of others, even a same-sex parent.

Masturbation increases during these years. Preadolescent boys and girls do not usually have much sexual experience, but they often have many questions. They usually have heard about sexual intercourse, homosexuality, rape, and incest, and they want to know more about all these things. The idea of actually having sexual intercourse, however, is unpleasant to most preadolescent boys and girls.

Same-gender sexual behavior can occur at this age. Boys and girls tend to play with friends of the same gender and are likely to explore sexuality with them. Same-gender sexual behavior is unrelated to a child’s sexual orientation.

Some group dating occurs at this age. Preadolescents may attend parties that have guests of both genders, and they may dance and play kissing games. By age 12 or 13, some young adolescents may pair off and begin dating and/or “making out.” Young women are usually older when they begin voluntary sexual intercourse. However, many very young

teens do practice sexual behaviors other than vaginal intercourse, such as petting to orgasm and oral sex.

*Sexuality in adolescent youth (age 13–19)*—Once youth have reached puberty and beyond, they experience increased interest in romantic and sexual relationships and in genital sex behaviors. As youth mature, they experience strong emotional attachments to romantic partners and find it natural to express their feelings within sexual relationships. There is no way to predict how a particular teenager will act sexually. Overall, most adolescents explore relationships with one another, fall in and out of love, and participate in sexual intercourse before the age of 20.

*Adult sexuality*—Adult sexual behaviors are extremely varied and, in most cases, remain part of an adult's life until death. At around age 50, women experience menopause, which affects their sexuality in that their ovaries no longer release eggs and their bodies no longer produce estrogen.<sup>78</sup> They may experience several physical changes. Vaginal walls become thinner and vaginal intercourse may be painful because there is less vaginal lubrication and the entrance to the vagina becomes smaller. Many women use estrogen replacement therapy to relieve physical and emotional side effects of menopause. Use of vaginal lubricants can also make vaginal intercourse easier. Most women are able to have pleasurable sexual intercourse and to experience orgasm for their entire lives.

Adult men also experience some changes in their sexuality, but not at such a predictable time as with menopause in women. Men's testicles slow testosterone production after age 25 or so. Erections may occur more slowly once testosterone production slows. Men also become less able to have another erection after an orgasm and may take up to 24 hours to achieve and sustain another erection. The amount of semen released during ejaculation also decreases, but men are capable of fathering a baby even when they are in their 80s and 90s. Some older men develop an enlarged or cancerous prostate gland. If the doctors deem it necessary to remove the prostate gland, a man's ability to have an erection or an orgasm is normally unaffected.

Although adult men and women go through some sexual changes as they age, they do not lose their desire or their ability for sexual expression. Even among the very old, the need for touch and intimacy remains, although the desire and ability to have sexual intercourse may lessen.

## **THEORIES OF SPIRITUAL DEVELOPMENT THROUGHOUT THE LIFESPAN**

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Many models attempt to explain the impact of spirituality and/or religious beliefs on behavior. Many of them describe this impact along a continuum as follows, with some individuals changing during their life course and others remaining at the same point.

*Individuals are unwilling to accept a will greater than their own.*

Behavior is chaotic, disordered, and reckless. Individuals tend to defy and disobey, and are extremely egoistic. They lack empathy for others. Very young children can be at this stage. Adults who do not move beyond this point in the continuum may engage in criminal activity because they cannot obey rules.

*Individuals have blind faith in authority figures and see the world as divided simply into good and evil and right and wrong.*

Children who learn to obey their parents and other authority figures move to this point in the continuum. Many “religious” people who have blind faith in a spiritual being and do not question its existence may also be at this point. Individuals who are good, law-abiding citizens may never move further in the continuum.

*Scientific skepticism and questioning are critical, because an individual does not accept things on faith, but only if convinced logically.*

Many people working in a scientific and technical field may question spiritual or supernatural forces because they are difficult to measure or prove scientifically. Those who do engage in this skepticism move away from the simple, official doctrines.

*The individual starts enjoying the mystery and beauty of nature and existence.*

The individual develops a deeper understanding of good and evil, forgiveness and mercy, compassion and love. Religiousness and spirituality differ significantly from other points in the continuum and things are not accepted on blind faith or out of fear. The individual does not judge people harshly or seek to inflict punishment on them for their transgressions. This is the stage of loving others as one loves oneself, losing attachment to ego, and forgiving enemies.

Basic principles of all models move from the “egocentric,” which are <sup>79</sup> associated particularly with childhood, to “conformist,” and eventually to “integration” or “universal.”

There is a positive relationship between spirituality and overall mental health, as well as with regard to certain problems or disorders. For example, there is a positive association between church attendance and lower levels of depression. Similar relationships have been found between spirituality and anxiety or stress. There may also be a positive effect on posttraumatic stress disorder (PTSD) because religion and spirituality may be beneficial in dealing with the aftermath of trauma. In these instances, clients may have religious openness and a readiness to face existential questions. In addition, traumatic experiences can lead to a deepening of religion or spirituality.

Those who share the same religious values as clients and their families may also serve as cohesive support networks. These religious and spiritual communities can provide tangible assistance in addition to being psychologically viewed by clients as supportive.

Some of the mechanisms by which spirituality assists include enhanced coping styles and locus of control, as well as providing social supports and a social network. Clients who are spiritual may use a more collaborative approach when coping (i.e., relying on a higher being to cope with stress), which is associated with the greatest improvement in mental health. Spirituality may also allow clients to reframe or reinterpret events that are seen as uncontrollable, in such a way as to make them less stressful and/or more meaningful.

Lastly, emotions encouraged in many spiritual traditions, including hope, contentment, love, and forgiveness, may be beneficial to clients in promoting positive mental health.

## **THEORIES OF RACIAL, ETHNIC, AND CULTURAL DEVELOPMENT THROUGHOUT THE LIFESPAN**

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**Ethnicity** refers to the idea that one is a member of a particular cultural, national, or racial group that may share culture, religion, race, language, or place of origin. Two people can share the same race but have different ethnicities.

The meaning of **race** is not fixed; it is related to a particular social, historical, and geographic context. The way races are classified has changed in the public mind over time; for example, at one time racial classifications were based on ethnicity or nationality, religion, or minority language groups. Today, society classifies people into different races primarily based on skin color.

**Cultural identity** is often defined as the identity of a group or culture of an individual who is influenced by their self-identification with that group or culture. Certain ethnic and racial identities may also bestow privilege.

Cultural, racial, and ethnic identities are important. They may instill feelings of shared commitment and values and a sense of belonging that may otherwise be missing.

Cultural, racial, and ethnic identities are passed from one generation to the next through customs, traditions, language, religious practice, and cultural values. Current events, mainstream media, and popular literature also influence cultural, racial, and ethnic identities.

Cultural, racial, and ethnic identities play a particularly large role among minority youth because they experience the contrasting and dominant culture of the majority ethnic group. Youth who belong to the majority ethnic culture may not even recognize or acknowledge their cultural, racial, and ethnic identities.

Following is a three-stage model for adolescent cultural and ethnic <sup>80</sup> identity development. These stages do not correspond to specific ages, but can occur at any time. Individuals may spend their entire lives at a particular stage.

- The first stage, **unexamined cultural, racial, and ethnic identity**, is characterized by a lack of exploration of culture, race, a ethnicity and cultural, racial, and ethnic differences—they are rather taken for granted without much critical thinking. This is usually the stage reserved for childhood when cultural, racial, and ethnic ideas provided by parents, the community, or the media are easily accepted. Children at this stage tend not to be interested in culture, race, ethnicity and are generally ready to take on the opinions of others.
- The second stage of the model is referred to as the **cultural, racial, and ethnic identity search** and is characterized by the exploration and questioning of culture, race, and ethnicity in order to learn more about them and to understand the implications of belonging. During this stage, there is questioning of where beliefs come from and why they are held. For some, this stage may arise from a turning point in their lives or from a growing awareness of other cultures, races, and ethnicities. It can also be a very emotional time.

- Finally, the third stage of the model is **cultural, racial, and ethnic identity achievement**. Ideally, people at this stage have a clear sense of their cultural, racial, and ethnic identity and are able successfully navigate it in the contemporary world, which is undoubtedly very interconnected and intercultural. The acceptance of cultural, racial, and ethnic identity may play a significant role in important life decisions and choices, influencing attitudes and behavior. This usually leads to an increase in self-confidence and positive psychological development.

The classic model of cultural, racial, and ethnic identity development refers to identity statuses rather than stages, because stages imply a linear progression of steps that may not occur for all.

- Preadcounters:** At this point, the client may not be consciously aware of culture, race, or ethnicity and how it may affect life.
- Encounters:** A client has an encounter that provokes thought about the role of cultural, racial, and ethnic identification in life. This may be a negative or positive experience related to culture, race, and ethnicity. For minorities, this experience is often a negative one in which they experience discrimination for the first time.
- Immersion–Emersion:** After an encounter that forces a client to confront cultural, racial, and ethnic identity, a period of exploration follows. A client may search for information and will also learn through interaction with others from the same cultural, racial, or ethnic groups.
- Internalization and Commitment:** At this point, a client has developed a secure sense of identity and is comfortable socializing both within and outside the group with which the person identifies.

## **THE EFFECTS OF PHYSICAL, MENTAL, AND COGNITIVE DISABILITIES THROUGHOUT THE LIFESPAN**

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The impacts of disabilities on human development are extremely varied depending upon the manifestations of the disability and when it occurs during the life course. Some disabilities are short-term, whereas others are lifelong. Critical to mitigating the negative impacts is the development

of coping skills that strengthen a client's ability to deal with limitations. Support (formal and informal) is also critical.

There may also be positive effects of disabilities because familial bonds may be stronger or individuals may develop skills to compensate for other tasks that cannot be performed.

Disability is a normal phenomenon in the sense that it exists in all societies. Although medical explanations remain primary in defining disability, the history of disability took an important turn in the latter half of the 20th century that has significantly influenced responses to it. Disability rights scholars and activists rejected the medical explanation for disability, since such explanations of permanent deficit did not advance social justice, equality of opportunity, and rights as citizens. Rather, these leaders proposed the intolerance and rigidity of social institutions, rather than medical conditions, as the explanation for disability. Words such as "inclusion," "participation," and "nondiscrimination" were introduced into the disability literature and reflected the notions that people who did not fit within the majority were disabled by stigma, prejudice, marginalization, segregation, and exclusion. This notion of disability requires the modification of societal structures to include all, rather than "fixing" individuals with varying abilities.

There must be policies, procedures, regulations, and legislation which provide accommodations for children and adults with disabilities. These disabilities may be related to mental and/or physical conditions. These conditions do not need to be severe or permanent. Social workers must ensure that these accommodations are available and the rights of those with disabilities are respected.

## **THE INTERPLAY OF BIOLOGICAL, PSYCHOLOGICAL, SOCIAL, AND SPIRITUAL FACTORS**

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Human development is a lifelong process beginning before birth and extending to death. At each moment in life, every human being is in a state of personal evolution. Physical changes largely drive the process, as our cognitive abilities advance and decline in response to the brain's growth in childhood and reduced functioning in old age. Psychosocial-spiritual development is also significantly influenced by physical growth, as changing body and brain, together with environment, shape a client's identity and relationships with other people.

Thus, development is the product of the elaborate interplay of biological, psychological, social, and spiritual influences. As children develop physically, gaining greater psychomotor control and increased brain function, they become more sophisticated cognitively—that is, more adept at thinking about and acting upon their environment. These physical and cognitive changes, in turn, allow them to develop psychosocially and spiritually, forming individual identities and relating effectively and appropriately with other people.

## BASIC HUMAN NEEDS

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Maslow's hierarchy of needs implies that clients are motivated to meet certain needs. When one need is fulfilled, a client seeks to fulfill the next one, and so on. This hierarchy is often depicted as a pyramid. This five-stage model can be divided into basic (or deficiency) needs (i.e., physiological, safety, social, and esteem) and growth needs (self-actualization).

1. Deficiency needs—also known as D-Needs
2. Growth needs—also known as “being needs” or B-Needs

### *Deficiency Needs:*

- Physiological
- Safety
- Social
- Esteem

Maslow called these needs “deficiency needs” because he felt that these needs arise due to deprivation. The satisfaction of these needs helps to “avoid” unpleasant feelings or consequence.

### *Growth Needs:*

- Self-actualization

These needs fall on the highest level of Maslow's pyramid. They come from a place of growth rather than from a place of “lacking.”

A client must satisfy lower-level basic needs before moving on to meet higher-level growth needs. After meeting lower levels of needs, a client can reach the highest level of self-actualization, but few people do so.

Every client is capable and has the desire to move up the hierarchy toward a level of self-actualization. Unfortunately, progress is often disrupted by failure to meet lower level needs. Life experiences, including divorce and loss of job, may cause a client to fluctuate between levels of the hierarchy.

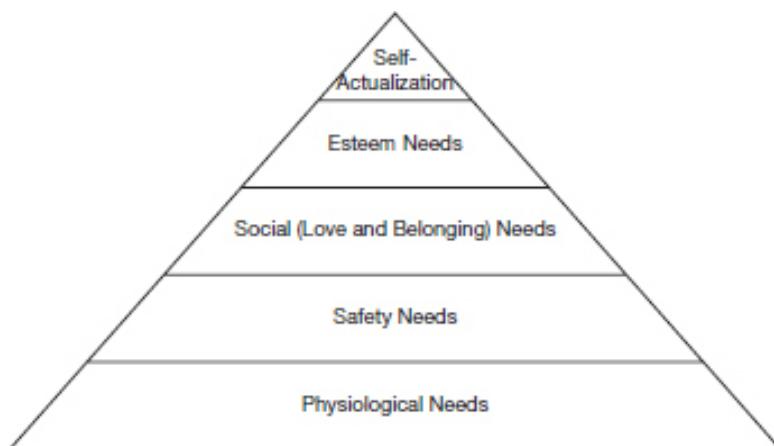
*Physiological needs:* These needs maintain the physical organism. These are biological needs such as food, water, oxygen, and constant body temperature. If a person is deprived of these needs, the person will die.

*Safety needs:* There is a need to feel safe from harm, danger, or threat of destruction. Clients need regularity and some predictability.

*Social needs:* Friendship, intimacy, affection, and love are needed—from one's work group, family, friends, or romantic relationships.

*Esteem needs:* People need a stable, firmly based level of self-respect and respect from others.

*Self-actualization needs:* There is a need to be oneself, to act consistently with whom one is. Self-actualization is an ongoing process. It involves developing potential, becoming, and being what one is capable of being. It makes possible true objectivity—dealing with the world as it is, rather than as one needs it to be. You are free to really do what you want to do. There are moments when everything is right (peak experience); a glimmer of what it is like to be complete. One is in a position to find one's true calling (i.e., being an artist, writer, and musician). Only 1% of the population consistently operates at this level.



**On the examination, Maslow's hierarchy of needs is often 83 not explicitly asked about, but it can be applied when asked about the order of prioritizing problems or issues with a client.** A client with an acute medical problem should focus on getting a medical evaluation first; a victim of domestic violence should prioritize medical and safety issues; and a refugee must initially meet basic survival needs (shelter, food, income, clothing, etc.) before working on fulfilling higher level needs.

## THE PRINCIPLES OF ATTACHMENT AND BONDING

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**Attachment theory** originated with the seminal work of John Bowlby. Bowlby defined attachment as a lasting psychological connectedness between human beings that can be understood within an *evolutionary* context in which a caregiver provides safety and security for a child. Bowlby suggests that children come into the world biologically preprogrammed to form attachments with others, because this will help them to survive. They initially form only one primary attachment (monotropy) and this attachment figure acts as a secure base for exploring the world. Disrupting this attachment process can have severe consequences because the critical period for developing attachment is within the first 5 years of life.

There is another major theory of attachment that suggests attachment is a set of *learned behaviors*. The basis for the learning of attachments is the provision of food. A child will initially form an attachment to whoever feeds it. This child learns to associate the feeder (usually the mother) with the comfort of being fed and, through the process of classical conditioning, comes to find contact with the mother comforting. The child also finds that certain behaviors (i.e., crying, smiling) bring desirable responses from others and through the process of operant conditioning learns to repeat these behaviors in order to get the things wanted.

In both of these theoretical approaches, parents have important impacts on their children's attachment system. Insecure attachment systems have been linked to psychiatric disorders and can result in clients reacting in a hostile and rejecting manner as children or adults.

These theories are, however, criticized because there are cultural influences that may impact on attachment and the ways in which children

interact with caregivers. Much of Bowlby and others' work has not fully considered these differences.

## THE EFFECT OF AGING ON BIOPSYCHOSOCIAL FUNCTIONING

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The process of human aging is complex and individualized, causing biological, psychological, and social changes. Biological aging is characterized by progressive age-changes in metabolism, organ functioning, and so on. It is a natural and irreversible process with biological changes that occur with age in the human body affecting mood, attitude, and social activity.

Social work with older adults is based on comprehensive assessments aimed at gathering information about the quality of their biopsychosocial functioning. Social workers evaluate older adults' capacity to function effectively in their environments and determine what resources are needed to improve interpersonal functioning. The purpose of biopsychosocial assessments is to gather information on functional capacity or everyday competence—the ability of older adults to care for themselves, manage their affairs, and live independent, quality lives in their communities. Assessments may also include diagnostic medical and physical evaluations.

During the life course, many events occur in older adulthood that can affect subjective and objective well-being. Some of the most significant are the onset of voluntary or involuntary retirement, loss of a spouse, and/or onset of disability. These can have negative effects, including having a lower income and an increased likelihood of living in poverty at an older age. A client's educational level and social class before these events occurred greatly influence their impacts. Women and those from ethnic minorities are at the greatest risk for adverse outcomes.

Experiencing loss, especially later in life, has physical, psychological, and social impacts. Maintaining a proper diet, with exercise, is important throughout the life course, but especially in older adulthood. Loss can result in sadness, isolation, and a breakdown in physical or emotional support that can cause neglect in maintaining a healthy lifestyle and/or the engagement in substance use and other maladaptive behaviors. Maintaining social support is essential as loss of family and friends due to death or disability in older adulthood occurs.

Although the negative impacts of aging and/or disability have received a lot of attention, there can be positive effects as well. Becoming a grandparent and/or receiving an inheritance are positive events that can occur in older adulthood. In addition, studies have indicated that there are some positive effects of caring for adults who are older and/or those with disabilities. Families' connections can be strengthened and satisfaction from helping another can result from fulfilling these caregiving roles.

## **GERONTOLOGY**

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Aging is scientifically defined as the accumulation of diverse deleterious changes occurring in cells and tissues with advancing age that are responsible for an increased risk of disease and death. Life expectancy is defined as the average total number of years that a human expects to live. The lengthening of life expectancy is mainly due to the elimination of most infectious diseases occurring in youth, better hygiene, and the adoption of antibiotics and vaccines.

The notion that aging requires treatment is based on the false belief that becoming old is undesirable. Aging has at times received a negative connotation and become synonymous with deterioration, approaching pathology, and death. Society should learn to value old age to the same extent as it presently values youth.

There are physical changes that naturally occur. In older adulthood,<sup>85</sup> age-related changes in stamina, strength, or sensory perception may be noticed and will vary based on personal health choices, medical history, and genetics.

Social workers understand that old age is a time of continued growth and that older adults contribute significantly to their families, communities, and society. At the same time, clients face multiple biopsychosocial–spiritual–cultural challenges as they age: changes in health and physical abilities; difficulty in accessing comprehensive, affordable, and high-quality health and behavioral health care; decreased economic security; increased vulnerability to abuse and exploitation; and loss of meaningful social roles and opportunities to remain engaged in society. Social workers are well positioned and trained to support and advocate for older adults and their caregivers.

## **PERSONALITY THEORIES**

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Personality theories attempt to explain both personality characteristics and the way these characteristics develop and impact behavior/functioning. Theories that have this aim can be categorized as biological, behavioral, psychodynamic, humanist, or trait focused.

## **Biological**

Biological theories suggest that genetics are responsible for personality. Research on heritability suggests that there is a link between genetics and personality traits.

## **Behavioral**

Behavioral theories suggest that personality is a result of interaction between the individual and the environment. Behavioral theorists study observable and measurable behaviors, rejecting theories that take internal thoughts and feelings into account.

## **Psychodynamic**

Psychodynamic theories emphasize the influence of the unconscious mind and childhood experiences on personality.

## **Humanist**

Humanist theories emphasize the importance of free will and individual experience in the development of personality. Humanist theorists emphasized the concept of self-actualization, which is an innate need for personal growth that motivates behavior.

## **Trait**

Trait theories posit that the personality is made up of a number of broad traits. A trait is basically a relatively stable characteristic that causes an individual to behave in certain ways.

## **FACTORS INFLUENCING SELF-IMAGE (E.G., CULTURE, RACE, RELIGION/SPIRITUALITY, AGE, DISABILITY, TRAUMA)**

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Self-image is how clients define themselves, which is often tied to physical description (i.e., tall, thin), social roles (i.e., mother, student),

personal traits (i.e., worthy, generous), and/or existential beliefs (i.e., one with the world, a spiritual being). It is how clients see themselves.

Self-esteem refers to the extent to which a client accepts or approves of this definition. Self-esteem always involves a degree of evaluation that may produce positive or negative feelings. Thus, self-image and self-esteem are linked throughout the life cycle.

Clearly, age has a profound impact on behavior and attitudes. Most developmental theorists trace physical, psychosocial, and other changes across the life course, marking distinctions in these areas by age. Interestingly, however, although behavior analysts have contributed to research on aging, the focus has largely been on remedying age-related deficits rather than a concern with aging as a developmental process. Thus, although there is much documented that confirms that behavior changes with advancing years, there is less known about the sources of those changes.

Age can influence health behaviors, social/emotional patterns, mobility, cognitive functioning, economic well-being, independence, and other areas of life. Ensuring that a client's quality of life is not adversely impacted by these changes is critical to ensuring the maintenance of a positive self-image.

Generally, self-esteem is relatively high in childhood, drops during adolescence, rises gradually throughout adulthood, and then declines sharply in old age.

*Childhood:* Young children have relatively high self-esteem, which gradually declines over childhood. This high self-image may be because children's self-views are unrealistically positive. As children develop cognitively, they begin to base their self-evaluations on external feedback and social comparisons, and thus form a more balanced and accurate appraisal of their academic competence, social skills, attractiveness, and other personal characteristics.

*Adolescence:* Self-esteem continues to decline during adolescence, perhaps due to a decrease in body image and other problems associated with puberty, as well as the increasing ability to think abstractly coupled with more academic and social challenges.

*Adulthood:* Self-esteem increases gradually throughout adulthood, peaking sometime around the late 60s. This increase is tied to assuming positions of power and status that might promote feelings

of self-worth. Adulthood also brings an increasing level of maturity and adjustment, as well as emotional stability.

*Older Adulthood:* Self-esteem declines in old age, beginning to drop around age 70. This decline may be due to loss of employment due to retirement, loss of a spouse or friends, and/or health problems.

Overall, males and females follow essentially the same course during the life cycle. However, there are some interesting gender differences. Although boys and girls report similar levels of self-esteem during childhood, a gender gap emerges by adolescence, with adolescent boys having higher self-esteem than adolescent girls. This gender gap persists throughout adulthood, and then narrows and perhaps even disappears in old age.

Individuals tend to maintain their ordering relative to one another, with <sup>87</sup> those who have relatively high self-esteem at one point in time tending to have relatively high self-esteem years later.

Research on self-image indicates that persons with disabilities may or may not suffer loss of self as they go through a process in which they try to operate in the same manner as they did before their impairments or as typically as possible. Central to self-image of clients' ability to view themselves as people first and their disabilities as just one characteristic of their personalities. Hence, impairment is reduced to, or interpreted as, one characteristic that is different among several similar characteristics in a person.

## **BODY IMAGE AND ITS IMPACT (E.G., IDENTITY, SELF-ESTEEM, RELATIONSHIPS, HABITS)**

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Body image is the way one perceives and relates to ones body, and how one thinks that one is seen by others.

Body image affects nearly everyone from time to time. Body image is not only influenced by the perceptions of others, but by the media and cultural forces as well. Senses are bombarded by an onslaught of mixed messages about how one "should" look or think about one's body.

Having a healthy body image is a key to well-being, both mentally and physically. A positive body image means that, most of the time, a client has a realistic perception of, and feels comfortable with, one's looks.

Factors associated with positive body image:

- Acceptance and appreciation of natural body shape and body differences
- Self-worth not tied to appearance
- Confidence in and comfort with body
- An unreasonable amount of time is not spent worrying about focusing on weight, or calories
- Judgment of others is not made related to their body weight, shape, and/or eating or exercise habits
- Knowing physical appearance says very little about character and value as a person

Factors of negative body image:

- Distorted perception of shape or body parts, unlike what they really are
- Believing only other people are attractive and that body size or shape is a sign of personal failure
- Feeling body doesn't measure up to family, social, or media ideals
- Ashamed, self-conscious, and anxious about body
- Uncomfortable and awkward in body
- Constant negative thoughts about body and comparisons to others

Some possible effects of a negative body image:

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- Emotional distress
- Low self-esteem
- Unhealthy dieting habits
- Anxiety
- Depression
- Eating disorders
- Social withdrawal or isolation

## **PARENTING SKILLS AND CAPACITIES**

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Although there are very few actual cause-and-effect links between specific actions of parents and later behavior of children, there are four distinct parenting styles that seem to impact behavior later in life.

### **Authoritarian Parenting**

Children are expected to follow the strict rules established by the parents. Failure to follow such rules usually results in punishment. Authoritarian parents fail to explain the reasoning behind these rules.

Authoritarian parenting styles generally lead to those who are obedient and proficient, but are lower in happiness, social competence, and self-esteem.

### **Authoritative Parenting**

Like authoritarian parents, those with an authoritative parenting style establish rules and guidelines that their children are expected to follow. However, this parenting style is much more democratic. Authoritative parents are responsive to their children and willing to listen to questions. When children fail to meet the expectations, these parents are more nurturing and forgiving rather than punishing.

Authoritative parenting styles generally tend to result in those who are happy, capable, and successful.

### **Permissive Parenting**

Permissive parents have very few demands on their children. These parents rarely discipline their children and are generally nurturing and communicative with their children, often taking on the status of a friend more than that of a parent.

Permissive parenting often results in children who rank low in happiness and self-regulation, experiencing problems with authority and tending to perform poorly in school.

### **Uninvolved Parenting**

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An uninvolved parenting style is characterized by few demands, low responsiveness, and little communication. Although these parents fulfill basic needs, they are generally detached from their children's lives.

Those who have experienced uninvolved parenting styles rank lowest across all life domains. They tend to lack self-control, have low self-esteem, and are less competent than their peers.

## **BASIC PRINCIPLES OF HUMAN GENETICS**

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Social workers in all settings must educate themselves about the process of genetic inheritance and understand the primary reasons that clients seek genetic testing and counseling. Minimally, a social worker must understand the types of genetic conditions, including single gene disorders, chromosome anomalies, and multifactorial disorders, and the effect of harmful environmental toxins on development. Furthermore, an understanding of the patterns of inheritance between generations (autosomal dominant, autosomal recessive, and X-linked recessive) is essential in working with families.

It is important that social workers be educated about the specific application of skills to genetic cases. Social workers are already trained to view people from a biopsychosocial–spiritual–cultural perspective. In order to identify the patterns of disease in a family, a social worker may need to develop a genogram as part of the assessment.

Because a client's genetic test produces information about the whole family, the biology of a genetic condition must be thoroughly understood and explained to a client and the client's family in order to make informed decisions about whether or not to be tested. Sensitivity to the principle of self-determination is essential in the process of informing clients and family members.

Social workers must take care to ensure that clients are fully informed about all aspects of genetic testing. Social workers should provide counseling before and after the decision to have a genetic test and after the test itself.

## **THE FAMILY LIFE CYCLE**

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The emotional and intellectual stages from childhood to retirement as a member of a family are called the “family life cycle.” In each stage, clients face challenges in family life that allow the building or gaining of new skills.

Not everyone passes through these stages smoothly. Situations such as severe illness, financial problems, or the death of a loved one can

have an effect. If skills are not learned in one stage, they can be learned in later stages.

## **Stage 1: Family of origin experiences**

Main tasks

- Maintaining relationships with parents, siblings, and peers
- Completing education
- Developing the foundations of a family life

## **Stage 2: Leaving home**

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Main tasks

- Differentiating self from family of origin and parents and developing adult-to-adult relationships with parents
- Developing intimate peer relationships
- Beginning work, developing work identity, and financial independence

## **Stage 3: Premarriage stage**

Main tasks

- Selecting partners
- Developing a relationship
- Deciding to establish own home with someone

## **Stage 4: Childless couple stage**

Main tasks

- Developing a way to live together both practically and emotionally
- Adjusting relationships with families of origin and peers to include partner

## **Stage 5: Family with young children**

Main tasks

- Realigning family system to make space for children
- Adopting and developing parenting roles

- Realigning relationships with families of origin to include parenting grandparenting roles
- Facilitating children to develop peer relationships

## **Stage 6: Family with adolescents**

Main tasks

- Adjusting parent-child relationships to allow adolescents more autonomy
- Adjusting family relationships to focus on midlife relationship career issues
- Taking on responsibility of caring for families of origin

## **Stage 7: Launching children**

Main tasks

- Resolving midlife issues
- Negotiating adult-to-adult relationships with children
- Adjusting to living as a couple again
- Adjusting to including in-laws and grandchildren within the family
- Dealing with disabilities and death in the family of origin

## **Stage 8: Later family life**

Main tasks

- Coping with physiological decline in self and others
- Adjusting to children taking a more central role in family maintenance
- Valuing the wisdom and experience of the elderly
- Dealing with loss of spouse and peers
- Preparing for death, life review, and reminiscence

Mastering the skills and milestones of each stage allows successful movement from one stage of development to the next. If not mastered, clients are more likely to have difficulty with relationships and future transitions. Family life cycle theory suggests that successful transitioning

may also help to prevent disease and emotional or stress-related disorders.

The stress of daily living, coping with a chronic medical condition, or other life crises can disrupt the normal life cycle. Ongoing stress or a crisis can delay the transition to the next phase of life.

## **MODELS OF FAMILY LIFE EDUCATION IN SOCIAL WORK PRACTICE**

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Family life education aims to strengthen individual and family life through a family perspective. Social workers are well suited to work with a client within the family context, which is essential for such a model.

Much of family life education is delivered through parenting classes, premarriage education, marriage enrichment programs, and/or family financial planning courses. All of these activities focus on improving a client's quality of life individually and, equally as important, within the client's family unit.

Social workers use a strengths perspective, as well as their knowledge of human development, systems and social role theories, and ecological or "person-in-environment (PIE)" influences, when engaging in family life education.

When conducting family life education, a social worker must be aware of the social worker's own cultural values and norms with regard to material covered and not impose these beliefs on others or be judgmental.

## **THE IMPACT OF AGING PARENTS ON ADULT CHILDREN**

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For social workers, there is an increasing need to provide services and supports to adult children as they become caregivers for their parents. In these new roles, adult children may need direct assistance with maintaining adequate nutrition, decent housing, economic stability, and access to appropriate medical care for both their parents and themselves. However, of even greater concern to adult children are a multitude of psychosocial stressors that come with the transitioning of roles and the expectations placed upon them. In these instances, there are often blurred familial roles, boundaries, and expectations.

The responsibility of caring for the aging parent often falls to adult children who are generally accepting of this responsibility. Their reasons

for doing so may include fulfilling expectations, religious beliefs, sense of duty, financial rewards, altruism, and/or respect/love.

Adult children may need the assistance of social workers due to feelings of guilt, fatigue, sadness, anxiety, and/or frustration. These feelings are compounded when the assistance of adult children is not appreciated by their aging parents. Often adult children need help getting other family members to share the burden and/or getting their parents' affairs in order.

Seeing parents grow old forces adult children to confront feelings about their own mortality. Feelings can include denial, hostility, resentment, hatred of their parents or themselves, helplessness, fear, anger, and <sup>92</sup> sadness. Clients may have any or all of these emotions at one time and the emotions may vary in range and intensity. In some instances, adult children may feel in a bind and begin to seek reasons for reducing their commitment to their older family members. A social worker can provide help in sorting out these feelings, finding their roots, and reframing them into empowerment, opportunity, and choice.

Clients may want help in areas such as communication (i.e., understanding requests for assistance/resistance of their parents), self-care (i.e., developing coping skills and attending to their own needs), and/or resource identification (i.e., finding services to assist in meeting child/parent needs).

Social workers need to be sensitive to client needs in these situations, since the transforming role of child to adult child of aging parents will most likely leave a client on shaky ground, especially if the role was not expected or anticipated. A social worker may need to act as a consultant, advocate, case manager, catalyst, broker, mediator, facilitator, instructor, mobilizer, and/or clinician in these situations as the family dynamic is complex and the needs are great.

## **SYSTEMS AND ECOLOGICAL PERSPECTIVES AND THEORIES**

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A system is a whole comprising component parts that work together. Applied to social work, systems theory views human behavior through larger contexts, such as members of families, communities, and broader society.

Important to this theory is the concept that when one thing changes within a system, the whole system is affected.

Systems tend toward equilibrium and can have closed or open boundaries.

## Applications to Social Work

1. Social workers need to understand interactions between the micro, mezzo, and macro levels.
2. Problems at one part of a system may be manifested at another.
3. Ecomaps and genograms can help to understand system dynamics.
4. Understanding “person-in-environment” is essential to identifying barriers or opportunities for change.
5. Problems and change are viewed within larger contexts.

## Some System Theory Terms

<b>Closed system</b>	Uses up its energy and dies
<b>Differentiation</b>	Becoming specialized in structure and function
<b>Entropy</b>	Closed, disorganized, stagnant; using up available energy
<b>Equifinality</b>	Arriving at the same end from different beginnings
<b>Homeostasis</b>	Steady state
<b>Input</b>	Obtaining resources from the environment that are necessary to attain the goals of the system
<b>Negative entropy</b>	Exchange of energy and resources between systems that promote growth and transformation
<b>Open system</b>	A system with cross-boundary exchange
<b>Output</b>	A product of the system that exports to the environment
<b>Subsystem</b>	A major component of a system made up of two or more interdependent components that interact in order to attain their own

<b>Suprasystem</b>	purpose(s) and the purpose(s) of the system in which they are embedded
<b>Throughput</b>	An entity that is served by a number of component systems organized in interacting relationships
	Energy that is integrated into the system so it can be used by the system to accomplish its goals

## **STRENGTHS-BASED AND RESILIENCE THEORIES**

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The strengths perspective is based on the assumption that clients have the capacity to grow, change, and adapt (**humanistic approach**). Clients also have the knowledge that is important in defining and solving their problems (clients or families are experts about their own lives and situations); they are resilient and survive and thrive despite difficulties.

Strength is any ability that helps an individual (or family) to confront and deal with a stressful life situation and to use the challenging situation as a stimulus for growth. Individual strengths include, but are not limited to, cognitive abilities, coping mechanisms, personal attributes, interpersonal skills, or external resources. Families may have other strengths such as kinship bonds, community supports, religious connections, flexible roles, strong ethnic traditions, and so on.

Strengths vary from one situation to another and are contextual. What may be an appropriate strength or coping mechanism in one situation may not be appropriate in another. Ideally, in a given situation, a client selects an appropriate way to cope by drawing from a repertoire of coping mechanisms or strengths. The appropriateness of a particular coping mechanism may vary according to life course stage, developmental tasks, kinds of stressors, situation, and so on. Having a variety of coping mechanisms and resources enables flexibility in the way a client copes with stresses.

The strengths perspective focuses on understanding clients (or families) on the basis of their strengths and resources (internal and external) and mobilizing the resources to improve their situations. There is a systematic assessment of all the strengths and resources available to meet desired goals.

Methods to enhance strengths include:

- Collaboration and partnership between a social worker and client
- Creating opportunities for learning or displaying competencies
- Environmental modification—environment is both a resource and target of intervention

A social worker should always use a strengths perspective when <sup>94</sup> interacting with clients. Central to this perspective is the use of supportive communication throughout the problem-solving process. A social worker should be instilling hope in a client when engaging so a client believes that change is possible.

Supportive techniques include ensuring that the positives are included in an assessment of a client's situation. It also includes using positive phrasing when communicating with a client or on a client's behalf. Opportunities for growth and development should be seen in the face of adversity and challenges. A social worker should always take a "glass half full" approach.

Supportive techniques also require a nonjudgmental attitude. A client should not be fearful of being judged, feel condemned, or retaliated against for expressing viewpoints or acting in a certain way.

Empathic communication is an essential supportive technique. A client should feel that a social worker understands what the client is going through. A social worker should be warm and friendly, treating a client as a valuable partner in the problem-solving process. Making clients realize their quality attributes helps boost their self image.

## **THE DYNAMICS AND EFFECTS OF LOSS, SEPARATION, AND GRIEF**

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Loss, separation, and grief are expressed differently, but it is essential that they involve mourning to allow healing. Loss, separation, and grief can be caused by death, disability, divorce, relocation, family conflict, and other life events. Loss is universal, but the reactions to it are not. Mourning is the expression of grief such as crying, talking to others, sharing stories, looking at photos, etc. Grief is not only expressed through emotion. It includes physical, behavioral, cognitive, social, and spiritual reactions. Responses to loss, separation, and grief are influenced by gender, culture, race, spirituality, and ethnicity. Instead of encouraging mourning, people often discourage showing emotions associated with

loss, separation, and grief by telling others to “be strong.” While people mourn in different ways, there are needs which exist such as:

- Acknowledging the reality of the loss or separation
- Embracing the pain of the loss
- Remembering the relationships that existed
- Developing a new self-identity
- Searching for meaning
- Receiving ongoing support from others

There is growth which can result from grief, but it is often not readily apparent and cannot be achieved immediately. There is no predefined timeframe for grief as it is processed differently by each person. Grief is a reaction to any loss, not just death. Emotional reactions can include but are not limited to sadness, guilt, loneliness, and yearning. Sometimes the emotions associated with grief can be intense and at other times, they can wane. However, they can return quickly and strongly, often without warning. There are often mourning rituals and customs around loss, separation, and grief.

Although most people retain or return to the levels of functioning prior to the loss, separation, or grief, a significant proportion struggle with protracted grief. Grieving can be thought of as a developmental process with phases which focus on reacting (focusing on safety, trust, and survival), reconstructing (focusing on validation and understanding), and reorienting (focusing on self-reinvention), though the process is not always linear.

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# CHAPTER 2

## Human Behavior in the Social Environment

### PERSON-IN-ENVIRONMENT (PIE) THEORY

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Social psychology focuses on the way in which social interaction influences the behavior of others. Ecological perspectives emphasize the nature of clients' interactions within their physical and sociocultural surroundings. Social ecology attempts to understand the interactions within the social, institutional, and cultural contexts of people-environment relationships. This approach adopts a systemic approach in focusing on the interdependencies of social systems.

All of these fields of study and perspectives recognize the importance of social context on behavior. Humans are social beings. Life depends on others. Infants are unable to care for themselves. Their survival depends on others. Clients develop and learn about the world through the filter of other people. Social interaction is essential to both survival and happiness.

Social workers must understand a systems perspective and the interplay between biological, psychological, and social processes. They must also understand contexts and conditions that inhibit and promote certain human behaviors and/or behavioral change.

The PIE perspective highlights the importance of understanding individual behavior in light of the environmental contexts in which a client lives and acts. The perspective has historical roots in the social work profession.

The PIE classification system was developed as an alternative to the commonly used disease and moral models (i.e., *DSM*, *International Statistical Classification of Diseases and Related Health Problems [ICD]*, civil or penal codes) to implement social work philosophy and area of expertise. PIE is client-centered, rather than agency-centered.

The PIE system is field-tested and examines social role functioning, the environment, mental health, and physical health.

## FAMILY DYNAMICS AND FUNCTIONING AND THE EFFECTS ON INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES

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Family dynamics are the patterns of relating or interactions between family members. Each family system and its dynamics are unique, although there are some common patterns. All families have some helpful and some unhelpful dynamics.

Even where there is little or no present contact with family, there is <sup>98</sup> almost always an influence on a client by dynamics in previous years.

Family dynamics often have a strong influence on the way individuals see themselves, others, and the world, and influence their relationships, their behaviors, and their well-being.

An understanding of the impact of family dynamics on a client's self-perception may help social workers pinpoint and respond to the driving forces behind her or his current needs.

Healthy functioning is characterized by:

- Treating each family member as an individual
- Having regular routines and structure
- Being connected to extended family, friends, and the community
- Having realistic expectations
- Spending quality time, which is characterized by fun, relaxed, a conflict-free interactions
- Ensuring that members take care of their own needs and not just t family needs
- Helping one another through example and direct assistance

Family dynamics significantly impact on a client's biological, psychological, and social functioning in both positive and negative ways. Having a close-knit and supportive family provides emotional support, ensures economic well-being, and increases overall health. However, the

opposite is also true. When family life is characterized by stress and conflict, well-being can be poor.

Social support is one of the main ways that family positively impacts well-being. Social relationships, such as those found in close families, have been demonstrated to decrease the likelihood of negative outcomes, such as chronic disease, disability, mental illness, and death.

Though good familial relations and social support serve as protective factors and improve overall well-being and health, studies have shown that not all familial relations positively impact these areas. Problematic and nonsupportive familial interactions have a negative impact. For example, growing up in an unsupported, neglectful, or violent home is associated with poor physical health and development.

## **THE DYNAMICS OF INTERPERSONAL RELATIONSHIPS**

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Family theory provides a theoretical and therapeutic base for dealing with family-related situations; it is also useful in understanding and managing individual problems by determining the extent to which such problems are related to family issues. A family systems approach argues that in order to understand a family system, a social worker must look at the family as a whole, rather than focusing on its members.

People do not exist in a vacuum. They live, play, go to school, and work with other people. Most anthropologists agree that, next to their peculiar tendency to think and use tools, one of the distinguishing characteristics of human beings is that they are social creatures. The social group that seems to be most universal and pervasive in the way it shapes human behavior is the family. For social workers, the growing awareness of the crucial impact of families on clients has led to the development of family systems theory.

Family systems theory searches for the causes of behavior, not in the <sup>99</sup> individual alone, but in the interactions among the members of a group. The basic rationale is that all parts of the family are interrelated. Further, the family has properties of its own that can be known only by looking at the relationships and interactions among all members.

The family systems approach is based on several basic assumptions:

- Each family is more than a sum of its members.
- Each family is unique, due to the infinite variations in person characteristics and cultural and ideological styles.

- A healthy family has flexibility, consistent structure, and effective exchange of information.
- The family is an interactional system whose component parts have constantly shifting boundaries and varying degrees of resistance to change.
- Families must fulfill a variety of functions for each member, both collectively and individually, if each member is to grow and develop.
- Families strive for a sense of balance or **homeostasis**.
- Negative feedback loops are those patterns of interaction that maintain stability or constancy while minimizing change. Negative feedback loops help to maintain homeostasis. Positive feedback loops, in contrast, are patterns of interaction that facilitate change or movement toward either growth or dissolution.
- Families are seen as being goal oriented. The concept of **equifinality** refers to the ability of the family system to accomplish the same goal through different routes.
- The concept of hierarchies describes how families organize themselves into various smaller units or **subsystems** that are comprised by the larger family system. When the members or tasks associated with each subsystem become blurred with those of other subsystems, families have been viewed as having difficulties. For example, when a child becomes involved in marital issues, difficulties often emerge that require intervention.
- Boundaries occur at every level of the system and between subsystems. Boundaries influence the movement of people and the flow of information into and out of the system. Some families have very open boundaries where members and others are allowed to freely come and go without much restriction; in other families, there are tight restrictions on where family members can go and who may be brought into the family system. Boundaries also regulate the flow of information in the family. In more closed families, the rules strictly regulate what information may be discussed and with whom. In contrast, information may flow more freely in families that have more permeable boundaries.
- The concept of interdependence is critical in the study of family systems. Individual family members and the subsystems comprised

the family system are mutually influenced by and are mutually dependent upon one another. What happens to one family member, what one family member does, influences other family members.

**Genograms** are diagrams of family relationships beyond a family tree allowing a social worker and client to visualize hereditary patterns and psychological factors. They include annotations about the medical <sup>100</sup> history and major personality traits of each family member. Genograms help uncover intergenerational patterns of behavior, marriage choices, family alliances and conflicts, the existence of family secrets, and other information that will shed light on a family's present situation.

## **INDICATORS AND DYNAMICS OF ABUSE AND NEGLECT THROUGHOUT THE LIFESPAN**

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There are various forms of abuse and neglect: **physical abuse** (infliction of physical injury); **sexual abuse** (inappropriate exposure or sexual contact, activity, or behavior without consent); **psychological abuse** (emotional/verbal/mental injury); and **neglect** (failing to meet physical, emotional, or other needs).

Different forms of abuse occur separately, but are often seen in combinations. Psychological abuse almost always accompanies other forms of abuse.

### **Indicators and Dynamics of Sexual Abuse**

Physical or anatomical signs/injuries associated with the genital and rectal areas are signs of physical or sexual abuse. Behavioral signs include any extreme changes in behavior, including regression, fears and anxieties, withdrawal, sleep disturbances, and/or recurrent nightmares. If the victim is a child, the child may also show an unusual interest in sexual matters or know sexual information inappropriate for the child's age group. Sexual promiscuity, sexual victimization, and prostitution can also be signs.

Some factors influencing the effect of sexual abuse include:

- Age of the victim (at time of abuse and time of assessment)
- Extent and duration of sexual abuse
- Relationship of offender to victim

- Reaction of others to the abuse
- Other life experiences

Immediately after disclosing the abuse, an individual is at risk for:

- Disbelief by others (especially if victim is a child or perpetrator is spouse/partner of an adult)
- Being rejected by others
- Being blamed for the abuse and the consequences of disclosing t sexual abuse

For a child, one of the most significant factors contributing to adjustment after sexual abuse is the level of parental support.

Some of the effects of sexual abuse can be:

- Aversive feelings about sex; overvaluing sex; sexual identity problem and/or hypersexual behaviors
  - Feelings of shame and guilt or feeling responsible for the abuse, which are reflected in self-destructive behaviors (such as substance abuse, self-mutilation, suicidal ideation and gestures, and acts that aim to provoke punishment) <sup>101</sup>
- Lack of trust, unwillingness to invest in others; involvement in exploitative relationships; angry and acting-out behaviors
- Perceived vulnerability and victimization; phobias; sleep and eating problems

## Indicators and Dynamics of Psychological Abuse and Neglect

Psychological abuse/neglect is sustained, repetitive, and inappropriate behavior aimed at threatening, isolating, discrediting, belittling, teasing, humiliating, bullying, confusing, and/or ignoring. Psychological abuse/neglect can be seen in constant criticism, belittling, teasing, ignoring or withholding of praise or affection, and placing excessive or unreasonable demands, including expectations above what is appropriate.

It can impact intelligence, memory, recognition, perception, attention, imagination, and moral development. Individuals who have been psychologically abused are likely to be fearful, withdrawn, and/or resentful,

distressed, and despairing. They are likely to feel unloved, worthless, and unwanted, or only valued in meeting another's needs.

Those who are victims of psychological abuse and neglect often:

- Avoid eye contact and experience deep loneliness, anxiety, and despair
- Have a flat and superficial way of relating, with little empathy toward others
- Have a lowered capacity to engage appropriately with others
- Engage in bullying, disruptive, or aggressive behaviors toward others
- Engage in self-harming and/or self-destructive behaviors (i.e., cutting physical aggression, reckless behavior showing a disregard for self and safety, drug taking)

## Indicators and Dynamics of Physical Abuse and Neglect

Most physical abuse and neglect occur within the family by those who are known to the victim. Physical abuse and neglect are also more common in families living in poverty and/or those with drug or alcohol problems.

Neglect can include physical neglect (failing to provide food, clothing, shelter, or other physical necessities), emotional neglect (failing to provide love, comfort, or affection), and/or medical neglect (failing to provide needed medical care).

The major reasons for physical abuse and neglect are feelings of isolation, stress, and frustration by the perpetrator. There is often a lack of coping skills to address feelings of frustration and anger. Support groups and social work services are helpful first steps to diminish the isolation or frustration that fuel physical abuse and neglect. As many perpetrators were themselves victims of physical abuse and neglect as children, they are in need of support to confront, address, and heal wounds in order to ensure that the cycle of abuse and neglect is not perpetuated.

Physical abuse is defined as nonaccidental trauma or physical injury caused by punching, beating, kicking, biting, or burning. It is the most visible form of abuse because there are usually physical signs.

With a child, physical abuse can result from inappropriate or excessive <sup>102</sup> physical discipline.

Indicators of physical abuse include:

- Unexplained bruises or welts on the face, lips, mouth, torso, bac

buttocks, or thighs, sometimes reflecting the shape of the article used to inflict them (electric cord, belt buckle, etc.)

- Unexplained burns from a cigar or cigarette, especially on soles, palm back, or buttocks—sometimes patterned like an electric burner, iron, similar
- Unexplained fractures to the skull, nose, or facial structure
- Unexplained lacerations or abrasions to the mouth, lips, gums, eyes and/or external genitalia

Behavioral indicators include being wary of individuals (parent or caretaker if a child is being abused) and behavioral extremes (aggressiveness or withdrawal), as well as fear related to reporting injury.

## **THE EFFECTS OF PHYSICAL, SEXUAL, AND PSYCHOLOGICAL ABUSE ON INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES**

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Abuse and neglect have both immediate and long-term consequences. The impacts are often influenced by various factors including the extent and type of abuse or neglect, whether it was continual or infrequent, the age at which it occurred, the relationship to the perpetrator (if abuse), and how the abuse or neglect was discovered and addressed upon disclosure. Client personality traits, inner strength, and support systems also influence the effects.

For many, the impacts of abuse and neglect will not be immediately evident. Physical injuries, if there are any, are usually temporary. The more damaging and lasting impacts are those that result from impaired language, cognitive, and physical development due to the abuse and neglect. Children who have been abused and neglected are at risk of academic problems and school failure due to difficulty following rules, being respectful, staying in their seats and keeping on-task, temper tantrums, and/or difficult peer relationships.

In addition, social and emotional problems, poor relationships, substance use and dependency, risky or violent behaviors, and delinquency are manifestations of abuse and neglect. The psychological consequences of abuse and neglect include isolation, fear, inability to trust, low self-esteem, anxiety, depression, and hopelessness. These difficulties

can lead to relationship problems and the possibility of antisocial behavioral traits.

It is important to note that not all those who have been abused and neglected will experience physical, behavioral, and/or psychological problems—though they are more likely. Thus, a lack of these problems should not be used as evidence that abuse or neglect did not occur.

## **THE CHARACTERISTICS OF PERPETRATORS OF ABUSE, NEGLECT, AND EXPLOITATION**

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Many individuals with these characteristics do not commit acts of abuse. However, some factors are more likely to be present in those who commit abusive acts. Thus, having one of these risk factors does not mean <sup>103</sup> that an individual will become an abuser, but an abuser is likely to have one or more of these risk factors.

**A past history of violent behavior is the best predictor of future violence.** Each prior act of violence increases the chance of future episodes of violence. In addition, those who suffered some form of abuse as children are more likely to be perpetrators of abuse as adults.

Risk factors include:

1. History of owning weapons and using them against others
2. Criminal history; repetitive antisocial behavior
3. Drug and alcohol use (substance use is associated with the most violent crimes)
4. Psychiatric disorder with coexisting substance abuse
5. Certain psychiatric symptoms such as psychosis, intense suspiciousness, anger, and/or unhappiness
6. Personality disorders (borderline and antisocial personality disorders)
7. History of impulsivity; low frustration tolerance; recklessness; inability to tolerate criticism; entitlement
8. Angry affect without empathy for others—high anger scores associated with increased chance of violence
9. Environmental stressors: lower socioeconomic status or poverty; job termination

A social worker should take all reports of abuse and all threats for harm seriously.

A social worker can distinguish between static and dynamic risk factors.

*Static risk factors:* These are factors that cannot be changed by interventions such as past history of violent behavior or demographic information.

*Dynamic risk factors:* These are factors that can be changed by interventions such as change in living situation, treatment of psychiatric symptoms, abstaining from drug and alcohol use, access to weapons, and so on. Each client presents with a unique set of risk factors that require an individualized plan.

Some of the risk factors include the following:

- *Stressors:* history of abuse; isolated with lack of social supports; low sense of self-competence and self-esteem; financial problems
- *Poor skills:* rigid, authoritarian; low intelligence quotient (IQ); poor self-control; poor communication, problem solving, and interpersonal skills
- *Family issues:* marital discord, imbalanced relationship with married partner (dominant or noninvolved); domestic violence; substance abuse

The victim is often blamed for the abuse by the perpetrator.

*Interventions to reduce dynamic risk factors include:*

- Pharmacological interventions
- Substance use treatment
- Psychosocial interventions
- Removal of weapons
- Increased level of supervision

## **THE EFFECTS OF LIFE EVENTS, STRESSORS, AND CRISES ON INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES**

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Crisis is an essential component in the understanding of human growth and development. It has important implications for quality of life and

subjective well-being. Crisis situations are viewed as unusual, mostly negative events that tend to disrupt the normal life of a person.

A crisis is an upset to a steady state. When a stressful event becomes a crisis, the individual or family is vulnerable and feels mounting anxiety, tension, and disequilibrium. *A precipitating cause of a crisis does not have to be a major event.* It may be the “last straw” in a series of events that exceed a client’s ability to cope.

An individual or family, at this point, may be emotionally overtaxed, hopeless, and incapable of effective functioning or making good choices and decisions. The person or family is at a “critical turning point” of coping effectively or not effectively.

The way in which life crises are addressed—whether surviving trauma, parental divorce, or a personal loss—has a very significant role to play in determining quality of life. When crises are understood, dealt with, and overcome, clients emerge as healthier and happier.

Crisis situations are viewed as unusual, mostly negative life events that tend to disrupt typical functioning. The concept of crises is an essential component in the understanding of human growth and development. Erickson’s theory of psychosocial development suggests that crises and major life transitions are similar in their components, though they vary in their degree and intensity.

It is difficult to avoid crises and the ways in which they are handled is significant in determining subsequent quality of life. The same life events can strengthen the mutual ties of one family and leave another ready to collapse.

Crises can result from family problems, domestic violence, separation and divorce, addictions, financial distress, illness, and/or death. According to systems theory, a life event or stress-producing situation for a client will result in impacts to family as well.

Family crises are disruptions in families’ usual patterns of functioning. Families in crisis find that their usual ways of coping or problem solving do not work; as a result, they feel vulnerable, anxious, and overwhelmed. Family members may have difficulty thinking clearly, dwell on meaningless activities, express hostility or numbness, be impulsive or dependent, and/or feel incompetent.

Families are thrust into crises when more than one of the following occurs:

- They experience a stress-producing situation.
- They have difficulty coping.

- They show chronic difficulty meeting basic family responsibilities.
- They lack sources of support.

These negative life events are not always the causes of crises.<sup>105</sup> Positive events, such as marriages or job promotions, can also trigger crises as individuals may move out of their family homes or have increased employment demands that impact the functioning of their family units.

Crises are time-limited and can be characterized by the following phases that are not necessarily sequential or discrete:

1. Life event occurs.
2. Life event is seen as threatening.
3. Family responds in a disorganized manner.
4. Family searches for a solution.
5. Family adopts new coping strategies.

Crises present opportunities for positive change, and social workers should work with families toward such change. Crises help families discover and strengthen problem-solving skills. During a period of intense crisis, when usual methods of coping fail, families may be open to learning new problem-solving approaches. The goal is to resolve crises constructively and better prepare families for their next challenges. Quick, highly active responses by social workers are essential during crises to mitigate negative effects.

## **THE IMPACT OF STRESS, TRAUMA, AND VIOLENCE**

Emotional and psychological trauma is the result of extraordinarily stressful events that destroy a sense of security, making a client feel helpless and vulnerable in a dangerous world.

Traumatic experiences often involve a threat to life or safety, but **any situation that leaves a client feeling overwhelmed and alone can be traumatic, even if it does not involve physical harm.** It is not the objective facts that determine whether an event is traumatic, but a subjective emotional experience of the event.

An event will most likely lead to emotional or psychological trauma if:

- It happened unexpectedly
- There was not preparation for it
- There is a feeling of having been powerless to prevent it
- It happens repeatedly
- Someone was intentionally cruel
- It happened in childhood

Emotional and psychological trauma can be caused by one-time events or ongoing, relentless stress.

Not all potentially traumatic events lead to lasting emotional and psychological damage. Some clients rebound quickly from even the most tragic and shocking experiences. Others are devastated by experiences that, on the surface, appear to be less upsetting.

A number of risk factors make clients susceptible to emotional and <sup>106</sup> psychological trauma. Clients are more likely to be traumatized by a stressful experience if they are already under a heavy stress load or have recently suffered a series of losses.

Clients are also more likely to be traumatized by a new situation if they have been traumatized before—especially if the earlier trauma occurred in childhood. Experiencing trauma in childhood can have a severe and long-lasting effect. Children who have been traumatized see the world as a frightening and dangerous place. When childhood trauma is not resolved, this fundamental sense of fear and helplessness carries over into adulthood, setting the stage for further trauma.

## **CRISIS INTERVENTION THEORIES**

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A “crisis” is an acute disruption of psychological homeostasis in which a client’s usual coping mechanisms fail and there is evidence of distress and functional impairment. While there are many theories used to explain and address crises, there are seven critical stages through which clients typically pass on the road to crisis stabilization, resolution, and mastery.

These stages are essential, sequential, and sometimes overlapping in the process of crisis intervention:

- 1. Plan and conduct a thorough biopsychosocial–spiritual–cultural a lethality/imminent danger assessment.*

A social worker must conduct a biopsychosocial–spiritual–cultural assessment covering a client's environmental supports and stressors, medical needs and medications, current use of drugs and alcohol, and internal and external coping methods and resources. Assessing lethality is first and foremost.

- 2. Make psychological contact and rapidly establish the collaborative relationship.*

In a crisis, a social worker must do this quickly, generally as part of assessment.

- 3. Identify the major problems, including crisis precipitants.*

A social worker should determine from a client why things have "come to a head." There is usually a "last straw," but a social worker should also find out what other problems a client is concerned about.

It can also be useful to prioritize the problems in terms of which problems a client wants to work on first.

- 4. Encourage an exploration of feelings and emotions.*

A social worker should validate a client's feelings and emotions and let the client vent about the crisis. The use of active listening skills, paraphrasing, and probing questions is essential. A social worker should also challenge maladaptive beliefs.

- 5. Generate and explore alternatives and new coping strategies.*

A social worker and a client must come up with a plan for what will help improve the current situation. Brainstorming possibilities and finding out what has been helpful in the past are critical.

- 6. Restore functioning through implementation of an action plan.*

This stage represents a shift from a crisis to a resolution. A client and a worker will begin to take the steps negotiated in the previous stage. This is also where a client will begin to make meaning of the crisis event.

Follow-up can take many forms as it can involve phone or in-person visits at specific intervals. A postcrisis evaluation may look at a client's current functioning and assess a client's progress.

## **THE EFFECT OF POVERTY ON INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES**

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Clients who are poor often do not have resources to meet their basic needs. There are many social problems that contribute to and result from poverty, including, but not limited to, little or no education, poor basic nutrition and hygiene, disability or illness, unemployment, substance abuse, and homelessness.

Family income has selective but, in some instances, quite substantial impacts on child and adolescent well-being. Family income appears to be more strongly related to children's ability and achievement than to their emotional outcomes.

Children who live in extreme poverty or who live below the poverty line for multiple years appear, all other things being equal, to suffer the worst outcomes. The timing of poverty also seems to be important for certain outcomes. Children who experience poverty during their preschool and early school years have lower rates of school completion than children and adolescents who experience poverty only in later years. Although more research is needed, findings to date suggest that interventions during early childhood may be most important in reducing poverty's impact on children.

Social workers must also consider the implications on the biopsychosocial–spiritual–cultural aspects of well-being. Medical care may be neglected in order to meet other needs. Coping skills are needed when there are dramatic changes in income and opportunities to adapt and return to economic stability are critical.

Wealth is often poorly distributed. A small minority has all the money, causing major societal tensions and divisions. There are the “haves” and the “have nots.” Communities are often homogeneous—with those comprised of poor people being segregated from those living above the poverty line. Communities comprised of the poor have fewer opportunities and resources to assist their members, leading to a greater likelihood that they will not be able to break out of the cycle that originally resulted in their economic insecurity. Thus, those born into poverty often remain there throughout their life course.

## **THE IMPACT OF THE ENVIRONMENT (E.G., SOCIAL, PHYSICAL, CULTURAL, POLITICAL, ECONOMIC) ON INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES**

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Social workers must be knowledgeable about human behavior across the life course, the range of social systems in which people live, and the ways social systems promote or deter people in maintaining or achieving health and well-being. Social workers should apply theories and knowledge to understand biological, social, cultural, psychological, and spiritual development.

The ecological perspective is rooted in systems theory, which views coping as a transactional process that reflects the “PIE” relationship. Using this perspective, the focus of intervention is the interface between a client (person, family, group, etc.) and a client’s environment. The ecological perspective is also concerned with the issues of power and privilege and how they are withheld from some groups, imposing enormous stress on affected individuals.<sup>108</sup>

Environmental factors can have strong positive or negative impacts on development.

## **SOCIAL AND ECONOMIC JUSTICE**

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Social work is a profession aimed at helping people address their problems and match them with the resources they need to lead healthy and productive lives. One of the most important values of the social work profession is social and economic justice. Social justice is the view that everyone deserves equal economic, political, and social rights and opportunities.

Economic justice is a component of social justice. It is a set of moral principles for building economic institutions, the ultimate goal is to provide an opportunity for each person to create a sufficient material foundation upon which to have a dignified, productive, and creative life.

Social workers promote social-justice and social change with and on behalf of clients who are individuals, families, groups, organizations, and/or communities.

Social workers aim to open the doors of access and opportunity for all, particularly those in greatest need.

Social workers also apply social justice principles to structural problems in the social service agencies in which they work. Armed with the long-term goal of empowering clients, they use knowledge of existing legal principles and organizational structure to suggest changes to protect clients, who are often powerless and underserved.

## **THEORIES OF SOCIAL CHANGE AND COMMUNITY DEVELOPMENT**

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There is no one way to define community development. Over the years, community development has been defined as an occupation, a movement, an approach, and a set of values. It has been labeled the responsibility of social workers because it is seen as the most practical framework for creating lasting change for clients.

Community development has been used to the benefit of communities of place, of interest, and of identity. But despite these differences, there are certain principles, characteristics, and values that underpin nearly every definition of community development—neighborhood work aimed at improving the quality of community life through the participation of a broad spectrum of people at the local level.

Community development is a **long-term** commitment. It is not a quick fix to address a community's problems, nor is it a time-limited process. It aims to address imbalances in power and bring about change founded on social justice, equality, and inclusion. Its key purpose is to build communities based on justice, equality, and mutual respect.

Community development is ultimately about getting community members **working together** in collective action to tackle problems that many individuals may be experiencing or to help in achieving a shared dream that many individuals will benefit from.

## **THE IMPACT OF SOCIAL INSTITUTIONS ON SOCIETY**

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Many social institutions exist within our society. They have many functions including satisfying individuals' basic needs, defining and promoting dominant social values, defining and promoting individual roles, creating permanent patterns of social behavior, and supporting other social institutions.

The five basic institutions are family, religion, government, education, and economics.

Some of the functions of each of these institutions include the following.

## Family

- To control and regulate sexual behavior
- To provide for new members of society (children)
- To provide for the economic and emotional maintenance of individuals
- To provide for primary socialization of children

## Religion

- To provide solutions for the unexplained
- To support the normative structure of the society
- To provide a psychological diversion from unwanted life situations
- To sustain the existing class structure
- To promote and prevent social change

## Government

- To create norms via laws and enforce them
- To adjudicate conflict via the courts
- To provide for the welfare of members of society
- To protect society from external threats

## Education

- To transmit culture
- To prepare for jobs and roles
- To evaluate and select competent individuals
- To transmit functional skills

- To provide methods for the production and distribution of goods and services
- To enable individuals to acquire goods and services that are produced

### **THE IMPACT OF GLOBALIZATION ON CLIENTS/CLIENT SYSTEMS (E.G., INTERRELATEDNESS OF SYSTEMS, INTERNATIONAL INTEGRATION, TECHNOLOGY, ENVIRONMENTAL OR FINANCIAL CRISES, EPIDEMICS)**

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Globalization has had a profound effect on social work practice, changing service delivery; creating new social problems for practitioners to address, such as human trafficking and environmental issues; and producing demands for indigenization, or the development of locality specific forms of theory and practice. **Globalization** refers to an interconnectedness of persons across the world.

The current globalization of the economy requires that social workers broaden their horizons and view many domestic social justice issues within a global framework. Social workers can benefit from knowing how the issues in their town or nation are played out in other towns and nations. There is so much to learn of innovative practices and of possible solutions to social problems that never would have been imagined without an international exchange of information. Globalization has the potential to transport traditional social policy analysis into an ever-widening international arena. Social workers must help people to influence their own governments to consider human rights issues in foreign relations. Contained in the *Universal Declaration of Human Rights* are principles germane to the alleviation of oppression and injustice. Social workers recognize the benefits and disadvantages of globalization for the most vulnerable people in the world, focusing especially on how the economic and environmental consequences affect social relationships and individual opportunity.

### **CRIMINAL JUSTICE SYSTEMS**

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Social work is an essential component of the criminal justice system. For the most part, social work practice as performed in the various criminal

(and juvenile) justice systems is referred to as criminal justice social work, correctional social work, or forensic social work.

Criminal justice social workers serve as frontline staff and administrators in criminal justice settings. There are many thousands of social workers employed in criminal justice settings, serving criminal justice populations, or both.

In the United States, the criminal justice system encompasses a broad spectrum of public and private agencies and settings including, but not limited to, federal and state correctional facilities; city and county jails; federal, state, and city parole and probation agencies; federal, state, and local court systems (including drug courts and mental health courts); community-based nonprofit agencies; faith-based agencies; and primary health and behavioral health care providers.

Schools of social work prepare their graduates to address the complex <sup>111</sup> psychosocial needs of individuals in the criminal justice system. Social work is adapting to the evolving changes in the country's philosophy on the best ways to balance the sometimes conflicted dichotomy between the need for public safety and the need to address the biopsychosocial needs of offenders. The ethical challenge to social workers is to weigh the needs of the justice system against those of the offender. The social worker should take on the challenge by participating in legislative action to mold social policy to create a balance between the justice system and the offender. Thus, the social worker can help the justice system provide more effective services to the offender, their families, and their communities as professionals by participating in the process of public policy development.

Two competing, dichotomous schools of thought drive the discussion related to crime prevention. One, the pro-punishment school of thought, postulates that punishment is the means to preventing; whereas the positivist (pro-treatment) philosophy suggests that some instances of criminal behavior are determined by factors, such as mental illness, that offenders find difficult to control. Therefore, treatment becomes a means of preventing future criminal behaviors. Social work has historically been strongly associated with the positivist school of thought of crime prevention. Social work must recognize its professional obligation both to the offender and to the community (from a public safety perspective) and participate in the process of developing crime reduction policies that reflect social work's commitment to both the offender and the community.

## **THE IMPACT OF OUT-OF-HOME PLACEMENT (E.G., HOSPITALIZATION, FOSTER CARE, RESIDENTIAL CARE,**

## **CRIMINAL JUSTICE SYSTEM) ON CLIENTS/CLIENT SYSTEMS**

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The use of out-of-home placement is generally viewed as an intervention that only occurs when there is a health or safety risk in the home. This risk can be due to the individual who is being removed (caused by a medical or behavioral health issue of the individual being removed) or family members (caused by child abuse or neglect, medical or behavioral health issues of a family member, etc.). Often, out-of-home placement occurs after in-home interventions have been tried and failed.

Individuals who are placed outside of their homes often experience significant life problems. Determining whether these issues are directly caused by the removal is difficult as these individuals are likely to be at-risk for such problems prior to the placements.

For example, children who are removed from their homes due to abuse and/or neglect typically use mental health or other social services more than before they were placed away from their parents. These children often report a high level of stress, which may manifest in substance abuse, chronic aggressive or destructive behavior, suicidal ideation or acting out, and/or patterns of runaway behavior. Academic problems are also common among these children.

For all those leaving their homes, regardless of age, there is a disruption of emotional bonds with other family members, which is often accompanied by rage, grief, sadness, and/or despair.

## **THEORIES OF COUPLES DEVELOPMENT**

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Although relationships vary significantly, there are some predictable stages that characterize intimate relationships. Couples interactions follow a developmental model, much like those that explain individual growth throughout the life course.

### **Stage 1: Romance**

The first stage of couples development begins when individuals are introduced and learn that they have common interests and are attracted to one another. Much of this stage consists of conversations and dates to learn more about the other partner. The focus of this stage is attachment. Like early stages of child development, the infancy of couples development is filled with passion, nurturing, and selfless attention to the needs of others. Differences are minimized and partners place few

demands on each other. This romantic bond is the foundation that is critical to the health of the relationship in the future.

In this first stage, members engage in *symbiotic or mutualistic relationships*—often putting the needs of others before their own. Individuals who are coupling do not see themselves as unique—much like babies identifying themselves as part of their mothers or caregivers. Differentiation and learning to balance and support the separate needs of others happens in later stages but is not present initially.

## **Stage 2: Power Struggle**

Soon individuals who are engaged in intimate relationships see that they have differences from their mates. These unique qualities result in unique needs that require an ongoing process of defining oneself and managing conflict which threatens intimacy. As the coupled individuals begin to notice differences and annoyances that were once overlooked, there can be greater separation and loss of romance resulting from self-expression. This stage differs as individuals focus on differences rather than similarities, which was the hallmark of the initial romantic stage.

Time away from each other is often needed for the partners, and the bliss associated with the initial stage of couples development dissolves. *Differentiation*, or seeing oneself as distinct within a relationship, must be managed so that these new feelings do not result in breakups as the illusion of “being one” fades. Critical effort must be made to balance the desire for self-discovery with the desire for intimacy. To “survive” this stage, individuals must acknowledge differences, learn to share power, forfeit fantasies of complete harmony, and accept partners without the need to change them.

## **Stage 3: Stability**

This stage in couples development is characterized by the redirection of personal attention, time, and activities away from partners and toward one’s self. Individuals focus on personal needs in a manner that is respectful of others. Autonomy and individuality are key. Relationships are seen as more mature as disagreements can occur with both parties “winning.” There is acceptance that partners are different from one another and power struggles to minimize these differences are avoided.

Margaret Mahler described “*practicing*” as a subphase of separation-individuation in infant development. Practicing occurs when toddlers begin to explore on their own, but still see themselves as part of their <sup>113</sup> mothers/caregivers. The stability stage of couples development mirrors

this subphase as partners learn to live independent lives while still identifying as and seeing the value of being part of an intimate relationship.

Another subphase of separation-individuation identified by Mahler, “*rapprochement*,” also relates to the stability stage of couples development. Often, partners who have been successful in achieving a well-defined sense of self in relationships will have crises that will threaten their identities or separateness. They may rely more heavily on companionship and intimacy, seeking more comfort and support from each other. Thus, the stability stage is a time when there is still some back and forth between intimacy and independence with the ultimate goal being intimacy that does not sacrifice separateness.

### **Stage 4: Commitment**

While the commitment stage of couples development is when marriage is ideal, it often occurs earlier in the romance stage, perhaps explaining the high rates of divorce caused by the inability to resolve power struggles. Individuals who have stabilized are able to embrace the reality that both partners are human, resulting in shortcomings in all relationships. Partners acknowledge that they want to be with each other and that the good outweighs the bad. Although much work has been done in building relationships, there is still more needed to effectively function in the next and last stage of couplehood.

### **Stage 5: Co-creation**

Constancy is the hallmark of this last stage. Just like children who are able to internalize and maintain images of their mothers/caregivers and use them to soothe in stressful moments, couples in this stage are able to do something similar. Each partner is able to value and respect the separateness of the other. The foundation of the relationship is no longer personal need, but the appreciation and love of the other and the support and respect for *mutual growth*.

Often, couples in this stage work on projects together, such as businesses, charities, and/or families. This stage aims to make a contribution beyond the relationship itself. Like Erik Erikson’s stage of psychosocial functioning in middle adulthood, which focuses on the crisis of generativity versus stagnation, this stage of couples development aims to create or nurture things that are enduring, often by creating positive change that benefits other people. Success leads to feelings of usefulness and accomplishment.

As with Erikson's and other theories of development, stages are not linear. Lessons learned help couples move forward, but couples can revert back to prior stages, especially those including power struggles.

Same gender couples also go through these developmental stages, but have unique challenges that impact relationship formation. For example, heterosexual couples have a much wider variety of public role models for their partnerships than their same gender peers. In addition, there may be heightened concerns by partners about acceptance of their mates or even the very existence of their intimate relationships by their respective families.

## THE IMPACT OF PHYSICAL AND MENTAL ILLNESS ON FAMILY DYNAMICS

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Physical illness and/or disability places a set of extra demands on the family system. An illness and/or disability can consume a lot of a family's resources of time, energy, and money, so that other individual and family needs may go unmet.

Day-to-day assistance may lead to exhaustion and fatigue, taxing the physical and emotional energy of family members. There can be emotional strain, including worry, guilt, anxiety, anger, and uncertainty about the cause or prognosis of the disability, about the future, about the needs of other family members, and about whether the individual is getting enough assistance.

There can be a financial burden associated with getting health, education, and social services; buying or renting equipment and devices; making accommodations to the home; transportation; and acquiring medications and/or special food. The person or family may be eligible for payment or reimbursement from an insurance company and/or a publicly funded program such as Medicaid or Supplemental Security Income. However, knowing about services and programs and then working to become eligible is another major challenge faced by families.

Working through eligibility issues and coordinating among different providers is a challenge faced by families for which they may want a social worker to assist.

Many communities still lack programs, facilities, and resources that allow for the full inclusion of persons with disabilities. Families often report that one burden comes from dealing with people in the community whose attitudes and behaviors are judgmental, stigmatizing, and rejecting.

There are differential impacts on families. The degree to which a physical illness and/or disability limits activities or functions of daily living or the ages of individuals or parents when an illness/disability emerges are important factors that may impact on adjustment.

The impact of mental illness on family dynamics also can be profound. Mental illness of a family member affects all aspects of family functioning, including physical, financial, and emotional well-being. These impacts often depend upon the relationship of family members to a person with a mental illness. For those closest, there can be considerable time spent addressing some of the practical impacts of mental illness, such as financial problems and disruptions to daily life. This time commitment can result in family members giving up things they care about or missing appointments needed for their own health or well-being.

When mental illness is first diagnosed, family members may deny that there is a continuing illness. If there is a crisis, family members may be upset about what is happening, but the desire to put the incident "behind them" often emerges once the episode is over. Thus, family members may believe that the symptomatic behavior of the mental illness will never return. Some family members often do understand the reality of the illness, whereas others do not. This can cause problems and tension within the family, as well as isolation and loss of meaningful relationships with those who are not supportive of the illness.

Due to the stigma sometimes associated with mental illness, family members may often be reluctant to discuss it with others because they do not know how other people will react. Isolation can also occur because family members may be reluctant to invite anyone to the home for fear of the presence of unpredictable behavior and/or the fear that the activity may be a stressor, triggering behavior related to the illness. This isolation causes families to withdraw from previous relationships to protect both themselves and their loved ones.

Families may have little knowledge about mental illness. They may inappropriately believe that it is a condition that is totally disabling. Without correct information, families may become very pessimistic about the <sup>115</sup> future. They may need assistance from social workers in learning how to manage the illness and to plan for the future.

It is difficult for anyone to deal with strange thinking and bizarre and unpredictable behavior. Family members may be bewildered, frightened, and exhausted. Even when stabilized, those with mental illness may have apathy and lack of motivation that can be frustrating to family members. Family members may become angry and frustrated as they struggle to get

back to a routine that previously they took for granted. If the illness is not stable, families go from crisis to crisis, feeling that they have no control over what is happening. Family life can be unsettled and unpredictable. It becomes very difficult, often impossible, to plan for family outings or vacations. The needs of those with mental illness take over the attention of families and siblings can feel that their needs are put off or ignored.

## **CO-OCCURRING DISORDERS AND CONDITIONS**

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Co-occurring disorders and conditions are present when there are two or more disorders occurring at the same time. For example, clients may have one or more disorders relating to the use of alcohol and/or other drugs, as well as one or more mental disorders. In order for a disorder or condition to be co-occurring, it must be independent and not symptomatology resulting from the other disorder(s)/condition(s).

Co-occurring disorders used to be called “dual diagnoses” or “dual disorders.” Just as the field of treatment for substance use and mental disorders has evolved to become more precise, so too has the terminology used to describe clients with both substance use and mental disorders. Many clients with severe mental illness are further impaired by substance use disorders. However, co-occurring can also be used to describe clients with other conditions, such as those with physical and/or intellectual disabilities.

Though co-occurring, disorders and conditions may not be equivalent in severity, chronicity, and/or degree of impairment in functioning. For example, disorders or conditions may each be severe or mild, or one may be more severe than the other. The severity of both disorders or conditions may also change over time.

Compared with clients who have a single disorder or condition, clients with co-occurring disorders or conditions often require longer treatment, have more crises, and progress more gradually in treatment. Integrated treatment or treatment that considers the presence of all the disorders or conditions at the same time is associated with lower costs and better outcomes.

## **THE IMPACT OF CAREGIVING ON FAMILIES**

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Although caregiving is at the heart of family functioning, the dynamics of families can be greatly altered when family members experience physical

illness or disability. For example, when a primary family caregiver becomes ill or disabled, family roles must shift to redistribute the tasks this family member is unable to perform. This redistribution includes both instrumental and emotional tasks, as the family may face a loss of both financial and emotional support that was provided by the primary family caregiver.

When a child is ill or disabled, parents can be overwhelmed by the added responsibilities to typical childrearing. In addition, healthy siblings may also feel the strain and may feel that they should not “burden” parents any <sup>116</sup> further, so they ignore their own emotional and/or physical needs.

The stage when physical illness or disability occurs within the life course can also have differential impacts. For example, parents of children born ill or disabled may be more accepting of the situation than those who are faced with the illness or disability of children that occurs later. At any time, it is a major challenge for a family to tend to its members’ individual developmental needs and meet the caregiving demands of a serious illness or disability. Some families may be paralyzed at the time of the illness or onset of the disability. Crisis intervention may be needed to stabilize the situation and develop coping skills.

Addressing the grief or loss that can accompany chronic illness or disability may also be needed. In addition, families may seek help from social workers to identify critical resources because they are not able to meet family members’ needs and/or their own without them. Lastly, illness and disability can be isolating for an individual, as well as the individual’s family.

## **PSYCHOLOGICAL DEFENSE MECHANISMS AND THEIR EFFECTS ON BEHAVIOR AND RELATIONSHIPS**

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To manage internal conflicts, people use defense mechanisms. **Defense mechanisms** are behaviors that protect people from anxiety. Defense mechanisms are automatic, involuntary, and usually unconscious psychological activities to exclude unacceptable thoughts, urges, threats, and impulses from awareness for fear of disapproval, punishment, or other negative outcomes. Defense mechanisms are sometimes confused with coping strategies, which are voluntary.

The following are some defense mechanisms (the list of defense mechanisms is huge, and there is no theoretical consensus on the exact number).

1. **Acting Out**—emotional conflict is dealt with through actions rather than feelings (i.e., instead of talking about feeling neglected, a person will get into trouble to get attention)
2. **Compensation**—enables one to make up for real or fancied deficiencies (i.e., a person who stutters becomes a very expressive writer; a short man assumes a cocky, overbearing manner)
3. **Conversion**—repressed urge is expressed as a disturbance of bodily function, usually of the sensory, voluntary nervous system (as pain, deafness, blindness, paralysis, convulsions, tics)
4. **Decompensation**—deterioration of existing defenses
5. **Denial**—primitive defense; inability to acknowledge true significance of thoughts, feelings, wishes, behavior, or external reality factors that are consciously intolerable
6. **Devaluation**—a defense mechanism frequently used by persons with borderline personality disorder in which a person attributes exaggerated negative qualities to self or another. It is the split primitive idealization
7. **Dissociation**—a process that enables a person to split mental functions in a manner that allows expression of forbidden or unconscious impulses without taking responsibility for the action, either because the person is unable to remember the disowned behavior, or because it is not experienced (i.e., pathologically <sup>117</sup> expressed as fugue states, amnesia, or dissociative neurosis, or normally expressed as daydreaming)
8. **Displacement**—directing an impulse, wish, or feeling toward a person or situation that is not its real object, thus permitting expression in a less threatening situation (i.e., a man angry at his boss kicks his dog)
9. **Idealization**—overestimation of an admired aspect or attribute of another
10. **Identification**—universal mechanism whereby individuals pattern themselves after significant others. Plays a major role in personal development, especially superego development

11. **Identification With the Aggressor**—mastering anxiety identifying with a powerful aggressor (such as an abusing parent) counteract feelings of helplessness and to feel powerful oneself. Usually involves behaving like the aggressor (i.e., abusing others after one has been abused oneself)
12. **Incorporation**—primitive mechanism in which psychological representation of a person is (or parts of a person are) figuratively ingested
13. **Inhibition**—loss of motivation to engage in (usually pleasurable) activity avoided because it might stir up conflict over forbidden impulses (i.e., writing, learning, or work blocks or social shyness)
14. **Introjection**—loved or hated external objects are symbolically absorbed within self (converse of projection) (i.e., in severe depression, unconscious unacceptable hatred is turned toward self)
15. **Intellectualization**—where the person avoids uncomfortable emotions by focusing on facts and logic. Emotional aspects are completely ignored as being irrelevant. Jargon is often used as device of intellectualization. By using complex terminology, the focus is placed on the words rather than the emotions
16. **Isolation of Affect**—unacceptable impulse, idea, or act separated from its original memory source, thereby removing the original emotional charge associated with it
17. **Projection**—primitive defense; attributing one's disowned attitudes, wishes, feelings, and urges to some external object or person
18. **Projective Identification**—a form of projection utilized by persons with borderline personality disorder—unconscious of perceiving others' behavior as a reflection of one's own identity
19. **Rationalization**—third line of defense; not unconscious. Gives believable explanation for irrational behavior; motivates unacceptable unconscious wishes or by defenses used to cope with such wishes
20. **Reaction Formation**—person adopts affects, ideas, attitudes, behaviors that are opposites of those harbored consciously

unconsciously (i.e., excessive moral zeal masking strong, ~~to~~ repressed asocial impulses or being excessively sweet to mask unconscious anger)

**Regression**—partial or symbolic<sup>21</sup>.

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return to more infantile patterns of reacting or thinking. Can be in service to ego (i.e., as dependency during illness)

22. **Repression**—key mechanism; expressed clinically by amnesia symptomatic forgetting serving to banish unacceptable ideas, fantasies, affects, or impulses from consciousness
23. **Splitting**—defensive mechanism associated with borderline personality disorder in which a person perceives self and others “all good” or “all bad.” Splitting serves to protect the good objects. person cannot integrate the good and bad in people
24. **Sublimation**—potentially maladaptive feelings or behaviors are diverted into socially acceptable, adaptive channels (i.e., a person who has angry feelings channels them into athletics)
25. **Substitution**—unattainable or unacceptable goal, emotion, object is replaced by one more attainable or acceptable
26. **Symbolization**—a mental representation stands for some other thing, class of things, or attribute. This mechanism underlies dream formation and some other symptoms (such as conversion reactions, obsessions, compulsions) with a link between the latent meaning of the symptom and the symbol; usually unconscious
27. **Turning Against Self**—defense to deflect hostile aggression or other unacceptable impulses from another to self
28. **Undoing**—a person uses words or actions to symbolically reverse or negate unacceptable thoughts, feelings, or actions (i.e., a person compulsively washing hands to deal with obsessive thoughts)

## **ADDICTION THEORIES AND CONCEPTS**

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There are many risk factors for alcohol and other drug abuse, including, but not limited to:

1. *Family*: Parents, siblings, and/or spouse use substances; family dysfunction (i.e., inconsistent discipline, poor parenting skills, lack of positive family rituals and routine); family trauma (i.e., death, divorce)
2. *Social*: Peers use drugs and alcohol; social or cultural norms condone use of substances; expectations about positive effects of drugs and alcohol; drugs and alcohol are available and accessible
3. *Psychiatric*: Depression, anxiety, low self-esteem, low tolerance to stress; other mental health disorders; feelings of desperation; loss of control over one's life
4. *Behavioral*: Use of other substances; aggressive behavior in childhood; impulsivity and risk-taking; rebelliousness; school-based academic behavioral problems; poor interpersonal relationships

Different models are believed to explain the causes of substance abuse.

1. *Biopsychosocial model*: There are a wide variety of reasons why people start and continue using substances. This model provides the most comprehensive explanation for the complex nature of substance abuse disorders. It incorporates hereditary predisposition, emotional and psychological problems, social influences, and environmental problems.<sup>119</sup>
2. *Medical model*: Addiction is considered a chronic, progressive, relapsing, and potentially fatal medical disease.
  - Genetic causes: Inherited vulnerability to addiction, particularly alcoholism
  - Brain reward mechanisms: Substances act on parts of the brain that reinforce continued use by producing pleasurable feelings
  - Altered brain chemistry: Habitual use of substances alters brain chemistry and continued use of substances is required to avoid feelings of discomfort from a brain imbalance
3. *Self-medication model*: Substances relieve symptoms of a psychiatric disorder and continued use is reinforced by relief of symptoms.
4. *Family and environmental model*: Explanation for substance abuse can be found in family and environmental factors such as behaviors shaped by family and community.

by family and peers, personality factors, physical and sexual abuse, disorganized communities, and school factors.

5. *Social model:* Drug use is learned and reinforced from others who serve as role models. A potential substance abuser shares the same values and activities as those who use substances. There are controls that prevent use of substances. Social, economic, and political factors, such as racism, poverty, sexism, and so on, contribute to the cause.

Whatever the root causes, a client's substance abuse problem must be addressed before other psychotherapeutic issues. A social worker should also rule out symptoms being related to a substance abuse problem before attributing them to a psychiatric issue.

## Substance Use Disorder

A substance use disorder is characterized by the problematic use of substances such as alcohol, drugs (both legal and illegal), or other addictive substances. It is a complex condition that involves a pattern of behaviors in which individuals continue to use the substance despite experiencing negative consequences in various areas of their life, including physical health, mental well-being, social relationships, and work or school performance.

A substance use disorder is typically categorized into different levels of severity, ranging from mild to moderate to severe, based on the number of symptoms and their impact on an individual's life. Some common substances associated with substance use disorders include alcohol, opioids, stimulants, cannabis, and sedatives.

Symptoms of a substance use disorder can include:

1. **Loss of control:** Individuals find it challenging to limit their use of the substance, often consuming more than intended or over longer periods than intended.
2. **Craving:** There is a strong desire or urge to use the substance.
3. **Physical dependence:** The body becomes accustomed to the substance, leading to withdrawal symptoms when its use is reduced or stopped.

**Tolerance:** Over time, more of the <sup>4</sup> substance is needed to achieve the desired effects.

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5. **Neglect of activities:** Important activities such as work, school, and social interactions are neglected due to substance use.
6. **Continued use despite consequences:** Despite experiencing negative consequences like health problems, relationship issues, legal troubles, or financial difficulties, individuals continue to use the substance.
7. **Failed attempts to quit:** There are repeated unsuccessful attempts to cut down or control substance use.
8. **Time spent obtaining and using the substance:** A significant amount of time is spent obtaining, using, or recovering from the effects of the substance.
9. **Reduced social and recreational activities:** Participation in previously enjoyed activities decreases due to substance use.

Treatment for substance use disorders often involves a combination of medical, psychological, and social interventions. These can include detoxification, counseling, therapy (such as cognitive-behavioral therapy), support groups (like Alcoholics Anonymous or Narcotics Anonymous), and in some cases, medication. The approach to treatment can vary based on the substance involved, the severity of the disorder, and the individual's specific needs.

## Non-Substance-Related Disorders

There are also many other addictions that involve the use of something besides drugs and alcohol. An addiction is any behavior that a client feels powerless to control and interferes with the client's normal daily life. Addictions can have serious physical, emotional, and psychological consequences.

Sexual addiction is often misunderstood because, although it is perfectly acceptable to enjoy sexual activity, letting desires dictate daily life can cause shame and embarrassment. Sexual addiction often involves compulsive and promiscuous sexual behavior, porn addiction, and/or excessive masturbation.

Though essential for survival, food can also be the focus of addiction. Consuming excessive amounts of food is used by some to fill voids related to loneliness, shame, or lack of self-worth. This addiction can result in obesity or the development of an eating disorder. Some clients who have eating disorders also get addicted to exercise, such as running, to control their weight. Computer usage is also related to other addictions, such as online gambling and shopping.

Essentially, people can become addicted, dependent, or compulsively obsessed with any activity, substance, object, or behavior that gives pleasure. These activities, substances, objects, or behaviors produce beta-endorphins in the brain, producing a “high,” leading to an addictive cycle. Those who are addicted will become obsessed with an activity, substance, object, or behavior and will seek it out, often to the detriment of work or interpersonal relationships. They will compulsively engage in the activity even if they do not want to do so. Cessation of the activity results in withdrawal symptoms of irritability, craving, and restlessness. Those with addictions do not appear to have control as to when, how long, or how <sup>121</sup> much they will continue the activity, use of the substance or object, or behavior (loss of control). Individuals with addictive behaviors deny problems resulting from the addiction, even though others can see the negative effects. They usually have low self-esteem because there are psychological factors associated with other addictions as well.

## Goals of Treatment

1. Abstinence from substances
2. Maximizing life functioning
3. Preventing or reducing the frequency and severity of relapse

The harm reduction model refers to any program, policy, or intervention that seeks to reduce or minimize the adverse health and social consequences associated with substance use without requiring a client to discontinue use. This definition recognizes that many substance users are unwilling or unable to abstain from use at any given time and that there is a need to provide them with options that minimize the harm that continued drug use causes to themselves, to others, and to the community.

Recovery is an ongoing process, and relapse occurs when attitudes, behaviors, and values revert to what they were during active drug or alcohol use. Relapse most frequently occurs during early stages of

recovery, but it can occur at any time. Prevention of relapse is a critical part of treatment.

## Stages of Treatment

1. Stabilization: Focus is on establishing abstinence, accepting substance abuse problem, and committing oneself to making changes.
2. Rehabilitation/habilitation: Focus is on remaining substance-free, establishing a stable lifestyle, developing coping and living skills, increasing supports, and grieving loss of substance use.
3. Maintenance: Focus is on stabilizing gains made in treatment, relapse prevention, and termination.

A social worker should be aware of the signs and symptoms of addiction, as well as withdrawal. For example, use of cocaine can be associated with dilated pupils, hyperactivity, restlessness, perspiration, anxiety, and impaired judgment.

Delirium tremens (DTs) is a symptom associated with alcohol withdrawal that includes hallucinations, rapid respiration, temperature abnormalities, and body tremors.

Wernicke's encephalopathy and Korsakoff's syndrome are disorders associated with chronic abuse of alcohol. They are caused by a thiamine (vitamin B<sub>1</sub>) deficiency resulting from the chronic consumption of alcohol. A person with Korsakoff's syndrome has memory problems. Treatment is administration of thiamine.

## Treatment Approaches

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1. *Medication-assisted treatment* interventions assist with interfering with the symptoms associated with use. For example, methadone, synthetic narcotic, can be legally prescribed. A client uses it to detoxify from opiates or on a daily basis as a substitute for heroin. Antabuse is a medication that produces highly unpleasant side effects (flushing, nausea, vomiting, hypotension, and anxiety) if a client drinks alcohol. It is a form of "aversion therapy." Naltrexone is a drug used to reduce cravings for alcohol; it also blocks the effects of opioids.
2. *Psychosocial or psychological interventions* modify maladaptive feelings, attitudes, and behaviors through individual, group, marital,

family therapy. These therapeutic interventions also examine the roles that are adopted within families in which substance abuse occurs; for example, the “family hero,” “scapegoat,” “lost child,” or “mascot” family member who alleviates pain in the family by joking around).

3. *Behavioral therapies* ameliorate or extinguish undesirable behaviors and encourage desired ones through behavior modification.
4. *Self-help groups* (Alcoholics Anonymous, Narcotics Anonymous) provide mutual support and encouragement while becoming abstinent or remaining abstinent. Twelve-step groups are utilized throughout phases of treatment. After completing formal treatment, the recovering person can continue attendance indefinitely as a means of maintaining sobriety.

## THE EFFECTS OF ADDICTION AND SUBSTANCE ABUSE ON INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES

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There are biopsychosocial–spiritual–cultural impacts of substance abuse or dependence on clients themselves. Clients who use drugs experience a wide array of physical effects other than those expected. The excitement or high that results from the use of cocaine is followed by a “crash”: a period of anxiety, fatigue, depression, and an acute desire for more cocaine to alleviate these continued feelings. Marijuana and alcohol interfere with motor control and are factors in many automobile accidents. Users of hallucinogenic drugs may experience flashbacks, which are unwanted recurrences of the drug’s effects weeks or months after use. Sudden abstinence from certain drugs results in withdrawal symptoms. For example, heroin withdrawal can cause vomiting, muscle cramps, convulsions, and delirium. With the continued use of substances that are physically addictive, tolerance develops; that is, constantly increasing amounts of the drug are needed to duplicate the initial effect.

Substance abuse or dependence also impacts mental health because it causes irrational behavior, violence, and lapses in memory. Chronic use of some substances can cause long-lasting changes in the brain, which may lead to paranoia, depression, aggression, and hallucinations.

In addition, because the purity and dosage of illegal drugs are uncontrolled, drug overdose is a constant risk. Many drug users also

engage in criminal activity, such as burglary and prostitution, to raise money to buy drugs.

Substance use can disrupt family life and destroy relationships. A <sup>123</sup> client's preoccupation with the substance, plus its impacts on mood and performance, can lead to relationship/marital problems. A client may spend more time on getting and using substances than attending to relationships with others. Drug use can also create destructive patterns of codependency. Codependency occurs when a partner/spouse or members of the family, out of love or fear of consequences, inadvertently enables a client to continue using substances by covering up, supplying money, or denying there is a problem.

In addition, substance abuse or dependence can result in accidental injury, disability, legal involvement, and/or loss of income or employment, which negatively impacts on those who are friends or family members of a client. Neglect of friends and family, as well as anger that can lead to verbal assaults or physical violence, are also seen as a result of substance abuse or dependence.

Clients who are using or dependent on substances may also tend to neglect "old" relationships and find those who also engage in similar behaviors.

Clients with other addictions feel strong cravings or a dependency on whatever they are addicted to and feel afraid or powerless to let it go. Clients may feel ashamed or fear the consequences of their addictions being discovered. They will sometimes lie to conceal engagement in the behaviors or the extent of their problems.

Secrecy and deceit cause breakdowns in trust within relationships. Family members of those who are addicted may question their behavior and feel confused, scared, and angry at changes that they witness. Family members are frightened by unpredictable situations encountered due to those who are addicted experiencing ups and downs. One moment they are happy and positive, but then they can quickly become anxious, irritable, or depressed. Individuals may be preoccupied with their addictions and pay less attention to role responsibilities or the feelings/needs of others. They also may lose interest in family activities and appear withdrawn.

Family members of those who are addicted often take on more responsibility at home to compensate for the unreliability or unpredictability that accompanies addiction. Family members may feel they have to take control of everything as a way of compensating for the feelings of instability or unpredictability. Family members often feel strained as they

try to successfully juggle extra responsibilities. Communication in these situations breaks down and relationships become strained or broken. Distance in relationships can result in a loss of interest in sex or intimacy.

Family members may be worried that their behavior will exacerbate the situation or cause clients' addictions to worsen. Children in families with addiction also feel the effects because they are aware of arguments and tension in the home and feel scared and confused. They are also more likely to develop addictive behaviors as ways of coping.

## **THE INDICATORS OF ADDICTION AND SUBSTANCE ABUSE**

Some people are able to engage in behaviors or use substances without abusing them and/or becoming addicted.

There are signs when clients are addicted to behaviors and/or substances are being abused. These include, but are not limited to, indications that the behavior or substance use is:

- Causing problems at work, home, school, and in relationships 124
- Resulting in neglected responsibilities at school, work, or home (i.e., flunking classes, skipping work, neglecting children)
- Dangerous (i.e., driving while on drugs, using dirty needles, having unprotected sex, binging/purging despite medical conditions)
- Causing financial and/or legal trouble (i.e., arrests, stealing to support shopping, gambling, or drug habit)
- Causing problems in relationships, such as fights with partner or family members or loss of old friends
- Creating tolerance (more of the behavior or substance is needed to produce the same impact)
- Out of control or causing a feeling of being powerless
- Life-consuming, resulting in abandoned activities that used to be enjoyed
- Resulting in psychological issues such as mood swings, attitude changes, depression, and/or paranoia

### **Signs of Drug Use**

- Marijuana: glassy, red eyes; loud talking, inappropriate laughter follow by sleepiness; loss of interest, motivation; weight gain or loss
- Cocaine: dilated pupils; hyperactivity; euphoria; irritability; anxiety excessive talking followed by depression or excessive sleeping at other times; may go long periods of time without eating or sleeping; weight loss; dry mouth and nose
- Heroin: contracted pupils; no response of pupils to light; needle marks; sleeping at unusual times; sweating; vomiting; coughing, sniffling, twitching; loss of appetite

## ROLE THEORIES

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A role is defined as the collection of expectations that accompany a particular social position. Clients have multiple roles in their lives; in different contexts or with different people, such as being students, friends, employees, spouses, or parents.

Each of these roles carries its own expectations about appropriate behavior, speech, attire, and so on. What might be rewarded in one role would be unacceptable for another (e.g., competitive behavior is rewarded for an athlete but not a preschool teacher). Roles range from specific, in that they only apply to a certain setting, to diffuse, in that they apply across a range of situations. For example, gender roles influence behavior across many different contexts. Role theory examines how these roles influence a wide array of psychological outcomes, including behavior, attitudes, cognitions, and social interaction.

There are some important terms used in role theory.

- **Role ambiguity:** lack of clarity of role
  - **Role complementarity:** the role is carried out in an expected way (i.e., parent-child; social worker-client) <sup>125</sup>
  - **Role discomplementarity:** the role expectations of others differ from one's own
  - **Role reversal:** when two or more individuals switch roles
  - **Role conflict:** incompatible or conflicting expectations

*When assessing, social workers view problems as differences between clients' behaviors and the expectations of others with regard to roles.*

## FEMINIST THEORY

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Feminist theory analyzes the status of women and men in society with the purpose of using that knowledge to better women's lives. Feminist theorists question the differences between women and men, including how race, class, ethnicity, sexuality, nationality, and age intersect with gender. Themes that are studied include discrimination, objectification (especially sexual objectification), oppression, stereotyping, and so on. Feminist theory is used in the fields of social work, sociology, economics, education, and others.

Feminism is a political, cultural, or economic movement aimed at establishing equal rights and legal protection for women.

## THEORIES OF GROUP DEVELOPMENT AND FUNCTIONING

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Humans are small group beings. Group work is a method of social work that helps individuals to enhance their social functioning through purposeful group experiences, as well as to cope more effectively with their personal, group, or community problems. In group work, **individuals help each other** in order to influence and change personal, group, organizational, and community problems.

A social worker focuses on helping each member change the environment or behavior through interpersonal experience. Members help each other change or learn social roles in the particular positions held or desired in the social environment.

A therapeutic group provides a unique microcosm in which members, through the process of interacting with each other, gain more knowledge and insight into themselves for the purpose of making changes in their lives. The goal of the group may be a major or minor change in personality structure or changing a specific emotional or behavioral problem.

A social worker helps members come to agreement regarding the purpose, function, and structure of a group. A group is the major helping agent.

Individual self-actualization occurs through:

- Release of feelings that block social performance
- Support from others (not being alone)
- Orientation to reality and check out own reality with others

- Reappraisal of self

Some types of groups include:

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- Groups centered on a shared problem
- Counseling groups
- Activity groups
- Action groups
- Self-help groups
- Natural groups
- Closed versus open groups
- Structured groups
- Crisis groups
- Reference groups (similar values)

**Psychodrama** is a treatment approach in which roles are enacted in a group context. Members of the group re-create their problems and devote themselves to the role dilemmas of each member.

Despite the differences in goals or purposes, all groups have common characteristics and processes.

The stages of group development are:

1. Preaffiliation—development of trust (known as forming)
2. Power and control—struggles for individual autonomy and group identification (known as storming)
3. Intimacy—utilizing self in service of the group (known as norming)
4. Differentiation—acceptance of each other as distinct individuals (known as performing)
5. Separation/termination—independence (known as adjourning)

Groups help through:

- Instillation of hope

- Universality
- Altruism
- Interpersonal learning
- Self-understanding and insight

Factors affecting group cohesion include:

- Group size
- Homogeneity: similarity of group members
  - Participation in goal and norm setting for group■ 127
- Interdependence: dependent on one another for achievement common goals
- Member stability: frequent change in membership results in low cohesiveness

There are some advantages to participation in group therapy that individual treatment does not provide. The group process serves as a support network and a sounding board for clients. Through the group process, clients hear specific ideas for improving difficult situations or circumstances from others who are going through similar challenges. Group members' opinions are often highly respected as they come with the credibility of having experienced similar issues.

Regularly talking and listening to others also helps clients put their own problems in perspective. Clients may feel that they are the only ones struggling, but they learn, through the group process, that they are not. The ability to see and hear others like themselves indicates to clients that they are not alone and, thereby, reduces stigma and isolation.

Diversity is another important benefit of group therapy. Clients have different personalities and backgrounds and look at situations in different ways. By seeing how others address problems, clients are afforded new strategies for facing their own concerns.

Observing maladaptive behavior in others also may help clients see the effects of their own similar behavior. Discussing problems in a group may make it easier for clients to discuss their feelings with others, such as friends and family members, outside of the group. Group interaction helps develop healthy social interaction skills. Members can observe the social

and coping skills of others who may serve as positive role models. Role playing is also feasible in the group context.

## Key Concepts

**Groupthink** is when a group makes faulty decisions because of group pressures. Groups affected by groupthink ignore alternatives and tend to take irrational actions that dehumanize other groups. A group is especially vulnerable to groupthink when its members are similar in background, when the group is insulated from outside opinions, and when there are no clear rules for decision making.

There are eight causes of groupthink:

1. Illusion of invulnerability—excessive optimism is created that encourages taking extreme risks
2. Collective rationalization—members discount warnings and do not reconsider their assumptions
3. Belief in inherent morality—members believe in the rightness of their cause and ignore the ethical or moral consequences of their decisions
4. Stereotyped views of those “on the out”—negative views of the “enemy” make conflict seem unnecessary
5. Direct pressure on dissenters—members are under pressure not to express arguments against any of the group’s views  
Self-censorship—doubts and deviations from the perceived group consensus are not expressed
6. Illusion of unanimity—the majority view and judgments are assumed to be unanimous
7. Self-appointed “mindguards”—members protect the group and the leader from information that is problematic or contradictory to the group’s cohesiveness, views, and/or decisions

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**Group polarization** occurs during group decision making when discussion strengthens a dominant point of view and results in a shift to a more extreme position than any of the members would adopt on their own. These more extreme decisions are toward greater risk if individuals’ initial

tendencies are to be risky and toward greater caution if individuals' initial tendencies are to be cautious.

## **COMMUNICATION THEORIES AND STYLES**

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Communication theory involves the ways in which information is transmitted; the effects of information on human systems; how people receive information from their own feelings, thoughts, memories, physical sensations, and environments; how they evaluate this information; and how they subsequently act in response to the information.

Effective communication skills are one of the most crucial components of a social worker's job. Every day, social workers must communicate with clients to gain information, convey critical information, and make important decisions. Without effective communication skills, a social worker may not be able to obtain or convey that information, thereby causing detrimental effects on clients.

One cannot not communicate. Even when one is silent one is communicating, and another person is reacting to the silence. **Silence** is very effective when faced with a client who is experiencing a high degree of emotion, because the silence indicates acceptance of these feelings. On the other hand, silence on the part of a client can indicate a reluctance to discuss a subject. A social worker should probe further with a client who is silent for an unusually long period of time. If people do not communicate clearly, mutual understanding, acceptance, or rejection of the communication will not occur, and relationship problems can arise.

Some communication styles can serve to inhibit effective communication with clients.

1. Using "shoulds" and "oughts" may be perceived as moralizing sermonizing by a client and elicit feelings of resentment, guilt, obligation. In reaction to feeling judged, a client may oppose a soc worker's pressure to change.
2. Offering advice or solutions prematurely, before thorough exploration the problem, may cause resistance because a client is not ready solve the problem.
3. Using logical arguments, lecturing, or arguing to convince a client take another viewpoint may result in a power struggle with a client. better way of helping a client is to assist in exploring options in order make an informed decision.

4. Judging, criticizing, and blaming are detrimental to a client, as well to the therapeutic relationship. A client could respond by becoming defensive or, worse yet, internalizing the negative reflections.

Talking to a client in professional <sup>5</sup>.

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jargon and defining a client in terms of the client's diagnosis may result in a client internalizing the view of being "sick."

6. Providing reassurance prematurely or without a genuine basis is often for a social worker's benefit rather than a client's. It is a social worker's responsibility to explore and acknowledge a client's feelings, no matter how painful they are. A client may also feel that a social worker does not understand the client's situation.
7. Ill-timed or frequent interruptions disrupt the interview process and can annoy clients. Interruptions should be purposeful, well-timed, and done in such a way that they do not disrupt the flow of communication.
8. It is counterproductive to permit excessive social interactions rather than therapeutic interactions. In order for a client to benefit from the helping relationship, the client has to self-disclose about problematic issues.
9. Social workers must provide structure and direction to the therapeutic process on a moment-to-moment basis in order to maximize the helping process. Passive or inactive social workers may miss fruitful moments that could be used for client benefit. Clients may lose confidence in social workers who are not actively involved in the helping process.

The following are some communication concepts that are critical to social work practice.

### *Acceptance*

An acknowledgment of "what is." Acceptance does not pass judgment on a circumstance and allows clients to let go of frustration and disappointment, stress and anxiety, regret and false hopes. Acceptance is the practice of recognizing the limits of one's control. Acceptance is not giving up or excusing other people's behavior and allowing it to continue. Acceptance is not about giving in to circumstances that are

unhealthy or uncomfortable. The main thing that gets in the way of acceptance is wanting to be in control.

### *Cognitive dissonance*

Arises when a person has to choose between two contradictory attitudes and beliefs. The most dissonance arises when two options are equally attractive. Three ways to reduce dissonance are to (a) reduce the importance of conflicting beliefs, (b) acquire new beliefs that change the balance, or (c) remove the conflicting attitude or behavior. This theory is relevant when making decisions or solving problems.

### *Context*

The circumstances surrounding human exchanges of information.

### *Double bind*

Offering two contradictory messages and prohibiting the recipient from noticing the contradiction.

### *Echolalia*

Repeating noises and phrases. It is associated with catatonia, autism spectrum disorder, schizophrenia, and other disorders.

### *Information*

Anything people perceive from their environments or from within themselves. People act in response to information.

### *Information processing*

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Responses to information that are mediated through one's perception and evaluation of knowledge received.

### *Information processing block*

Failure to perceive and evaluate potentially useful new information.

### *Metacommunication*

The context within which to interpret the content of the message (i.e., nonverbal communication, body language, vocalizations).

### *Nonverbal communications*

Facial expression, body language, and posture can be potent forms of communication.

In communication, there are two types of content, manifest and latent. Manifest content is the concrete words or terms contained in a communication, whereas latent content is that which is not visible, the underlying meaning of words or terms.

Relying just on the manifest content to understand client experiences or problems may result in not really understanding their meaning to individuals.

There are social work techniques such as clarifying, paraphrasing, confronting, and interpreting that can assist social workers in developing a better understanding of the meaning of clients' communication.

In addition, therapeutic techniques, such as psychoanalysis, focus on the hidden meaning of fantasies or dreams.

## **THEORIES OF CONFLICT**

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Conflict theory, derived from the works of Karl Marx, posits that society is fragmented into groups that compete for social and economic resources. Social order is maintained by consensus among those with the greatest political, economic, and social resources.

According to conflict theory, inequality exists because those in control of a disproportionate share of society's resources actively defend their advantages. The masses are bound by coercion by those in power. This perspective emphasizes social control, not consensus and conformity. Groups and individuals advance their own interests, struggling over control of societal resources.

There is great attention paid to class, race, and gender in this perspective since they relate to the most pertinent and enduring struggles in society.

Conflict theorists challenge the status quo, encourage social change, and believe rich and powerful people force social order on the poor and the weak. Conflict theorists note that unequal groups usually have conflicting values and agendas, causing them to compete against one another. This constant competition between groups forms the basis for the ever-changing nature of society.

# Diversity and Discrimination

## **THE EFFECT OF DISABILITY ON BIOPSYCHOSOCIAL FUNCTIONING THROUGHOUT THE LIFESPAN**

With increased age comes increased likelihood of disability as people live longer and do not encounter fatal diseases. Unfortunately, this positive association between age and disability sometimes leads to a negative image of aging. Given that the aging process often results in some type of disability, examinations of differences in aging outcomes have not centered around whether disabilities will occur, but rather when they will happen, how many will occur, and how severe they will be.

Disability occurs when physical or mental health declines associated with aging, illness, or injury restrict ability to perform activities of daily living (ADLs). Mobility impairment is often tied to disability because being able to ambulate and/or use one's upper extremities are critical to engaging in many activities that allow independence.

The most common causes of disability among older adults are chronic diseases, injuries, mental impairment, and/or malnutrition. Major chronic conditions related to disability include cardiovascular diseases, hypertension, stroke, diabetes, cancer, chronic obstructive pulmonary disease, musculoskeletal conditions including arthritis and osteoporosis, mental health conditions such as dementia and depression, and blindness and visual impairment. Injuries can be due to accidents and/or falls.

There is a relationship between disability and poverty. Poverty can lead to malnutrition, poor or no health services, and/or unsafe living conditions that can result in increased risk for disability. Disability can also result in loss of income and, thus, a greater likelihood of living in poverty.

Interestingly, happiness and well-being tend to be high among older adults overall despite declines in physical and mental health and the onset of disability for some. This discrepancy is due to the fact that not all disability leads to dependence. If the consequences of disability can be reduced or eliminated altogether, its negative effects on quality of life can be minimized.

The environment and improvements in lifestyle are critical. The environment plays an important role in the impact of disability on the lives of older adults, with those remaining outside of institutional settings—such as nursing homes—being more productive and satisfied. In addition, environments based on accessible design promote independent living, which can result in good quality of life for those who are older and/or have disabilities.

Improvements in lifestyle and health behaviors include better <sup>132</sup> nutrition, quitting or reducing smoking, less obesity, and greater physical activity. Benefits from exercise, even when begun later in life, can postpone and/or minimize disability.

## **THE EFFECT OF CULTURE, RACE, AND ETHNICITY ON BEHAVIORS, ATTITUDES, AND IDENTITY**

Cultural, racial, and ethnic groups are diverse and behaviors, attitudes, and identities of their members change over time. Understanding the effects cannot be achieved by learning facts about specific populations or attending trainings on cultural competence. Working with those from diverse cultural, racial, and/or ethnic groups is a developmental process that begins with awareness and commitment and evolves into skill building and culturally responsive behavior.

Social workers must recognize the importance of culture, race, and/or ethnicity on behaviors, attitudes, and identity. Clients do not share the same beliefs and practices or perceive, interpret, or encounter similar experiences in the same way. Social workers must recognize that people have ethnocentric views that are shaped by their

culture, race, and/or ethnicity. It is often difficult to appreciate differences and to address these differences effectively, because many people tend to see things solely from their own culture-bound perspectives.

The following listing describes some effects of culture, race, and/or ethnicity, as well as factors which can contribute to behavioral, attitudinal, and identity differences.

## Language and Communication

Language is a key element of culture but speaking the same language does not necessarily mean the sharing of the same cultural beliefs. Conversely, those who share an ethnicity do not automatically share a language. Families who immigrated to this country several generations earlier may identify with their culture of origin but no longer be able to speak its language.

Styles of communication and nonverbal methods of communication are also important aspects of cultural groups. Issues such as the use of direct versus indirect communication, appropriate personal space, social parameters for and displays of physical contact, use of silence, preferred ways of moving, meaning of gestures, degree to which arguments and verbal confrontations are acceptable, degree of formality expected in communication, and amount of eye contact expected are all culturally defined and reflect very basic cultural, racial, and/or ethnic differences. More specifically, the relative importance of nonverbal messages varies greatly from culture to culture.

## Geographic Location

Cultural groups form within communities and among people who interact meaningfully with each other. Any culture is subject to local adaptations. For example, clients coming from a geographic area—even if they come from different ethnicities—can have a great deal in common, whereas individuals from the same ethnicity who were raised in different geographic locales can have very different experiences and, consequently, attitudes.

Geography can strongly affect substance use and abuse, mental <sup>133</sup> health and well-being, and access to and use of behavioral health

services. Even among members of the same culture, race, and/or ethnicity, these factors differ across geographic areas.

## **Worldview, Values, and Traditions**

There are many ways of conceptualizing how culture influences behaviors, attitudes, and identity. Culture can be seen as a frame through which to look at the world, beliefs and practices that can be used to explain why people do what they do, sets of values and traditions to delineate one group of people from another, and so on. Cultural groups define the values, worldviews, and traditions of their members, from food preferences to appropriate leisure activities.

## **Family and Kinship**

Although families are important in all cultural groups, concepts of and attitudes toward family are culturally defined and can vary in a number of ways, including the relative importance of particular family ties, family inclusiveness, hierarchies within families, and how family roles and behaviors are defined. In some cultural groups, family is limited to the nuclear family, whereas in other groups, the idea of family typically includes many other blood or marital relations. Some cultural groups clearly define roles for different family members and carefully prescribe methods of behaving toward one another based on specific relationships. Despite culture, family dynamics may change as the result of internal or external forces. Acculturation can significantly affect family roles and dynamics among immigrant families, causing the dissolution of longstanding cultural hierarchies and traditions, resulting in potential conflict between spouses or different generations of a family.

## **Gender Roles**

Gender roles are largely cultural constructs; diverse cultural groups have different understandings of the proper roles, attitudes, and behaviors for those of different genders. Culturally defined gender has a strong effect on behaviors, attitudes, and identity. Some cultural groups identify gender as binary—male and female—while others do not.

## Socioeconomic Status and Education

Socioeconomic status (SES) affects culture in several ways, namely through the accumulation of material wealth, access to opportunities, and use of resources. Education is also an important factor related to SES, with higher levels of education associated with increased income. Discrimination and historical racism have led to lasting inequalities in SES. Poverty results in limited access to resources, increased stress, and enhanced vulnerabilities to substance use and mental illness.

Health disparities are defined as differences in the incidence, prevalence, morbidity, and burden of diseases and other adverse health conditions that exist between specific groups. There are <sup>134</sup> longstanding health disparities between cultural, racial and ethnic groups. The causes of these historical inequalities include lack of insurance coverage and persistent discrimination, as well as distrust of the service delivery system by certain groups. Social determinants of health are conditions that affect functioning and quality-of-life outcomes, including access to educational, economic, and vocational training; job opportunities; transportation; healthcare services; emerging technologies; availability of community-based resources, basic resources to meet daily living needs, language services, and social support; exposure to crime; community and concentrated poverty; and residential segregation.

## Immigration and Migration

Immigration is stressful, though the reasons for migrating and the legal status of immigrants affect the degree of stress. Immigrants who are refugees from war, famine, oppression, and other dangerous environments are more vulnerable to psychological distress. They are likely to have left behind painful and often life-threatening situations in their countries of origin and are likely to be impacted by these experiences.

For immigrants, there may be conflicts in identities—wanting to fit in with new cultures while also wanting to retain the values of their cultures of origin. Cultural identification may change over time and vary from group to group. Adaptation and acculturation can be a source of conflict within families, especially when parents and children adapt or acculturate at different rates.

For documented residents, the process of adaptation tends to be smoother than for those who are undocumented. However, they can have concerns surrounding the renewal of visas and obtainment of citizenship. Undocumented persons may be wary of deportation, are less likely to seek social services, and frequently encounter hostility. There are numerous variables that contribute to or influence well-being, quality of life, cultural adaptation, and the development of resilience.

Immigration nearly always includes separation from family and culture and can involve a grieving process resulting from these losses, as well as changes in socioeconomic status, physical environment, social support, and/or cultural practices. For immigrant families, disruption of roles and norms often occurs. Clients who are migrants (e.g., seasonal workers) pose a particular set of challenges as they are particularly marginalized and underserved due to lack of childcare, insurance, access to regular health care, and transportation. High rates of alcohol use, alcohol use disorders, and binge drinking, often occur as a response to stress or boredom associated with the migrant lifestyle.

## **Sexuality**

Attitudes toward sexuality and toward sexual identity or orientation are culturally defined. Each culture determines how to conceptualize specific sexual behaviors, the degree to which they accept same-gender relationships, and the types of sexual behaviors considered acceptable or not. Diverse views and attitudes about appropriate gender norms and behavior exist between cultural, racial, and/or ethnic groups. Sexual behaviors considered acceptable for one gender can be considered unacceptable for another. Other factors that can vary across cultural groups include the appropriate age for sexual activity, the rituals and actions surrounding sexual activity, the use of birth control, the level of secrecy or openness related to sexual acts, the role of sex workers, attitudes toward sexual dysfunction, and the level of sexual freedom in choosing partners.<sup>135</sup>

## **Perspectives on Health, Illness, and Healing**

Behaviors and attitudes related to health, illness, and healing vary across racial, ethnic, and cultural groups. In general, cultural groups

differ in how they define and determine health and illness; who is able to diagnose and treat an illness; their beliefs about the causes of illness; and their remedies, treatments, and healing practices for illness. In addition, there are complex rules about which members of a community or family can make decisions about health care across cultural groups. Mental disorders or symptoms may be socially defined norms. For instance, in some societies, those who hear voices can be considered to have greater access to the spirit world and to be blessed in some way. Furthermore, there are mental disorders that only present in a specific cultural group or locality. Other specific examples of cultural differences relate to the use of health care and alternative approaches to medical diagnoses and treatments.

## **Religion and Spirituality**

Religious traditions or spiritual beliefs are often very important factors associated with culture, race, and ethnicity. However, members of religious groups can racially or ethnically diverse. It is important to distinguish between spirituality and religion. Some clients are willing to think of themselves as spiritual but not necessarily religious. Religion is organized, with each religion having its own set of beliefs and practices designed to organize and further its members' spirituality. Spirituality, on the other hand, is typically conceived of as a personal matter involving a search for meaning; it does not require an affiliation with any religious group. People can have spiritual experiences or develop their own spirituality outside of the context of an organized religion.

## **THE EFFECTS OF DISCRIMINATION AND STEREOTYPES ON BEHAVIORS, ATTITUDES, AND IDENTITY**

The negative impacts of discrimination can be seen on both the micro and macro levels. Exposure to discrimination is linked to anxiety and depression as well as other mental health and behavioral problems. In addition, there may be physical effects such as diabetes, obesity, and high blood pressure. These health problems may be caused by not maintaining healthy behaviors (such as physical activity) or engaging in unhealthy ones (such as smoking and alcohol or drug abuse).

These impacts can be long term or short term, including having:

- Low self-esteem
- Depression
- Fear of rejection
- Stress
- Low self-worth
- Feelings of being withdrawn from society
- Humiliation
- Fear
- Anger

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These impacts can result in long-term effects, including:

- Loss of motivation
- Restricted opportunities
- Limited access to services
- Long-term depression
- Increased behavior problems
- Difficulty communicating
- Lack of education and achievement

Those who have been discriminated against based on culture, race, and/or ethnicity can become isolated from society and feel embarrassed about the shame imposed on them and/or their family. Internalized racism can occur in which negative discriminatory attitudes based on culture, race, and/or ethnicity can result, with those in minority groups applying stereotypes toward their own cultural, racial, and/or ethnic groups.

Those who discriminate against others often do so because they have been discriminated against themselves. They may be unhappy or have watched people close to them discriminate against others and/or are copying and responding to their actions.

On a macro level, discrimination also restricts access to the resources and systems needed for good health, education, employment, social support, and participation in sports, cultural, and civic activities. Discrimination and intolerance can also create a climate of despondence, apprehension, and fear within a community. The social and economic effects of discrimination on one generation may flow on to affect future generations, which can lead to cycles of poverty and disadvantage through those generations.

## **THE INFLUENCE OF SEXUAL ORIENTATION ON BEHAVIORS, ATTITUDES, AND IDENTITY**

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Sexuality is a crucial part of who we are. Sexual orientation, sexual behavior, and sexual identity are three parts of sexuality that can help to understand the term better.

**Sexual orientation** refers to an individual's pattern of physical and emotional arousal toward other persons. People do not choose their sexual orientation—it is simply part of who they are.

**Sexual behavior** refers to sexual contacts or actions. It is important to realize that people's sexual orientation may not fit perfectly with their sexual behavior (what they do sexually). There are many factors that shape or determine sexual behavior and sexual orientation is only one of those factors. Sexual behavior <sup>137</sup> can be influenced by peer pressure, family expectations, cultural expectations, religious beliefs, and so on.

**Sexual identity** also may be very different to their sexual orientation. Sexual identity is about the way people present their sexual preferences. People may have private sexual identities which may be different to their public identities. Even private sexual identities can differ from sexual orientation or attractions. Many people who experience same-sex attraction and/or have sexual contact with others of the same sex do not see themselves as homosexual or bisexual.

Sexual orientation often does not fit “neatly” into a label or category. People's attractions can be complicated and often are not clear. Clients

may be struggling to determine what feels right for them.

Sexual orientation can be fluid with attractions changing over time. Some people take a while to figure out these attractions. That does not mean people “grow out of” their sexual attractions or that one set of feelings was a stage, it just means people change. *It is important to not use labels and let individuals define their own sexual orientation.*

## **THE IMPACT OF TRANSGENDER AND TRANSITIONING PROCESS ON BEHAVIORS, ATTITUDES, IDENTITY, AND RELATIONSHIPS**

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“Transgender” is a term for people whose gender identity, expression, or behavior is different from those typically associated with their assigned sex at birth. “Trans” is sometimes used as shorthand for “transgender.”

People might realize they are trans (that their gender identity does not align with their birth sex designation) at any point in their lives. Some people may first experience an internal sense of identity that does not match their external characteristics in early childhood. Others report realizing this in puberty or later. Societal gender norms and expectations may contribute to realization of their true gender identity. These assumptions can also contribute to dysphoria, as people might first attempt to conform to societal expectations by expressing gender identities they do not have. Feelings of distress frequently arise, during which people realize that they cannot meet these gender norms as they do not match their identities.

Transition is a time when individuals begin living as the gender with which they identify rather than the gender they were assigned at birth, which often includes changing one’s first name and dressing and grooming differently. Transitioning may or may not also include medical and legal aspects, including taking hormones, having surgery, or changing identity documents (e.g., driver’s license, Social Security record) to reflect one’s gender identity. Medical and legal steps are costly and, therefore, unaffordable.

Transition, whether social, through hormone therapy, through surgery, or through some combination, often improves feelings of dysphoria, though it may not relieve them completely. The goal of many is for their gender to be perceived correctly by others, which is often

referred to as “passing.” Typically, people transition to align their physical appearance and characteristics with their gender identities. Many people begin the process after years of dysphoria and distress, and transitioning may help them feel as if they are finally able to be their true selves.

Transitioning can have significant psychological, social, and physical benefits. Anxiety and depression caused by gender dysphoria may diminish as dysphoria improves. Individuals who no longer have to <sup>138</sup> make uncomfortable adjustments—such as hiding unwanted physical characteristics—may not only feel better physically but may have greater confidence and self-esteem.

People’s reasons for choosing to transition, and the goals they have regarding transition, are personal and unique. Some individuals may not pursue certain aspects of transition, whether through personal choice, lack of resources, or lack of access. There is no single “right” way to transition. Gender identity does not depend on whether they have had surgery or if they are taking hormones.

Friends and family members who may have little to no understanding of gender transition or of what it means to be trans may ask invasive questions or say things that are invalidating or hurtful, regardless of intention. They may also find people’s true genders difficult to accept. “You’ll always be \_\_\_\_\_ to me,” a mother might say, without the intention of harm. But this type of remark may be invalidating and cause distress.

Social work services can help individuals who are transgender as they consider and move through the transitioning process. They can also help family members by creating safe spaces where they can ask questions, develop a better understanding of what it means to be transgender, and learn more about what transition entails.

## **SYSTEMIC (INSTITUTIONALIZED) DISCRIMINATION (E.G., RACISM, SEXISM, AGEISM)**

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability (*NASW Code of Ethics—Discrimination*).

Discrimination can occur at the individual or institutional level. Individual discrimination is when an individual is treated differently whereas institutionalized discrimination refers to policies or practices that discriminate against a group of people based on these characteristics (achievement gaps in education, residential segregation, etc.).

Social workers are charged with challenging discriminatory practices and upholding the belief of equal rights for all.

## **THE PRINCIPLES OF CULTURALLY COMPETENT SOCIAL WORK PRACTICE**

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Cultural awareness involves working in conjunction with natural, informal support and helping networks within a minority community (neighborhoods, churches, spiritual leaders, healers, etc.). It extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture.

Social workers should promote conditions that encourage respect for cultural and social diversity and promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural awareness, and promote policies that safeguard the rights of all people.

Social workers should act to prevent and eliminate domination of,<sup>139</sup> exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

Since every client's cultural experiences are different, services must be delivered using a flexible and individualized approach. Social workers should be aware of the standards on cultural awareness and social diversity.

1. Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in cultures.

2. Social workers should have a knowledge base of their client cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups. *When social workers are from different racial or cultural backgrounds than their clients, they must clearly understand how these differences impact the problem-solving process.*
3. Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.
4. Social workers should also not use derogatory language in the written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients (*NASW Code of Ethics—Derogatory Language*).

Social workers should be aware of terminology related to cultural barriers and goals.

*Ethnocentrism:* an orientation that holds one's own culture, ethnic, or racial group as superior to others

*Stratification:* structured inequality of entire categories of people who have unequal access to social rewards (e.g., ethnic stratification, social stratification)

*Pluralism:* a society in which diverse members maintain their own traditions while cooperatively working together and seeing others' traits as valuable (cultural pluralism—respecting and encouraging cultural difference)

Social workers must possess specific knowledge about the cultural groups with whom they work, including diverse historical experiences, adjustment styles, socioeconomic backgrounds, learning styles, cognitive skills, and/or specific cultural customs. This knowledge must include theories and principles concerning human behavior

development, psychopathology, therapy, rehabilitation, and community functioning because they relate to cultural group members. Institutions, class, culture, and language barriers that prevent ethnic group members from accessing or using services must be identified and addressed.

Some approaches within organizations to promote cultural diversity include recruiting multiethnic staff, including cultural awareness requirements in job descriptions and performance/promotion measures, reviewing demographic trends for the geographic area served to <sup>140</sup> determine service needs, creating service delivery systems that are more appropriate to the diversity of the target population, and advocating for clients as major stakeholders in the development of service delivery systems to ensure they are reflective of their cultural heritage.

## **SEXUAL ORIENTATION CONCEPTS**

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“Sexual orientation” is a term used to describe patterns of emotional, romantic, and sexual attraction—and our sense of personal and social identity based on those attractions. Sexual orientation exists along a continuum, with exclusive attraction to the opposite sex on one end of the continuum and exclusive attraction to the same sex on the other.

There are a bunch of identities associated with sexual orientation:

- People who are attracted to a different gender (e.g., women who are attracted to men or men who are attracted to women) often call themselves straight or heterosexual.
- People who are attracted to people of the same gender often call themselves gay or homosexual. Gay women may prefer the term “lesbian.”
- People who are attracted to both men and women often call themselves bisexual.
- People whose attractions span across many different gender identities (male, female, transgender, genderqueer, intersex, etc.) may call themselves pansexual or queer.
- People who are unsure about their sexual orientation may call themselves questioning.

themselves questioning or curious.

- People who do not experience sexual attraction often consider themselves asexual.

It is also important to note that some people don't think any of these labels describe them accurately. Some people don't like the idea of labels at all. Other people feel comfortable with certain labels and not others.

Social workers must let clients identify and use their own labels to describe their own sexual orientations.

## **GENDER AND GENDER IDENTITY CONCEPTS**

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A gender role is a theoretical construct that refers to a set of social and behavioral norms that, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex. Socially accepted gender roles differ widely between different cultures. Gender role theory asserts that observed gender differences in behavior and personality characteristics are, at least in part, socially constructed, and therefore the product of socialization experiences; this contrasts with other models of gender, which assert that gender differences are "essential" to biological sex. Thus, there is a debate over the environmental or biological causes for the development of gender roles.

Gender role theory posits that boys and girls learn to perform one's biologically assigned gender through particular behaviors and attitudes. Gender role theory emphasizes the environmental causes of gender roles and the impact of socialization, or the process of transferring norms, values, beliefs, and behaviors to group members, in learning how to behave as a male or a female. Social role theory proposes <sup>141</sup> that the social structure is the underlying force in distinguishing genders and that sex-differentiated behavior is driven by the division of labor between two sexes within a society. The division of labor creates gender roles, which, in turn, lead to gendered social behavior.

Gender has several definitions. It usually refers to a set of characteristics that are either seen to distinguish between male and female, one's biological sex, or one's gender identity. Gender identity is

the gender(s), or lack thereof, a person self-identifies as; it is not based on biological sex, either real or perceived, nor is it always based on sexual orientation. There are two main genders, masculine (male) and feminine (female), although in some cultures there are more genders. Gender roles refer to the set of attitudes and behaviors socially expected from those with a particular gender identity.

**Gender identity** usually conforms to anatomic sex in both heterosexual and homosexual individuals. However, individuals who identify as transgender feel themselves to be of a gender different from their biological sex; their gender identity does not match their anatomic or chromosomal sex.

**Sexual orientation and gender identity are distinct with those who are transgender exhibiting the same full range of possible sexual orientations and interests of those who are not transgender.**

It is important to let individuals define their own gender identity. For some, gender is not just about being male or female; in fact, identity can change every day or even every few hours. **Gender fluidity**, when gender expression shifts between masculine and feminine, can be displayed in dress, expression, and self-description.

There are lots of misconceptions about gender fluidity. Gender fluidity is also not the equivalent of transgender, in which a person's gender identity is different from the one assigned at birth. It is the belief that gender exists on a spectrum and is not binary with the ability to change at any time.

It is important for social workers to use proper "gender pronouns" when working with clients as it is a sign of mutual respect between the parties. A "gender pronoun" is the pronoun that a person chooses to use to be referred to in a sentence or conversation. Some people do not use pronouns at all, using their names as pronouns instead. It is not possible to know people's gender pronouns by looking at them. Gender pronouns can also change over time to match shifts in gender identity.

Being referred to with the wrong pronoun results in feeling disrespected, invalidated, dismissed, alienated, and/or dysphoric. Being misgendered can be a source of great distress. It is also important to use the correct pronouns for the safety of a person. Using

incorrect pronouns can “out” someone or expose someone’s identity without consent.

Asking about and correctly using gender pronouns is one of the most basic ways to show respect for gender identity. Clients determine quickly if they feel respected. Social workers must set an example by asking about and correctly using gender pronouns, educating others about pronoun privilege. Pronoun privilege occurs when one does not have to worry about which pronoun is going to be used based on gender perception.

Gender pronouns can include, but are not limited to:

- he/him/his (masculine pronouns)
- she/her/hers (feminine pronouns)
- they/them/theirs (neutral pronouns)—can be used in the <sup>142</sup> singular and a common gender-neutral pronoun, often used when unsure what pronoun someone uses
- ze/zir/zirs (neutral pronouns)
- ze/hir/hirs (neutral pronouns)

Asking about gender pronouns can occur by using one of the following questions:

- “What gender pronouns should I use to refer to you?”
- “What are your gender pronouns?”
- “I don’t want to make any assumptions, so what gender pronouns do you use?”
- “How should I refer to you in conversations?”

## Content Area I: Practice Questions

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The following section has 41 unique practice questions that assess retention of material related to human development, diversity, and behavior in the environment. The number of questions reflects the

approximate proportion of a typical exam (24%) devoted to this content.

- 1.** In which stage of cognitive development do imaginary friends **MOST** often emerge?

  - A.** Formal operations
  - B.** Preoperational
  - C.** Sensorimotor
- 2.** According to the family life cycle, which of the following is the **MOST** significant role issue in families with young children?

  - A.** Adjusting to children taking a more central role in family maintenance
  - B.** Adopting and developing parenting roles
  - C.** Assisting children to develop peer relationships
- 3.** A family seeks treatment with a social worker. During the assessment process, the social worker learns that the parents expect their children to follow strict rules and the children are severely punished if they do not. When the social worker asks the children why they have to follow several of the rules, the children are not sure why and respond, "just because we do." Which of the following parenting styles is **MOST** likely being used by the parents in this family?

  - A.** Authoritative
  - B.** Authoritarian
  - C.** Corporal

**4145**

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A social worker is a facilitator of a group for clients diagnosed as having anorexia nervosa. Over several weeks, clients talk about their diverse backgrounds, including their varied early childhood experiences. The social worker comments that this

disorder is caused by many different factors. Which of the following concepts is the social worker mentioning?

- A. Homeostasis
- B. Equifinality
- C. Subsystems

**5.** Which of the following is accurate about self-image during the life cycle?

- A. Self-esteem generally increases in older adulthood because individuals have fewer demands placed upon them in retirement
- B. Young children have relatively low self-esteem, but it gradually increases over childhood
- C. Self-esteem declines during adolescence due to body image concerns, puberty, and academic/social challenges

**6.** A man is seeing a social worker because he is struggling to “find himself” as his children have become adults and left the family home. He feels that his job has become mundane, and he is feeling “bored with life.” Which stage of psychosocial development **BEST** describes the client’s feelings?

- A. Generativity versus stagnation
- B. Industry versus inferiority
- C. Intimacy versus isolation

**7.** Which of the following **BEST** describes the typical mental functioning of older adults?

- A. They continue to learn but may experience declines in memory skills
- B. They are at their peak with regard to problem solving and mental processes
- C. They do not learn and may experience declines in memory skills

**8147**

- A client reports to a social worker that she was often criticized by her parents when she was in elementary and middle school and now has poor self-esteem and doubts her abilities. According to Erikson's stages of psychosocial development, in which of the following stages is the client experiencing a crisis?
    - A.** Identity versus role confusion
    - B.** Generativity versus stagnation
    - C.** Industry versus inferiority
- 9.** A social worker advises a 16-year-old client who has often been bullied in public by a group of peers to walk away each time such an incident occurs in the future. In the past, the boy would often cry when teased, causing the peers to laugh at his reaction. Which technique is the social worker recommending to reduce the teasing?
- A.** Systematic desensitization
  - B.** Time out
  - C.** Extinction
- 10.** Which of the following perspectives on human behavior is based on the belief that clients have the capacity to change themselves and actions are driven by a desire for growth, personal meaning, and competence?
- A.** Humanistic
  - B.** Developmental
  - C.** Rational choice
- 11.** Which of the following is a respondent behavior by a client?
- A.** Crying when feeling sad
  - B.** Becoming an outstanding scholar when not good at sports
  - C.** Walking away from someone when angry

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- <sup>149</sup> Which of the following is the **MOST** appropriate method
- 12.** for understanding attachment and bonding?
- A. Attachment and bonding are best viewed separately from a client's culture because the theoretical approaches are universal
- B. Theories of connectedness must be understood within an evolutionary context
- C. Attachment can be viewed as a set of learned behaviors focused on survival and operant conditioning
- 13.** Which of the following **BEST** describes entropy?
- A. Randomness or disorder in a system, leading to decline
- B. Forward motion, leading toward goal achievement
- C. Specialization in system function and purpose
- 14.** Which of the following is **MOST** important when understanding theories of human development in social work?
- A. A strength-based approach
- B. An ecological orientation
- C. A focus on mental health
- 15.** According to Erikson, which sequence of relationship formation does psychosocial development follow?
- A. Attachment-autonomy-intimacy
- B. Intimacy-attachment-autonomy
- C. Autonomy-attachment-intimacy
- <sup>151</sup> Which of the following parenting styles is generally associated with the **MOST** negative outcomes in children?
- A. Uninvolved
- B. Authoritarian

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### C. Permissive

- 17.** A social worker is referring a client for genetic counseling. Based on this information, which of following groups is the client **MOST** likely a member?
- A. Men who are sexually active with a family history of birth defects
  - B. Women who are trying to get pregnant but have not been able to despite fertility treatment
  - C. Mothers who have suffered postpartum depression
- 18.** A couple comes in to see a social worker because of their destructive pattern of fighting. The husband complains that his wife is always nagging him to do things around the house and suggests that he will get them done if she just stops complaining. Which of the following behavioral techniques does the husband state will improve his behavior?
- A. Negative punishment
  - B. Positive punishment
  - C. Negative reinforcement
- 19.** A client is extremely upset because her 14-year-old son is not helping around the house, independently doing his homework, or arriving to school on time. The son states that his mother watches over him too closely and does not give him needed privacy. What is **MOST** likely the root of this problem?
- A. Communication
  - B. Role expectations
  - C. Developmental functioning
- 153 **20.** Which of the following is a physical symptom associated with Wernicke's encephalopathy or Korsakoff's syndrome?
- A. Memory loss

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- B. Confusion
- C. Coordination problems

**21.** A client has dilated pupils, appears jittery, and complains that "he just needs to get some sleep." Which of the following substances is the client **MOST** likely using?

- A. Cocaine
- B. Heroin
- C. Marijuana

**22.** A client shows a social worker a large tattoo on his arm dedicated to his mother who recently died. He begins to cry and states that it always makes him very emotional when he sees it because it reminds him of her bravery in fighting her illness. Which of the following **MOST** likely explains why the client decided to get the tattoo?

- A. Symbolization
- B. Substitution
- C. Sublimation

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**155**      Which of the following is **MOST** important for a social  
**23.**      worker to consider when treating clients with co-occurring disorders and conditions?

- A. Substance use disorders must be treated prior to mental health problems
- B. Both substance use and mental health disorders may be mild or severe with the most severe needing immediate attention
- C. Both substance use and mental health disorders must be treated simultaneously, regardless of severity

**24.** Which medication is used to treat alcoholism by making clients feel ill if they consume alcohol while taking this drug?

- A.** Clozaril
- B.** Antabuse
- C.** Topamax

**25.** What is the **MOST** important for a social worker to focus on when working with a justice-involved client to reduce recidivism of criminal activity?

- A.** Dynamic risk factors
- B.** Static risk factors
- C.** Arrest records and past legal involvement

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A man comes in to see a social worker and tells her that, after years of substance use, he “has had enough” and gave up using heroin two days ago. He appears anxious and agitated and reports vomiting, as well as being unable to sleep. In order to meet his immediate treatment needs, the social worker should:

- A.** Assist him to develop a relapse prevention plan
- B.** Arrange for him to see a physician to address physical concerns
- C.** Complete a biopsychosocial–spiritual–cultural assessment focusing on the reasons for the substance use

**27.** Which of the following is an example of a role reversal?

- A.** A 14-year-old boy told by his mother that he has to work to financially contribute to household expenses
- B.** A 13-year-old girl physically and emotionally taking care of her father who was permanently injured in an accident
- C.** A 10-year-old boy yelling at his mother that she is not doing enough work around the house

**28.** A social worker is working with a family who has become

homeless after a fire destroyed their home. The 10-year-old daughter begins to use “baby talk” and suck her thumb, behaviors that were not present before the fire. The mother reports that the daughter now always wants to sit on her lap and clings to her side when they go out in public. Which of the following defense mechanisms is **MOST** likely being used by the daughter?

- A. Undoing
- B. Reaction formation
- C. Regression

**29.** Which of the following factors is the **MOST** important focus of the person-in-environment classification system?

- A. Social role functioning
- B. Mental and physical health
- C. Psychiatric pathology

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**159** Which of the following stages of group development are  
**30.** in sequential order?

- A. Preaffiliation, differentiation, intimacy, power and control, and separation/termination
- B. Preaffiliation, power and control, intimacy, differentiation, and separation/termination
- C. Differentiation, preaffiliation, power and control, intimacy, and separation/termination

**31.** Which of the following **BEST** describes delirium tremens?

- A. Neurological deterioration that can occur in older adults
- B. Physical symptoms associated with alcohol withdrawal
- C. Psychotic features linked with certain mental health diagnoses

**32.** A client who reports that she repeatedly feels the urge to

physically strike her child when angry tells the social worker that she is having trouble moving her arm. Which of the following defense mechanisms is the client **MOST** likely exhibiting?

- A. Introjection
- B. Reaction formation
- C. Conversion

**33.** In a dysfunctional family, the role of the “mascot” is to:

- A. Complete the responsibilities of others who are not able
- B. Help the family’s image with others by doing well
- C. Get others to laugh as a way of drawing attention away from family problems

**34.** A client tells a social worker that he has been screamed at by his boss on a daily basis for the last month. He is very angry but has not said anything for fear of being fired. He also reports that he is having problems with his wife and children because he has not been able to control his temper in the last few weeks at home. Which of the following defense mechanisms **BEST** represents the client’s behavior?

- A. Displacement
- B. Incorporation
- C. Compensation

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**161**      **35.** Which of the following is **MOST** important for a social worker to know about cultural, racial, and ethnic identities?

- A. These identities are passed from one generation to the next
- B. These identities are often stable over the life course
- C. These identities are linked to feeling of belonging

- 36.** Which of the following is accurate about youth who are homosexual and/or gender non-conforming?
- A. They go through different developmental stages than their peers
  - B. They are likely to develop strong identities due to the availability of many role models
  - C. They are more at risk for social isolation and poor self-image than their peers
- 37.** Which of the following **BEST** describes acculturation?
- A. One culture seeking ways to establish its own identity from others that exist
  - B. One culture incorporating elements of another culture into its own ways
  - C. One culture trying to work with others despite differences
- 38.** A school social worker asks the parents of a boy who is Asian to come in for a conference because he has been experiencing problems at school. These problems include not obeying rules and deliberately annoying others. The grandparents of the boy come to the meeting with the parents. Which of the following is **MOST** likely given the presence of the grandparents at the meeting?
- A. The boy is having problems at home and the grandparents are needed by the parents to assist with the behaviors
  - B. The grandparents are an important part of the boy's support system and should be incorporated into the treatment plan
  - C. The boy will only listen to the grandparents and they will be needed in the treatment process in order for him to stop the behaviors in school
- 162
- 39.** Which of the following **BEST** defines the relationship between race and ethnicity?

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- A.** Individuals who are the same race are always part of the same ethnic group
- B.** Individuals who are the same race may or may not be part of the same ethnic group
- C.** Individuals who are the same race are never part of the same ethnic group

**40.** A client reports to a social worker that she is thinking of ending her marriage and would like to get guidance from her priest about her desire. In response to the client's request, the social worker should **FIRST**:

- A.** Determine why the client thinks that speaking to her priest will be helpful
- B.** Praise the client as the priest should be involved in religious/spiritual concerns
- C.** Identify what support is needed to prepare the client for the meeting with the priest

**41.** Which of the following is a true statement about a client who is transgender?

- A.** The client is likely to undergo gender affirming surgery in the future
- B.** The client is likely to dress in clothing of the opposite gender assigned at birth
- C.** The client is likely to experience stigma, bias, and/or discrimination due to gender identity

Practice Questions					
Content Area I: Human Development, Diversity, and Behavior in the Environment (24%)					
Competency	Question Numbers	Number of Questions	Number Correct	Percentage Correct	Area Requiring Further Study?
1. Human Growth and Development	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18	18	____/18	____%	
2. Human Behavior in the Social Environment	19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34	16	____/16	____%	
3. Diversity and Discrimination	35, 36, 37, 38, 39, 40, 41	7	____/7	____%	

**1. B.** Piaget defined four stages of cognitive development. They are sensorimotor, preoperational, concrete operations, and formal operations. The preoperational stage begins at about age 2 and ends at about age 7. It is characterized by magical thinking. Imaginary friends often emerge in this stage, when reality is not firm, and can last into elementary school.

### Question Assesses

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

**2. B.** Families with young children must realign the family system to make space for children with adopting and developing parenting roles usually being the most challenging. Helping children to develop peer relationships is not a role issue and adjusting to

children taking a more central role in family maintenance is usually associated with later family life when children are adults.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); The Family Life Cycle (KSA)

- 3. B.** In authoritarian parenting, children are expected to follow the strict rules established by the parents. Failure to follow such rules usually results in punishment. Authoritarian parents fail to explain the reasoning behind these rules. Like authoritarian parents, those with an authoritative parenting style establish rules and guidelines that their children are expected to follow. However, this parenting style is much more democratic. Authoritative parents are responsive to their children and willing to listen to questions. When children fail to meet the expectations, these parents are more nurturing and forgiving rather than punishing.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Parenting Skills and Capacities (KSA)

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- 4. B.** Equifinality refers to the concept that similar outcomes may stem from different experiences. Different early experiences in life (i.e., parental divorce, physical abuse, and parental substance abuse) can lead to similar outcomes (i.e., diagnoses). In other words, there are many different experiences that can lead to the same problems, behaviors, and/or disorders.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Systems and Ecological Perspectives and Theories (KSA)

**5. C.** Self-esteem is relatively high in childhood, drops during adolescence, rises gradually throughout adulthood, and then declines sharply in old age. Declines during adolescence are perhaps due to a decrease in body image and other problems associated with puberty, as well as the increasing ability to think abstractly, coupled with more academic and social challenges.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Factors Influencing Self-Image (e.g., Culture, Race, Religion/Spirituality, Age, Disability, and Trauma) (KSA)

**6. A.** During middle adulthood, individuals establish careers, settle down within relationships, begin families, and develop a sense of being a part of the bigger picture. They give back to society through raising children, being productive at work, and becoming involved in community activities and organizations. By failing to achieve these objectives, individuals become stagnant and feel unproductive.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

**7. A.** The mental development of older adults (age 65–79) and elders (age 80 and above) is characterized by being active learners and thinkers, but with declines in memory. In the oldest years, confusion may signal illness and/or medication problems. Older adults do continue to learn but are not at their peak with regard to problem solving due to some declines associated with age.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); The Indicators of Normal and Abnormal Physical, Cognitive, Emotional, and Sexual Development Throughout the Lifespan (KSA)

- 8. C.** From age 6 to puberty, children begin to develop a sense of pride in their accomplishments. If they are encouraged and reinforced for their initiative, they begin to feel industrious and feel confident in their ability to achieve goals. If this initiative is not encouraged, it produces feelings of inferiority.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

- 9. C.** Extinction is withholding a reinforcer that normally follows a behavior. Since the behavior no longer is reinforced, it will eventually cease. The boy's reaction of crying is desired by the bullies, so removal of this response by walking away will hopefully reduce the incidents in the future.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

- 10. A.** In social work, human behavior of clients is often explained using systems, conflict, rational choice, social constructionist, psychodynamic, developmental, social behavioral, and humanistic perspectives. Rational choice believes clients behave in a manner

that tries to maximize rewards and minimize costs. A developmental perspective sees human development as occurring in defined, age-related stages, which build upon one another and are distinct. However, the humanistic perspective is based on seeing each client as unique and responsible for choices made. Accordingly, clients have the capacity to change themselves as human behavior is driven by a desire for growth, personal meaning, and competence.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Personality Theories (KSA)

- 11. A.** Respondent behavior is a reflex that is not under a client's control. Respondent behavior is not affected by consequences, but instead only elicited by stimuli. It is not learned and is well organized at birth. Walking away and studying hard are voluntary, not involuntary, actions that are not able to readily be modified, altered, or controlled.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

- 12. C.** Connectedness between human beings can be understood within an *evolutionary* context. Children come into the world biologically preprogrammed to form attachments with others, because this will help them to survive. In addition, some theories suggest that attachment is a set of *learned behaviors*. The correct answer focuses on both survival and environment (i.e., reinforced behavior). Cultural influences impact on attachment. Thus attachment and bonding must be viewed, keeping in mind a client's cultural background and traditions.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); The Principle of Attachment and Bonding (KSA)

- 13. A.** Entropy is associated with disorder in a system. Higher entropy means higher disorder and lower availability of the system's energy to do useful work. Although the concept of entropy originated in thermodynamics, it is applicable to communications, psychology, and sociology. The term is often used in systems theory.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Systems and Ecological Perspectives and Theories (KSA)

- 14. B.** Human development in social work must use a person-in-environment orientation. While strengths-based approaches are important, they do not help to understand how humans develop and grow throughout the life course. Additionally mental health is not the only factor that contributes to well-being. Social work focuses on how the environment helps promote or hinder growth which is known as the ecological perspective.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

- 15. A.** Erikson's first stage, which occurs in the first year of life, focuses on children learning the ability to trust others. They learn

whether their needs can be met by others, and insecurities can develop if these attachments are not nurturing. Children then go through three states (autonomy vs. shame/doubt, initiative vs guilt, and industry vs. inferiority) that all focus on autonomy and exertion of independence. In adulthood, there is a need to begin to connect with others as part of intimacy versus isolation.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

- 16. A.** Those who have experienced uninvolved parenting styles usually rank lowest across all life domains. They tend to lack self-control, have low self-esteem, and are less competent than their peers.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Parenting Skills and Capacities (KSA)

- 17. A.** Genetic counseling helps individuals understand the risk for an inherited disease or abnormal pregnancy outcome, discussing with men and women their chances of having children who are affected. When providing such counseling, social workers must have the experience and knowledge to help families understand birth defects and how inheritance works. They provide information that helps families make personal decisions about pregnancy and genetic testing. Women who have suffered postpartum depression do not need genetic counseling. Although there is evidence that depression may be both due to “nature and nurture,” the best assistance for new mothers with family history of postpartum depression is to be aware of the signs of depression and get assistance immediately if they recur. Genetic counseling will not

help those who have already experienced such depression. These mothers will need to have heightened awareness of their vulnerability if they get pregnant in the future. Also genetic counseling is not focused on infertility so women trying to get pregnant would also not be likely to referred for this service.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Basic Principles of Human Genetics (KSA)

- 18. C.** Negative reinforcement is the removal of an aversive (negative) stimulus with the goal of increasing the targeted behavior. The husband says that he will do more around the house (targeted behavior) if the wife stops (removes) the nagging (negative stimulus).

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Growth and Development (Competency); Theories of Human Development Throughout the Lifespan (e.g., Physical, Social, Emotional, Cognitive, and Behavioral) (KSA)

- 19. B.** Role discomplementarity occurs when role expectations are not being met and activities associated with these expectations are not carried out in an expected manner. The client's belief about what her son should be doing is not consistent with his behavior. In addition, the son is dissatisfied with the fulfillment of the role expectations that he has for his mother. The issue solely involves role expectations and not communication or developmental problems.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment

(Competency); Role Theories (KSA)

**20. C.** Wernicke's encephalopathy and Korsakoff's syndrome (sometimes called "Wet Brain") are disorders associated with chronic abuse of alcohol. They are caused by a thiamine (vitamin B<sub>1</sub>) deficiency resulting from the chronic consumption of alcohol. Korsakoff's syndrome or Korsakoff's psychosis tends to develop as Wernicke's symptoms go away. Wernicke's encephalopathy causes brain damage in lower parts of the brain called the thalamus and hypothalamus. Korsakoff's psychosis results from permanent damage to areas of the brain involved with memory. Symptoms of Wernicke's encephalopathy include confusion and loss of mental activity that can progress to coma and death, loss of muscle coordination that can cause leg tremor, and/or vision changes such as abnormal eye movements. Symptoms of Korsakoff's syndrome include inability to form new memories or even seeing or hearing things that are not really there. All the response choices are associated with Wernicke's encephalopathy and Korsakoff's syndrome but only coordination problems are physical symptoms which is the focus of the question.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Addiction Theories and Concepts (KSA)

**21. A.** Cocaine use is indicated by dilated pupils, hyperactivity, euphoria, anxiety, and/or excessive talking. Heroin use is indicated by contracted pupils, sleeping at unusual times, sweating, vomiting, twitching, and/or loss of appetite. Marijuana use is indicated by glassy, red eyes; inappropriate laughter; and/or loss of interest/motivation.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment

(Competency); The Indicators of Addiction and Substance Abuse (KSA)

- 22. A.** Symbolization occurs when emotional feelings are associated with an object or, in this instance, the client's tattoo. The tattoo represents internal ideas, attitudes, and/or feelings of the client's mother. It evokes emotions that were present during her illness and represents her bravery.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Psychological Defense Mechanisms and Their Effects on Behavior and Relationships (KSA)

- 23. C.** Co-occurring disorders typically refer to coexisting mental health and substance use disorders. There are several other terms that have been used to describe people in this category, including dually diagnosed. There are no specific combinations of substance use disorders and mental disorders that are defined uniquely as co-occurring disorders. Best practice is to address both issues simultaneously as a client cannot adequately deal with mental health concerns when using substances and substance use is often rooted in mental health problems.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Co-occurring Disorders and Conditions (KSA)

- 24. B.** Antabuse produces unpleasant side effects when combined with alcohol. It is used together with behavior modification, psychotherapy, and support to assist those who have alcohol use disorder.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Addiction Theories and Concepts (KSA)

- 25. A.** Risk factors can be categorized in a number of ways, but the most common distinctions in forensic risk assessments are between static and dynamic factors. Static risk factors are historical factors that do not frequently fluctuate (i.e., genetic predisposition). Static risk factors include characteristics such as number of previous convictions, age, offense type, age at first conviction, and marital status. Many risk assessment tools are based entirely, or almost entirely, on static risk factors. A problem with such assessments is that it is virtually impossible for the offender to alter a risk assessment for the better. Dynamic risk factors are those that can be changed by interventions such as change in living situation, treatment of psychiatric symptoms, abstaining from drug and alcohol use, or access to weapons. Each client presents with a unique set of risk factors that require an individualized plan.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); The Characteristic of Perpetrators of Abuse, Neglect, and Exploitation (KSA)

- 26. B.** According to Maslow's hierarchy of needs, health and safety are basic needs that must be addressed initially. Abstinence from substances, such as heroin, can cause nausea, vomiting, diathermia, agitation, sleeplessness, and/or depression. These symptoms must be treated first before attempting relapse prevention or identifying a treatment plan. Completing an assessment is useful but is not as directly tied to "meeting his immediate treatment needs" as the question directs. Ensuring that detoxification occurs safely is critical, especially after long-term use such as that described.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Addiction Theories and Concepts (KSA)

- 27. B.** A role reversal is when two individuals switch roles. The 13-year-old girl has become the caregiver for her father, who is dependent due to his permanent injury. This is a role reversal because a parent would usually be meeting the physical and emotional needs of a child. The other response choices are all role issues, but none contain a reversal in a parent–child relationship.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Role Theories (KSA)

- 28. C.** Regression occurs when someone returns to an early state of being. In this instance, the daughter is using more infantile actions, such as “baby talk” and sucking her thumb. Because she did not do them immediately prior to the family’s crisis, she may be relieving some of the anxiety of the situation through her dependency, which is further evidenced by clinging and wanting to be physically close to her mother.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Psychological Defense Mechanisms and Their Effects on Behavior and Relationships (KSA)

- 29. A.** The person-in-environment (PIE) classification system allows social workers to classify and code problems in social functioning. It was developed as an alternative to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and incorporates a strengths

perspective to evaluate a client. The ecological perspective of examining individuals in their environment is the basis of social role functioning, which is the most important focus.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); person-in-environment (PIE) Theory (KSA)

- 30. B.** Group development can be characterized by the sequential steps of forming (preaffiliation), storming (power and control) norming (intimacy), performing (differentiation), and adjourning (separation/termination).

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Theories of Group Development and Functioning (KSA)

- 31. B.** Delirium tremens are caused by alcohol withdrawal. The prescription of benzodiazepines is the treatment of choice to minimize their impacts. The main symptoms of delirium tremens are nightmares, agitation, confusion, disorientation, visual and auditory hallucinations, fever, sweating, and rapid respiration.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Addiction Theories and Concepts (KSA)

- 32. C.** Conversion is when mental conflict or disturbance is transferred into a physical symptom to relieve anxiety. The loss of movement in her arm may have resulted from the desire to strike her child.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Psychological Defense Mechanisms and Their Effects on Behavior and Relationships (KSA)

- 33. C.** The “mascot” tries to get others to laugh as a way of improving the atmosphere and drawing attention away from the dysfunctional household.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Addiction Theories and Concepts (KSA)

- 34. A.** Displacement is directing an impulse, wish, or feeling toward a less threatening object. The client is getting angry at his family instead of expressing this emotion with his boss.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Human Behavior in the Social Environment (Competency); Psychological Defense Mechanisms and Their Effects on Behavior and Relationships (KSA)

- 35. C.** Cultural, racial, and ethnic identities are important, particularly for those who are members of minority groups. They may instill feelings of belonging to a particular group or groups and identification with that group (i.e., shared commitment and values). Cultural, racial, and ethnic identities may change over time as individuals interact with those from other groups and are influenced by popular media, literature, and current events. While cultural, racial, and ethnic identities are passed from one generation to the next through customs, traditions, language, religious practice, and cultural values, this information is not the most important as it is a static factor that cannot be changed. Understanding how identities impact self-esteem and belonging

has the most substantial impact on a client's current situation and must be considered in the assessment process.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Effect of Culture, Race, and Ethnicity on Behaviors, Attitudes, and Identity (KSA)

- 36. C.** Youth who are homosexual and/or gender nonconforming face the same developmental tasks as their peers. However, they also face additional challenges that are different from their peers, such as the need to develop an identity with few role models. They may have poor self-image; experience harassment, family rejection, stigma, or social isolation; or engage in self-harm or risky behavior. They are often taunted and bullied, resulting in greater risk for mental and physical health complications compared with their peers.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Effect of Discrimination and Stereotypes on Behaviors, Attitudes, and Identity (KSA)

- 37. B.** Acculturation is a process in which members of one cultural group adopt the beliefs and behaviors of another. Although acculturation is usually in the direction of a minority group adopting habits and language patterns of the majority, acculturation can be reciprocal with the majority also adopting patterns typical of the minority group.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Principles of Culturally Competent Social Work Practice (KSA)

**38. B.** In the Asian culture, there is usually respect for elders and a hierarchical family structure with strictly prescribed roles and rules of behavior. The family and extended kinship network is often involved in treatment. The grandparents are traditionally viewed as the most knowledgeable and their opinions are held in high esteem.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Effect of Culture, Race, and Ethnicity on Behaviors, Attitudes, and Identity (KSA)

**39. B.** Ethnicity refers to the idea that one is a member of a particular cultural group that may share some of the following elements religion, language, customs, and/or beliefs. Two people can share the same race, but have different ethnicities. Their customs and beliefs, as well as traditions, may be very different. However, individuals in a racial group may also be in the same cultural group.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Principles of Culturally Competent Social Work Practice (KSA)

**40. C.** Cultural awareness involves working in conjunction with natural, informal support, as well as helping networks (i.e., neighborhoods, churches, spiritual leaders, and healers). The social worker should help prepare the client for the meeting and provide other support as needed. The social worker should not be evaluating the client's reasons for seeking guidance from her priest or praising her as the priest may not be involved in all spiritual/religious concerns.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Effect of Culture, Race, and Ethnicity on Behaviors, Attitudes, and Identity (KSA)

- 41. C.** Most individuals who are transgender do not undergo gender affirming surgery. Clothing is linked to gender expression so does not necessarily change due to shifts in identity. Those who are transgender often experience stigma, bias, or discrimination due to myths and misconceptions.

### **Question Assesses**

Content Area I—Human Development, Diversity, and Behavior in the Environment; Diversity and Discrimination (Competency); The Impact of Transgender and Transitioning Process on Behaviors, Attitudes, Identity, and Relationships (KSA)      166 165

## **Content Area II: Assessment, Diagnosis, and Treatment Planning (30%)**

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# CHAPTER

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# 4

## Biopsychosocial History and Collateral Data

### **THE COMPONENTS OF A BIOPSYCHOSOCIAL ASSESSMENT**

Social workers use an ecological perspective. They understand that, regardless of origin, all problems are systemic and are maintained by an imbalance within and between systems. All client problems are examined through a biopsychosocial–spiritual–cultural lens to understand the interplay between and among these elements.

The *biological* dimension refers to the role of biological systems within the body (i.e., genetic predispositions) and outside (i.e., airborne pathogens that impact functioning).

The *psychological* dimension refers to the role of thoughts, emotion, and behavior on individual, group, or community functioning. Inclusion of this dimension also acknowledges the mind–body connection in the assessment of problems.

The *social* dimension refers to how a client relates to various groups and institutions in society, as well as how groups and institutions relate to the client. Social workers assist not only individual clients, but all others who might be similarly affected by an issue.

The *spiritual* dimension refers to the role of religious or spiritual belief on well-being, whereas the *cultural* dimension acknowledges the importance of considering traditions, customs, rituals, values, and communications that may be part of a client's cultural heritage.

Systems theory indicates that biopsychosocial–spiritual–cultural dimensions of a client are interrelated and work together. Thus, when

one dimension changes within a system, the whole system or a client's well-being is affected.

The biopsychosocial-spiritual-cultural history is a tool that provides information on the current/presenting issue or issues; a client's past and present physical health, including developmental milestones; a client's emotional functioning; educational or vocational background; cultural issues; spiritual and religious beliefs; environmental issues; and social functioning. Each issue may be reviewed for its relationship and/or impact with the presenting issue.

The *biological section* assesses a client's medical history, developmental history, current medications, substance abuse history, and family history of medical illnesses. Issues related to medical problems should be explored because mental health symptoms can exacerbate them. Referrals should be made to address medical concerns that are not being treated. Clients who are on medications should have care coordinated with the treating provider, and more should be known about the medications because side effects can also mask or exacerbate psychiatric symptoms or illnesses.

The *psychological section* assesses a client's present psychiatric <sup>170</sup> illness or symptoms, history of the current psychiatric illness or symptoms, past or current psychosocial stressors, and mental status. Exploration of how the problem has been treated in the past, past or present psychiatric medications, and the family history of psychiatric and substance-related issues is also included.

The *social section* focuses on client systems and unique client context, and may identify strengths and/or resources available for treatment planning. Included are sexual identity issues or concerns, personal history, family of origin history, support system, abuse history, education, legal history, marital/relationship status and concerns, work history, and risks.

The assessment should also include information about a client's spiritual beliefs, as well as the client's cultural traditions.

## **TECHNIQUES AND INSTRUMENTS USED TO ASSESS CLIENTS/CLIENT SYSTEMS**

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There are many psychological tests in existence for assessment and diagnostic purposes. The following are a few of the most well known.

## **Beck Depression Inventory**

The Beck Depression Inventory (BDI) is a 21-item test, presented in multiple-choice formats, that assesses the presence and degree of depression in adolescents and adults.

## **The Minnesota Multiphasic Personality Inventory**

The Minnesota Multiphasic Personality Inventory (MMPI) is an objective verbal inventory designed as a personality test for the assessment of psychopathology consisting of 550 statements, 16 of which are repeated.

## **Myers–Briggs Type Indicator**

The Myers–Briggs Type Indicator (MBTI) is a forced-choice, self-report inventory that attempts to classify individuals along four theoretically independent dimensions. The first dimension is a general attitude toward the world, either extraverted (E) or introverted (I). The second dimension, perception, is divided between sensation (S) and intuition (N). The third dimension is that of processing. Once information is received, it is processed in either a thinking (T) or feeling (F) style. The final dimension is judging (J) versus perceiving (P).

## **Rorschach Inkblot Test**

Client responses to inkblots are used to assess perceptual reactions and other psychological functioning. It is one of the most widely used projective tests.

## **Stanford–Binet Intelligence Scale**

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The Stanford–Binet Intelligence Scale is designed for the testing of cognitive abilities. It provides verbal, performance, and full scale scores for children and adults.

## **Thematic Apperception Test**

The Thematic Apperception Test (TAT) is another widely used projective test. It consists of a series of pictures of ambiguous scenes. Clients are asked to make up stories or fantasies concerning what is happening, has happened, and is going to happen in the scenes, along with a

description of their thoughts and feelings. The TAT provides information on a client's perceptions and imagination for use in the understanding of a client's current needs, motives, emotions, and conflicts, both conscious and unconscious. Its use in clinical assessment is generally part of a larger battery of tests and interview data.

## Wechsler Intelligence Scale

The Wechsler Intelligence Scale (WISC) is designed as a measure of a child's intellectual and cognitive ability. It has four index scales and a full scale score.

### **THE TYPES OF INFORMATION AVAILABLE FROM OTHER SOURCES (E.G., AGENCY, EMPLOYMENT, MEDICAL, PSYCHOLOGICAL, LEGAL, OR SCHOOL RECORDS)**

Assessment is ongoing within the problem-solving process. In order to ensure that all relevant information is considered, social workers often rely on information available from clients' existing records in addition to the data that they collect directly.

In order to access this information, it is critical that social workers are aware of laws governing the release of such information and get the informed consent of clients prior to requesting these documents. The consent process must make clients aware of the reasons for such requests and the benefits and risks of social workers obtaining this information.

When information is obtained, it becomes part of the client record. Though protected by the Health Insurance Portability and Accountability Act (HIPAA), these client records can be subject to subpoenas and/or court orders. Thus, inclusion of this information in their records can have some additional risks associated with the legal duty to release them if court ordered to do so.

Despite this risk, using existing employment, medical, psychological, psychiatric, and educational records can be very helpful when completing a biopsychosocial–spiritual–cultural history.

Employment records may help social workers construct clients' work histories and obtain data about income earned from their jobs. These records may be essential if clients need assistance with applying for Unemployment Insurance or other public benefits (Temporary

Assistance for Needy Families [TANF], Supplemental Nutrition Assistance Program [SNAP], and so on).

Medical records are essential to ensure that client problems are not <sup>172</sup> a result of health issues and to better understand the impact of past or current medical problems on client functioning.

Psychological records can be helpful as they can contain the results of any psychological testing that has been completed and whether any mental health diagnoses have been assigned. Whether or not a client has been prescribed psychotropic medications and/or received any subsequent treatment for behavioral health concerns would also be contained in psychiatric records.

When working with children, educational records are often consulted to determine performance in school and whether any problems experienced at home or elsewhere are being manifested in this setting as well. When working with adults, educational records can provide clues as to the age at which problems or difficulties began. Historical educational records are often used to diagnose adults with intellectual or developmental disabilities if they were not appropriately identified while in school.

Children with disabilities are eligible for free, appropriate public education between the ages of 3 and 21. Children with disabilities may have Individual Educational Plans (IEPs) which are revised annually. Teams composed of social workers, teachers, administrators, and other relevant school personnel typically create IEPs. Parents, and often the children, also participate. IEPs include goals, means of attaining goals, and ways of evaluating goal attainment. Children with IEPs must be educated in the “least restrictive environment.” Thus, these children should either spend part or all their time in regular classrooms or in environments that are as close to this as possible while still leading to the attainment of educational goals. Services needed, such as speech therapy and others related to educational goals, are provided at no extra cost to families.

## **Components of a Sexual History**

Some clients may not be comfortable talking about their sexual history, sex partners, or sexual practices. It is critical that social workers try to put clients at ease and let them know that taking a sexual history may be an important part of the assessment process. A history is usually

obtained through a face-to-face interview, but can also be gotten from a pencil-and-paper document.

Questions included in a sexual history may vary depending upon client issues. However, they usually involve collecting information about partners (number, gender, risk factors, length of relationships), practices (risk behaviors, oral/vaginal/anal intercourse, satisfaction with practices, desire/arousal/orgasm), protection from and past history of sexually transmitted diseases (STDs); condom use), and prevention of pregnancy (if desired)/reproductive history.

If clients are experiencing dissatisfaction or dysfunction, social workers will need to understand the reasons for dissatisfaction and/or dysfunction. Medical explanations must be ruled out before psychological factors are considered as causes. A systems perspective should be used to understand issues in this area. For example, a medical/biological condition that decreases satisfaction or causes dysfunction may heavily impact on psychological and social functioning. In addition, a psychological or social issue can lead to a lack of desire, inability to become aroused, or failure to attain orgasm.

Alcohol and/or drug use should also be considered related to concerns about desire, arousal, or orgasm because they can cause decreased interest or abilities in these areas.

## Components of a Family History

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Understanding a client's family history is an important part of the assessment process. A client is part of a larger family system. Thus, gaining a better understanding of the experiences of other family members may prove useful in understanding influences imposed on a client throughout the life course.

One tool used by social workers to depict a client as part of a larger family system is a **genogram**. A genogram is a graphic representation of a family tree that displays the interaction of generations within a family. It goes beyond a traditional family tree by allowing the user to analyze family, emotional, and social relationships within a group. It is used to identify repetitive patterns of behavior and to recognize hereditary tendencies. A social worker can also ask about these relationships, behaviors, and tendencies without using a genogram.

There are no set questions that must be included in a family history; often, they relate to the problem or issue experienced by a client at the

time. However, they may include identifying family members':

- Ethnic backgrounds (including immigration) and traditions
- Biological ties (adoption, blended family structures, foster children)
- Occupations and educational levels
- Unusual life events or achievements
- Psychological and social histories, as well as current well-being
- Past and present substance use behaviors
- Relationships with other family members
- Roles within the immediate and larger family unit
- Losses such as those from death, divorce, or physical separation
- Current and past significant problems, including those due to medical, financial, and other issues
- Values related to economic status, educational attainment, and employment
- Coping skills or defense mechanisms

Finding out which adults and/or children get the most attention or recognition and which get the least may also provide insight.

## **METHODS TO OBTAIN SENSITIVE INFORMATION (E.G., SUBSTANCE ABUSE, SEXUAL ABUSE)**

Clients are often reluctant to reveal sensitive information about themselves and others in their families. However, this information may be vital to understanding client problems and designing interventions that will be effective. While there is no set road map of how to elicit this information, there are some techniques that may assist.

- A social worker should start off with some open-ended and nonthreatening questions to gather needed background and get a client used to talking about the situation before having to <sup>174</sup> disclose more sensitive material. This initial questioning will

also give a client time to “test the waters” with a social worker and gauge the social worker’s reaction as more sensitive information is provided. Trust is often needed in a therapeutic relationship before a client can be completely honest about the situation.

- A social worker should be aware of verbal and nonverbal clues while speaking with a client. A client may avoid eye contact, fail completely answer a question, look down when speaking, or laugh nervously when feeling anxious about a topic. A social worker may want to repeat a question or probe further into this area to see if there is something undisclosed which is causing this behavior.
- A client who is engaged in couples, family or group treatment may worry about the confidentiality of revealing sensitive information, as well as the reactions of others to such disclosure. In these instances a social worker may want to explore with a client whether individual treatment in lieu of or in conjunction with couples, family, or group treatment may be appropriate.
- A social worker may want to review with a client the professional mandate for confidentiality and what information will be stored in the client file.
- A client may be reluctant to reveal sensitive information if the client thinks there could be negative repercussions as a result of the information being disclosed to others verbally or lack of security related to the file.
- A client is much more likely to disclose sensitive information if a social worker reacts to such disclosures with acceptance and a neutral stance, being neither judgmental nor confrontational and not interrupting when information is being gathered.

## **THE PRINCIPLES OF ACTIVE LISTENING AND OBSERVATION**

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Active listening skills are an essential part of building relationships and trust. The active part in the listening process can be achieved by showing interest in clients’ words. Once clients notice that social workers are understanding what is said and really taking an interest, communication will be more open.

Active listening establishes trust and respect, so clients will feel comfortable confiding in social workers. Thus, it helps build a therapeutic alliance.

Active listening can also include speaking by using mirroring techniques to paraphrase and reflect back to clients what they have just said. For example, a client may say, “I hate my job and my boss yells at me all the time.” An active listening response might involve saying something such as, “So you feel like your boss doesn’t appreciate you or treat you with respect.” Responses need to be tailored to what clients are saying to demonstrate listening and engagement in what is being said.

Although most information that a social worker uses during assessment comes from the social work interview, direct observation of interactions between family members and the client’s nonverbal behavior can produce a lot of information about emotional states and interaction patterns.

Social workers also may use observation as part of macrolevel <sup>175</sup> intervention in order to assess the extent of a problem/issue, driving and restraining forces for change, key policy influencers, and community members who can work as part of a task group for reform.

When functioning as an observer, a social worker can take many roles, including *complete participant* (living the experience as a participant), *participant as observer* (interacting with those who are participating), *observer as participant* (limited relationship with others participating—primarily observer), or *complete observer* (removed from activity—observer only). Observation is also a method used in scientific inquiry to collect data.

## **THE INDICATORS OF SEXUAL DYSFUNCTION**

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Sexual dysfunction is a problem associated with sexual desire or response. Many issues can be included under the term “sexual dysfunction.” For example, for men, sexual dysfunction may include erectile dysfunction and premature or delayed ejaculation. For women, sexual dysfunction may refer to pain during sexual intercourse.

Problems may be caused by psychological factors, physical conditions, or a combination of both. It is essential that a medical examination be the first step in treating sexual dysfunction in order to identify medications or medical conditions that are the causes of the

problems. Many of the symptoms can be addressed medically. However, sexual dysfunction can also be due to childhood sexual abuse, depression, anxiety, stressful life events, and/or other psychological issues. Treatment may also be needed to assist with coping with the signs and symptoms; these include, but are not limited to:

- Premature or delayed ejaculation in men
- Erectile disorder (not being able to get or keep an erection)
- Pain during sex
- Lack or loss of sexual desire
- Difficulty having an orgasm
- Vaginal dryness

## **SYMPTOMS OF NEUROLOGIC AND ORGANIC DISORDERS**

Neurologic and organic symptoms are those that are caused by disorders that affect part or all of the nervous system or are biologically based. These symptoms can vary greatly. For example, the nervous system controls many different body functions. Symptoms can, but do not have to, be associated with pain, including headache and back pain. Neurologic symptoms can also include muscle weakness or lack of coordination, abnormal sensations in the skin, and disturbances of vision, taste, smell, and hearing.

They may be minor (such as a foot that has fallen asleep) or life threatening (such as coma due to stroke).

### **Some Common Neurologic Symptoms**

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#### *Pain*

- Back pain
- Neck pain
- Headache
- Pain along a nerve pathway (as sciatica)

### *Muscle malfunction*

- Weakness
- Tremor (rhythmic shaking of a body part)
- Paralysis
- Involuntary (unintended) movements (such as tics)
- Clumsiness or poor coordination
- Muscle spasms

### *Changes in the senses*

- Disturbances of smell and taste
- Partial or complete loss of vision
- Double vision
- Deafness
- Ringing or other sounds originating in the ears (tinnitus)

### *Other symptoms*

- Vertigo
- Loss of balance
- Slurred speech (dysarthria)

### *Changes in consciousness*

- Fainting
- Confusion or delirium
- Seizures (ranging from brief lapses in consciousness to severe muscle contractions and jerking throughout the body)

### *Changes in cognition (mental ability)*

- Difficulty understanding language or using language to speak or write (aphasia)
- Poor memory
- Inability to recognize familiar objects (agnosia) or familiar faces <sup>177</sup> (prosopagnosia)
- Inability to do simple arithmetic (acalculia)

*Other symptoms*

- Vertigo
- Loss of balance
- Slurred speech (dysarthria)

**Organic brain syndrome** is a term used to describe physical disorders that impair mental function. The most common symptoms are confusion; impairment of memory, judgment, and intellectual function; and agitation. Disorders that cause injury or damage to the brain and contribute to organic brain syndrome include, but are not limited to, alcoholism, Alzheimer's disease, fetal alcohol spectrum disorders (FASDs), Parkinson's disease, and stroke.

Elderly clients are at high risk for depression, as well as cognitive disorders, the latter of which can be chronic (as in dementia) or acute (as in delirium). Some patients have both affective (mood) and cognitive disorders. Clarifying the diagnosis is the first step to effective treatment, but this can be particularly difficult because elderly clients often have medical comorbidities that can contribute to cognitive and affective changes.

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	Delirium	Dementia	Depression
<b>Alertness</b>	Altered level of consciousness; alertness may fluctuate	May vary	May vary
<b>Motor behavior</b>	Fluctuates; lethargy or hyperactivity	May vary	Psychomotor behavior may be agitated or unaffected
<b>Attention</b>	Impaired and fluctuates	Usually normal	Usually normal, but may be distractible
<b>Awareness</b>	Impaired, reduced	Clear	Clear
<b>Course</b>	Acute; responds to treatment	Chronic, with deterioration over time	Chronic; responds to treatment
<b>Progression</b>	Abrupt	Slow but stable	Varies

	Delirium	Dementia	Depression
<b>Orientation</b>	Fluctuates in severity; usually impaired	May be impaired	May be selective disorientation
<b>Memory</b>	Recent and immediate impaired	Recent and remote impaired	Selective or patchy impairment
<b>Thinking</b>	Disorganized, distorted, incoherent; slow or accelerated	Difficulty with abstraction; thoughts impoverished; difficulty finding words; poor judgment	Intact, but may voice hopelessness and self-deprecation
<b>Instrumental activities of daily living (IADLs)</b>	May be intact or impaired	May be intact early; impaired ADLs as disease progresses	May be intact or impaired
<b>Stability</b>	Variable, hour-to-hour	Fairly stable	Some variability
<b>Emotions</b>	Irritable, aggressive, fearful	Labile, apathetic, irritable	Flat, unresponsive, or sad; may be irritable
<b>Activities of daily living (ADLs)</b>	May be intact or impaired	May be intact early, impaired as disease progresses	May neglect basic self-care

# CHAPTER

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# 5

## Assessment and Diagnosis

### THE FACTORS AND PROCESSES USED IN PROBLEM FORMULATION

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In micro and macro practice, social workers must work with clients to identify the problem(s) to be addressed. Problem identification concerns determining the problem targeted for intervention. Although this seems straightforward, it is often difficult to isolate the issue that, when addressed, will result in a change in the symptomology of a client and/or client system.

Part of problem identification is determining the issue in exact definable terms, when it occurs, and its magnitude. When doing macro practice, a social worker may often need to get consensus from the group regarding whether there is agreement as to the nature of the problem and its occurrence and magnitude.

It is often useful in problem identification to determine that which is not the problem. Such a technique will ensure that these elements are not grouped in with those that are targeted and will assist in narrowing down the focus.

The problem should always be considered within the person-in-environment perspective and using a strengths-based approach. It should not blame a client and/or client system for its existence.

### METHODS OF INVOLVING CLIENTS/CLIENT SYSTEMS IN PROBLEM IDENTIFICATION (E.G., GATHERING COLLATERAL INFORMATION)

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Social workers focus on assisting clients to identify problems and areas of strength, as well as increasing problem-solving strategies.

It is essential that, throughout the problem-solving process, social workers view clients as experts in their lives.

Clients should be asked about what they would like to see changed in their lives and clients' definitions of problems should be accepted.

Clients should be asked about what will be different in their lives when their problems are solved. Social workers should listen carefully for, and work hard to respect, the directions in which clients want to go with their lives (their goals) and the words they use to express these directions.

Clients should be asked about the paths that they would like to take to make desired changes. Clients' perceptions should be respected and clients' inner resources (strengths) should be maximized as part of treatment.<sup>180</sup>

## Use of Collateral Sources

Social workers often use collateral sources—family, friends, other agencies, physicians, and so on—as informants when collecting information to effectively treat clients. These sources can provide vital information because other professionals or agencies may have treated clients in the past. Family members and friends may also provide important information about the length or severity of issues or problems.

Collateral information is often used when the credibility and validity of information obtained from a client or others is questionable. For example, child custody cases are inherently characterized by biased data within an adversarial process. Thus, it is often necessary to evaluate the integrity of information gathered through use of collateral information.

However, social workers should always assess the credibility of collateral informants, because data from more neutral parties has higher integrity. In addition, informants who have greater access to key information may produce more valid data.

When an account by a collateral informant agrees with information gathered from a client, it enhances the trustworthiness of the data collected.

Using multiple information sources (or triangulation) is an excellent method for social workers to have accurate accounts upon which to make assessments or base interventions.

It is essential that a social worker get a client's informed consent prior to reaching out to collateral sources. However, they can be a valuable

source of data to supplement that obtained directly from a client, as well as provide contextual or background information that a client may not know.

## THE COMPONENTS AND FUNCTION OF THE MENTAL STATUS EXAMINATION

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A mental status examination is a structured way of observing and describing a client's current state of mind under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight, and judgment. A mental status examination is a necessary part of any client assessment no matter what the presenting problem. It should be documented in the record either in list form or in narrative form. The following client functions should be included:

1. *Appearance*—facial expression, grooming, dress, gait, and so on
2. *Orientation*—awareness of time and place, events, and so on
3. *Speech pattern*—slurred, pressured, slow, flat tone, calm, and so on
4. *Affect/mood*—mood as evidenced in both behavior and client statements (sad, jittery, manic, placid, etc.)
5. *Impulsive/potential for harm*—impulse control with special attention potential suicidality and/or harm to others  
*Judgment/insight*—ability to predict <sup>6</sup> the consequences of her or his behavior, to make “sensible” decisions, to recognize her or his contribution to her or his problem
6. *Thought processes/reality testing*—thinking style and ability to know reality, including the difference between stimuli that are coming from inside oneself and those that are coming from outside ones (statements about delusions, hallucinations, and conclusions about whether or not a client is psychotic would appear here)
7. *Intellectual functioning/memory*—level of intelligence and of recent and remote memory functions

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A paragraph about mental status in the record might read as follows:

“Client is a 43-year-old woman who looks older than her stated age. She is well groomed and appropriately dressed for a professional interview. She is well oriented. Her speech is slow as if it is painful to talk. She has had occasional thoughts of ‘ending it all,’ but has not made any suicidal plans or preparations. She talks about future events with expectation to be alive. She is aware that she is ‘depressed’ and recognizes that the source of some of the feeling comes from ‘inside moods’ although she often refers to the difficulties of her situation. Her thoughts are organized. She is not psychotic.”

## METHODS TO INCORPORATE THE RESULTS OF PSYCHOLOGICAL AND EDUCATIONAL TESTS INTO ASSESSMENT

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Social workers use both tests and assessments to help formulate diagnoses and to guide treatment for their clients.

**Psychological tests** are instruments used to measure an assortment of mental abilities and characteristics, such as personality, achievement, intelligence, and neurological functioning. They often take the form of questionnaires. They may be written, verbal, or pictorial tests (like the famous Rorschach test that uses inkblot images). The tests may also be referred to as scales, surveys, screens, checklists, assessments, measures, inventories, and so on.

**Educational tests** measure cognitive (thinking) abilities and academic achievement. These measurements provide a profile of strengths and weaknesses that accurately identify areas for academic remediation and insight into the best learning strategies. They provide details into the learning process that will provide clients, family members, and school staff the best learning strategies. Educational assessments provide the necessary documentation for the legal purposes of establishing the presence of disabilities, but they do not guarantee that their findings will be accepted by schools and/or accommodations provided. Reaching decisions to have educational testing is often arrived at after a period

of struggle, distress, and different efforts at improving the educational process with limited success.

**Social work assessment** is a more comprehensive process that may utilize the results from educational and psychological tests, but can also involve interviewing a client and/or family, reviewing a client's history, checking existing records, and consulting with previous or concurrent providers.

Some common tests are:

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- **Achievement/Aptitude tests:** typically used in education, measure how much clients know (have *achieved*) in a certain subject subjects, or have ability (*aptitude*) to learn
- **Intelligence tests:** measure intelligence (IQ)
- **Job/Occupational tests:** match interests with careers
- **Personality tests:** measure basic personality traits/characteristics
- **Neuropsychological tests:** assess and measure cognitive function (e.g., how a particular problem with the brain affects recall, concentration, and so on)
- **Specialized clinical tests:** investigates areas of clinical interest, such as anxiety, depression, posttraumatic stress disorder, and so on

## **THE INDICATORS OF PSYCHOSOCIAL STRESS**

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Psychosocial stress results when there is a perceived threat (real or imagined). Examples of psychosocial stress include threats to social status, social esteem, respect, and/or acceptance within a group; threats to self-worth; or threats that are perceived as uncontrollable.

Psychosocial stress can be caused by upsetting events, such as natural disasters, sudden health problems or death, and/or breakups or divorce.

Although current upsetting events certainly create stress, events from the past can also still affect clients. Social workers should assess the

impacts of events such as childhood abuse, bullying, discrimination, violence, and/or trauma.

Often, psychosocial stress is not caused by single events, but by ongoing problems such as caring for a parent or child with disabilities.

Stress may manifest itself in many different ways, such as high blood pressure, sweating, rapid heart rate, dizziness, and/or feelings of irritability or sadness.

When psychosocial stress triggers a stress response, the body releases a group of stress hormones that lead to a burst of energy, as well as other changes in the body. The changes brought about by stress hormones can be helpful in the short term, but can be damaging in the long run.

It is essential that clients learn to manage psychosocial stress so that the stress response is only triggered when necessary and not for prolonged states of chronic stress.

## **THE INDICATORS, DYNAMICS, AND IMPACT OF EXPLOITATION ACROSS THE LIFESPAN (E.G., FINANCIAL, IMMIGRATION STATUS, SEXUAL TRAFFICKING)**

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Exploitation is treating someone badly in order to benefit from the person's resources or work. It is when someone uses a situation to gain unfair advantage. Exploitation is more common when there is a power differential between parties due to social status, abilities, income, education, job position, and so on.

Social workers have ethical mandates not to exploit clients, supervisees, students, and others who they come in contact with in their work.

They also may be asked to assess exploitation of clients by others <sup>183</sup> and intervene when needed. For example, a form of maltreatment sometimes seen with older adults is financial/material exploitation or unauthorized use of an older person's resources. Individuals may befriend an older person to gain trust so that the older adult's money or items of value can be inappropriately used for the individual's wants or needs and not the care of the older adult.

On a macro level, it is also important to see the relationship between discrimination and exploitation of individuals. When individuals are not provided the same access to social rewards, they are inherently

exploited. Most social problems are aggravated by the status of particular groups in the society, including that:

- There is a greater prevalence of poverty among people of color and female household heads.
- Poverty decreases the opportunities for employment, education, goods, and so on.
- Poverty creates greater stresses that lead to physical and mental illnesses, family breakdown, inability to work, and other problems.
- Discrimination creates deficits in social power.

## **THE INDICATORS OF TRAUMATIC STRESS AND VIOLENCE**

Stress is a typical response to feeling overwhelmed or threatened. Fight, flight, and freeze are survival responses to protect individuals from danger. Individuals react and respond to stress in different ways. There are many disadvantages to a stressful lifestyle that creates constant feelings of being overwhelmed, as well as physiological stimulation. Interventions aimed at social and lifestyle changes can usually restore physiological and psychological balance in order to address stress.

This is not the case when traumatization occurs. Traumatization is when a client experiences neurological distress that does not go away or when the client is not able to return to a state of equilibrium. Traumatization can lead to mental, social, emotional, and physical disability. Like stress, trauma is also experienced differently by different individuals.

There are many indicators of traumatic stress and violence, including:

1. Addictive behaviors related to drugs, alcohol, sex, shopping, and gambling
2. An inability to tolerate conflicts with others or intense feelings
3. A belief of being bad, worthless, without value or importance
4. Dichotomous “all or nothing” thinking
5. Chronic and repeated suicidal thoughts/feelings
6. Poor attachment

- |  |    |     |
|--|----|-----|
| 7. Dissociation  |    |     |
| 8. Eating disorders—anorexia, bulimia, and overeating            |    |     |
| Self-blame   | 9. | 184 |
| 10. Intense anxiety and repeated panic attacks                   |    |     |
| 11. Depression   |    |     |
| 12. Self-harm, self-mutilation, self-injury, or self-destruction |    |     |
| 13. Unexplained, but intense, fears of people, places, or things |    |     |

When trauma or violence occurs during childhood, children may have problems regulating their behaviors and emotions. They may be clingy and fearful of new situations, easily frightened, difficult to console, aggressive, impulsive, sleepless, delayed in developmental milestones, and/or regressing in functioning and behavior.

In order to practice competently in this area, social workers must:

1. Realize the widespread impact of trauma and understand potent paths for recovery
2. Recognize the signs and symptoms of trauma in clients, families, staff and other systems
3. Respond by fully integrating knowledge about trauma into social work policies, procedures, and practices
4. Seek to actively resist retraumatization

## **METHODS USED TO ASSESS TRAUMA**

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Trauma is the response that a client has to an extremely negative event. Although trauma is a normal reaction to a horrible event, the effects can be so severe that they interfere with a client's ability to live life. Thus, a social worker is needed to treat the stress and dysfunction caused by the traumatic event and to restore a client to a previous emotional state.

Emotional reactions are the common effects of trauma. Impacts of trauma on clients' self-image include, but are not limited to:

- Anxiety

- Denial
- Agitation
- Irritability or rage
- Flashbacks or intrusive memories
- Feeling disconnected from the world
- Unrest in certain situations
- Being “shut down”
- Being very passive
- Feeling depressed
- Guilt/shame/self-blame
- Unusual fears
- Impatience
- Having a hard time concentrating
- Wanting to hurt oneself
- Being unable to trust anyone
- Feeling unlikable
- Feeling unsafe

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Trauma often manifests physically, including both physiological and behavioral symptoms. Behavioral manifestations of trauma include, but are not limited to:

- Insomnia or fatigue
- Using harmful substances
- Keeping to oneself
- Overworking
- Lethargy
- Eating problems

- Drug or alcohol use
- Needing to do certain things over and over
- Always having to have things a certain way
- Doing strange or risky things

Clients may have anxiety or panic attacks and be unable to cope in certain circumstances. Social workers must often work with clients to address the underlying emotional impacts of the trauma in order for clients to make behavioral changes.

Clients who experience trauma often believe that they cannot trust, the world is not safe, and they are powerless to change their circumstances. Beliefs about themselves, others, and the world diminish their sense of competency. Thus, clients view themselves as powerless or “damaged” and have trouble feeling hopeful.

Clients who have experienced trauma may display intense emotions toward others, such as friends or family members. Clients can also emotionally retreat from these individuals, choosing to isolate themselves. Thus, trauma can be difficult for those who are close to clients as well.

## RISK ASSESSMENT METHODS

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Social workers are often called upon to assess risks of clients to themselves and others. Such assessments are not easy, because there are no indicators that definitively predict whether a client will act on feelings or desires to do self-harm. A social worker must review all assessment data in order to determine the appropriate level of care and a treatment plan. Such an assessment must include examining risk and protective factors, as well as the presence of behavioral warning signs. Such an assessment may include examining:

- Frequency, intensity, and duration of suicidal or violent thoughts
- Access to or availability of method(s)
- Ability or inability to control suicidal/violent thoughts
- Ability not to act on thoughts
- Factors making a client feel better or worse

- Consequences of actions
- Deterrents to acting on thoughts
- Whether client has been using drugs or alcohol to cope
- Measures a client requires to maintain safety

In situations where a client is seen to be a danger to self or others, a social worker may limit a client's right to self-determination and seek involuntary treatment such as commitment to an inpatient setting. If a client is deemed to be a danger to others, a social worker should consider this as a "duty to warn" situation (under the Tarasoff decision), and notify the authorities as well as the party in danger.

## **THE INDICATORS AND RISK FACTORS OF THE CLIENT'S/CLIENT SYSTEM'S DANGER TO SELF AND OTHERS**

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There are risk factors that must be considered in any assessment, because they are linked to a risk of suicide or violence.

### **Danger to Self: Suicide**

#### ***Risk Factors***

- History of previous suicide attempt (best predictor of future attempt; medical seriousness of attempt is also significant)
- Lives alone; lack of social supports
- Presence of psychiatric disorder—depression (feeling hopeless), anxiety disorder, personality disorder (*A client is also at greater risk after being discharged from the hospital or after being started on antidepressants as the client may now have the energy to implement a suicide plan.*)
- Substance abuse
- Family history of suicide
- Exposure to suicidal behavior of others through media or peers

- Losses—relationship, job, financial, social
- Presence of firearm or easy access to other lethal methods

## ***Some Protective Factors***

- Effective and appropriate clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support (including medical and mental health care)
- Restricted access to highly lethal methods
- Family and community support
- Learned coping and stress reduction skills
- Cultural and religious beliefs that discourage suicide and support self-preservation

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## ***Some Behavioral Warning Signs***

- Change in eating and sleeping habits
- Drug and alcohol use
- Unusual neglect of personal appearance
- Marked personality change
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards
- Giving away belongings
- Isolation from others
- Taking care of legal and other issues
- Dramatic increase in mood (might indicate a client has made decision to end life)
- Verbalizes threats to commit suicide or feelings of despair and hopelessness

- “I’m going to kill myself.”
- “I wish I were dead.”
- “My family would be better off without me.”
- “The only way out for me is to die.”
- “It’s just too much for me to put up with.”
- “Nobody needs me anymore.”

## Danger to Others: Violence

### *Risk Factors*

- Youth who become violent before age 13 generally commit more crimes, and more serious crimes, for a longer time; these youth exhibit a pattern of escalating violence throughout childhood, sometimes continuing into adulthood.
- Most highly aggressive children or children with behavioral disorders do not become serious violent offenders.
- Serious violence is associated with drugs, guns, and other risk behaviors.
- Involvement with delinquent peers and gang membership are two of the most powerful predictors of violence.

### *Some Protective Factors*

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- Effective programs combine components that address both individual risks and environmental conditions; building individual skills and competencies; changes in peer groups
- Interventions that target change in social context appear to be more effective, on average, than those that attempt to change individual attitudes, skills, and risk behaviors
- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support (i.e.,

- medical and mental health care)
- Restricted access to highly lethal methods
- Family and community support
- Learned coping and stress reduction skills

### ***Some Behavioral Warning Signs***

- Drug and alcohol use
- Marked personality changes
- Angry outbursts
- Preoccupation with killing, war, violence, weapons, and so on
- Isolation from others
- Obtaining guns or other lethal methods

## **METHODS TO ASSESS THE CLIENT'S/CLIENT SYSTEM'S STRENGTHS, RESOURCES, AND CHALLENGES (E.G., INDIVIDUAL, FAMILY, GROUP, ORGANIZATION, COMMUNITY)**

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Clients typically seek social work services for help with problems or difficulties. As a result, the assessment generally focuses on the problems. This focus can lead to an overemphasis on client pathology and dysfunction without the same attention to client strengths, capabilities, and achievements. Information on both strengths and challenges are needed to get a full understanding of the client situation.

Social workers must be sensitive to client strengths and skillful in using them to achieve service goals. Social workers who do not attend to client strengths will not be able to determine clients' potential for growth and the steps needed to get there. Often clients are experiencing self-doubt or poor self-esteem. To assist with helping clients view themselves more positively, social workers must be able to emphasize their strengths.

Strengths which may be overlooked include clients:

- Facing problems by seeking help—rather than denying them
- Taking risks by sharing problems with social workers

- Persevering under difficult situations

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- Being resourceful
- Meeting family and financial obligations
- Seeking to understand the actions of others
- Functioning in stressful situations
- Considering alternative courses of action

Methods to identify more about client strengths, resources, and challenges can be obtained by:

- Seeking exceptions—determining when the problem does not exist or occur (locations, times, and contexts)
- Scaling the problem—identifying the severity of the problem on a scale from 1 to 10 according to the client
- Scaling motivation—estimating the degree to which client feels hopeful about resolution
- Miracle question—having the client determine what would be different if problem did not exist

When conducting community assessments, it is essential for social workers to identify strengths and challenges. Strengths are positive features of the community that can be leveraged to develop solutions to problems. Strengths can include organizations, people, partnerships, facilities, funding, policies, regulations, and culture.

A social worker should consider the current assets that are already in existence to promote the quality of life of community members. For example, organizations that provide after-school programs that help youth graduate on time would be included in a community assessment focused on keeping kids in school. In some instances, a social worker may want to look at experiences of other communities with similar demographics that have successfully addressed similar problems. Examining the presence and utilization of strengths in these communities can assist a social worker in determining if similar assets can be found in its target community.

A social worker must also develop an informed understanding of the gaps or needs that exist within a community. These needs serve as

challenges that can affect a large or small number of community members. If community needs affect a large number of community members, there may be more support for addressing them. Collaboration and community building are essential in addressing community challenges.

There are a number of methods for data collection related to community strengths and challenges including interviews, observation, and surveys. Ensuring that the data collection procedures are robust is essential in conducting a complete and accurate community assessment.

## **THE INDICATORS OF MOTIVATION, RESISTANCE, AND READINESS TO CHANGE**

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Social workers should not assume that clients are ready or have the skills needed to make changes in their lives. Clients may be oppositional, reactionary, noncompliant, and/or unmotivated. These attitudes or behaviors are often referred to as resistance.

There are indicators that a social worker should use as evidence that <sup>190</sup> a client may be resistant or not ready/able to fully participate in services. These indicators include as follows:

- Limiting the amount of information communicated to a social worker
- Silence/minimal talking during sessions
- Engaging in small talk with a social worker about irrelevant topics
- Engaging in intellectual talk by using technical terms/abstract concept or asking questions of a social worker that are not related to client issues or problems
- Being preoccupied with past events, instead of current issues
- Discounting, censoring, or editing thoughts when asked about them by a social worker
- False promising
- Flattering a social worker in an attempt to “soften” the social worker so the client will not be pushed to act
- Not keeping appointments
- Payment delays or refusals

It is essential to determine the extent to which this resistance or these inabilities are caused by a client, a social worker, and/or the conditions present.

A client may be resistant due to feelings of guilt or shame and may not be ready to recognize or address the feelings and behaviors being brought up by a social worker. Clients may be frightened of change and may be getting some benefit from the problems that they are experiencing.

Social workers may experience a lack of readiness, as they have not developed sufficient rapport with clients. There also may not be clear expectations by clients of their role versus those of social workers. Social workers need to use interventions that are appropriate for clients.

Sometimes, a lack of readiness or ability is a result of external factors, such as changes in clients' living situations, physical health problems, lack of social support, and/or financial problems.

Whatever the causes, a social worker must address these barriers as clients will not make changes until they are ready and able.

Behavior change is best understood as a process with different stages of readiness. For most clients, behavior change occurs gradually over time, with a client progressing from being uninterested, unaware, or unwilling to make a change (*precontemplation*), to considering a change (*contemplation*), to deciding and preparing to make a change (*preparation*). This is followed by definitive action, as well as attempts to maintain the new behavior over time (*maintenance*). Clients can progress in both directions in the stages of change.

Often a client comes to a social worker in the *precontemplation* stage, in which the client is not even considering changing or is in denial about the need to change. *Contemplation* is the first time that there is some movement toward change because a client, while ambivalent about changing, may weigh the benefits versus costs (i.e., time, expense, effort) of change. In *preparation*, a client may indicate a willingness to experiment with small changes, whereas the *action* stage is characterized by definitive change behaviors.

The goal is to move a client along the continuum toward making a positive change. Patience is needed as it is unrealistic to expect that change will occur with a single intervention.

Techniques that a social worker can use to determine a client's <sup>191</sup> readiness to change include asking the client:

- What would your life be like ... (describe behavior needing change)?

- Is that a life that you would like?
- What would be a good result of changing?
- How will you know when it is time to think about changing?
- What signals will tell you to think about making a change?
- How ready are you on a scale from 1 to 10 to make a change?
- What are the good things about the way you are currently trying to change?
- What are the things that are not so good?
- What are the barriers to changing?
- What are some things that could help you overcome this barrier?

Participating in the problem-solving process and showing up for appointments on time are good indicators that a client is engaged and willing to work toward change. Small considerations toward making change or a willingness to discuss behavioral alternatives should be built upon as they are strong indicators that real action steps toward change can occur next.

## **METHODS TO ASSESS MOTIVATION, RESISTANCE, AND READINESS TO CHANGE**

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Motivation and resistance exist along a continuum of readiness. When assessing motivation and resistance of a client, it is important to determine what stage of change a client is in. This will provide a social worker with appropriate clinical strategies to use to address these issues. If social workers push clients at a faster pace than they are ready to take, the therapeutic alliance may break down.

A lack of motivation and resistance are often found in *precontemplation* and *contemplation* before making the decision to change. There can also be motivational challenges during preparation, action, and maintenance, but they are more easily addressed. When resistance occurs in these latter stages of change, a social worker should reassess the problem and appropriateness of the intervention to ensure that there have not been new developments in a client's life that need to

be considered. They may be distracting a client from making progress or serving as barriers to making real change.

In precontemplation, a client is unaware, unable, and/or unwilling to change. In this stage, there is the greatest resistance and lack of motivation. It can be characterized by arguing, interrupting, denial, ignoring the problem, and/or avoiding talking or thinking about it. A client may not even show up for appointments and does not agree that change is needed.

A social worker can best deal with lack of motivation and resistance in <sup>192</sup> this stage by establishing a rapport, acknowledging resistance or ambivalence, keeping conversation informal, trying to engage a client, and recognizing a client's thoughts, feelings, fears, and concerns.

In contemplation, a client is ambivalent or uncertain regarding behavior change; thus, behaviors are unpredictable. In this stage, a client may be willing to look at the pros and cons of behavior change, but is not committed to working toward it.

A social worker can best deal with lack of motivation and resistance in this stage by emphasizing a client's free choice and responsibility, as well as discussing the pros and cons of changing. It is also useful to discuss how change will assist a client in achieving life goals. Fear can be reduced by producing examples of change and clarifying what change is and is not.

There are many *self-motivating techniques* that a client can use to assist in reaching a goal. A social worker can assist a client in identifying which of these techniques may be useful, as well as creating others that may be helpful. Some common self-motivating techniques include a client:

- Visualizing goals, including using visual images on the refrigerator or in a place that will remind a client of the desired aim
- Reminding oneself of why change is needed
- Making up a contract with oneself of steps that will be taken toward reaching the desired end result
- Rewarding oneself when progress is made on the goals
- Taking a break to do something that is liked or be with a friend to stay encouraged
- Being around positive people who will encourage and not create barriers to change

- Educating oneself about steps that will assist in the change effort
- Breaking down goals into achievable steps
- Forgiving oneself when setbacks in progress occur
- Conceptualizing a new reality or what life will be like when change happens

## **METHODS TO ASSESS THE CLIENT'S/CLIENT SYSTEM'S COMMUNICATION SKILLS**

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Social workers must involve clients in every aspect of treatment. In order to do so, social workers must assess clients' communication skills and determine effective methods to gather needed information, as well as to ensure that clients understand data that is presented to them. Thus, the expressive and receptive communication of clients must be considered.

As many clients may have experienced trauma, it is essential that social workers understand how such experiences may impact on clients' communication styles and patterns. Much of communication is also cultural and should be viewed within the context of clients' backgrounds and experiences.

Silence is a form of communication and should be considered by a social worker when used by a client.

Social workers should understand how to communicate with clients who are upset and angry, as well as how some wording choices and tones can be upsetting to clients based on their ethnic backgrounds and/or past experiences, such as victimization.

## **METHODS TO ASSESS THE CLIENT'S/CLIENT SYSTEM'S COPING ABILITIES**

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Social workers can learn a lot about clients' difficulties by determining how clients have attempted to cope with their problems in the past. The coping abilities that clients employ give valuable clues about their levels of stress and functioning. Investigation may indicate that clients have few coping abilities, but rely on rigid patterns that are unhelpful or cause further problems. Some clients follow avoidance pattern by immersing themselves in work, withdrawing, or using drugs or alcohol.<sup>193</sup>

Others attempt to cope by being aggressive or acting out. Lastly, others become dependent and rely on family members or friends to manage difficulties for them.

Exploring how clients have attempted to cope with problems may reveal that they have struggled with the same or similar problems in the past. As they are no longer able to manage, it is important to find out what has changed (“why now?”). In order to assess coping skills, social workers might want to ask about the extent to which clients:

- Turn to work or other substitute activities to take their minds off things
- Get upset and let their emotions out
- Get advice from others about what to do
- Concentrate on doing something about their problems
- Put their trust in high beings
- Laugh about their situations
- Discuss their feelings with others
- Use alcohol or drugs to make themselves feel better
- Pretend that their problems do not exist
- Seek out others who have similar experiences

## **THE INDICATORS OF CLIENT'S/CLIENT SYSTEM'S STRENGTHS AND CHALLENGES**

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Strength is the capacity to cope with difficulties, to maintain functioning under stress, to return to equilibrium in the face of significant trauma, to use external challenges to promote growth, and to be resilient by using social supports.

There is not a single approach to the assessment of strengths. However, social workers can view all of these areas as strengths or protective factors that can assist clients when they experience challenges. These characteristics can also be abilities that need to be bolstered as a focus of treatment.

### ***Cognitive and Appraisal Skills***

- Intellectual/cognitive ability
- Creativity and curiosity
- Initiative, perseverance, and patience
- Common sense
- Ability to anticipate problems
- Realistic appraisal of demands and capacities
- Ability to use feedback

### ***Defenses and Coping Mechanisms***

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- Ability to regulate impulses and affect
- Self-soothing
- Flexible; can handle stressors

### ***Temperamental and Dispositional Factors***

- Belief in trustworthiness of others
- Belief in justice
- Self-esteem and self-worth
- Sense of mastery, confidence, and optimism
- Ability to tolerate ambiguity and uncertainty
- Ability to make sense of negative events
- Sense of humor
- Lack of hostility, anger, and anxiety
- Optimistic and open
- Ability to grieve
- Lack of helplessness
- Responsibility for decisions
- Sense of direction, mission, and purpose

## ***Interpersonal Skills and Supports***

- Ability to develop/maintain good relationships
- Ability to confide in others
- Problem-solving skills
- Capacity for empathy
- Presence of an intimate relationship
- Sense of security

## ***Other Factors***

- Supportive social institutions, such as church
- Good physical health
- Adequate income
- Supportive family and friends

## **METHODS TO ASSESS EGO STRENGTHS**

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Ego strength is the ability of the ego to effectively deal with the demands of the id, the superego, and reality. It is a basis for resilience and helps maintain emotional stability by coping with internal and external stress. Traits usually considered to be indicators of positive ego strengths include tolerance of pain associated with loss, disappointment, shame, or guilt; forgiveness of others, with feelings of compassion rather than <sup>195</sup> anger; persistence and perseverance in the pursuit of goals; and/or openness, flexibility, and creativity in learning to adapt. Those with positive ego strength are less likely to have psychiatric crises.

Other indicators of positive ego strength include clients:

- Acknowledging their feelings—including grief, insecurity, loneliness and anxiety
- Not getting overwhelmed by their moods
- Pushing forward after loss and not being paralyzed by self-pity

resentment

- Using painful events to strengthen themselves
- Knowing that painful feelings will eventually fade
- Empathizing with others without trying to reduce or eliminate their pain
- Being self-disciplined and fighting addictive urges
- Taking responsibility for actions
- Holding themselves accountable
- Not blaming others
- Accepting themselves with their limitations
- Setting firm limits even if it means disappointing others or risking rejection
- Avoiding people who drain them physically and/or emotionally

## **THE USE OF THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS of THE AMERICAN PSYCHIATRIC ASSOCIATION**

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The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is used by social workers and other mental health professionals as an authoritative guide to the diagnosis of mental disorders. The *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders.

A social worker might give a client an ***other specified diagnosis*** if the client is missing one or two of the symptoms that are necessary for a diagnosis. For example, a diagnosis of generalized anxiety disorder (GAD) requires that the client experience anxiety more days than not. A social worker might see that a client has all the other symptoms of that disorder and that anxiety is interfering with life, but the anxiety might not show up on enough days to technically count as GAD. In that case, the client could be diagnosed with other specified anxiety disorder. The social worker would add a note to the diagnosis explaining the reason that the diagnosis is not GAD.

An ***unspecified diagnosis*** is used when a social worker has determined that a client's challenges fall within a certain group of

disorders, but it's not clear exactly which diagnosis in that group best suits the client. The main difference is that an ***unspecified diagnosis*** doesn't include detailed information or the reason that the criteria for a specific diagnosis are not met.

**Specifiers** are extensions to a diagnosis that further clarify the course, severity, or special features of the client disorders or illnesses. Specifiers allow for a more specific diagnosis that will help social workers select more effective treatment for clients.

## Neurodevelopmental Disorders

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### ***Intellectual Developmental Disorders***

*Intellectual developmental disorder (intellectual disability)*

This disorder involves limitations in intellectual functioning (such as reasoning, problem-solving, and learning) and adaptive behavior. It begins during the developmental period and impacts an individual's ability to independently function in daily life.

Specify current severity: Mild, Moderate, Severe, and Profound

*Global developmental delay*

*Unspecified intellectual developmental disorder (intellectual disability)*

### ***Communication Disorders***

This category includes disorders such as language disorder (difficulties in language expression or comprehension) and speech sound disorder (pronunciation difficulties), among others. These disorders impact effective communication skills.

*Language disorder*

*Speech sound disorder*

*Childhood-onset fluency disorder (stuttering)*

Note: Later-onset cases are diagnosed as adult-onset fluency disorder.

*Social (pragmatic) communication disorder*

This disorder involves difficulties in using and understanding verbal and nonverbal communication for social purposes. Individuals struggle to effectively use language in social contexts.

#### *Unspecified communication disorder*

### **Autism Spectrum Disorder**

#### *Autism spectrum disorder (ASD)*

ASD is characterized by difficulties in social communication and interaction, as well as restricted and repetitive patterns of behavior, interests, or activities. Symptoms vary widely in severity, and early intervention is crucial for improving outcomes.

Specify current severity: Requiring very substantial support, Requiring substantial support, Requiring support

Specify if: With or without accompanying intellectual impairment, With or without accompanying language impairment

Specify if: Associated with a known genetic or other medical condition or environmental factor; Associated with a neurodevelopmental, mental, or behavioral problem

Specify if: With catatonia

### **Attention-Deficit/Hyperactivity Disorder**

#### *Attention-deficit/hyperactivity disorder (ADHD)*

ADHD is marked by persistent patterns of inattention, hyperactivity, and impulsivity that can interfere with daily functioning and development. It commonly starts in childhood and may persist into adulthood.

Specify if: In partial remission

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Specify current severity: Mild, Moderate, and Severe

Specify whether: Combined presentation, Predominantly inattentive presentation, Predominantly hyperactive/impulsive presentation, other specified attention-deficit/hyperactivity disorder, unspecified attention-deficit/hyperactivity disorder

### **Specific Learning Disorder**

#### *Specific learning disorder*

Individuals with this disorder struggle with specific academic skills, such as reading, writing, or mathematics, despite having average or above-

average intelligence. These difficulties significantly interfere with academic achievement or daily activities.

Specify current severity: Mild, Moderate, and Severe

Specify if: With impairment in reading (specify if with word reading accuracy, reading rate or fluency, and reading comprehension); With impairment in written expression (specify if with spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression); With impairment in mathematics (specify if with number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning)

## ***Motor Disorders***

This category includes disorders such as developmental coordination disorder (difficulty with motor coordination and physical tasks) and Tourette's disorder (presence of both motor and vocal tics).

*Developmental coordination disorder*

*Stereotypic movement disorder*

Specify if: With self-injurious behavior, Without self-injurious behavior

Specify if: Associated with a known genetic or other medical condition, neurodevelopmental disorder, or environmental factor

Specify current severity: Mild, Moderate, and Severe

*Tic disorders*

Apart from Tourette's disorder, this category includes persistent (chronic) motor or vocal tic disorder (single or multiple motor or vocal tics present for more than a year) and provisional tic disorder (tics present for less than a year).

*Tourette's disorder*

*Persistent (chronic) motor or vocal tic disorder*

Specify if: With motor tics only, With vocal tics only

*Provisional tic disorder*

*Other specified tic disorder*

*Unspecified tic disorder*

## **Other Neurodevelopmental Disorders**

*Other specified neurodevelopmental disorder*

*Unspecified neurodevelopmental disorder*

## **Schizophrenia Spectrum and Other Psychotic Disorders** 198

The following specifiers apply to schizophrenia spectrum and other psychotic disorders where indicated:

Specify if: The following course specifiers are only to be used after a 1-year duration of the disorder: First episode, currently in acute episode; First episode, currently in partial remission; First episode, currently in full remission; Multiple episodes, currently in acute episode; Multiple episodes, currently in partial remission; Multiple episodes, currently in full remission; Continuous; Unspecified

Specify if: With catatonia

Specify current severity of delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, and mania symptoms

*Schizotypal (personality) disorder*

### *Delusional disorder*

Individuals with this disorder have non-bizarre delusions (false beliefs that could be plausible) that are present for at least 1 month. These delusions significantly impact their daily lives, but other aspects of functioning remain relatively intact.

Specify whether: Erotomanic type, Grandiose type, Jealous type, Persecutory type, Somatic type, Mixed type, and Unspecified type  
Specify if: With bizarre content

### *Brief psychotic disorder*

This disorder is characterized by the sudden onset of psychotic symptoms such as hallucinations, delusions, disorganized speech, or grossly disorganized or catatonic behavior. The duration is brief, lasting less than 1 month, with eventual return to full premorbid functioning.

Specify if: With marked stressor(s), Without marked stressor(s), With peripartum onset

### *Schizophreniform disorder*

Similar to schizophrenia, this disorder involves the presence of symptoms like delusions, hallucinations, disorganized speech, and/or negative symptoms. However, the duration of these symptoms is shorter, lasting between 1 and 6 months.

Specify if: With good prognostic features, Without good prognostic features

### *Schizophrenia*

Schizophrenia is a complex disorder characterized by a range of symptoms including delusions (false beliefs), hallucinations (false sensory perceptions), disorganized thinking and speech, grossly disorganized or catatonic behavior, and negative symptoms (diminished emotional expression or motivation). These symptoms significantly impair an individual's ability to function in daily life.

### *Schizoaffective disorder*

This disorder combines symptoms of schizophrenia (hallucinations, delusions) with prominent mood episodes (depression or mania). These mood episodes occur alongside periods of psychosis but are not solely due to mood disturbances.

Specify whether: Bipolar type, Depressive type

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### *Substance/medication-induced psychotic disorder*

Psychotic symptoms (hallucinations, delusions, etc.) emerge due to substance intoxication, withdrawal, or after exposure to a medication. These symptoms are not better explained by a primary psychotic disorder.

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

### *Psychotic disorder due to another medical condition*

Psychotic symptoms arise as a direct result of a medical condition (such as a neurological disorder or endocrine disorder). The symptoms are not better explained by another primary psychotic disorder.

Specify whether: With delusions, With hallucinations

### *Catatonia associated with another mental disorder (catatonia specifier)*

Catatonic symptoms, such as motoric immobility or excessive motor activity, are present in the context of another mental disorder (e.g., mood

disorders, schizophrenia).

#### *Catatonic disorder due to another medical condition*

Catatonic symptoms are directly caused by a medical condition, such as neurodevelopmental or neurological disorders.

#### *Unspecified catatonia*

Diagnosis is applied when the catatonic symptoms are present and causing distress or impairment, but they do not neatly fit into any of the more specific diagnostic categories within the catatonia-related disorders.

#### *Other specified schizophrenia spectrum and other psychotic disorder*

This diagnosis includes presentations of psychotic symptoms that do not fit neatly into the other defined categories but still warrant clinical attention.

#### *Unspecified schizophrenia spectrum and other psychotic disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific psychotic disorder but still cause significant distress or impairment.

## **Bipolar and Related Disorders**

The following specifiers apply to bipolar and related disorders where indicated:

Specify: With anxious distress (specify current severity: mild, moderate, moderate-severe, and severe); With mixed features; With rapid cycling; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood incongruent psychotic features; With catatonia; With peripartum onset; With seasonal pattern

Specify: With anxious distress (specify current severity: mild, moderate, moderate-severe, and severe); With mixed features; With rapid cycling; With peripartum onset; With seasonal pattern

#### *Bipolar I disorder*

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This disorder involves the occurrence of at least one manic episode, which is a distinct period of abnormally elevated or irritable mood, along with potential episodes of major depressive or hypomanic episodes. The manic episode may include symptoms such as increased energy, decreased need for sleep, racing thoughts, and risky behavior.

Current or most recent episode manic: Mild, Moderate, Severe, With psychotic features, In partial remission, In full remission, Unspecified, Current or most recent episode hypomanic, In partial remission, In full remission, Unspecified

Current or most recent episode depressed: Mild, Moderate, Severe, With psychotic features, In partial remission, In full remission, Unspecified

Current or most recent episode unspecified

#### *Bipolar II disorder*

This disorder is characterized by at least one major depressive episode and at least one hypomanic episode. Hypomania is similar to mania but with less severe symptoms and less impairment in daily functioning.

Specify current or most recent episode: Hypomanic, Depressed

Specify course if full criteria for a mood episode are not currently met: In partial remission, In full remission

Specify severity if full criteria for a major depressive episode are currently met: Mild, Moderate, and Severe

#### *Cyclothymic disorder*

Individuals with this disorder experience numerous periods of hypomanic symptoms and depressive symptoms that do not meet the criteria for major depressive or manic episodes. These mood fluctuations are chronic and persist for at least two years in adults (one year in children and adolescents).

Specify if: With anxious distress (specify current severity: Mild, Moderate, Moderate-Severe, and Severe)

#### *Substance/medication-induced bipolar and related disorder*

Mood episodes (manic, depressive, or mixed) are caused by substance intoxication, withdrawal, or medication effects. The symptoms are not better explained by a primary mood disorder.

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

#### *Bipolar and related disorder due to another medical condition*

Mood disturbances, including manic or depressive symptoms, are directly attributed to the physiological effects of a medical condition, such as a neurological disorder or endocrine disorder.

Specify if: With manic features, With manic- or hypomanic-like episode, With mixed features

#### *Other specified bipolar and related disorder*

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This diagnosis includes presentations of bipolar symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

#### *Unspecified bipolar and related disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific bipolar or related disorder but still cause significant distress or impairment.

#### *Unspecified mood disorder*

Diagnosis is applied when a person experiences mood-related symptoms that don't align with the specific criteria for disorders such as major depressive disorder, bipolar disorder, or others within the mood disorder category.

### **Depressive Disorders**

#### *Disruptive mood dysregulation disorder*

This diagnosis is typically made in children and adolescents who experience severe and frequent temper outbursts that are out of proportion to the situation. The mood between outbursts is persistently irritable or angry. It is a way to differentiate this pattern from early-onset bipolar disorder.

#### *Major depressive disorder (MDD)*

Also known as clinical depression, MDD involves persistent feelings of sadness, loss of interest or pleasure in activities (anhedonia), and a range of other symptoms such as changes in appetite or sleep patterns, fatigue, feelings of worthlessness or guilt, difficulty concentrating, and even thoughts of death or suicide. To receive a diagnosis, a person must experience these symptoms for at least two weeks.

Specify: With anxious distress (specify current severity: mild, moderate, moderate-severe, and severe); With mixed features; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia; With peripartum onset; With seasonal pattern

Single episode: Mild, Moderate, Severe, With psychotic features, In partial remission, In full remission, Unspecified

Recurrent episode: Mild, Moderate, Severe, With psychotic features, In partial remission, In full remission, Unspecified

#### *Persistent depressive disorder*

This disorder involves chronic low-grade depression lasting for at least two years in adults (one year in children or adolescents). The symptoms are less severe than in MDD but are still impactful, and they can include changes in appetite or sleep, fatigue, low self-esteem, and difficulty making decisions.

Specify: With anxious distress (specify current severity: mild, moderate, moderate-severe, and severe); With atypical features

Specify if: In partial remission, In full remission

Specify if: Early onset, Late onset

Specify if: With pure dysthymic syndrome; With persistent major <sup>202</sup> depressive episode; With intermittent major depressive episodes, with current episode; With intermittent major depressive episodes, without current episode

Specify current severity: Mild, Moderate, and Severe

#### *Premenstrual dysphoric disorder*

This disorder involves severe mood disturbances that occur in the week before menstruation and improve shortly after menstruation begins. Symptoms include mood swings, irritability, anxiety, and physical symptoms like bloating or fatigue.

#### *Substance/medication-induced depressive disorder*

Depressive symptoms arise due to substance intoxication, withdrawal, or as a side effect of a medication. These symptoms are not better explained by a primary depressive disorder.

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

#### *Depressive disorder due to another medical condition*

Depressive symptoms emerge as a direct result of a medical condition, such as a neurological disorder or endocrine disorder. The symptoms are not better explained by another primary depressive disorder.

Specify if: With depressive features, With major depressive—like episode, With mixed features

### *Other specified depressive disorder*

This diagnosis includes presentations of depressive symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

### *Unspecified depressive disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific depressive disorder but still cause significant distress or impairment.

### *Unspecified mood disorder*

Diagnosis is often applied when the presentation of symptoms is not well-defined or when the symptoms are atypical.

## **Anxiety Disorders**

### *Separation anxiety disorder*

Primarily diagnosed in children, separation anxiety disorder involves excessive distress and anxiety related to separation from attachment figures or home. These fears go beyond what's developmentally appropriate and can impact daily functioning.

### *Selective mutism*

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Selective mutism is characterized by consistent failure to speak in specific social situations despite speaking in other settings. This typically occurs due to anxiety or discomfort.

### *Specific phobia*

Specific phobia involves an intense and irrational fear of a specific object or situation, such as heights, animals, or flying. This fear causes immediate anxiety and may lead to avoidance behavior.

Specify if: Animal, Natural environment, Blood-injection-injury, Fear of blood, Fear of injections and transfusions, Fear of other medical care, Fear of injury, Situational, Other

### *Social anxiety disorder*

People with social anxiety disorder experience intense fear and anxiety in social situations due to a fear of being judged, embarrassed, or humiliated. This fear leads to avoidance of social interactions.

Specify if: Performance only

### *Panic disorder*

Panic disorder involves recurrent and unexpected panic attacks, which are intense periods of fear or discomfort that reach a peak within minutes. Panic attacks can be accompanied by physical symptoms such as heart palpitations, sweating, trembling, and a fear of losing control or dying.

#### *Panic attack specifier*

### *Agoraphobia*

Agoraphobia is marked by a fear of situations where escape might be difficult or help might not be available if a panic attack or other distressing symptoms occur. Individuals often avoid places or situations that trigger this fear.

### *Generalized anxiety disorder (GAD)*

GAD is characterized by excessive and persistent worry and anxiety about various life situations or events, often without a specific trigger. This worry is difficult to control and is associated with physical symptoms such as restlessness, muscle tension, and fatigue.

### *Substance/medication-induced anxiety disorder*

Anxiety symptoms arise due to substance intoxication, withdrawal, or as a side effect of medication. These symptoms are not better explained by a primary anxiety disorder.

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

### *Anxiety disorder due to another medical condition*

Anxiety symptoms emerge as a direct result of a medical condition, such as a neurological disorder or endocrine disorder. The symptoms are not better explained by another primary anxiety disorder.

### *Other specified anxiety disorder*

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This diagnosis includes presentations of anxiety symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

### *Unspecified anxiety disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific anxiety disorder but still cause significant distress or impairment.

## **Obsessive-Compulsive and Related Disorders**

The following specifier applies to obsessive-compulsive and related disorders where indicated:

Specify if: With good or fair insight, With poor insight, With absent insight/delusional beliefs

### ***Obsessive-compulsive disorder (OCD)***

OCD is characterized by the presence of obsessions and/or compulsions. Obsessions are intrusive and distressing thoughts, images, or urges that cause significant anxiety. Compulsions are repetitive behaviors or mental acts performed to alleviate the distress caused by obsessions. These behaviors are often time-consuming and interfere with daily life.

Specify if: Tic-related

### ***Body dysmorphic disorder (BDD)***

Individuals with BDD have an intense preoccupation with perceived flaws or defects in their physical appearance, which are not noticeable to others or are very minor. This obsession leads to distress and often results in behaviors like checking mirrors excessively or seeking cosmetic procedures.

Specify if: With muscle dysmorphia

### ***Hoarding disorder***

People with this disorder excessively accumulate and struggle to discard possessions, regardless of their value. This behavior leads to clutter that significantly impairs living spaces and daily functioning.

Specify if: With excessive acquisition

### ***Trichotillomania (hair-pulling disorder)***

Individuals repetitively pull out their own hair, often leading to noticeable hair loss. This behavior is usually driven by tension or an urge and may be an attempt to alleviate distress.

### ***Excoriation (skin-picking) disorder***

This disorder involves recurrent and compulsive picking of one's own skin, resulting in skin lesions. This behavior is typically driven by the urge to remove perceived imperfections or relieve tension.

*Substance/medication-induced obsessive-compulsive and related disorder* <sup>205</sup>

Obsessive-compulsive or related symptoms arise due to substance intoxication, withdrawal, or as a side effect of medication. These symptoms are not better explained by a primary obsessive-compulsive or related disorder.

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

*Obsessive-compulsive and related disorder due to another medical condition*

Obsessive-compulsive or related symptoms emerge as a direct result of a medical condition, such as a neurological disorder or endocrine disorder. The symptoms are not better explained by another primary obsessive-compulsive or related disorder.

Specify if: With obsessive-compulsive disorder—like symptoms, With appearance preoccupations, With hoarding symptoms, With hair-pulling symptoms, With skin-picking symptoms

*Other specified obsessive-compulsive and related disorder*

This diagnosis includes presentations of obsessive-compulsive or related symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

*Unspecified obsessive-compulsive and related disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific obsessive-compulsive or related disorder but still cause significant distress or impairment.

## Trauma- and Stressor-Related Disorders

### *Reactive attachment disorder*

Typically diagnosed in children, this disorder involves significantly disturbed and developmentally inappropriate social interactions due to early neglect, deprivation, or other forms of trauma. Children with this disorder may struggle to form appropriate emotional bonds.

Specify if: Persistent

Specify current severity: Severe

### *Disinhibited social engagement disorder*

Also diagnosed in children, this disorder manifests as a pattern of overly familiar behavior with unfamiliar individuals, often due to a history of

neglect or multiple caregivers. Children with this disorder may lack appropriate social boundaries.

Specify if: Persistent

Specify current severity: Severe

#### *Posttraumatic stress disorder (PTSD)*

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PTSD occurs after exposure to traumatic events, causing symptoms like intrusive memories, nightmares, flashbacks, avoidance of reminders, negative changes in mood and cognition, and increased arousal. Symptoms may significantly impair daily functioning.

Specify whether: With dissociative symptoms

Specify if: With delayed expression

Posttraumatic stress disorder in individuals older than 6 years

Posttraumatic stress disorder in children 6 years and younger

#### *Acute stress disorder*

Similar to PTSD, acute stress disorder involves symptoms like intrusion, negative mood, dissociation, avoidance, and arousal, but these symptoms arise immediately after exposure to a traumatic event and last up to a month, while PTSD symptoms present slower and last longer, especially if not treated.

#### *Adjustment disorders*

These are characterized by emotional or behavioral symptoms that arise in response to an identifiable stressor. Symptoms may include sadness, anxiety, or behavior changes. The stressor's impact exceeds what is typically expected in relation to the event.

Specify if: Acute, Persistent (chronic)

Specify whether: With depressed mood, With anxiety, With mixed anxiety and depressed mood, With disturbance of conduct, With mixed disturbance of emotions and conduct, Unspecified

#### *Prolonged grief disorder*

This diagnosis refers to an intense and prolonged form of grief that extends beyond the expected period of mourning. It is characterized by a persistent and severe longing for the deceased individual, along with emotional pain and difficulty adapting to life without them.

#### *Other specified trauma- and stressor-related disorder*

This diagnosis includes presentations of trauma- or stressor-related symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

#### *Unspecified trauma- and stressor-related disorder*

This diagnosis is used when the symptoms do not meet the criteria for any specific trauma- and-stressor-related disorder but still cause significant distress or impairment.

### **Dissociative Disorders**

#### *Dissociative identity disorder (DID)*

Formerly known as multiple personality disorder, DID involves the presence of two or more distinct identity states that control an individual's behavior, thoughts, and feelings. Gaps in memory, awareness, and personal information are common between these identity states.

#### *Dissociative amnesia*

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This disorder involves memory gaps related to personal information, often about traumatic or stressful events. It can be localized (specific time period), selective (specific events), generalized (overall identity and life history), or continuous (ongoing inability to recall new information).

Specify if: With dissociative fugue

#### *Depersonalization/derealization disorder*

Depersonalization is characterized by feelings of detachment from oneself, as if observing from outside the body. Derealization involves a sense of unreality or detachment from the surroundings. These experiences are distressing and can impair daily functioning.

#### *Other specified dissociative disorder*

This diagnosis includes presentations of dissociative symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

#### *Unspecified dissociative disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific dissociative disorder but still cause significant distress or impairment.

## **Somatic Symptom and Related Disorders**

### *Somatic symptom disorder*

This disorder involves excessive and distressing thoughts, feelings, and behaviors related to physical symptoms. Individuals may have a preoccupation with their symptoms and experience significant distress or impairment due to these concerns.

Specify if: With predominant pain

Specify if: Persistent

Specify current severity: Mild, Moderate, and Severe

### *Illness anxiety disorder*

Formerly known as hypochondriasis, this disorder involves excessive worry about having a serious illness, despite minimal or no medical evidence to support the belief. Individuals often misinterpret normal bodily sensations as signs of a severe medical condition.

Specify whether: Care-seeking type, Care-avoidant type

### *Functional neurological symptom disorder (conversion disorder)*

This disorder involves neurological symptoms that can't be explained by a medical condition. These symptoms may resemble those of a neurological disorder, such as paralysis or blindness, but they are not caused by a physiological issue.

Specify if: Acute episode, Persistent

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Specify if: With psychological stressor (specify stressor), Without psychological stressor

Specify symptom type: With weakness or paralysis, With abnormal movement, With swallowing symptoms, With speech symptom, With attacks or seizures, With anesthesia or sensory loss, With special sensory symptom, With mixed symptoms

### *Psychological factors affecting other medical conditions*

A disorder that is diagnosed when a general medical condition is adversely affected by psychological or behavioral factors; the factors may precipitate or exacerbate the medical condition, interfere with treatment, or contribute to morbidity and mortality.

Specify current severity: Mild, Moderate, Severe, and Extreme

### *Factitious disorder*

Specify: Single episode, Recurrent episodes

### *Factitious disorder imposed on self*

In this disorder, individuals intentionally falsify, exaggerate, or induce physical or psychological symptoms in themselves for the purpose of assuming a “sick role.” There is no apparent external reward, such as financial gain.

### *Factitious disorder imposed on another*

Formerly known as Munchausen syndrome by proxy, in this disorder, individuals falsify, exaggerate, or induce physical or psychological symptoms in another person, often someone under their care, to assume a caregiver role. There is no apparent external reward.

### *Other specified somatic symptom and related disorder*

This diagnosis includes presentations of somatic and related symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

### *Unspecified somatic symptom and related disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific somatic symptom and related disorder but still cause significant distress or impairment.

## **Feeding and Eating Disorders**

These disorders involve disruptions in eating behaviors, such as avoidant/restrictive food intake disorder (extreme pickiness) and can lead to nutritional deficiencies or developmental problems.

The following specifiers apply to feeding and eating disorders where indicated:

Specify if: In remission

Specify if: In partial remission, In full remission

Specify current severity: Mild, Moderate, Severe, and Extreme

### **Pica**

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Pica involves eating non-nutritive, non-food substances over a period of at least one month, and the behavior is developmentally inappropriate. Common substances ingested might include paper, clay, hair, cloth, or string.

*In children*

*In adults*

### *Rumination disorder*

This disorder involves the repeated regurgitation of food, which may be re-chewed, re-swallowed, or spit out. It's not due to a medical condition and lasts for at least one month.

### *Avoidant/restrictive food intake disorder (ARFID)*

ARFID involves an extreme limitation in food intake, often due to sensory sensitivities, concerns about adverse consequences, or lack of interest in eating. It is not driven by concerns about weight or body shape.

### *Anorexia nervosa*

Anorexia involves severe restriction of food intake, leading to significantly low body weight. Fear of gaining weight and distorted body image are common. It often involves intense efforts to control weight through dieting, excessive exercise, or other behaviors.

Specify whether: Restricting type, Binge-eating/purging type

### *Bulimia nervosa*

Bulimia involves recurrent episodes of binge eating followed by compensatory behaviors like vomiting, excessive exercise, or laxative use to prevent weight gain. It's often characterized by a cycle of bingeing and purging.

### *Binge-eating disorder (BED)*

BED involves recurrent episodes of eating large amounts of food in a short period, with a sense of lack of control during the binge. Unlike bulimia, there are no regular compensatory behaviors.

### *Other specified feeding or eating disorder*

This diagnosis includes presentations of feeding and eating symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

### *Unspecified feeding or eating disorder*

This diagnosis is used when the symptoms do not meet criteria for any specific feeding and eating disorder but still cause significant distress or impairment.

## **Elimination Disorders**

### *Enuresis*

Enuresis refers to the repeated involuntary urination in inappropriate places, typically occurring during sleep (nocturnal enuresis) or during waking hours (diurnal enuresis). The behavior is considered <sup>210</sup> developmentally inappropriate and typically occurs in children who are old enough to have bladder control.

Specify whether: Nocturnal only, Diurnal only, Nocturnal and diurnal

### *Encopresis*

Encopresis involves the repeated involuntary passage of feces in inappropriate places, often after the age when bowel control is expected. This behavior is not due to a medical condition and typically occurs in children.

Specify whether: With constipation and overflow incontinence, Without constipation and overflow incontinence

### *Other specified elimination disorder*

#### *With urinary symptoms*

This subcategory would include cases where the individual experiences problematic patterns related to urination, but the symptoms do not meet the criteria for enuresis or other well-defined disorders. The symptoms might involve issues with urgency, frequency, or other urinary difficulties.

#### *With fecal symptoms*

This subcategory would include cases where the individual experiences problematic patterns related to bowel movements or feces, but the symptoms do not meet the criteria for encopresis or other specific disorders. The symptoms might involve issues with soiling, discomfort, or other fecal-related difficulties.

### *Unspecified elimination disorder*

#### *With urinary symptoms*

#### *With fecal symptoms*

## **Sleep–Wake Disorders**

The following specifiers apply to sleep–wake disorders where indicated:

Specify if: Episodic, Persistent, and Recurrent

Specify if: Acute, Subacute, and Persistent

Specify current severity: Mild, Moderate, and Severe

### *Insomnia disorder*

Insomnia involves difficulty falling asleep, staying asleep, or experiencing non-restorative sleep, despite having adequate opportunity for sleep. This pattern leads to significant daytime distress or impairment.

Specify if: With mental disorder, With medical condition, With another sleep disorder

### *Hypersomnolence disorder*

Individuals with hypersomnolence experience excessive daytime sleepiness, which often results in prolonged sleep episodes during the day. Despite getting sufficient sleep, they struggle to stay awake and alert.

Specify if: With mental disorder, With medical condition, With another sleep disorder

### *Narcolepsy*

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Narcolepsy is characterized by excessive daytime sleepiness and sudden, uncontrollable episodes of falling asleep during the day. It may also involve cataplexy (sudden loss of muscle tone), sleep paralysis, and hallucinations during sleep onset or upon awakening.

Specify whether: Narcolepsy with cataplexy or hypocretin deficiency (type 1); narcolepsy without cataplexy and either without hypocretin deficiency or hypocretin unmeasured (type 2); narcolepsy with cataplexy or hypocretin deficiency due to a medical condition; narcolepsy without cataplexy and without hypocretin deficiency due to a medical condition

### *Breathing-related sleep disorders*

This category includes sleep disorders caused by disrupted breathing patterns, such as obstructive sleep apnea, central sleep apnea, and sleep-related hypoventilation disorders. These disorders often lead to disrupted sleep and excessive daytime sleepiness.

#### *Obstructive sleep apnea hypopnea*

#### *Central sleep apnea*

Specify current severity

Specify whether: Idiopathic central sleep apnea, Cheyne-Stokes breathing, Central sleep apnea comorbid with opioid use

### *Sleep-related hypoventilation*

Specify current severity

Specify whether: Idiopathic hypoventilation, Congenital central alveolar hypoventilation, Comorbid sleep-related hypoventilation

### *Circadian rhythm sleep–wake disorders*

Circadian rhythm sleep–wake disorders involve disruptions in the sleep–wake schedule due to misalignment with the body's natural circadian rhythms. Conditions like delayed sleep phase disorder and shift work disorder are examples.

Specify whether: Delayed sleep phase type (specify if: Familial, Overlapping with non-24-hour sleep–wake type); Advanced sleep phase type (specify if: Familial); Irregular sleep-wake type; Non-24-hour sleep–wake type; Shift work type; Unspecified type

### *Parasomnias*

Parasomnias are abnormal behaviors or experiences during sleep or during transitions between sleep stages. Examples include sleepwalking, sleep terrors, nightmares, and REM sleep behavior disorder.

### *Non-rapid eye movement sleep arousal disorders*

Specify whether: Sleepwalking type (specify if: With sleep-related eating, With sleep-related sexual behavior [sexsomnia]), Sleep terror type

### *Nightmare disorder*

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Specify if: During sleep onset

Specify if: With mental disorder, With medical condition, With another sleep disorder

### *Rapid eye movement sleep behavior disorder*

### *Restless legs syndrome*

### *Substance/medication-induced sleep disorder*

Specify whether: Insomnia type, Daytime sleepiness type, Parasomnia type, and Mixed type

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

### *Other specified insomnia disorder*

This diagnosis is used when an individual experiences symptoms of insomnia that do not meet the full criteria for insomnia disorder, but still warrant clinical attention. This might include atypical patterns of difficulty falling asleep, staying asleep, or experiencing non-restorative sleep that cause distress or impairment. The symptoms may not fit all the specific criteria for insomnia disorder, but they are still significant enough to require assessment and possible intervention.

#### *Unspecified insomnia disorder*

This diagnosis is used when an individual experiences symptoms of insomnia causing distress or impairment, but the specific nature of the symptoms or their relationship to other sleep disorders is not fully understood. In other words, the symptoms meet the general criteria for insomnia, but they do not meet criteria for any specific subtype or diagnosis within the insomnia disorder category.

#### *Other specified hypersomnolence disorder*

This diagnosis is used when an individual experiences excessive daytime sleepiness that does not meet the full criteria for hypersomnolence disorder, but the symptoms still require clinical attention. This could involve atypical patterns of daytime sleepiness, sleep attacks, or difficulty staying awake during appropriate waking hours.

#### *Unspecified hypersomnolence disorder*

This diagnosis is used when an individual experiences significant excessive daytime sleepiness causing distress or impairment, but the specific nature of the symptoms or their relationship to other sleep disorders is not fully understood. The symptoms meet the general criteria for excessive daytime sleepiness, but they do not meet criteria for any specific subtype or diagnosis within the hypersomnolence disorder category.

#### *Other specified sleep–wake disorder*

This diagnosis includes presentations of sleep–wake symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

#### *Unspecified sleep–wake disorder*

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This diagnosis includes presentations of sleep–wake symptoms that do not fit neatly into the other defined categories but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

## **Sexual Dysfunctions**

The following specifiers apply to sexual dysfunctions where indicated:

Specify whether: Lifelong, Acquired

Specify whether: Generalized, Situational

Specify current severity: Mild, Moderate, and Severe

### *Delayed ejaculation*

Delayed ejaculation involves a significant delay or absence of ejaculation during sexual activity, despite adequate sexual arousal and stimulation. This issue causes distress or impairment.

### *Erectile disorder*

Erectile disorder (previously known as erectile dysfunction) involves persistent difficulty achieving or maintaining an erection sufficient for satisfactory sexual performance. The issue causes distress or impairment.

### *Female orgasmic disorder*

This disorder involves a delay, absence, or reduced intensity of orgasm during sexual activity, even when arousal and stimulation are adequate. The difficulty in achieving orgasm causes distress or impairment.

Specify if: Never experienced an orgasm under any situation

### *Female sexual interest/arousal disorder*

This disorder involves a persistent or recurrent deficiency in sexual interest, thoughts, or arousal. Individuals may have difficulty becoming sexually aroused or maintaining arousal during sexual activity, leading to distress or impairment.

### *Genito-pelvic pain/penetration disorder*

This disorder involves persistent or recurrent pain during intercourse, difficulty with vaginal penetration, or fear or anxiety about pain during sexual activity. The pain or fear causes distress or impairment.

### *Male hypoactive sexual desire disorder*

This disorder involves a persistent or recurrent lack of interest in sexual activity, often accompanied by reduced sexual thoughts or fantasies. The lack of sexual desire causes distress or impairment in the individual's life.

#### *Premature (early) ejaculation*

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Premature ejaculation involves the recurrent ejaculation before or shortly after penetration during sexual activity, often with minimal sexual stimulation. The timing of ejaculation causes distress or impairment.

#### *Substance/medication-induced sexual dysfunction*

Diagnosis refers to the development of sexual dysfunction as a result of substance use or medication. This category recognizes that certain substances and medications can have a direct impact on sexual function, leading to changes in sexual desire, arousal, and performance.

Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

#### *Other specified sexual dysfunction*

This diagnosis includes presentations of sexual dysfunction symptoms that do not meet the criteria for any specific sexual dysfunction but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

#### *Unspecified sexual dysfunction*

This diagnosis is used when the symptoms of sexual dysfunction cause distress or impairment, but the specific nature of the dysfunction or its relationship to other sexual disorders is not fully understood.

## **Gender Dysphoria**

Gender dysphoria is a diagnostic category that pertains to individuals whose emotional and psychological identity as male, female, or another gender does not align with their birth-assigned sex. This category replaced the previous diagnosis of gender identity disorder and reflects a more affirming and understanding approach to individuals experiencing gender incongruence.

The following specifier and note apply to gender dysphoria where indicated:

Specify if: With a disorder/difference of sex development

#### *Gender dysphoria*

### *Gender dysphoria in children*

This diagnosis is given when a child experiences a marked incongruence between their experienced/expressed gender and their assigned sex at birth. The child may express a desire to be of a different gender, to be treated as a different gender, or assert that they are of a different gender.

### *Gender dysphoria in adolescents and adults*

Similar to the diagnosis in children, this diagnosis is given when adolescents and adults experience a marked incongruence between their experienced/expressed gender and their assigned sex at birth. The individual may experience significant distress related to the incongruence and may seek social, hormonal, or surgical interventions to bring their body and gender identity into alignment.

Specify if: Posttransition

### *Other specified gender dysphoria*

This diagnosis is used when an individual's gender-related experiences do not fully meet the criteria for gender dysphoria in children, adolescents, or adults, but they still warrant clinical attention. This could include atypical patterns of gender identity, expression, or incongruence that do not align with the specific criteria of other diagnoses. The individual may experience some degree of distress or impairment related to their gender identity.<sup>215</sup>

### *Unspecified gender dysphoria*

This category is used when an individual's gender-related experiences do not fully meet the criteria for gender dysphoria in children, adolescents, or adults, but they still warrant clinical attention. This could include atypical patterns of gender identity, expression, or incongruence that do not align with the specific criteria of other diagnoses. The individual may experience some degree of distress or impairment related to their gender identity.

## **Disruptive, Impulse-Control, and Conduct Disorders**

### *Oppositional defiant disorder (ODD)*

ODD involves a pattern of defiant, hostile, and disobedient behavior directed toward authority figures. Individuals with ODD may often argue with adults, refuse to comply with rules, and deliberately annoy others.

This behavior is consistent and causes significant distress or impairment in social, academic, or occupational functioning.

Specify current severity: Mild, Moderate, and Severe

#### *Intermittent explosive disorder*

This disorder involves recurrent episodes of impulsive and aggressive behavior, often out of proportion to the situation. Individuals may have difficulty controlling their anger, leading to verbal or physical aggression that is not premeditated. These outbursts cause distress and impairment.

#### *Conduct disorder*

Conduct disorder is characterized by persistent patterns of behavior that violate the rights of others or societal norms. These behaviors may include aggression toward people or animals, destruction of property, deceitfulness, and serious violations of rules. Conduct disorder can range from mild to severe and is often a precursor to antisocial personality disorder in adulthood.

Specify if: With limited prosocial emotions

Specify current severity: Mild, Moderate, and Severe

Specify whether: Childhood-onset type, Adolescent-onset type, Unspecified onset

#### *Antisocial personality disorder (ASPD)*

ASPD is a personality disorder characterized by a pattern of disregard for the rights of others, impulsivity, deceitfulness, irritability, aggressiveness, and lack of remorse. Individuals with ASPD may engage in illegal activities, lie or manipulate others for personal gain, and have difficulty forming meaningful relationships. This disorder typically emerges in late childhood or adolescence and continues into adulthood. It is often <sup>216</sup> associated with a history of conduct disorder during childhood.

#### *Pyromania*

Pyromania is a rare impulse-control disorder characterized by an urge to deliberately set fires for pleasure, gratification, or relief. Individuals with pyromania are often fascinated by fire and may experience a sense of excitement or relief while setting fires. This behavior is not driven by financial gain, political ideology, or a desire for revenge.

#### *Kleptomania*

Kleptomania is another impulse-control disorder characterized by recurrent acts of stealing objects that are not needed for personal use or monetary gain. Individuals with kleptomania may experience tension before committing the theft and a sense of relief or gratification afterward. The stolen items are typically of little or no value to the individual.

*Other specified disruptive, impulse-control, and conduct disorder*

This diagnosis is used when an individual's symptoms do not fully meet the criteria for any specific disorder within this category but still warrant clinical attention. This could involve atypical symptom patterns or specific circumstances.

*Unspecified disruptive, impulse-control, and conduct disorder*

This diagnosis is used when an individual's symptoms cause distress or impairment, but the specific nature of the symptoms or their relationship to other disorders is not fully understood.

## **Substance-Related and Addictive Disorders**

### *Substance-related disorders*

Substance use disorders (SUDs): These disorders involve problematic and repeated use of substances such as alcohol, drugs, or medications. Symptoms include an inability to control use, spending excessive time seeking or using the substance, neglecting responsibilities, cravings, and withdrawal symptoms when not using the substance. Severity ranges from mild to severe, and treatment involves counseling, therapy, and sometimes medication.

Substance-induced intoxication: This occurs when using a substance leads to temporary changes in behavior, mood, cognition, or perception. Intoxication can vary depending on the substance, ranging from euphoria to confusion, and can sometimes result in dangerous behaviors or accidents.

Substance-induced withdrawal: This involves physical and psychological symptoms that occur when a person stops using a substance that has reached dependency. Symptoms can include nausea, tremors, anxiety, irritability, and in severe cases, seizures, or hallucinations.

Substance-induced mental disorders: These are mental health conditions triggered by substance use. For instance, substance-

induced anxiety or substance-induced depressive disorder can <sup>217</sup> emerge as a result of using certain substances. The symptoms of these disorders usually resolve once the substance use stops.

Substance-induced sleep disorders: Substance use can disrupt sleep patterns and lead to sleep disorders. This may involve insomnia, hypersomnia (excessive sleepiness), or other sleep-related problems triggered by substance consumption.

## ***Alcohol-Related Disorders***

Alcohol is a depressant that affects the central nervous system. In small amounts, it can lead to relaxation and lowered inhibitions. However, in larger amounts, it can cause impaired judgment, slowed reaction times, slurred speech, memory impairment, and motor coordination difficulties. Long-term heavy use can lead to liver damage, cognitive deficits, addiction, and various physical and mental health problems.

### *Alcohol use disorder*

This is a specific type of substance use disorder related to alcohol consumption. It involves problematic drinking patterns, such as excessive consumption, unsuccessful attempts to cut down, and continued use despite negative consequences.

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

### *Alcohol intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

### *Alcohol withdrawal*

*Without perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*With perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol-induced mental disorders*

Specify: With onset during intoxication, With onset during withdrawal

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

*Alcohol-induced psychotic disorder*

218

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol-induced bipolar and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol-induced depressive disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol-induced anxiety disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol-induced sleep disorder*

Specify whether Insomnia type

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol-induced sexual dysfunction*

Specify if: Mild, Moderate, and Severe

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Alcohol intoxication delirium*

*With mild use disorder*

*With moderate or severe use disorder*  
*Without use disorder*

*Alcohol withdrawal delirium*

*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Alcohol-induced major neurocognitive disorder*

219

*Specify if: Persistent*

*Amnestic-confabulatory type*

*With moderate or severe use disorder*  
*Without use disorder*

*Nonamnestic-confabulatory type*

*With moderate or severe use disorder*  
*Without use disorder*

*Alcohol-induced mild neurocognitive disorder*

*Specify if: Persistent*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Unspecified alcohol-related disorder*

## **Caffeine-Related Disorders**

Caffeine-related disorders refer to a set of conditions that are related to the consumption of caffeine, a stimulant found in various beverages, foods, and medications.

*Caffeine intoxication*

*Caffeine withdrawal*

*Caffeine-induced mental disorders*

*Specify: With onset during intoxication, With onset during withdrawal, With onset after medication use*

*Caffeine-induced anxiety disorder*

*Caffeine-induced sleep disorder*

Specify whether: Insomnia type, Daytime sleepiness type, Mixed type

*Unspecified caffeine-related disorder*

## **Cannabis-Related Disorders**

Cannabis, often referred to as marijuana, has both depressant and mild hallucinogenic effects. It can lead to relaxation, altered perception of time, and euphoria. Common short-term effects include bloodshot eyes, increased heart rate, dry mouth, and impaired memory and coordination. Long-term use can lead to cognitive impairment, respiratory issues, and potential addiction.

*Cannabis use disorder*

This disorder involves problematic use of marijuana or cannabis products, leading to impairment or distress. Symptoms include unsuccessful attempts to quit, increased tolerance, and reduced engagement in important activities.

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

*Cannabis intoxication*

220

*Without perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*With perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cannabis withdrawal*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cannabis-induced mental disorders*

Specify: With onset during intoxication, With onset during withdrawal, With onset after medication use

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

#### *Cannabis-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

#### *Cannabis-induced anxiety disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

#### *Cannabis-induced sleep disorder*

Specify whether: Insomnia type, Daytime sleepiness type, and Mixed type

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

#### *Cannabis intoxication delirium*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

#### *Pharmaceutical cannabis receptor agonist-induced delirium*

#### *Unspecified cannabis-related disorder*

### **Hallucinogen-Related Disorders**

Hallucinogens can alter perception, thoughts, and feelings. They can cause hallucinations, sensory distortions, and profound changes in consciousness. Short-term effects can vary widely, but long-term <sup>221</sup> effects are less well-defined. However, some users may experience persistent changes in perception or emotional states.

#### *Phencyclidine use disorder*

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

*Other hallucinogen use disorder*

Specify the particular hallucinogen

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

*Phencyclidine intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other hallucinogen intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Hallucinogen persisting perception disorder*

*Phencyclidine-induced mental disorders*

Specify: With onset during intoxication, With onset after medication use

*Phencyclidine-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Phencyclidine-induced bipolar and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Phencyclidine-induced depressive disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Phencyclidine-induced anxiety disorder*

*With mild use disorder*

222

*With moderate or severe use disorder*  
*Without use disorder*  
*Phencyclidine intoxication delirium*  
Specify if: Acute, Persistent  
Specify if: Hyperactive, Hypoactive, and Mixed level of activity  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Hallucinogen-induced mental disorders*

Specify: With onset during intoxication, With onset after medication use

Specify if: Acute, Persistent  
Specify if: Hyperactive, Hypoactive, and Mixed level of activity

*Other hallucinogen-induced psychotic disorder*  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Other hallucinogen-induced bipolar and related disorder*  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Other hallucinogen-induced depressive disorder*  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Other hallucinogen-induced anxiety disorder*  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Other hallucinogen intoxication delirium*  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Ketamine or other hallucinogen-induced delirium*

*Unspecified phencyclidine-related disorder*

## *Unspecified hallucinogen-related disorder*

### **Inhalant-Related Disorders**

Inhalants are volatile substances that produce chemical vapors that can be inhaled to induce a psychoactive, or mind-altering, effect. Short-term effects can include dizziness, confusion, impaired coordination, and nausea. Long-term use can lead to serious neurological and other health-related consequences.

#### *Inhalant use disorder*

223

Specify the particular inhalant

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

#### *Inhalant intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

#### *Inhalant-induced mental disorders*

Specify: With onset during intoxication

##### *Inhalant-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

##### *Inhalant-induced depressive disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

##### *Inhalant-induced anxiety disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

#### *Inhalant intoxication delirium*

Specify if: Acute, Persistent  
Specify if: Hyperactive, Hypoactive, and Mixed level of activity  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Inhalant-induced major neurocognitive disorder*  
Specify if: Persistent  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Inhalant-induced mild neurocognitive disorder* 224  
Specify if: Persistent  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Unspecified inhalant-related disorder*

### **Opioid-Related Disorders**

Opioids are central nervous system depressants that induce pain relief, relaxation, and euphoria. Short-term effects include pain relief, drowsiness, and constipation. Long-term use can lead to physical dependence, respiratory depression, increased risk of overdose, and potential addiction.

*Opioid use disorder*

Specify if: On maintenance therapy, In a controlled environment  
Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

*Opioid intoxication*

*Without perceptual disturbances*  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*  
*With perceptual disturbances*  
*With mild use disorder*

*With moderate or severe use disorder*  
*Without use disorder*

*Opioid withdrawal*

*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Opioid-induced mental disorders*

Specify: With onset during intoxication, With onset during withdrawal, With onset after medication use.

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

*Opioid-induced depressive disorder*

*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Opioid-induced anxiety disorder*

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*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Opioid-induced sleep disorder*

Specify whether: Insomnia type, Daytime sleepiness type, and Mixed type

*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Opioid-induced sexual dysfunction*

Specify if: Mild, Moderate, and Severe  
*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Opioid intoxication delirium*

*With mild use disorder*  
*With moderate or severe use disorder*  
*Without use disorder*

*Opioid withdrawal delirium*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Opioid-induced delirium*

*When opioid medication taken as prescribed*

*During withdrawal from opioid medication taken as prescribed*

*Unspecified opioid-related disorder*

## **Sedative-, Hypnotic-, or Anxiolytic-Related Disorders**

These substances are commonly prescribed medications that are used to manage anxiety, promote sleep, or induce relaxation. However, when used inappropriately or excessively, they can lead to negative consequences and potential addiction.

Sedatives: These are substances that have a calming effect and can help reduce anxiety and induce relaxation. They may also be referred to as “tranquilizers.” Common sedatives include benzodiazepines like diazepam (Valium) and lorazepam (Ativan). 226

Hypnotics: Hypnotics are substances that promote sleep. They are often prescribed for individuals with insomnia or sleep disorders. Common hypnotics include medications like zolpidem (Ambien) and eszopiclone (Lunesta).

Anxiolytics: Anxiolytics are substances used to manage anxiety. They help alleviate feelings of anxiety and tension. Benzodiazepines and certain other medications can also fall under this category

*Sedative, hypnotic, or anxiolytic use disorder*

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), Severe (In early remission, In sustained remission)

*Sedative, hypnotic, or anxiolytic intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative, hypnotic, or anxiolytic withdrawal*

*Without perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*With perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

***Sedative-, hypnotic-, or anxiolytic-induced mental disorders***

Specify: With onset during intoxication, With onset during withdrawal, With onset after medication use.

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

*Sedative-, hypnotic-, or anxiolytic-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced bipolar and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced depressive* <sup>227</sup>  
*disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced anxiety disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced sleep disorder*

Specify whether: Insomnia type, Daytime sleepiness type, Parasomnia type, and Mixed type

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced sexual dysfunction*

Specify if: Mild, Moderate, and Severe

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic intoxication delirium*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic withdrawal delirium*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced delirium*

*When sedative, hypnotic, or anxiolytic medication taken as prescribed*

*During withdrawal from sedative, hypnotic, or anxiolytic medication taken as prescribed*

*Sedative-, hypnotic-, or anxiolytic-induced major neurocognitive disorder*

Specify if: Persistent

*With moderate or severe use disorder*

*Without use disorder*

*Sedative-, hypnotic-, or anxiolytic-induced mild <sup>228</sup> neurocognitive disorder*

Specify if: Persistent

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Unspecified sedative-, hypnotic-, or anxiolytic-related disorder*

## **Stimulant-Related Disorders**

Stimulants increase alertness, energy, and focus. They can cause heightened heart rate, increased blood pressure, and intense euphoria.

Short-term effects include increased energy and reduced appetite. Long-term use can lead to cardiovascular issues, anxiety, paranoia, and addiction.

### *Stimulant use disorder*

Specify if: In a controlled environment

Specify current severity/remission: Mild (amphetamine-type substance, cocaine, other or unspecified stimulant), Mild in early remission (amphetamine-type substance, cocaine, other or unspecified stimulant), Mild in sustained remission (amphetamine-type substance, cocaine, other or unspecified stimulant), Moderate (amphetamine-type substance, cocaine, other or unspecified stimulant), Moderate in early remission (amphetamine-type substance, cocaine, other or unspecified stimulant), Moderate in sustained remission (amphetamine-type substance, cocaine, other or unspecified stimulant), Severe (amphetamine-type substance, cocaine, other or unspecified stimulant), Severe in early remission (amphetamine-type substance, cocaine, other or unspecified stimulant), Severe in sustained remission (amphetamine-type substance, cocaine, other or unspecified stimulant)

### *Stimulant intoxication*

Specify the particular intoxicant

*Without perceptual disturbances*

*Amphetamine-type substance or other stimulant intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cocaine intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*With perceptual disturbances*

*Amphetamine-type substance or other stimulant intoxication*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cocaine intoxication*

*With mild use disorder*

*With moderate or severe use disorder*  
*Without use disorder*

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*Stimulant withdrawal*

Specify the particular substance that causes the withdrawal syndrome

*Amphetamine-type substance or other stimulant withdrawal*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cocaine withdrawal*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Stimulant-induced mental disorders*

Specify: With onset during intoxication, With onset during withdrawal, With onset after medication use

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

*Amphetamine-type substance (or other stimulant)-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cocaine-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Amphetamine-type substance (or other stimulant)-induced bipolar and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cocaine-induced bipolar and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type substance (or other stimulant)-induced depressive disorder**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Cocaine-induced depressive disorder**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type substance (or other stimulant)-induced <sup>230</sup> anxiety disorder**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Cocaine-induced anxiety disorder**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type substance (or other stimulant)-induced obsessive-compulsive and related disorder**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Cocaine-induced obsessive-compulsive and related disorder**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type substance (or other stimulant)-induced sleep disorder**

Specify whether: Insomnia type, Daytime sleepiness type, and Mixed type

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Cocaine-induced sleep disorder**

Specify whether: Insomnia type, Daytime sleepiness type, and Mixed type

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type substance (or other stimulant-induced sexual dysfunction)**

Specify if: Mild, Moderate, and Severe

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Cocaine-induced sexual dysfunction**

Specify if: Mild, Moderate, and Severe

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type substance (or other stimulant) intoxication delirium**

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Cocaine intoxication delirium**

231

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

**Amphetamine-type (or other stimulant) medication-induced delirium**

**Amphetamine-type substance (or other stimulant)-induced mild neurocognitive disorder**

Specify if: Persistent

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Cocaine-induced mild neurocognitive disorder*

Specify if: Persistent

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Unspecified stimulant-related disorder*

*Amphetamine-type substance or other stimulant*

*Cocaine*

## **Tobacco-Related Disorders**

Tobacco products, which contain nicotine, are stimulants. Nicotine causes a quick release of adrenaline, leading to increased heart rate, increased blood pressure, and a sense of alertness. Regular use can lead to addiction and long-term health issues, including respiratory problems and various forms of cancer.

*Tobacco use disorder*

Specify if: On maintenance therapy, In a controlled environment

Specify current severity/remission: Mild, Moderate (In early remission, In sustained remission), and Severe (In early remission, In sustained remission)

*Tobacco withdrawal*

*Tobacco-induced mental disorders*

*Tobacco-induced sleep disorder, With moderate or severe use disorder*

Specify whether: Insomnia type, Daytime sleepiness type, and Mixed type

Specify: With onset during withdrawal, With onset after medication use

*Unspecified tobacco-related disorder*

## **Other (or Unknown) Substance-Related Disorders**

*Other (or unknown) substance use disorder*

Specify if: In a controlled environment

Specify current severity/remission: Mild (In early remission, In sustained remission), Moderate (In early remission, In sustained remission), and Severe (In early remission, In sustained remission)

*Other (or unknown) substance intoxication*

*Without perceptual disturbances*

*With mild use disorder*

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*With moderate or severe use disorder*

*Without use disorder*

*With perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance withdrawal*

*Without perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*With perceptual disturbances*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced mental disorders*

Specify: With onset during intoxication, With onset during withdrawal, With onset after medication use

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

*Other (or unknown) substance-induced psychotic disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced bipolar and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced depressive disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced anxiety disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced obsessive-compulsive and related disorder*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced sleep disorder*

Specify whether: Insomnia type, Daytime sleepiness type, Parasomnia type, and Mixed type

*With mild use disorder*

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*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced sexual dysfunction*

Specify if: Mild, Moderate, and Severe

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance intoxication delirium*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance withdrawal delirium*

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) medication-induced delirium*

*When other (or unknown) medication taken as prescribed*

*During withdrawal from other (or unknown) medication taken as prescribed*

*Other (or unknown) substance-induced major neurocognitive disorder*

Specify if: Persistent

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Other (or unknown) substance-induced mild neurocognitive disorder*

Specify if: Persistent

*With mild use disorder*

*With moderate or severe use disorder*

*Without use disorder*

*Unspecified other (or unknown) substance-related disorder*

## **Non-Substance-Related Disorders**

*Gambling disorder*

Specify if: Episodic, Persistent

Specify if: In early remission, In sustained remission

Specify current severity: Mild, Moderate, and Severe

## **Neurocognitive Disorders**

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Neurocognitive disorders refer to a group of conditions characterized by a significant decline in cognitive functioning (thinking abilities, memory, reasoning, perception, and more) that goes beyond what might be expected due to normal aging. These disorders reflect impairments that impact a person's ability to perform everyday activities independently.

*Delirium*

Specify if: Acute, Persistent

Specify if: Hyperactive, Hypoactive, and Mixed level of activity

Specify whether: Substance intoxication delirium; Substance withdrawal delirium; Medication-induced delirium

*Delirium due to another medical condition*

*Delirium due to multiple etiologies*

*Other specified delirium*

*Unspecified delirium*

## ***Major and Mild Neurocognitive Disorders***

Specify whether due to (any of the following medical etiologies): Alzheimer's disease, frontotemporal degeneration, lewy body disease, vascular disease, traumatic brain injury, substance/medication use, HIV infection, prion disease, Parkinson's disease, Huntington's disease, another medical condition, multiple etiologies, unspecified etiology

Specify current severity: Mild, Moderate, and Severe. This specifier applies only to major neurocognitive disorders (including probable and possible).

Specify: Without behavioral disturbance, With behavioral disturbance. For all mild neurocognitive disorders, substance/medication-induced major neurocognitive disorder, and unspecified neurocognitive disorder, behavioral disturbance cannot be coded but should still be recorded.

*Major or mild neurocognitive disorder due to Alzheimer's disease*

*Major neurocognitive disorder due to probable Alzheimer's disease*

*With behavioral disturbance*

*Without behavioral disturbance*

*Major neurocognitive disorder due to possible Alzheimer's disease*

*With behavioral disturbance*

*Without behavioral disturbance*

*Mild neurocognitive disorder due to Alzheimer's disease*

*Major or mild frontotemporal neurocognitive disorder*

*Major neurocognitive disorder due to probable frontotemporal degeneration*

*With behavioral disturbance*

*Without behavioral disturbance*

*Major neurocognitive disorder due to possible frontotemporal degeneration*

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*With behavioral disturbance*  
*Without behavioral disturbance*  
*Mild neurocognitive disorder due to frontotemporal degeneration*

*Major or mild neurocognitive disorder with Lewy bodies*  
*Major neurocognitive disorder with probable Lewy bodies*  
    *With behavioral disturbance*  
    *Without behavioral disturbance*  
*Major neurocognitive disorder with possible Lewy bodies*  
    *With behavioral disturbance*  
    *Without behavioral disturbance*  
*Mild neurocognitive disorder with Lewy bodies*

*Major or mild vascular neurocognitive disorder*  
*Major neurocognitive disorder probably due to vascular disease*  
    *With behavioral disturbance*  
    *Without behavioral disturbance*  
*Major neurocognitive disorder possibly due to vascular disease*  
    *With behavioral disturbance*  
    *Without behavioral disturbance*  
*Mild neurocognitive disorder due to vascular disease*

*Major or mild neurocognitive disorder due to traumatic brain injury*  
*Major neurocognitive disorder due to traumatic brain injury*  
    *With behavioral disturbance*  
    *Without behavioral disturbance*  
*Mild neurocognitive disorder due to traumatic brain injury*

*Substance/medication-induced major or mild neurocognitive disorder*  
Specify if: Persistent  
*Substance/medication-induced major neurocognitive disorder*  
*Substance/medication-induced mild neurocognitive disorder*

*Major or mild neurocognitive disorder due to HIV infection*  
*Major neurocognitive disorder due to HIV infection*  
    *With behavioral disturbance*  
    *Without behavioral disturbance*  
*Mild neurocognitive disorder due to HIV infection*

*Major or mild neurocognitive disorder due to prion disease*

*Major neurocognitive disorder due to prion disease*

*With behavioral disturbance*

*Without behavioral disturbance*

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*Mild neurocognitive disorder due to prion disease*

*Major or mild neurocognitive disorder due to Parkinson's disease*

*Major neurocognitive disorder probably due to Parkinson's disease*

*With behavioral disturbance*

*Without behavioral disturbance*

*Major neurocognitive disorder possibly due to Parkinson's disease*

*With behavioral disturbance*

*Without behavioral disturbance*

*Mild neurocognitive disorder due to Parkinson's disease*

*Major or mild neurocognitive disorder due to Huntington's disease*

*Major neurocognitive disorder due to Huntington's disease*

*With behavioral disturbance*

*Without behavioral disturbance*

*Mild neurocognitive disorder due to Huntington's disease*

*Major or mild neurocognitive disorder due to another medical condition*

*Major neurocognitive disorder due to another medical condition*

*With behavioral disturbance*

*Without behavioral disturbance*

*Mild neurocognitive disorder due to another medical condition*

*Major or mild neurocognitive disorder due to multiple etiologies*

*Major neurocognitive disorder due to multiple etiologies*

*With behavioral disturbance*

*Without behavioral disturbance*

*Mild neurocognitive disorder due to multiple etiologies*

*Unspecified neurocognitive disorder*

## **Personality Disorders**

Each personality disorder involves a distinct pattern of thinking, feeling, and behaving that differs from societal norms and causes significant impairment in daily life.

### **Cluster A Personality Disorders**

*Paranoid personality disorder*—a pattern of distrust and suspicion of others, interpreting their motives as malevolent, without justification

*Schizoid personality disorder*—detachment from social relationships,<sup>237</sup> limited emotional expression, and preference for solitary activities

*Schizotypal personality disorder*—eccentric behavior, odd beliefs or magical thinking, and discomfort with close relationships, along with perceptual distortions

### ***Cluster B Personality Disorders***

*Antisocial personality disorder*—disregard for others' rights, lack of empathy, manipulative behavior, impulsivity, and a history of conduct problems

*Borderline personality disorder*—instability in relationships, self-image, and emotions, marked by impulsivity, self-destructive behavior, and intense fear of abandonment

*Histrionic personality disorder*—attention-seeking behavior, strong emotions, and exaggerated expressions, often seeking reassurance and approval

*Narcissistic personality disorder*—grandiosity, a need for admiration, lack of empathy, and a sense of entitlement

### ***Cluster C Personality Disorders***

*Avoidant personality disorder*—extreme social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, leading to avoidance of social interactions

*Dependent personality disorder*—excessive need to be cared for, submissive behavior, fear of separation, and difficulty making decisions independently

*Obsessive-compulsive personality disorder*—preoccupation with orderliness, perfectionism, and control, often at the expense of flexibility and interpersonal relationships

### ***Other Personality Disorders***

*Personality change due to another medical condition*

Specify whether: Labile type, Disinhibited type, Aggressive type, Apathetic type, Paranoid type, Other type, Combined type,

### **Unspecified type**

*Other specified personality disorder*—traits of one or more personality disorders that do not align with any specific category but cause significant distress or impairment

*Unspecified personality disorder*—when personality traits cause distress or impairment but do not fit the criteria for any specific personality disorder

## ***Paraphilic Disorders***

Paraphilic disorders refer to a group of mental health conditions characterized by atypical sexual interests or behaviors that are outside the cultural norm and may cause distress, impairment, or harm to oneself or others. These disorders involve recurrent and intense sexual fantasies, urges, or behaviors that center around non-human objects, non-consenting individuals, suffering or humiliation, or other unconventional preferences. Not all unconventional sexual interests are considered disorders; only those that lead to distress, impairment, or harm are diagnosed as paraphilic disorders.

The following specifier applies to paraphilic disorders where indicated:

Specify if: In a controlled environment, In full remission

### *Voyeuristic disorder*

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Arousal is derived from secretly observing others undressing or engaging in sexual activities without their knowledge or consent.

### *Exhibitionistic disorder*

Arousal is achieved through exposing one's genitals to others without their consent, often seeking reactions or shock.

Specify whether: Sexually aroused by exposing genitals to prepubertal children, Sexually aroused by exposing genitals to physically mature individuals, Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals

### *Frotteuristic disorder*

Arousal is obtained from touching or rubbing against non-consenting individuals in crowded situations.

### *Sexual masochism disorder*

Arousal is linked to experiencing pain, humiliation, or suffering during sexual activities.

Specify if: With asphyxiophilia

*Sexual sadism disorder*

Arousal is derived from inflicting pain, humiliation, or suffering on others during sexual activities.

*Pedophilic disorder*

Sexual attraction is directed toward prepubescent children.

Specify whether: Exclusive type, Nonexclusive type

Specify if: Sexually attracted to males, Sexually attracted to females,

Sexually attracted to both

Specify if: Limited to incest

*Fetishistic disorder*

Arousal is achieved from non-human objects or specific body parts that are not typically sexual.

Specify: Body part(s), Nonliving object(s), Other

*Transvestic disorder*

Arousal is gained from cross-dressing, mainly in males, which causes distress or impairment.

Specify if: With fetishism, With autogynephilia

*Other specified paraphilic disorder*

Atypical sexual interests cause distress but don't fit established categories.

*Unspecified paraphilic disorder*

Distressful sexual interests don't meet criteria for specific paraphilic disorders.

## **Medication-Induced Movement Disorders and Other Adverse Effects of Medication**

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These are involuntary and abnormal movements, like tardive dyskinesia or akathisia, triggered by certain medications, often antipsychotics.

*Medication-induced parkinsonism*

*Antipsychotic medication—and other dopamine receptor blocking agent-induced parkinsonism*  
*Other medication-induced parkinsonism*

*Neuroleptic malignant syndrome*

*Medication-induced acute dystonia*

*Medication-induced acute akathisia*

*Tardive dyskinesia*

*Tardive dystonia*

*Tardive akathisia*

*Medication-induced postural tremor*

*Other medication-induced movement disorder*

*Antidepressant discontinuation syndrome*

*Initial encounter*

*Subsequent encounter*

*Sequelae*

*Other adverse effect of medication*

*Initial encounter*

*Subsequent encounter*

*Sequelae*

## **THE INDICATORS OF MENTAL AND EMOTIONAL ILLNESS THROUGHOUT THE LIFESPAN**

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Psychopathology refers to either the study of mental illness or the manifestation of behaviors that may be indicative of mental illness or psychological impairment.

In the 16th and 17th centuries, bizarre behavior associated with mental illness was believed to be acts of evil spirits, demons, or the devil. To remedy this, many individuals suffering from mental illness were tortured in an attempt to drive out demons. When the torturous methods failed to

return individuals to sanity, they were typically deemed eternally possessed and were executed.

By the 18th century, mental illness was viewed differently. It was during this time period that “madness” began to be seen as an illness beyond the control of an individual rather than the act of a demon. Because of this, thousands of people were confined to asylums where medical forms of treatment began to be investigated.

Today, the medical model is a driving force in the diagnosing and <sup>240</sup> treatment of psychopathology.

There is a general consensus that psychopathology is influenced by the milieus in which clients are socialized and the cultural experiences to which they have been exposed. The magnitude of cultural influences on psychopathology is not fully known. Certainly definitions of aberrant behavior vary between cultural groups.

Many different professions, including social work, are involved in studying and/or treating mental illness or psychopathology.

Although the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provides a framework and criteria for applying uniform labels to psychiatric dysfunction, the process of social work assessment and diagnosis is much broader.

Diagnosis refers to the process of identifying problems, with their underlying causes and practical solutions.

A diagnosis is generally obtained after a social worker utilizes information gained through the assessment. Diagnosing includes drawing inferences and reaching conclusions based on the data available. A social worker should not diagnose if adequate information or data is not available.

A social worker must consider biological, psychological, and social factors when identifying the root causes of client problems.

Diagnostic information should always be shared with clients and used to facilitate the establishment of intervention plans.

*Assessment and diagnosis must be a continual part of the problem-solving process.*

The assessment process must focus on client strengths and resources for addressing problems.

There are some terms and concepts that a social worker should be familiar with when making assessments and/or diagnosing.

1. *Comorbid:* existing with or at the same time; for instance, having t

different illnesses at the same time

2. *Contraindicated*: not recommended or safe to use (a medication treatment that is contraindicated would not be prescribed because it could have serious consequences)
3. *Delusion*: false, fixed belief despite evidence to the contrary (believing something that is not true)
4. *Disorientation*: confusion with regard to person, time, or place
5. *Dissociation*: disturbance or change in the usually integrative functions of memory, identity, perception, or consciousness (often seen in clients with a history of trauma)
6. *Endogenous depression*: depression caused by a biochemical imbalance rather than a psychosocial stressor or external factors
7. *Exogenous depression*: depression caused by external events or psychosocial stressors
8. *Folie à deux*: shared delusion
9. *Hallucinations*: hearing, seeing, smelling, or feeling something that is not real (auditory most common)  
*Hypomanic*: elevated, expansive, or <sup>10.</sup> irritable mood that is less severe than full-blown manic symptoms (not severe enough to interfere with functioning and not accompanied by psychotic symptoms)
11. *Postmorbid*: subsequent to the onset of an illness
12. *Premorbid*: prior to the onset of an illness
13. *Psychotic*: experiencing delusions or hallucinations

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## **BIOPSYCHOSOCIAL FACTORS RELATED TO MENTAL HEALTH**

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When a client has a mental health problem or illness, it impacts on all aspects of life, including health, psychological functioning, and socialization. In addition, there are biological, psychological, and social risk factors related to mental health and illness.

It is not possible to understand mental health and the onset or course of mental disorders without knowing about biological, psychological, and social factors and how they interact across the lifespan.

## **Biological Factors**

There is clear evidence to support the role that genes play as a factor in the development of psychiatric disorders. New information also keeps emerging about how brain structure and functioning relate to the existence of mental disorders. It is thought that brain growth in utero or early life can be affected by exposure to adverse factors, leading to changes in brain structure that increase the risk of development of particular mental disorders.

For example, some mental illnesses have been linked to *biological* factors, such as abnormal brain functioning, and medication/procedures can assist in improving the brain to operate more efficiently. Injury and/or abnormal development to certain areas of the brain have also been linked to some mental conditions.

Mental illnesses can also be present in families, suggesting that those who have family members with them may be somewhat more susceptible to their development. Such susceptibility does not mean that mental illnesses will occur, only that there is a greater likelihood. Lastly, certain infections have been linked to brain damage and the development of mental illness or the worsening of its symptoms. Poor nutrition and exposure to toxins may also exacerbate symptoms and/or be related to the development of mental health problems.

## **Psychological Factors**

Personality, relating to others and reacting to the world, include a wide range of psychological responses to cope with different situations. Psychoanalytic, cognitive, and behavioral theories have all had an influence on how personality is understood, its impact on mental disorders and how it can be influenced in treatment.

*Psychological* trauma suffered as a child, such as emotional, physical, or sexual abuse; loss of a caregiver; neglect; or poor ability to relate to others, also adversely impacts mental health and can place individuals at risk, especially those with a biological predisposition.

## **Social Factors**

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Social factors can influence mental health in dramatic ways and it is necessary to investigate social factors thoroughly to fully understand mental health and disorder. Factors such as socioeconomic situation, age, gender, social networks, level of support, life events, migration and culture can all play a role in influencing the onset and course of mental illnesses.

Certain *social* stressors can also trigger mental health problems or the development of mental illness in those who are susceptible to it. These stressors include death, divorce, dysfunctional family life, feelings of inadequacy, low self-esteem, anxiety, anger, loneliness, change in life circumstance, social or cultural expectations, and/or substance use/abuse.

A *social worker must use a systems approach in assessment of client mental health*. A change in one aspect of a client's life—such as loss of a job, diagnosis of a physical illness, and so on—can affect the client's mental health. Conversely, mental health problems can have a dramatic impact on earnings, role fulfillment, friendships and social relationships, and even physical health.

## **BIOPSYCHOSOCIAL RESPONSES TO ILLNESS AND DISABILITY**

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The ways in which clients experience chronic illness or disability are influenced by numerous factors including:

- Personal characteristics (such as gender, race, age, coping style, experience)
- Social and family supports
- Socioeconomic status
- Culture
- Environment (physical, social, and political)
- Activities (restrictions on those related to daily living, work, sc social)
- Personal goals

The responses to illness or disability are dependent on the interplay between these factors. Limitations faced may not be due to the illness or disability, but instead the environment. In addition, societal attitudes may influence their responses with norms focused more on the limitations than on actual functioning.

Clients also vary in terms of their personal resources such as tolerance of symptoms, functional capabilities, coping strategies, and social supports. Consequently, social workers must assess biopsychosocial responses individually. The health condition or disability is only one factor that determines clients' abilities to function effectively.

## **COMMON PSYCHOTROPIC AND NON-PSYCHOTROPIC PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATIONS AND THEIR SIDE EFFECTS**

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Psychotropic medications affect brain chemicals associated with mood and behavior. Psychotropic drugs are prescribed to treat a variety of mental health problems and typically work by changing the amounts <sup>243</sup> of important chemicals in the brain called "neurotransmitters." Psychotropic drugs are usually prescribed by psychiatrists, though other physicians and professionals may be allowed to prescribe them in certain jurisdictions. Psychotropic drugs may be needed to treat disorders such as schizophrenia or bipolar disorder, but are often combined with other supports, such as that from family and friends, therapy, lifestyle changes, and other treatment protocols, to ensure healthy everyday living.

### **Antipsychotics**

Used for the treatment of schizophrenia and mania

#### ***Typical***

Haldol (haloperidol)

Haldol Decanoate (long-acting injectable)

Loxitane (loxapine)

Mellaril (thioridazine)

Moban (molindone)  
Navane (thiothixene)  
Prolixin (fluphenazine)  
Serentil (mesoridazine)  
Stelazine (trifluoperazine)  
Thorazine (chlorpromazine)  
Trilafon (perphenazine)

### **Atypical**

Abilify (aripiprazole)  
Clozaril (clozapine)  
Geodon (ziprasidone)  
Risperdal (risperidone)  
Seroquel (quetiapine)  
Zyprexa (olanzapine)

With Clozaril, there is an increased risk of agranulocytosis that <sup>244</sup> requires blood monitoring.

Some antipsychotics are available in injectable forms; these are useful for clients who are noncompliant with oral medications.

Tardive dyskinesia (abnormal, involuntary movements of the tongue, lips, jaw, and face, as well as twitching and snakelike movement of the extremities and occasionally the trunk) may result from taking high doses of antipsychotic medications over a long period of time. Symptoms may persist indefinitely after discontinuation of these medications. Thus, antipsychotic use should be closely monitored and prescribed at low doses if possible.

### **Antimanic Agents (Mood Stabilizers)**

Used for the treatment of bipolar disorder

Depakene (valproic acid, divalproex sodium), Depakote sprinkles

Lamictal (lamotrigine)

Lithium (lithium carbonate), Eskalith, Lithobid

Tegretol (carbamazepine), Carbatrol

Topamax (topiramate)

There is a small difference between toxic and therapeutic levels (narrow therapeutic index) that necessitates periodic checks of blood levels of lithium. Also, there is a need for periodic checks of thyroid and kidney functions, because lithium can affect the functioning of these organs.

## **Antidepressants**

Used for the treatment of depressive disorders

### **Selective Serotonin Reuptake Inhibitors (SSRIs)**

Celexa (citalopram)

Lexapro (escitalopram)

Luvox (fluvoxamine)

Paxil (paroxetine)

Prozac (fluoxetine)

Zoloft (sertraline)

### **Tricyclics**

Anafranil (clomipramine)

Asendin (amoxapine)

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Elavil (amitriptyline)  
Norpramin (desipramine)  
Pamelor (nortriptyline)  
Sinequan (doxepin)  
Surmontil (trimipramine)  
Tofranil (imipramine)  
Vivactil (protriptyline)

### ***Monoamine Oxidase Inhibitors (MAOIs)***

Nardil (phenelzine)  
Parnate (tranylcypromine)

There are dietary restrictions of foods that contain high levels of tyramine (generally food that has been aged). Foods to avoid may include beer, ale, wine (particularly Chianti), cheese (except cottage and cream cheese), smoked or pickled fish (herring), beef or chicken liver, summer (dry) sausage, fava or broad bean pods (Italian green beans), and yeast vitamin supplements (brewer's yeast).

### ***Others***

Desyrel (trazodone)  
Effexor (venlafaxine)  
Remeron (mirtazapine)  
Serzone (nefazodone)  
Wellbutrin (bupropion)

### ***Antianxiety Drugs***

Used for the treatment of anxiety disorders

Ativan (lorazepam)

Buspar (buspirone)

Klonopin (clonazepam)

Valium (diazepam)

Xanax (alprazolam)

**Benzodiazepines** are a class of drugs primarily used for treating anxiety, but they also are effective in treating several other conditions.

There is a high abuse potential of these drugs and they can be dangerous when combined with alcohol or illicit substances. It is critical to look for signs of impaired motor or other functioning.

## Stimulants

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Used for the treatment of attention-deficit/hyperactivity disorder

Adderall (amphetamine, mixed salts)

Concerta (methylphenidate, long acting)

Dexedrine (dextroamphetamine)

Dexedrine Spansules (dextroamphetamine, long acting)

Metadate (methylphenidate, long acting)

Ritalin (methylphenidate)

## Common Prescription Medications

Many people take at least one prescription medication, with more than half taking two or more. The most commonly prescribed include the following medications.

*Advair Diskus* is a prescription used to treat asthma and chronic obstructive pulmonary disease (COPD).

*Crestor* is a lipid-lowering agent taken orally.

*Cymbalta* is a selective serotonin and norepinephrine reuptake inhibitor (SSNRI) for oral administration used to treat depression, anxiety, and pain caused by nerve damage.

*Diovan* is used to treat heart disease or heart failure.

*Hydrocodone/acetaminophen* is the most popular painkiller used to treat moderate to severe pain. Hydrocodone, a narcotic analgesic, relieves pain through the central nervous system, and it also is used to stop or prevent coughing. This drug can become habit-forming when used over an extended period of time.

*Levothyroxine sodium* is used to treat hypothyroidism, a condition where the thyroid gland does not produce enough of the thyroid hormone. This drug also is used to treat thyroid cancer and to help shrink an enlarged thyroid gland.

*Lantus* is a sterile solution of insulin glargine for use as a subcutaneous injection for diabetes.

*Lisinopril* (which used to be sold under the brand names Zestril and Prinivil) is a high blood pressure medication. Its main function is to block chemicals in the body that trigger the tightening of blood vessels. Lisinopril also is used to help treat heart failure.

*Lyrica* is used to control seizures, as well as treat nerve pain and fibromyalgia.

*Metoprolol*, the generic version of Lopressor, is used to treat high blood pressure and also helps reduce the risk of repeated heart attacks. Metoprolol also treats heart failure and heart pain or angina.

*Nexium* is used to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions involving excessive stomach acid.

*Simvastatin* (generic form of Zocor) is prescribed to treat high cholesterol and is typically recommended in conjunction with diet changes. This drug is believed to have a variety of benefits including helping to prevent heart attacks and strokes.

*Synthroid* is a prescription, man-made thyroid hormone that is used to treat hypothyroidism.

*Ventolin* solution is used in inhalers for asthma.

*Vyvanse* is used to treat hyperactivity and impulse control disorders.

## **THE INDICATORS OF SOMATIZATION**

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Somatization is the unconscious process by which psychological distress is expressed as physical symptoms. Somatic symptoms often occur as

reactions to stressful situations and are not considered abnormal if they occur sporadically. However, some clients experience continuing somatic symptoms and even seek medical care for them.

Persistent somatization is associated with considerable distress and disability. Somatization may lead to overutilization of medical care, including unnecessary medical tests, and even increased hospitalization rates.

Not all somatizing clients are motivated by an unconscious wish to adopt the sick role, as is observed in clients with factitious disorder. Clients may vary in their degree of conviction that their symptoms are caused by a physical illness or disease. Clients may also present in multiple ways, including having multiple unexplained somatic symptoms, exhibiting predominantly illness worry or hypochondriacal beliefs, and/or displaying somatization as a manifestation of a variety of mental disorders.

## **THE INDICATORS OF FEIGNING ILLNESS**

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Malingering is not considered a mental illness. Malingering is a condition that requires clinical attention. The *DSM* defines malingering as intentionally falsely or grossly exaggerating physical or psychological problems. Motivation for malingering is usually external, such as avoiding work/military, obtaining reward (financial resources, medications, etc.), avoiding legal action, and so on. On the other hand, malingering also may be an adaptive response such as an inmate with mental illness trying to obtain relatively sparse and difficult-to-obtain mental health resources in prison.

Malingering varies in intensity, from all symptoms being falsified to some symptoms being falsified or symptoms being exaggerated. Malingering is not easy to diagnose because of the difficulty in gathering external evidence.

Prolonged direct observation can reveal evidence of malingering because it is difficult for a client who is malingering to maintain consistency with the false or exaggerated claims for extended periods. Malingering can be detected by discrepancies between the claimed distress and the objective findings or lack of cooperation during evaluation and in complying with prescribed treatment. Clues may be reports of rare or improbable symptoms. Rare symptoms—by definition—occur very infrequently, and clients almost never report improbable

symptoms. In addition, social workers should watch closely for internal or external inconsistent presentation of symptoms. Often diagnosis comes as a result of the use of collateral data beyond the social work interview.

Malingering is different from factitious disorder (in which the motive is the desire to occupy a sick role, rather than some form of material gain) and somatic symptom and related disorders (in which symptoms are not produced willfully).

Three categories of malingering are:

- Pure malingering (feigning a nonexistent disorder)
- Partial malingering (consciously exaggerating real symptoms)
- False imputation (ascribing real symptoms to a cause a client knows unrelated to the symptoms)

## BASIC MEDICAL TERMINOLOGY

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Social workers must recognize the relationship between physical well-being and mental status. Social workers should always rule out medical etiology before making psychiatric diagnoses. A **differential diagnosis** is a systematic diagnostic method used to identify the presence of an entity where multiple alternatives are possible.

Social workers must know the major body systems and medical conditions associated with them that can affect psychological functioning and mood.

### 1. Circulatory System

The circulatory system is the body's transport system. It is made up of a group of organs that transport blood throughout the body. The heart pumps the blood and the arteries and veins transport it.

### 2. Digestive System

The digestive system is made up of organs that break down food into protein, vitamins, minerals, carbohydrates, and fats, which the body needs for energy, growth, and repair.

### 3. Endocrine System

The endocrine system is made up of a group of glands that produce the body's long-distance messengers, or hormones.

Hormones are chemicals that control body functions, such as metabolism, growth, and sexual development.

#### *4. Immune System*

The immune system is a body's defense system against infections and diseases. Organs, tissues, cells, and cell products work together to respond to dangerous organisms (like viruses or bacteria) and substances that may enter the body from the environment.

#### *5. Lymphatic System*

The lymphatic system is also a defense system for the body. It filters out organisms that cause disease, produces white blood cells, and generates disease-fighting antibodies. It also distributes fluids and nutrients in the body and drains excess fluids and protein so that tissues do not swell.

#### *6. Muscular System*

The muscular system is made up of tissues that work with the skeletal system to control movement of the body. Some muscles—like those in arms and legs—are voluntary, meaning that an individual decides when to move them. Other muscles, like the ones in the stomach, heart, intestines, and other organs, are involuntary. This means that they are controlled automatically by the nervous system and hormones—one often does not realize they are at work.

#### *7. Nervous System*

The nervous system is made up of the brain, the spinal cord, and nerves. One of the most important systems in the body, the nervous system is the body's control system. It sends, receives, and processes nerve impulses throughout the body. These nerve impulses tell muscles and organs what to do and how to respond to the environment.

#### *Reproductive System*

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The reproductive system allows humans to produce children. Sperm from the male fertilizes the female's egg, or ovum, in the fallopian tube. The fertilized egg travels from the fallopian tube to the uterus, where the fetus develops over a period of 9 months.

#### *9. Respiratory System*

The respiratory system brings air into the body and removes carbon dioxide. It includes the nose, trachea, and lungs.

#### 10. *Skeletal System*

The skeletal system is made up of bones, ligaments, and tendons. It shapes the body and protects organs. The skeletal system works with the muscular system to help the body move.

#### 11. *Urinary System*

The urinary system eliminates waste from the body in the form of urine. The kidneys remove waste from the blood. The waste combines with water to form urine.

### **THE INDICATORS OF BEHAVIORAL DYSFUNCTION**

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“Normal” and “abnormal” depend on the person, place, and situation, and are largely shaped by social standards. Definitions of “normal” change with societal standards and norms. Normality is often viewed as good, whereas abnormality is seen as bad. When people do not conform to what is perceived as “normal,” they are often given a number of negative labels, including unusual, sick, or disabled. These labels can lead to that individual being marginalized, or stigmatized.

The most comprehensive attempt to distinguish normality from abnormality is the *DSM*. The *DSM* shows how normality has changed throughout history and how it often involves value judgments. The *DSM* explicitly distinguishes mental disorders and nondisordered conditions.

### **PLACEMENT OPTIONS BASED ON ASSESSED LEVEL OF CARE**

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Social workers must assess the client’s needed level of care, with the belief that there should be a continuum of intensity depending upon the level of crisis. Clients should enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed. An effective continuum of care features successful transfer of a client between levels of care.

Levels of care for behavioral health services, for example, vary from early intervention services/outpatient services to intensive outpatient/partial hospitalization to residential/inpatient services.

Early intervention or outpatient services are appropriate unless a client is experiencing crisis or at risk for residential/inpatient services, which may then warrant a step up to intensive outpatient or partial hospitalization. The goal is to serve clients in the least restrictive environment, while ensuring health and safety.

## **METHODS TO ASSESS ORGANIZATIONAL FUNCTIONING 250 (E.G., AGENCY ASSESSMENTS)**

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There are many ways to measure the functioning and effectiveness of organizations. For example, the functioning can be analyzed related to productivity, turnover, stability, cohesion, and so on. Usually, functioning is assessed as it relates to organizational structures, processes, and outcomes.

Structural indicators influence the capacity of the organization for effective performance. Assessments aimed at organizational structure evaluate organizational features, such as training, equipment, office space, and so on or worker characteristics including degrees attained and licenses held. Structural characteristics form the basis for accreditation reviews and licensing. When an organization is not operating efficiently or effectively, a review of the available structural resources is often completed to determine the extent to which they may be responsible for the problems.

Evaluations of organizational processes assess effort rather than effect. Formative evaluations look at how the work gets done in organizations and the satisfaction of those doing the work, rather than the ultimate outcomes or performance. Given that the majority of social work services are delivered in organizations with complex structures, it is essential to determine the extent to which processes inhibit or promote quality outcomes.

Outcomes assessment determines the extent to which tangible, defined differences have been made. Though essential, these assessments can be difficult to make due to threats to internal validity.

The complexity of organizational assessments varies widely. They can be as simple as asking stakeholders for feedback on how the organization is operating or can involve intensive, structured work plans, information collection and analyses, and reporting. Typically this complexity is driven by financial and time constraints and the degree to

which there is concern about the organization's performance and effectiveness.

## **DATA COLLECTION AND ANALYSIS METHODS**

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Qualitative research usually involves collecting information through unstructured interviews, observation, and/or focus groups. Data can be collected from a single individual at a time or multiple people in group settings. Qualitative data collection methods are usually very time consuming, so they are confined to smaller samples than usually found in quantitative approaches. Quantitative research mainly collects data through the input of responses to research instruments containing questions (i.e., such as questionnaires). Information can be input either by the respondents themselves (e.g., online or mail survey) or social workers can input data (e.g., phone surveys or interviews). Methods for distributing surveys are via postal mail, phone, website, or in person. However, newer technologies have created additional delivery options, including through wireless devices such as smartphones.

Social workers can also do research using secondary data, which is information that has already been collected for other purposes. Use of existing data is efficient since time and money associated with data collection are spared. However, the completeness of existing data, as well as its reliability, may be a concern as sound research practices <sup>251</sup> covering its collection may not have been used.

Data analysis procedures begin with preparation that involves cleaning the data, checking it for accuracy, coding it for analysis, developing a database, and entering the data into the computer.

Once entered into the computer, *descriptive statistics* are used to describe the basic features of the data. They provide simple summaries about the sample and the measures. Together with simple graphics analysis, they form the basis of virtually every quantitative analysis of data. Descriptive statistics describe what the data shows.

*Inferential statistics* are used to answer research questions or test models or hypotheses. In many cases, the conclusions from inferential statistics extend beyond the immediate data. For instance, inferential statistics determine the probability that an observed difference between groups is a dependable one or one that might have happened by chance.

In most research, analyses include both descriptive and inferential statistics. Social workers must balance the level of detail that is included

in a research report with the need to avoid overwhelming readers and missing the highlighting of major findings. If too much detail is included, readers may not be able to pick out the key results. Analysis details are appropriately relegated to appendices, reserving only the most critical analysis summaries for the body of the report itself.

When reading and interpreting experimental research findings, social workers must be able to identify independent variables (or those that are believed to be causes) and dependent variables (which are the impacts or results). In many studies, the independent variable is the treatment provided and the dependent variable is the target behavior that is trying to be changed.

The reliability and validity of research findings should also be assessed.

*Reliability* (dependability, stability, consistency, predictability): Can you get the same answer repeatedly?

*Validity* (accuracy): Is what is believed to be measured actually being measured or is it something else?

*External validity*: Can the results be generalized?

*Internal validity*: Is there confidence in cause/effect?

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# Treatment Planning

## **METHODS TO INVOLVE CLIENTS/CLIENT SYSTEMS IN INTERVENTION PLANNING**

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The participation of clients in the process of identifying what is important to them now and in the future, and acting upon these priorities, is paramount. Clients' participation in the process will reduce resistance, increase motivation to change, and ensure sustainability of progress made.

In order to involve clients, social workers must continually listen to, learn about, and facilitate opportunities with clients who they are serving. Client involvement should not just occur during intervention planning, but instead during the entire problem-solving process.

The problem-solving process drives intervention planning.

In *engagement*, a social worker should be actively involved with a client in determining why treatment was sought; what has precipitated the desire to change now; the parameters of the helping relationship, including defining the roles of a social worker and client; and the expectations for treatment (what will occur and when it will happen). Client involvement is essential in determining what is important to a client now and in the future.

In *assessment*, a client is the source of providing essential information upon which to define the problem and solutions, as well as identifying collateral contacts from which gaps in data can be collected.

In *planning*, a client and social worker must develop a common understanding of a client's preferred lifestyle. Goals are developed from this common understanding in order to provide a direction to help a client move toward this lifestyle. Specific action plans are developed and

agreed upon in order to specify who will do what, what and how resources will be needed and used, and timelines for implementation and review.

In planning, a social worker and client should be:

1. Defining the problem (in a well-defined, clear, and data-driven form)
2. Examining the causes of the problem and how it relates to other positive/negative aspects of a client's life
3. Generating possible solutions that will impact on the problem
4. Identifying the driving and restraining forces related to the implementation of each of the possible solutions
5. Rating the driving and restraining forces related to consistency and potency
6. Prioritizing these solutions based on these ratings
7. Developing SMART objectives—Specific, Measurable, Achievable, Relevant, and Time-specific—related to the chosen solutions
8. Creating strategies and activities related to the objectives

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In *intervention*, a client must be actively involved in mobilizing a support network to realize continued progress and sustainable change. A client must bring to the attention of a social worker issues that arise which may threaten goal attainment. Progress, based upon client reports, must be tracked and plans/timelines adjusted accordingly.

In *evaluation*, subjective reports of a client, in conjunction with objective indicators of progress, should be used to determine when goals or objectives have been met and whether new goals or objectives should be set. Client self-monitoring is a good way to involve a client so the client can see and track progress.

In *termination*, a client should reflect on what has been achieved and anticipate what supports are in place if problems arise again. Although this is the last phase of the problem-solving process, it still requires active involvement by both a social worker and client.

## CULTURAL CONSIDERATIONS IN THE CREATION OF AN INTERVENTION PLAN

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It is essential that a social worker factor cultural considerations into treatment or intervention planning. These considerations should include the identification of cross-cultural barriers, which may hinder a client's engagement and/or progress in treatment.

Social workers also have an ethical mandate to take information learned when working with individual clients and adapt agency resources to meet others who may also have similar cultural considerations and/or language assistance needs.

Social workers who provide electronic social work services must be aware of cultural and socioeconomic differences among clients and how they may use electronic technology. Social workers should assess all issues (cultural, environmental, economic, mental or physical ability, and linguistic) that may affect the delivery or use of these services.

A social worker should understand and validate each client's cultural norms, beliefs, and values. Areas in treatment or intervention planning that can be greatly influenced by cultural factors include identification of client strengths and problems, goals and objectives, and modalities of treatment.

For example, a client's culture can provide the client with strengths that can be brought to the intervention process. These strengths can include, but are not limited to:

- Supportive family and community relations
- Community and cultural events and activities
  - Faith and spiritual or religious beliefs
- Multilingual capabilities
- Healing practices and beliefs
- Participation in rituals (religious, cultural, familial, spiritual community)
- Dreams and aspirations

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A culturally informed intervention plan must be based on a therapeutic relationship in which a client feels safe to explore problems

within the client's cultural context.

Intervention will be most effective when it is consistent with a consumer's culture. A social worker should consider the following given their cultural appropriateness:

- Individual versus group treatment
- Alternative treatment approaches (yoga, aromatherapy, music writing)
- Medication (western, traditional, and/or alternative)
- Family involvement
- Location/duration of intervention

Different cultures and communities exhibit or explain symptoms in various ways. Because of this, it is important for social workers to be aware of relevant contextual information stemming from clients' cultures, races, ethnicities, religious affiliations, and/or geographical origins so social workers can more accurately diagnose client problems, as well as more effectively treat them.

*The Cultural Formulation Interview Guide* is included in the *DSM* to help social workers assess cultural factors influencing clients' perspectives of their symptoms and treatment options. It includes questions about clients' backgrounds in terms of their culture, race, ethnicity, religion, or geographical origin. Use of this tool provides an opportunity for clients to define their distress in their own words and then relate this distress to how others, who may not share their culture, see their problems.

## **THE CRITERIA USED IN THE SELECTION OF INTERVENTION/TREATMENT MODALITIES (E.G., CLIENT/CLIENT SYSTEM ABILITIES, CULTURE, LIFE STAGE)**

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Social workers are employed in different settings, such as hospitals, mental health centers, child welfare agencies, schools, and correctional facilities. In addition, clients within these settings have different needs or problems. The types of interventions or treatments used by social

workers are strongly influenced by both practice settings and the needs or problems of clients.

Social work interventions/treatments must be selected based upon the biopsychosocial–spiritual–cultural assessments of clients, which include the strengths that they possess, as well as the identification of feasible and desired outcomes within these larger service contexts.

There are diverse intervention or treatment models within <sup>256</sup> gerontology, behavioral health, child welfare, and so forth. Interventions include those at the micro, mezzo, and macro levels. Micro interventions include, but are not limited to, the provision of therapy, case management, education, and/or crisis intervention. Macro interventions include advocacy and organizing.

In all instances, social workers should work in partnership with clients to select and reevaluate choices related to the selection of intervention or treatment approaches. Social workers should also keep abreast of research done on the effectiveness of these strategies and select those that are evidence based.

A social worker develops an intervention plan by consulting the relevant practice research and then flexibly implementing an approach to fit a client's needs and circumstances. The intervention plan is driven by the data collected as part of assessment. Assessment is informed by current human behavior and development research that provides key information about how clients behave and research about risk and resilience factors that affect human functioning. These theories inform social workers about what skills, techniques, and strategies must be used by social workers, clients, and others for the purpose of improving well-being. These techniques and strategies are outlined in an intervention plan.

An intervention plan should be reviewed during the intervention, at termination, and, if possible, following the termination of services to make adjustments, ensure progress, and determine the sustainability of change after treatment.

## **THE COMPONENTS OF INTERVENTION, TREATMENT, AND SERVICE PLANS**

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Planning is the bridge between assessment and intervention. It begins with specifying goals that a client hopes to achieve, then identifying what

changes need to be made to achieve the goals, the change strategies needed to reach the goals, and the timelines for completing these actions.

Effective planning is the responsibility of both a social worker and a client. A social worker supports a client while structuring the process, and a client evaluates alternative courses of action. Planning should be based on information collected during the assessment phase.

It is important for a social worker and a client to develop a contract (i.e., an agreement that spells out the activities to be conducted by each, along with a timetable for action). **A contract can be a written, oral, or even implied agreement, although the more specific a contract, the more likely it is to prevent misunderstandings.** A contract should delineate the problems or concerns to be addressed, goals and objectives of the intervention, activities that a client will undertake, tasks to be performed by a social worker, expected duration of the intervention, schedule of time and place for meetings, and/or identification of other persons, agencies, or organizations expected to assist with the change process.

Except in instances in which contracts are written into court orders, contracts are not viewed as legally binding.

Contracts are also known as service agreements/plans, case plans, treatment plans, intervention plans, or individual/family support plans.

The greater the specificity about who will do what, when, and how, the greater the chances of the plan being fully implemented. Contracting is often reassuring to clients because it provides blueprints for change. It also encourages social workers to rethink assumptions and steps, ensuring that all change efforts are unique to individual client situations.

## **THEORIES OF TRAUMA-INFORMED CARE**

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Trauma-informed care organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that

these services and programs can be more supportive and avoid re-traumatization.

Trauma-informed care also can be viewed as an overarching philosophy and approach based on the understanding that many clients have suffered traumatic experiences and providers must be responsible for being sensitive to this issue, regardless of whether clients are being treated specifically for the trauma. Therefore, social workers should initially approach all of their clients as if they have a trauma history, regardless of the services for which the clients are being seen.

It is important for social workers to understand trauma and how it affects people regardless of their diagnoses or identified needs. Thus, in everyday practice, social workers need to recognize how the organizations, programs, and environments in which they practice could potentially act as trauma triggers for their clients; social workers should make every effort to minimize these triggers.

An important component of trauma-informed care is recognizing trauma's centrality to clients and how this plays into their perception of physical and emotional safety, relationships, and behaviors. When trauma goes unrecognized, it can be difficult to understand clients' behaviors or attitudes, and social workers may be tempted to assign unfounded pathologies to clients. Clients even may end up being barred from services as a result of what appears to be bizarre behavior or unfounded beliefs. Often, however, clients' otherwise challenging behavior is provoked by a legitimate trigger that easily could have been avoided.

## **METHODS AND APPROACHES TO TRAUMA-INFORMED CARE**

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Although there are many specific interventions or treatments used with clients who have suffered trauma, they all recognize that there are phases of trauma treatment. However, clients rarely proceed through them in a linear fashion. Social workers' knowledge of these phases should inform the use of specific interventions. For example, if a client is in the safety and stability phase, exposure therapies, which reduce avoidant behaviors and increase exposure to trauma-related material, are not recommended. In addition, classical psychodynamic treatment may be too destabilizing for a client inundated by flashbacks and

intrusive thoughts. Thus, a trauma-informed social worker uses the three-phase model for choosing and using appropriate treatment strategies.

## **Phase 1: Safety and Stabilization**

This initial stage is focused on establishing safety and stability, which must occur for trauma treatment to proceed. For many trauma survivors, basic needs, as described in Maslow's hierarchy of needs, are not being met. Survivors may need housing, food, and/or other essentials. In addition, survivors of complex trauma are often engaged in trauma reenactments in their lives. This means that they are frequently in relationships that are physically and/or emotionally dangerous. They may also be using substances, engaged in self-harm, and/or exhibiting risky or suicidal behaviors.

In this phase, social work interventions include case management to <sup>258</sup> obtain housing, health services, transportation, and other critical supports. Crisis intervention models aimed at developing safety plans and establishing equilibrium or stability are also used. Stabilization focuses on the replacement of problematic and risky coping strategies with others that are nonharmful. At this phase of treatment, interventions that improve clients' capacities to regulate emotion, self-soothe, use relationships appropriately, and/or develop compassion for self are central.

## **Phase 2: Mourning and Remembrance**

The second stage is when survivors acknowledge and speak about what happened and are ready to integrate experiences into a larger life context. This process allows emotional space in which the future can be constructed. Addressing what is and is not remembered is the focus of creating healing stories about the trauma experienced. Psychoeducation can be a very important component of addressing questions about the trauma experience and its effects. Trauma always results in a loss of some kind. Grief for what was, for what never was, and/or for what could have been must be addressed.

## **Phase 3: Reconnection and Reintegration**

The third stage is marked by a commitment to move forward in life, searching for ways to use the trauma experience for empowerment.

Trauma survivors may engage in new activities and/or relationships. A client moves from surviving into a new identity marked by an understanding of the client's history of trauma. Therapeutic strategies include integration of self-care strategies into everyday life and developing deepening resilience.

A good trauma-informed approach is multidimensional. The following list includes several elements that indicate a good, trauma-informed program:

## **Environment of Care**

- Soothing colors for decor and paint
- Overall quiet; soft music
- Neutral or pleasant aroma
- Individual chairs with discrete seating areas
- Individual bathroom options

## **Staff Appearance**

- Attire connotes professionalism; easy to identify staff members
- Clothing not sexually provocative

## **Staff Behavior**

- Clearly demonstrate proper manners and respect
  - Make every effort to minimize delays
- Speak in clear, nonthreatening tones
- Make eye contact
- Smile and demonstrate a generally pleasant demeanor
- Open physical stance, nodding
- Open to change/not rigid

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## **Organizational Understanding**

- Trauma policy/philosophy in place
- Commitment to trauma-informed care articulated
- All staff/clients/family members taught about trauma and its impact
- Universal trauma screenings for all clients
- Trauma status continually assessed
- Clear organization plan for dealing with behavioral crises
- Discrete areas for calming or crisis management identified
- Feedback valued and concerted outreach efforts made

## **Treatment Considerations**

- Treatment goals reflect consumer preferences
- Treatment integrated across disciplines
- Offering choice of treatment provider when possible
- Everyday language used
- All statements of abuse acknowledged and addressed
- Sensitivity to seating configuration and proximity of seating options
- Co-occurring treatment needs assessed and incorporated into services provided
- Culture of origin respected and incorporated into service planning
- Recognize the importance of physical boundaries and aware that touch—sometimes even a handshake—could trigger trauma
- Avoid jokes and stories which can serve as triggers

## **THE IMPACT OF IMMIGRATION, REFUGEE, OR UNDOCUMENTED STATUS ON SERVICE DELIVERY**

Social workers may have a general concept of immigration requirements, but this area of law is both complex and volatile. Laws and policies affecting the status of immigrants have evolved over time in

response to various social, political, and economic pressures. Most recently, immigration policy has had an exclusionary focus that has turned toward conflating criminality and undocumented immigration status. Although immigration laws are within the exclusive purview of the federal government, some states have attempted to address concerns by passing their own measures. This situation creates legal <sup>260</sup> questions and ethical dilemmas for social workers who are employed in programs or areas serving immigrants.

Professional social work standards support immigration and refugee policies that uphold and support equity and human rights, while protecting national security. The social work profession recognizes the challenge of competing claims; however, immigration policies must promote social justice and avoid racism and discrimination or profiling on the basis of race, religion, country of origin, gender, or other grounds. The impact of refugee and immigration policies on families and children have to be closely monitored. Policies that encourage family reunification and ensure that children do not grow up unduly disadvantaged by the immigration status of their parents must be enacted and upheld.

Given the great diversity and myriad needs of the growing immigrant population, it is essential that social workers understand the legal and political, as well as psychological and social, issues surrounding immigration. Undocumented immigrants represent a large and vulnerable population. When conducting individual practice with undocumented immigrants, social workers must be aware of the laws that impact service provision and the unique psychosocial stressors that are experienced by this population.

Numerous immigrant households comprise mixed-status families in which family members hold different legal statuses. Each status carries different benefit entitlements, services, and legal rights.

## **METHODS TO DEVELOP, REVIEW, AND IMPLEMENT CRISIS PLANS**

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A crisis is defined as an acute *disruption of psychological homeostasis (steady state) in which usual coping mechanisms fail* and there exists evidence of distress and functional impairment. The subjective reaction

to a stressful life is a compromised stability and ability to cope or function.

Given such a definition, it is imperative that social workers have a framework or blueprint to guide them in responding. When confronted by clients in crisis, social workers need to address their distress, impairment, and instability by operating in a logical and orderly process. Social workers can easily exacerbate crises with well-intentioned, but haphazard responding. Comprehensive plans allow for responses that are active and directive, but do not take problem ownership away from clients. Finally, plans should meet clients where they are at, assessing their levels of risk, mobilizing client resources, and moving strategically to stabilize the crisis and improve functioning.

The development, review, and implementation of crises plans require actions aimed at crisis stabilization, resolution, and mastery. Social workers should:

1. Plan and conduct a thorough biopsychosocial and lethality/imminent danger assessment.
2. Make psychological contact and rapidly establish the collaborative relationship.
3. Identify the major problems, including crisis precipitants.
4. Encourage an exploration of feelings and emotions.
5. Generate and explore alternatives and new coping strategies.
6. Restore functioning through implementation of an action plan.
7. Plan follow-up and “booster” sessions.

## **DISCHARGE, AFTERCARE, AND FOLLOW-UP PLANNING**

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Discharge may occur for a variety of reasons; for example, a client may have met the goals or no longer needs the services; decides not to continue to receive them from a particular social worker or in general; and/or requires a different level of care. In addition, when a social worker leaves an agency, a client may continue to receive the same service from this agency, but from another worker. Although this is not a

“discharge” from services, there is careful planning and standards that need to be followed to ensure continuity of care and prevent gaps in service.

The *NASW Code of Ethics* provides some guidance with regard to discharge or terminations, as well as aftercare and follow-up services.

Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve client needs or interests (*NASW Code of Ethics—Termination of Services*).

Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary (*NASW Code of Ethics—Termination of Services*).

Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to a client, if a client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with a client (*NASW Code of Ethics—Termination of Services*).

Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client (*NASW Code of Ethics—Termination of Services*).

Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to client needs and preferences (*NASW Code of Ethics—Termination of Services*).

Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options (*NASW Code of Ethics—Termination of Services*).

*It is unethical to continue to treat clients when services are no longer needed or in their best interests.*

Another standard that is relevant to termination of services (*NASW Code of Ethics—Interruption of Services*) mandates that social workers should make reasonable efforts to ensure continuity of services in the

event that services are interrupted by factors such as unavailability, disruptions in electronic communication, relocation, illness, disability, or death.

Social workers must involve clients and their families (when appropriate) in making their own decisions about follow-up services or aftercare. Involvement must include, at a minimum, discussion of client and family preferences (when appropriate).

Social workers are often responsible for coordination of clients' follow-up services, when needed.

A return of clients to services quickly may suggest either that they did not receive needed follow-up services or that these services were inadequate. Termination may have occurred prematurely.

Clients who are at high risk for developing problems after services have ended should receive regular assessments after discharge to determine whether services are needed or discharge plans are being implemented as planned.

## **TECHNIQUES USED TO EVALUATE A CLIENT'S/CLIENT SYSTEM'S PROGRESS** 262

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Evaluating progress is a critical part of the problem-solving process. Examining with a client what has occurred and what still needs to occur involves the client in treatment decisions.

Evaluation methods can be simple or complex. They can rely on quantitative information that shows data on reductions in target behaviors, health care improvements, or psychiatric symptom increases, and/or qualitative information in which a client and/or social worker subjectively report on progress made in various areas.

When evaluating progress, a social worker and client should gather all needed information and identify factors that helped or hindered progress. Goals outlined in the contract/service plan should be modified, if needed, based upon the outcome of the evaluation.

Social workers should assist clients to understand the progress they have made so they can clearly understand and celebrate their accomplishments, as well as identify areas that need attention. This process should ensure that clients understand why progress has happened, as well as include a dialogue about any changes that need to occur in the problem-solving process to facilitate continued growth.

## **METHODS, TECHNIQUES, AND INSTRUMENTS USED TO EVALUATE SOCIAL WORK PRACTICE**

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Social workers have an ethical mandate to ensure that they are providing the most efficient and effective services possible. They also must do no harm and ensure that the intervention provided enhances the well-being of clients.

These goals require the evaluation of practice. Routine practice evaluation by social workers can enhance treatment outcomes and agency decision making, planning, and accountability.

There are two main types of evaluations—formative and summative. Formative evaluations examine the process of delivering services, whereas summative evaluations examine the outcomes.

**Formative evaluations** are ongoing processes that allow for feedback to be implemented during service delivery. These types of evaluations allow social workers to make changes as needed to help achieve program goals. Needs assessments can be viewed as one type of formative evaluation.

**Summative evaluations** occur at the end of services and provide an overall description of their effectiveness. Summative evaluation examines outcomes to determine whether objectives were met. Summative evaluations enable decisions to be made regarding future service directions that cannot be made during implementation. Impact evaluations and cost–benefit analyses are types of summative evaluations.

There are ethical standards that must be followed when evaluating practice (*NASW Code of Ethics—Evaluation and Research*). Some of these guidelines include:

1. Obtaining voluntary and written informed consent from clients, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to <sup>263</sup> participate; and with due regard for participants' well-being, privacy, and dignity
2. Informing clients of their right to withdraw from evaluation and research at any time without penalty
3. Ensuring clients in evaluations have access to appropriate support

services

4. Avoiding conflicts of interest and dual relationships with those being evaluated

## THE PRINCIPLES AND FEATURES OF OBJECTIVE AND SUBJECTIVE DATA

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A social worker uses both objective and subjective data throughout the problem-solving process. For example, in assessment, a social worker must understand the “facts” related to a client’s situation (objective data), but also how those “facts” are perceived by the client through descriptions of feelings, experiences, and perceptions (subjective data). It is not the objective facts that determine whether an event is traumatic, but a subjective emotional experience of the event. Thus, having a client describe the meaning of an event is critically important.

*Treatment plans* are often developed and progress is often assessed based upon objective and subjective data-gathered by a social worker. For example, in health care, a **SOAP format** is often used.

**S (Subjective):** The subjective component is a client’s report of how the client has been doing since the last visit and/or what brought a client into treatment.

**O (Objective):** In health care, the objective component includes vital signs (temperature, blood pressure, pulse, and respiration), documentation of any physical examinations, and results of laboratory tests. In other settings, this section may include other objective indicators of problems such as disorientation, failing school, legal issues, and so forth.

**A (Assessment):** A social worker pulls together the objective and subjective findings and consolidates them into a short assessment.

**P (Plan):** The plan includes what will be done as a consequence of the assessment.

Lastly, in evaluation, subjective reports of a client, in conjunction with objective indicators of progress, should be used to determine when goals or objectives have been met and whether new goals or objectives should be set. Client self-monitoring (subjective data) is a good way to involve a client so the client can see and track progress toward goal attainment.

## **BASIC AND APPLIED RESEARCH DESIGN AND METHODS**

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Social work research needs a design or a structure before data collection or analysis can commence. The function of a research design is to ensure that the evidence or data collected enables the research questions to be answered. Research design is different from the method by which data are collected. Many research methods texts confuse research designs with methods. It is not uncommon to see research design treated as a mode of data collection rather than as a logical structure of the inquiry.

Research design is a blueprint, with the research problem <sup>264</sup> determining the type of design used. The research process will:

1. Identify the research problem clearly and justify its selection.
2. Review previously published literature associated with the problem area.
3. Clearly and explicitly specify hypotheses (i.e., research question central to the problem selected).
4. Effectively describe the data that will be necessary for an adequate test of the hypotheses and explain how such data will be obtained.
5. Describe the methods of analysis that will be applied to the data determining whether or not the hypotheses are true or false.

### **Types of Research**

There are three broad types of research— *experimental*, *quasi-experimental*, and *pre-experimental*. Randomized experiments, also called “experimental,” are the most rigorous. When randomization of subjects or groups is neither practical nor feasible, quasi-experimental approaches can be used. Quasi-experimental research uses intervention and comparison groups, but assignment to the groups is nonrandom. Pre-experimental studies contain intervention groups only and lack comparison/control groups, making them the weakest.

### **Single-Subject Research**

Single-subject research aims to determine whether an intervention has the intended impact on a client, or on many clients who form a group.

The most common single-subject research is *pre- and post-test* or *single-case study* (AB) in which there is a comparison of behavior before treatment (baseline; denoted by an “A”) and behavior after the start of treatment (intervention; denoted by a “B”). The *reversal* or *multiple baseline* (ABA or ABAB) is also commonly used.

In single-subject research, a client is used as the client’s own control. The focus differs from experimental research, which looks at the average effect of an intervention between groups of people.

Single-subject research is ideal for studying the behavioral change a client exhibits as a result of some treatment. When done correctly and carefully, single-subject research can show a causal effect between the intervention and the outcome.

The flexibility, simplicity, and low cost of single-subject research are also beneficial. It can be more flexible and easier to plan because it is usually smaller in scale than experimental research.

Attempts should be made to maximize both internal and external validity.

**Internal validity** addresses the extent to which causal inferences can be made about the intervention and the targeted behavior. **External validity** addresses how generalizable those inferences are to the <sup>265</sup> general population. Due to the small number of study participants, single-subject research tends to have poor external validity, limiting the ability to generalize the findings to a wider audience.

*It is important to remember that, in some cases, it would be unethical to withdraw treatment if clients would be put at risk for harm. Also, in a crisis, treatment would not be delayed in an effort to obtain baseline data.*

## METHODS TO ASSESS RELIABILITY AND VALIDITY IN SOCIAL WORK RESEARCH

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Reliability in social work research concerns the ability to get consistent assessments or data by reducing random errors associated with its collection. There are four main methods to assess reliability.

### ■ *Interrater or Interobserver Reliability*

Assesses the degree to which different raters/observers give consistent estimates of the same phenomenon

- *Test-Retest Reliability*

Assesses the consistency of a measure from one time to another

- *Parallel Forms Reliability*

Assesses the consistency of the results of two tests constructed in the same way from the same content domain

- *Internal Consistency Reliability*

Assesses the consistency of results across items within a test

Validity is the degree to which what is being measured is what is claimed to be measured. It attempts to minimize systematic errors that may yield reliable results but do not actually assess the constructs of interest. There are different means to assess validity.

- *Face Validity*

Examines whether the assessments “on their face” measure the constructs

- *Content Validity*

Examines whether all of the relevant content domains are covered

- *Criterion-Related Validity (including predictive, concurrent, convergent, and discriminant validities)*

Examines whether constructs perform as anticipated in relation to other theoretical constructs

*Predictive validity* assesses whether constructs predict what they should theoretically be able to predict.

*Concurrent validity* assesses whether constructs distinguish <sup>266</sup> between groups that should be able to be distinguished.

*Convergent validity* assesses the degree to which constructs are similar to (converge on) other constructs to which they should be similar.

*Discriminant validity* assesses the degree to which constructs are different from (diverge away from) other constructs to which they should be dissimilar.

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## Content Area II: Practice Questions

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The following section has 51 unique practice questions that assess retention of material related to assessment, diagnosis, and treatment planning. The number of questions reflects the approximate proportion of a typical exam (30%) devoted to this content.

- 1.** Which of the following mental health conditions or states is not typically assessed using the Minnesota Multiphasic Personality Inventory?

  - A.** Paranoia
  - B.** Depression
  - C.** Substance use
- 2.** Which statement **BEST** describes the difference between screening and assessment in social work practice?

  - A.** Screening focuses on determining potential problems that need more thorough assessment aimed at diagnosis and treatment
  - B.** Screening is completed by paraprofessionals while assessment requires skill and expertise associated with education and training
  - C.** Screening consists of asking very structured questions while assessments are less formal
- 3.** A hospital social worker is charged with completing a biopsychosocial–spiritual–cultural assessment on a client upon admission. In the biological section of the assessment, the social worker lists the client's current medications, weight, height, blood pressure, and subjective assessment of well-being. The social worker then moves on to the psychological section of the assessment. Which of the following will **BEST** describe the assessment of the social worker's supervisor with regard to the biological section?

  - A.** Complete because it gives critical information about the

- client's current physical well-being
- B. Useful in understanding the current functioning of the client
  - C. Incomplete because the narrative lacks the client's current medical problems and history

<sup>269</sup> Which of the following is **MOST** commonly used to identify

4. sexual dysfunction?

- A. Client self-reports
- B. Medical screenings
- C. Biopsychosocial assessments

5. When collecting sensitive information in a social work interview, a social worker should:

- A. Ask sensitive questions in the latter part of the interaction
- B. Reiterate limits to confidentiality that may require the release of the sensitive information
- C. Offer the opportunity to provide the sensitive information anonymously

6. Which of the following behaviors is **MOST** likely an indicator of resistance by a client?

- A. Engaging in small talk about irrelevant topics during a session
- B. Limiting the amount of sensitive information communicated during treatment
- C. Arriving late to an initial session after being referred by another person

7. A client who has just been fired from his job is focusing solely on the stress associated with the financial challenges that he is facing. Using a systems approach, the social worker can expect his unemployment to:

- A. Develop resiliency that can be used to deal with other life crises

- B.** Affect other areas of his life such as his physical and mental health
- C.** Result in him being worried about finding another job

<sup>271</sup> **8.** Which of the following medications is **MOST** likely going to be prescribed for the treatment of attention-deficit/hyperactivity disorder?

- A.** Elavil
- B.** Dexedrine
- C.** Tofranil

**9.** In order to meet the mandates imposed by the Tarasoff decision, a social worker would need to:

- A.** Notify authorities about imminent danger likely to be imposed by a client
- B.** Seek inpatient hospitalization if a client displays behavior dangerous to self or others
- C.** Identify risk factors that may be present in a client that will result in dangerousness to others

**10.** Which of the following is **BEST** indicator of low ego strength?

- A.** Viewing challenges as something to avoid
- B.** Finding new ways to deal with struggles
- C.** Using wishful thinking or fantasies

**11.** Which of the following **BEST** describes personality disorders?

- A.** Personality disorders are characterized by distorted patterns of thinking
- B.** Personality disorders are resistant to change despite insight that behaviors are problematic
- C.** Personality disorders are used to adapt to new situations which challenge coping skills

<sup>273</sup> 12. Which of the following is a therapeutic advantage of injectable antipsychotic medications?

- A. Injectable medications reduce medication noncompliance
- B. Injectable medications can be used in addition to oral administration of other medications
- C. Injectable medications are less expensive than oral medications

13. A social worker is delivering services to a client with borderline personality disorder. Based on this diagnosis, which of the following can a social worker expect from the client?

- A. Poor impulse control
- B. Control of aggressive drives
- C. Delusional thinking

14. Which of the following is accurate about risk factors for violence?

- A. Risk factors are present only at the individual level
- B. Risk factors determine who will engage in aggressive acts
- C. Risk factors increase the likelihood that a community will be affected by violence

15. A social worker is reviewing intake paperwork received for a new 65-year-old client. The intake states that the client is currently taking Paxil after being switched from Zoloft. Based on the medications prescribed, which of the following diagnoses is **MOST** appropriate for this client?

- A. Insomnia disorder
- B. Schizoaffective disorder
- C. Major depressive disorder

<sup>275</sup> 16. Which of the following statements is accurate with regard to a diagnosis of conduct disorder?

- A. Symptoms must cause significant impairment in social, academic, or occupational functioning
  - B. Symptoms must occur in childhood, preferably before the age of 12
  - C. At least one symptom must be present in the last 18 months
- 17.** When assessing the global functioning of a client, which of the following tests should be used by a social worker?
- A. Global Assessment of Functioning Scale (GAF)
  - B. World Health Organization Disability Assessment Schedule (WHODAS)
  - C. Thematic Apperception Test
- 18.** According to the *DSM*, which of the following does not need to be present for a client to be diagnosed with gambling disorder?
- A. Lying to conceal gambling
  - B. Loss of relationship, job, or opportunity due to gambling
  - C. Legal problems associated with gambling
- 19.** Which of the following diagnoses is **MOST** likely to be given as the result of mental status examinations?
- A. Delirium
  - B. Oppositional defiant disorder
  - C. Avoidant personality disorder
- 277  
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- A social worker is worried that he does not have all the necessary information to make a practice decision, so he uses multiple sources to collect data. Which of the following approaches to problem solving is the social worker using?  

A. Cooptation  
B. Triangulation

**C. Social exchange**

21. Which of the following systems is affected by tardive dyskinesia, a side effect of taking antipsychotic medications?
- A.** Nervous system
  - B.** Circulatory system
  - C.** Muscular system
22. A client has been prescribed nardil to treat the client's depression. As a result of taking this medication, the client will likely be required to:
- A.** Receive regular blood testing
  - B.** Limit certain foods high in tyramine
  - C.** Get her blood pressure taken frequently
23. Which of the following is a neurotransmitter in the brain that is responsible for maintaining mood balance and depression?
- A.** Serotonin
  - B.** Acetylcholine
  - C.** Ketamine

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A social worker is charged with evaluating the effectiveness of a mental health outpatient treatment program. He constructs an evaluation strategy that consists of collecting data on the quality of services by holding focus groups with current clients so that they can relay their firsthand experiences. In addition, he uses existing agency data to compute the proportion of clients who have been rehospitalized since admission. Which of the following types of evaluation is the the social worker conducting?

- A.** Qualitative
- B.** Quasi-experimental

**C. Mixed method**

25. Which of the following is a protective factor for dangerousness to others?
- A. Violence at an early age  
B. Drug and/or alcohol use  
C. Physical and behavioral care
26. A client reports that he was just diagnosed with Hodgkin's disease. Which of the major body systems is this cancer associated?
- A. Lymphatic  
B. Circulatory  
C. Endocrine
27. Which of the following is **MOST** significant limitation of using existing case records as the basis for practice evaluations?
- A. Records may not contain consistent and/or complete information  
B. Evaluations are limited to only topics contained in the case records  
C. The client's opinions about service quality are not considered
- 281     Which of the following personality disorders is clustered with antisocial personality disorder in a grouping characterized by dramatic, emotional, and erratic behavior?
- A. Schizoid personality disorder  
B. Narcissistic personality disorder  
C. Obsessive-compulsive personality disorder
29. Which of the following medications is associated with an increased risk of agranulocytosis?

- A.** Clozaril
- B.** Lexapro
- C.** Lithium

30. Which of the following impairments must be present for a client to be diagnosed with borderline personality disorder?

- A.** Impairments in personality and interpersonal functioning
- B.** Impairments in interpersonal functioning but not personality functioning
- C.** Impairments in personality functioning but not interpersonal functioning

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A client tells a social worker that he “can’t stand it anymore,” but does not believe that he can make needed changes in his life. He engages with the social worker in discussions about what his life would be like without his problem behaviors. Which stage of change is the client **MOST** likely engaged in?

- A.** Contemplation
- B.** Precontemplation
- C.** Preparation

32. A client shows up for the initial session with a coworker. The **BEST** response for a social worker is to:

- A.** Tell the client that confidentiality policies preclude the coworker from sitting in on the session
- B.** Ask the coworker to also complete all necessary intake paperwork and releases
- C.** Let the client determine the extent to which the coworker attends or participates in sessions

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33. Which of the following is the **BEST** indicator of ego strength?

- A. Taking responsibility for actions
- B. Regulating mood swings
- C. Blaming others

34. Which of the following is a diagnostic characteristic of transvestic disorder according to the *DSM*?

- A. The diagnosis is restricted to males
- B. Significant distress caused by this disorder can only be related to social relationships
- C. Sexual arousal must result from cross-dressing

35. Which of the following is true of substance-related disorders in the *DSM*?

- A. Substance use disorders are diagnosed along a single continuum measured from severe to mild
- B. Legal problems due to substance use is a key diagnostic criterion
- C. Substance use places individuals in situations that increase risk of harm to self and others

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6

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Upon intake, a client states that she “feels like hurting herself but will be fine.” She assures the social worker that she will not act on her feelings. In order to assist the client, the social worker should **FIRST**:

- A. Conduct a safety assessment
- B. Acknowledge the client’s feelings and concerns
- C. Determine the reasons that have caused the client to feel this way

37. What is it called when two or more people share the same delusion or delusional system?

- A.** Folie à deux
- B.** Trichotillomania
- C.** Comorbid psychosis

**38.** Which of the following *DSM* diagnoses is **BEST** used to label intellectual difficulties as well as problems in conceptual, social, and practical areas of living?

- A.** Mental retardation
- B.** Intellectual disability
- C.** Intellectual developmental disorder

**39.** Which of the following is a condition for further study in the *DSM*?

- A.** Pica
- B.** Caffeine use disorder
- C.** Frotteuristic disorder

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A client reports that the client is under the surveillance of the police and that they have been following her for days, as well as listening in on her phone conversations. There is no other evidence to support this belief. What is **MOST** likely the basis of the client's report?

- A.** Hypomanic state
- B.** Delusion
- C.** Hallucination

**41.** A client is being discharged from an inpatient hospitalization. Upon admission, he slept most of the time, reported extreme despair, and felt hopeless. Several days later, while hospitalized, he appeared jittery and agitated. His speech was rambling, and he wandered around the unit, talking to others for hours. He also had trouble sleeping. Which of the following

medications will the client **MOST** likely be prescribed upon discharge?

- A. Lithium
- B. Ativan
- C. Haldol

42. According to the *DSM*, how long does depressed mood need to be present for a diagnosis of persistent depressive disorder in adults?

- A. 6 months
- B. 1 year
- C. 2 years

43. Which of the following must a social worker consider before making a diagnosis of gender dysphoria?

- A. Gender dysphoria is only diagnosed in adulthood after the age of 18
- B. Sexual orientation must be established before making a diagnosis of gender dysphoria
- C. A desire for physical characteristics of the identified gender in those with gender dysphoria are not attributable to fixation on flaws in appearance

4291

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A client has made substantial progress in treatment and has achieved all established goals. When the social worker speaks to the client about discharge, the client states that he does not want to stop seeing the social worker because he is worried about his future needs. As there are no additional treatment goals, the social worker agrees to see the client pro bono for the next 6 months or until the client feels comfortable. Which of the following **BEST** describes the social worker's actions?

- A. Unethical because termination decisions are the

- responsibility of the social worker
- B. Unethical since there are no new treatment goals
- C. Ethical since the client does not feel ready to end treatment
- 45.** Which of the following is an objective outcome that might be associated with a foster care program?
- A. Number of children served who are reunified with their biological families
- B. Satisfaction of foster parents with the program
- C. Perceived safety of children
- 46.** Which of the following is the **MOST** important factor in choosing an appropriate intervention or treatment strategy?
- A. The intervention is currently being used by a social worker to assist clients with similar problems
- B. The intervention results from the biopsychosocial–spiritual–cultural assessment of a client
- C. The intervention is approved as medically necessary by third-party payers
- 47.** A social worker is using a SOAP documentation format. In which of the following settings is the social worker **MOST** likely employed?
- A. Mental health agency
- B. Hospital
- C. Community action program

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8

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A social worker needs to evaluate the behavior of a client who is living in a group home. The social worker asks two staff to each record the frequency of the behavior independently and to submit their tracking sheets to the social worker without sharing

them with one another. Which of the following approaches is the social worker using to ensure reliability of the data collected?

- A. Alternate or parallel forms
  - B. Interrater
  - C. Internal consistency
- 49.** A social worker employed to work with juvenile offenders has developed an innovative program that has yielded very positive outcomes. The social worker approaches the agency director about using the same approach with adult offenders. The director is skeptical about its ability to achieve the same outcomes. Which is **MOST** likely the basis of the director's concern?
- A. Internal validity
  - B. Multicollinearity
  - C. External validity
- 50.** After completing an assessment, a client states that the client would like to work on being more assertive at work. In order to assist the client, the social worker should **FIRST**:
- A. Provide the client with communication strategies aimed at self-expression
  - B. Gather information about communication issues at the client current and past jobs
  - C. Identify the outcome that the client hopes to attain from this behavioral change
- 51.** A mother is very upset because she feels that her 4-year-old daughter is "selfish" and states that the daughter does not understand how her behavior impacts on others in the family. She reports that the child has no problems in preschool and gets along with peers outside the family according to their parents. In order to **BEST** assist, the social worker should:
- A. Work with the daughter to behave more appropriately in the

- family unit
- B.** Explain the development of young children to the mother
  - C.** Gather more information about the daughter's development

1268

- C.** The Minnesota Multiphasic Personality Inventory (MMPI) has scales to measure the following clinical conditions: hypochondriasis, indicating stress over physical health; depression, indicating hopelessness; hysteria, indicating anxiety and tension; psychopathic, indicating aggression, acting out, and rebellion; masculinity-femininity, indicating gender identity; paranoia, indicating disturbed thinking; psychasthenia, indicating worrying; schizophrenia, indicating orientation to reality; hypomania, indicating energy; and social introversion, indicating being withdrawn. The MMPI is not used to assess substance use.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Biopsychosocial History and Collateral Data (Competency); Techniques and Instruments Used to Assess Clients/Client Systems (KSA)

- 2. A.** Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no. Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

Many standardized instruments and interview protocols are available to help social workers perform appropriate screening and assessment. Skill and expertise may be needed for both screening and intervention, both of which must consider client strengths.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Biopsychosocial History and Collateral Data (Competency); Techniques and Instruments Used to Assess Clients/Client Systems (KSA)

**3. C.** The biopsychosocial-spiritual-cultural assessment provides critical information on the current/presenting issue or issues including a client's past and present physical health and developmental milestones. In order to be complete, the biological section should contain a client's medical history, developmental history, current medications, substance abuse history, and family history of medical illnesses. The information that was collected from the social worker in the vignette is acceptable but is not complete and may not be useful as information is missing for a thorough assessment.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Biopsychosocial History and Collateral Data (Competency); The Components of a Biopsychosocial Assessment (KSA)

4270

**A.** In most cases, clients recognize that there is a problem interfering with enjoyment (or partner enjoyment) of a sexual relationship. Social workers then begin with complete histories of symptoms and referrals for physical exams. Diagnostic tests are used to rule out any medical problems that may be contributing to the dysfunction, if needed. Understanding attitudes about sex, as well as other possible contributing factors (fear, anxiety, past sexual trauma/abuse, relationship concerns, medications, alcohol or drug abuse, etc.) will help the social worker understand the underlying cause of the problem and make recommendations for appropriate treatment. Sexual dysfunction is not going to be typically identified through medical screenings or social work assessments. Social workers will usually learn about these issues through client self-reports.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Biopsychosocial History and Collateral Data (Competency); The Indicators of Sexual Dysfunction (KSA)

**5. A.** In general, it is recommended that sensitive questions be placed

in the latter part of a social work interview to allow rapport to develop between the client and social worker. Reiterating that information is kept confidential is helpful but bringing up the “limits to confidentiality” can make clients more reluctant to answer. Information is never collected anonymously, only confidentially, in interviews as the identity of respondents is known.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Biopsychosocial History and Collateral Data (Competency); Methods to Obtain Sensitive Information (e.g., Substance Abuse, Sexual Abuse) (KSA)

- 6. B.** All the response choices could be indicators of resistance. Indicators of resistance can also include engaging in intellectual talk by using technical terms or abstract concepts, asking questions of a social worker that are not related to presenting issues or problems, being preoccupied with past events instead of current issues, false promising, and/or flattering a social worker in an attempt to “soften” the social worker so as not to be pushed. While speaking about irrelevant topic and arriving late may be resistant behaviors, they also can be due to a lack of clarity of the problem-solving process. Limiting the amount of sensitive information is a more salient indicator of resistance than the other response choices provided.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Indicators of Motivation, Resistance and Readiness to Change (KSA)

- 7. B.** The social worker must view the unemployment “using a systems approach.” Although the job loss is causing financial concerns, it would also have an impact on other aspects of the client’s life, such as his physical and mental health. Systems theory indicates that a change to one part of a client’s life will impact on others.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Biopsychosocial

## Factors Related to Mental Health (KSA)

8272

- **B.** Dexedrine, like Adderall and Ritalin, is a stimulant that is used for the treatment of attention-deficit/hyperactivity disorder. Tofranil and Elavil are antidepressants and are used primarily to treat depressive disorders. However, these medications are also used at times for the treatment of anxiety disorders.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

9. **A.** Since the Tarasoff case in 1974, duty to warn has become an important concept in social work. Being able to protect potential victims from harm and protecting clients from self-harm are ethical obligations. Duty to warn means that social workers must verbally tell authorities and/or intended victims that there is a foreseeable danger of violence. In addition, social workers have a duty to protect, so social workers who determine that their clients present a serious danger of violence to others have an obligation to use reasonable care to protect the intended victims against danger. This may entail police notification or other necessary steps.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Risk Assessment Methods (KSA)

10. **A.** Those with high ego strength approach problems with a sense that they can overcome problems and even grow as a result. They try to find new ways to cope with struggles and handle challenges without losing their sense of self. On the contrary, those with low ego strength view challenges as something to avoid. While wishful thinking or fantasies can be a form of avoidance, they are not the most salient indicators of low ego strength. Those with low egc

strength often cannot find new ways to cope with struggles as reality seems overwhelming.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Methods to Assess Ego Strengths (KSA)

- 11. A.** Personality disorders make it hard to function in everyday life as they distort thinking. People with personality disorders find it hard to change their behavior or adapt to different situations. Those with personality disorders have little insight into their maladaptive behaviors.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

1274

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- A.** Clients who receive their antipsychotic medications via injection are more likely to continue their medications than those who take them orally. Since injectable medications are usually only needed once or twice per month, it may be easier to remember these appointments than taking pills several times a day. This consistency in medication compliance may result in fewer hospitalizations and few symptom relapses. The cost of the medications is not a therapeutic consideration. While injectable medications can be used in addition to oral administration, there is no therapeutic advantage stated.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

**13. A.** Clients with borderline personality disorder tend to view the world in black-and-white, all-or-nothing, dichotomous thinking. These polarized thoughts lead to intense emotional reactions that are unable to be regulated. Clients with borderline personality disorder often engage in self-destructive behavior and act impulsively. Clients with this diagnosis often have little control over their behavior. While thought patterns are fixed, they are not always delusional.

#### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

**14. C.** Risk factors are associated with an increased likelihood that a client or community will be affected by, or become a perpetrator of violence. Risk factors can occur at the individual, family, school, and community levels. Not everyone who is identified as being “at risk” becomes involved in violence.

#### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Indicators and Risk Factors of the Client’s/Client System’s Danger to Self and Others (KSA)

**15. C.** Paxil and Zoloft are both selective serotonin reuptake inhibitors (SSRIs) for the treatment of depression. Although the client may have other diagnoses, she is likely diagnosed with major depressive disorder, which would require the use of an antidepressant.

#### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

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- A.** Conduct disorder is repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) criteria in the past 12 months, with at least one criterion present in the past 6 months. *Although conduct disorder can be diagnosed in adults, symptoms usually already emerge in childhood or adolescence, though they do not need to be present before age 12.*

#### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

- 17. B.** The World Health Organization Disability Assessment Schedule (WHODAS) is recommended as a tool to determine functioning and level of disability. The Global Assessment of Functioning Scale (GAF), which provided a numeric rating as an indicator of a client's well-being, has been eliminated from the *DSM*. The Thematic Apperception Test, or TAT, is a type of projective test that involves describing ambiguous scenes to learn more about a person's emotions, motivations, and personality.

#### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

- 18. C.** Legal involvement is not a diagnostic criterion of the substance-related and addictive disorders as there are many factors that are strongly associated with being arrested or coming into contact with legal authorities.

## **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

- 19.** **A.** A mental status examination is a structured way of observing and describing a client's current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought processes, thought content, perception, cognition, insight, and judgment. It is not a psychiatric evaluation aimed at diagnosing disorders. Many disorders or conditions cause delirium, such as alcohol/drug abuse or withdrawal and infections. Delirium involves a quick change between mental states (e.g., from lethargy to agitation and back to lethargy). Symptoms that can be detected by a mental status examination include changes in alertness (usually more alert in the morning, less alert at night), awareness, orientation to time or place, memory, recall, and mood (personality changes).

## **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Components and Function of the Mental Status Examination (KSA)

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- B.** In social work, triangulation indicates that multiple sources or methods are used to gather information and/or check results. A social worker may be more confident that the social worker has the information needed or is accurate with conclusions drawn if different sources/methods lead to the same result. By using multiple sources or methods, a social worker can hope to overcome the weakness or intrinsic biases and the problems that come from a single source or method.

## **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Methods of Involving

Clients/Client Systems in Problem Identification (e.g., Gathering Collateral Information) (KSA)

21. **A.** Tardive dyskinesia is a neurological disorder of involuntary movements caused by long-term use of antipsychotic drugs. These medications may be used to treat schizophrenia spectrum and other psychotic disorders. Symptoms include tongue protrusion, grimacing, lip smacking, or other involuntary movements of the head, face, neck, and tongue muscles.

**Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

22. **B.** Nardil is a monoamine oxidase inhibitor (MAOI), and there are dietary restrictions of foods that contain high levels of tyramine (generally food that has been aged), including cheeses, cured meats, and yeast extract spreads.

**Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

23. **A.** Serotonin is a chemical created by the human body that works as a neurotransmitter. It is responsible for maintaining mood balance. An association is made between serotonin and depression. It is unclear if decreased levels of serotonin contribute to depression or depression causes a decrease in serotonin levels. Selective serotonin reuptake inhibitors (SSRIs) are a classification of antidepressants.

**Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Basic Medical Terminology (KSA)

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**C.** Evaluation methods can be classified as either qualitative or quantitative. In qualitative evaluations, data are collected through observations and/or interviews. Findings are generated via identification of themes in the language used and content contained in the communication observed or generated. The focus groups employed by the social worker are qualitative in nature. Contrarily, quantitative evaluations are conducted by making numerical comparisons and statistical inferences. The social worker's comparison of the number of clients rehospitalized versus the number who were not is a quantitative approach. Since both qualitative and quantitative methods are being used, the social worker is using a mixed method approach to evaluation.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Data Collection and Analysis Methods (KSA)

25. **C.** Protective factors are attributes that are associated with not engaging in dangerous behaviors. They are the opposite of risk factors. All of the response choices are associated with an increased likelihood of engaging in violence except the provision of physical and behavioral care, which is a protective factor.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Indicators and Risk Factors of the Client's/Client System's Danger to Self and Others (KSA)

26. **A.** Hodgkin's disease is a type of lymphoma, a cancer of the lymphatic system. The first sign of Hodgkin's disease is often an enlarged lymph node. The disease can spread to nearby lymph nodes. Later, it may spread to the lungs, liver, or bone marrow. The exact cause is unknown.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Basic Medical Terminology (KSA)

27. **B.** Case records are often an excellent source of information for evaluating the impacts of services. However, there are a few limitations. All the response choices are potential issues but only one is a consistent constraint. If looking at records completed by multiple workers, there may be inconsistencies in recording styles or detail that may impact on evaluations, but such inconsistencies and omissions do not have to occur. Client's views on service delivery may be noted in case records. The most important consideration is that records and evaluations would need to be limited to only information that is explicitly stated, which may not reflect all progress that has been made or the outcomes that need to be studied.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Methods to Assess Organizational Functioning (e.g., Agency Assessments) (KSA)

282

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- B.** Cluster B includes the personality disorders that are characterized by dramatic, emotional, and erratic behavior. It includes borderline personality disorder, narcissistic personality disorder, histrionic personality disorder, and antisocial personality disorder. Schizoid personality disorder is in Cluster A (odd and eccentric behavior) and obsessive-compulsive personality disorder is in Cluster C (anxious and fearful behavior).

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

**29.** **A.** Agranulocytosis is a lowering of the white blood cell count that requires monitoring via bloodwork. A large number of drugs have been associated with agranulocytosis, including antiseizure, antibiotic, and antipsychotic medications, such as Clozaril. All clients receiving Clozaril must get baseline bloodwork and be enrolled in the Clozaril National Registry, which records adverse impacts from taking Clozaril and bloodwork results.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

**30.** **A.** The essential features of a personality disorders are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, there has to be significant impairments in personality and interpersonal functioning. Personality deficits may be manifested by unstable self-image, chronic feelings of emptiness, dissociative states under stress and/or instability in goals. Deficits in interpersonal functioning may be manifested by an inability to recognize the feelings of others, intense, unstable, and conflicted close relationships; and/or alternating between overinvolvement and withdrawal.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

3284

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**A.** Behavior change is best understood as a process with different stages of readiness. For most clients, behavior change occurs gradually over time, with a client progressing from being uninterested, unaware, or unwilling to make a change

(precontemplation), to considering a change (contemplation), to deciding and preparing to make a change (preparation). This is followed by definitive action and attempts to maintain the new behavior over time (maintenance).

Contemplation is the first time that there is some movement toward change because a client, while ambivalent about changing, may weigh the benefits versus costs (i.e., time, expense, and effort) of change. The client is willing to examine what his life would be like if change occurred which is characteristic of contemplation.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Methods to Assess Motivation, Resistance, and Readiness to Change (KSA)

- 32. C.** Cultural awareness involves working in conjunction with natural informal support and helping networks (i.e., neighborhoods coworkers, churches, spiritual leaders, and healers). The coworker is probably a member of the client's support network and can be useful in the problem-solving process. It is the client's decision of whether information can be shared. The social worker should use the coworker as a valuable source of information about the problem as the coworker is a collateral source. There is nothing that precludes the coworker from sitting in on the session and the coworker does not need to complete all intake paperwork.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Methods of Involving Clients/Client Systems in Problem Identification (e.g., Gathering Collateral Information) (KSA)

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- A.** Ego strength is the ability of the ego to effectively deal with the demands of the id, the superego, and reality. It is a basis for resilience and helps maintain emotional stability by coping with internal and external stress.

Indicators of ego strength include clients:

- Using painful events to strengthen themselves
- Taking responsibility for actions
- Holding themselves accountable
- Accepting themselves with their limitations

Blaming others is not an indicator of ego strength. Ego strength allows individuals to feel more in control of their emotions, responses, decisions, and future path, thereby helping people to better manage internal and external stress, work toward their goals, and remain calm during conflict or anxiety-provoking situations. However, regulating mood “swings” is not the best response choice as individuals with ego strength are less likely to have such swings.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Methods to Assess Ego Strengths (KSA)

- 34. C.** Transvestic disorder identifies people who are sexually aroused by dressing as the opposite sex, but who experience significant distress or impairment in their lives, socially or occupationally because of their behavior. The disorder can be diagnosed in women or men who have this sexual interest.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

- 35. A.** Like other illnesses, substance misuse worsens over time. The substance use disorder criteria explained in the *DSM* allow social workers to determine how severe a substance use disorder has become depending on how many symptoms are present. Legal involvement is not a diagnostic criterion and using substances ir

risky settings that put an individual or others in danger is not required.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

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**A.** Despite the client's report that she will not act on her thoughts, she is at risk because she has these feelings. The vignette does not describe the social worker taking any action yet. A safety assessment will determine the severity of the depression and whether she is at risk for a suicide attempt. It must be done FIRST before any other action is taken.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Indicators and Risk Factors of the Client's/Client System's Danger to Self and Others (KSA)

37. **A.** Folie à deux is very rare and describes when identical or similar psychiatric disorders affect two or more people, who usually have a close relationship. Often these disorders involve delusions, especially those that are paranoid.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Indicators of Mental and Emotional Illness Throughout the Lifespan (KSA)

38. **C.** The term “intellectual developmental disorder” is used to clarify the disorder’s relationship with the World Health Organization’s International Classification of Diseases classification system, which uses the term “disorders of intellectual development.” Intellectual

disability is placed in parentheses given its continued use but is not the best diagnosis. Mental retardation has been discontinued with strong advocacy to eliminate the “R” word and stigma that those with intellectual challenges are “less than.”

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

- 39.** **B.** Caffeine use disorder, along with attenuated psychosis syndrome, depressive episodes with short-duration hypomania, internet gaming disorder, neurobehavioral disorder associated with prenatal alcohol exposure, suicidal behavior disorder, and nonsuicidal self-injury, are listed in the *DSM* as conditions for further study.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

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- B.** A delusion is a false or erroneous belief that usually involves a misinterpretation of perceptions or experiences. A delusion is a belief that is held despite evidence to the contrary. A hallucination involves the senses. An auditory hallucination—hearing something that is not said—is the most common type. In this vignette, the client had a false, fixed belief despite a lack of supporting evidence, but there was no indication that it resulted from seeing or hearing anything that would support these beliefs. Hypomania is a condition characterized by a period of abnormally elevated, extreme changes in mood or emotions, energy level or activity level. Hypomania does not have to include delusional thoughts.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Indicators of Mental and Emotional Illness Throughout the Lifespan (KSA)

- 41.** **A.** The client's behavior is consistent with bipolar disorder. He was depressed upon admission and then appeared to be manic during the hospitalization. Only lithium, out of those medications listed, is a mood stabilizer. Ativan is an antianxiety agent and haldol is an antipsychotic medication.

**Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); Common Psychotropic and Nonpsychotropic Prescriptions and Over-the-Counter Medications and Their Side Effects (KSA)

- 42.** **C.** Persistent depressive disorder requires that a depressed mood occur for most of the day, for more days than not, and for at least 2 years in adults (at least 1 year for children and adolescents).

**Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

- 43.** **C.** Many children can make decisions about their gender identity. Based on the current understanding of gender dysphoria, the period before an individual reaches puberty is critical. Thus, children can be diagnosed with gender dysphoria. Sexual orientation, by definition, is not the same as gender identity. Gender identity is defined as the particular gender an individual associates or does not associate with (e.g., female, male, an alternative gender or lack thereof) versus sexual orientation, which is defined as a general pattern of attraction and sexual arousal to other people (or lack thereof). Gender dysphoria must be differentiated from body dysmorphic disorder in which persons fixate on perceived flaws in their appearance. Those with gender dysphoria may strongly wish

for the physical features of the gender they gravitate towards but not because they are fixated on flaws.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Assessment and Diagnosis (Competency); The Use of the Diagnostic and Statistical Manual of the American Psychiatric Association (KSA)

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**B.** The NASW Code of Ethics states that it is unethical to continue to treat clients when services are no longer needed. The waiving of cost associated for this treatment is not relevant. Continuing to see the client with no treatment goals is not in the client's best interest. The social worker should have addressed the client's apprehension and nervousness about termination. Central to the termination process is working with the client to anticipate future needs and how to address them. Continuing to see him "just in case" does not assist the client to be autonomous and to practice, on his own, coping skills that he has attained during treatment.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); Discharge, Aftercare, and Follow-Up Planning (KSA)

45. **A.** Program evaluation usually relies on both subjective and objective data. The "facts" or objective outcomes include days incarcerated, number of subsequent hospitalizations, and so forth. Subjective information, such as how the "facts" are perceived by clients through descriptions of their feelings, experiences, and perceptions, is equally important. Subjective outcomes often provide valuable information about how the service experience was viewed by those served. The satisfaction of foster parents and perceived safety of children are subjective, not objective, outcomes of a foster care program. The number of children reunified is the only objective outcome in the response choices provided.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); The Principles and Features of Objective and Subjective Data (KSA)

- 46.** **B.** Social work interventions or treatments must be selected based upon the biopsychosocial–spiritual–cultural assessments of clients which include the strengths that they possess, as well as the identification of feasible and desired outcomes within larger service contexts. Many interventions or treatments are not paid for by third parties and each intervention must be individualized so the treatment does not need to be used with others.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); The Criteria Used in the Selection of Intervention/Treatment Modalities (e.g., Client/Client System Abilities, Culture, and Life Stage) (KSA)

- 47.** **B.** SOAP stands for subjective, objective, assessment, and plan. In the subjective and objective sections, a client's subjective and objective well-being are reported by the social worker. In the assessment section, a social worker pulls together these subjective and objective findings and consolidates them into a short assessment. A plan is then made based upon the assessment. The SOAP format is most often used in healthcare settings.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); The Principles and Features of Objective and Subjective Data (KSA)

4294

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- B.** There are four different ways to assess reliability or consistency. Interrater reliability uses different independent raters/observers to see if there are consistent estimates of the behavior. Alternative or

parallel forms use two means of data collection constructed in the same way to see if they yield the same result. Test-retest reliability determines if assessments fluctuate from one time to another. Internal consistency looks at measurements within a test or assessment to see if they yield comparable results. Only interrater requires two or more independent staff to record the data.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); Methods to Assess Reliability and Validity in Social Work Research (KSA)

- 49. C.** External validity is concerned with the ability to generalize the results. The director agency is worried about the effectiveness of the program with adults versus children.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); Methods to Assess Reliability and Validity in Social Work Research (KSA)

- 50. C.** The client and social worker are in the planning stage of the problem-solving process. Planning comes after engagement and assessment. Providing strategies is an intervention. Gathering information is an assessment but the question states that the assessment has been completed. The social worker must clarify with the client the desired outcomes and what is meant by “being more assertive.” Clearly defining the problem and how it relates to positive and negative aspects of the client’s life will assist in the formation of an appropriate intervention, treatment, or service plan.

### **Question Assesses**

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); Methods to Involve Clients/Client Systems in Intervention Planning (KSA)

- 51. B.** The daughter’s behavior is egocentric, and she has trouble seeing the viewpoint of others. This behavior is typical of children in the preoperational stage of cognition. Because others do not see

her actions as problematic, it is likely that the mother has an unrealistic expectation that can be helped by understanding child development. The mother needs education about child development.

## Question Assesses

Content Area II—Assessment, Diagnosis, and Treatment Planning; Treatment Planning (Competency); The Criteria Used in the Selection of Intervention/Treatment Modalities (e.g., Client/Client System Abilities, Culture, and Life Stage) (KSA)

295

Practice Questions Content Area II: Assessment, Diagnosis, and Treatment Planning (30%)					
Competency	Question Numbers	Number of Questions	Number Correct	Percentage Correct	Area Requiring Further Study
1. Biopsychosocial History and Collateral Data	1, 2, 3, 4, 5	5	___/5	___%	
2. Assessment and Diagnosis	6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43	38	___/38	___%	
3. Treatment Planning	44, 45, 46, 47, 48, 49, 50, 51	8	___/8	___%	

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## **Content Area III: Psychotherapy, Clinical Interventions, and Case Management (27%)**

# CHAPTER

299

# 7

# Therapeutic Relationship

## **THE COMPONENTS OF THE SOCIAL WORKER–CLIENT/CLIENT SYSTEM RELATIONSHIP**

A social worker–client relationship is an emotional or connecting bond. The relationship is the communication bridge whereby messages pass over the bridge with greater or lesser difficulty, depending on the nature of the emotional connection or alliance.

A positive relationship is an important tool of helping. Social workers must create a warm, accepting, trustworthy, and dependable relationship with clients.

In working with a client, a social worker must convey a sense of respect for a client's individuality, as well as the client's right and capacity for self-determination and for being fully involved in the helping process from beginning to end.

*The most consistent factor associated with beneficial outcomes of a helping relationship is a positive relationship between a social worker and a client*, but other factors, such as a social worker's competence and the motivation and involvement of a client, are also influential.

## **THE PRINCIPLES AND TECHNIQUES FOR BUILDING AND MAINTAINING A HELPING RELATIONSHIP**

Helping is based on acceptance of a client's situation and the ability of the client to make changes only if desired. In a helping relationship, a social worker is trying to constructively assist a client—that is, to have an impact on or to influence thinking and acting. The influence is further

presumed to be in the direction of increasing the autonomy, understanding, effectiveness, and skill of a client.

Helping is distinguished from the more common concepts of advice giving, reprimanding, or punishing. These often involve threats and seldom result in more than outward conformity or superficial change. They generally do not increase strength or willingness and ability to carry responsibility.

*The core of the helping process is the relationship between a social worker and a client.*

The relationship between a social worker and a client is expressed through interaction. This interaction is commonly thought of in terms of verbal communication, which is natural, because the greater part of treatment consists of talking.<sup>300</sup> However, nonverbal behavior is also very important. Body posture, gestures, facial expressions, eye movements, and other reactions often express feelings and attitudes more clearly than do spoken words. It is often for these reasons that a social worker must be aware of personal feelings, attitudes, and responses, as well as those of a client if the social worker is to understand what is taking place and be of assistance.

A social worker cannot be useful in helping others unless the social worker understands and is willing to accept the difficulties that all human beings encounter in trying to meet their needs. A social worker must know that the potential for all the weaknesses and strengths known to humanity exists at some level in every person. Social workers must also understand that human beings become more capable of dealing with their problems as they feel more adequate. Social workers recognize positive, as well as negative, aspects of a client, which will influence efforts to change and successful achievement of goals.

The interaction between a social worker and a client that takes place about a problem involves and is affected by the relationship between the two persons. Human beings act in terms of their feelings, attitudes, and understandings; hence, these must be taken into account and explored if the helping process is to result in change. Both a social worker and a client have objectives; a social worker's perceived objective is to be of assistance. Clarification and definition of these objectives often become important parts of the helping process. Both a social worker and a client have a degree of power (i.e., ability to influence the situation and the results).

The therapeutic process calls for several basic conditions.

*There must be trust with a social worker.* Unless this condition exists, facts will be withheld and there will be no real exploration of problems. Trust grows as clients talk about themselves and their circumstances, revealing things they do not ordinarily disclose, and discovering that social workers do not condemn them. Trust does not come quickly.

There must be recognition that *the therapeutic process is a joint exploration*. Both a social worker and client must be willing to examine problems, attitudes, and feelings.

*There must be listening on both sides.* However, a social worker must listen more than a client does. There is no movement when a social worker is doing all the talking and a client listens passively. A social worker must behave in a manner that makes it easier for a client to speak freely by listening attentively, by *accepting what is said in a nonjudgmental manner*, and by giving occasional support or encouragement.

A social worker may be encouraging by simply repeating reflectively or paraphrasing what a client has said. A social worker may, without other comment, say, "Tell me more" or show acceptance when a client reveals ideas, attitudes, or behaviors that are generally viewed unfavorably. A social worker may also point out that other persons also have such attitudes or make similar mistakes. By assisting a client to speak more freely, a social worker not only furthers mutual exploration of the problem, but also frees a client of anxieties that stand in the way of readiness to accept suggestions. A social worker is also obligated to respect the confidence a client has placed in the social worker and to refrain from sharing the information with others.

## **Process of Engagement in Social Work Practice**

The beginning of the problem-solving process includes activities of a social worker and a client to be helped that are directed at (a) becoming engaged with each other (engagement), (b) assessing a <sup>301</sup> client's situation in order to select appropriate goals and the means of attaining them (assessment), and (c) planning how to employ these means (planning). During engagement, the limits to confidentiality must be explicitly stated at the beginning of this stage. Social workers must

also explain their roles and how they can assist clients in addressing their problems.

It is important to consider how a client feels about coming for help and to deal with any negative feelings a client may feel (particularly if a client is involuntarily seeking help). A social worker must be open to discussing these feelings openly, because very little in a client can be changed until negative feelings are addressed. If a social worker is empathic with a client, it may be possible to find a common ground between what a client wishes and what a social worker can legitimately do.

A social worker and a client establish a therapeutic alliance in which they view themselves as allies in the helping process. A working alliance or a willingness by a client to work with a social worker should be established. A working alliance is sometimes referred to as a treatment alliance.

A social worker should express hopefulness that change can occur.

Resistance may occur during this stage. If clients are resistant to engage, social workers should clarify the process or specify what will happen and discuss this ambivalence.

## **THE DYNAMICS OF POWER AND TRANSPARENCY IN THE SOCIAL WORKER–CLIENT/CLIENT SYSTEM RELATIONSHIP**

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Social workers have power and privileges associated with their roles, titles, and education. Being conscious of these privileges is critical because there is a responsibility to challenge hierarchical assumptions and power dynamics inherent in social worker–client relationships. Social workers should use egalitarian and collaborative approaches that give clients choices, decision-making power, and opportunities for honest feedback.

If social workers are transparent and honest about their positions of privilege, they help to undercut the power differentials. Transparency about the process and intent of social work interventions is essential. Role expectations should be discussed and power differences should be acknowledged.

Transparency and power are linked. If clients are not informed about what is going to occur in each stage of the problem-solving

process and do not understand the theoretical models which help explain their situations, they cannot be full participants in the change process. Thus, transparency or the provision of all available information is the underpinning of the therapeutic relationship. If social workers deliberately withhold observations or knowledge from clients, they are reinforcing the power differential which inherently exists and disempowering clients. This is not helpful to clients or in accordance with the values of social work practice.

## **THE SOCIAL WORKER'S ROLE IN THE PROBLEM-SOLVING PROCESS**

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Social worker roles in the problem-solving process include consultant, advocate, case manager, catalyst, broker, mediator, facilitator, instructor, mobilizer, resource allocator, and so on.

Key social work practice roles include the following.

### **Advocate**

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In the advocate role, social workers champion the rights of others with the goal of empowering the client system being served. Social workers speak on behalf of clients when others will not listen or when clients are unable to do so. Social workers have a particular responsibility to advocate on behalf of those disempowered by society.

### **Broker**

In the role of broker, social workers are responsible for identifying, locating, and linking client systems to needed resources in a timely fashion. Once client needs are assessed and potential services identified, the broker assists in choosing the most appropriate service option and assists in negotiating the terms of service delivery. Social workers are concerned with the quality, quantity, and accessibility of services.

### **Change Agent**

A change agent participates as part of a group or organization seeking to improve or restructure some aspect of service provision. A change

agent, working with others, uses the problem-solving model to identify the problem, solicit input, and plan for change. A change agent acts in a coordinated manner to achieve planned change at multiple levels that helps to shift the focus of institutional resources to meet identified goals.

## Counselor

The role of the counselor focuses on improving social functioning. Social workers help client systems articulate their needs, clarify their problems, explore resolution strategies, and apply intervention strategies to develop and expand the capacities of client systems to deal with problems more effectively. A key function of this role is to empower clients by affirming their personal strengths and their capacities to deal with problems more effectively.

## Mediator

When dispute resolution is needed in order to accomplish goals, social workers will carry out the role of mediator. Social workers intervene in disputes between parties to help them find compromises, reconcile differences, and reach mutually satisfying agreements. The mediator takes a neutral stance among the involved parties.

*The primary role of social workers is to act as a resource—assuming various roles depending upon the nature of client problems.*

## METHODS TO CLARIFY THE ROLES AND RESPONSIBILITIES OF THE SOCIAL WORKER AND CLIENT/CLIENT SYSTEM IN THE INTERVENTION PROCESS

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A social worker can be supportive in these roles, but is not supposed to be the client's support system. Instead, a social worker should assist the client to mobilize or build natural supports. People generally like to give advice. It gives them the feeling of being competent and important. Hence, social workers may easily fall into this inappropriate role without taking into account the abilities, the fears, and the interests of clients and/or their circumstances.

Social workers should also not be insensitive to clients' resistance. When a client does not claim any difficulties, is unable or refuses to talk, explains that it is someone else's fault, and/or denies what has happened, a social worker may try to argue or in other ways exert pressure. This response tends to increase a client's resistance. This approach does nothing for a client.

A social worker may also confuse the situation and hinder clarification of the problem. In an effort to establish a relationship, a social worker may overpraise or fail to confront a client. Clients must look at their own roles in situations and recognize their own limitations.

## **THE CONCEPT OF ACCEPTANCE AND EMPATHY IN THE SOCIAL WORKER–CLIENT/CLIENT SYSTEM RELATIONSHIP**

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Empathic understanding involves being nonjudgmental, accepting, and genuine.

### *Empathic Communication*

- Establishes rapport with clients—empathic communication is one means of bridging the gap between a social worker and client.
- Starts where a client is and stays attuned to a client throughout the encounter (being perceptive to changes in frame of mind).
- Increases the level at which clients explore themselves and their problems.
- Responds to a client's nonverbal messages (a social worker can observe body language and make explicit a client's feelings).
- Decreases defensiveness and engages a client in processing and testing new information.
- Defuses anger that represents obstacles to progress.

Empathic responding encourages more rational discussion and sets the stage for problem solving. For those clients who have learned to cope with feelings of helplessness and frustration by becoming angry

and/or violent, an empathic response may be the first step in engaging in helping relationships.

## **THE DYNAMICS OF DIVERSITY IN THE SOCIAL WORKER–CLIENT/ CLIENT SYSTEM RELATIONSHIP**

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A social worker's self-awareness about personal attitudes, values, and beliefs about cultural differences and a willingness to acknowledge cultural differences are critical factors in working with diverse populations. A social worker is responsible for bringing up and addressing issues of cultural difference with a client and is also ethically responsible for being culturally competent by obtaining the appropriate knowledge, skills, and experience.

Social workers should:

1. Move from being culturally unaware to being aware of their own heritage and the heritage of others.
2. Value and celebrate differences of others rather than maintaining an ethnocentric stance.
3. Have an awareness of personal values and biases and how they may influence relationships with clients.
4. Demonstrate comfort with racial and cultural differences between themselves and clients.
5. Have an awareness of personal and professional limitations.
6. Acknowledge their own racial attitudes, beliefs, and feelings.

Although experiences will differ, many individuals have experienced racism, oppression, or discrimination in some form and are very sensitive to being treated with disrespect or to being exploited. They will be skeptical and cautious about seeking help for fear of being mistreated or misunderstood.

Trust is an important element in establishing a therapeutic alliance. Clients want to know if a social worker can be trusted and is competent to help them solve their problems. Clients regard and treat social workers as experts and authority figures.

**Matching clients and social workers of the same race and ethnicity may decrease dropout rates and increase utilization of services, but the quality of the therapeutic relationship remains the most important factor in predicting the outcome of treatment.**

Clients will ascribe credibility to a social worker using their cultural norms as a reference point (i.e., role, age, education, gender).

Understanding the cultural heritage of a client is important. Conflict between older and younger generations is often a common occurrence. Younger members assume the values and traditions of the majority, which can conflict with the more traditional values of the original culture that are held by an older generation.

Power and role reversals that threaten and undermine parental authority and leadership can also occur in families as parents rely on younger members of the family to become cultural interpreters. Role reversals may also occur if a woman becomes the main breadwinner because her husband cannot find employment. In a traditional marital relationship with strict gender roles, men may have difficulty dealing with this role reversal.

Although no culture condones child abuse or neglect, there are cultural variations about what constitutes child abuse and neglect, as well as acceptable disciplinary measures.

There are greater incidences of domestic violence in cultures where women have lower statuses than men.

Cultural groups have various explanations for an illness, particularly mental illness, and also have different ideas of what will help (often depends on the identified cause of the illness). <sup>305</sup>

## **Impact of Diversity in Styles of Communicating**

Communication styles may be strongly influenced by culture, race, and/or ethnicity.

Communication is far more than an exchange of words. Facial expressions, hand gestures, posture, eye contact, and even silence are constantly sending messages about attitudes, emotions, status, and relationships.

Nonverbal cues are critical. For example, personal space or the distance two people keep between themselves in order to feel

comfortable is culturally based. Personal space may be influenced by gender or status. It can also be influenced by intimacy of a relationship.

Eye contact is also influenced by culture. For some, direct eye contact is very brief, with the gaze then sliding away to the side, especially with superiors or members of the opposite sex, whereas others may engage in more direct eye contact.

Speaking volume can be nearly as important as the words themselves. Normal baseline volumes also vary among cultures and among individuals in these cultures.

The appropriateness of physical touch is also important to understand. In some cultures, individuals rarely touch each other, limiting themselves to handshakes and occasional pats on the shoulder or arm in business relationships, or hugs in closer friendships. In other cultures, however, physical touch, such as hugging, is part of many interactions, even those that are casual.

Smiling, facial expressions, time, and silence are also communication factors that vary among those from different cultures, races, or ethnic groups.

In order to be effective with those from diverse cultural, racial, and/or ethnic groups, social workers must:

1. Recognize direct and indirect communication styles
2. Demonstrate sensitivity to nonverbal cues
3. Generate a wide variety of verbal and nonverbal responses and strategies
4. Use language that is culturally appropriate
5. Identify their own professional style and recognize limitations and strengths
6. Identify and reduce barriers that will inhibit engagement with persons who are culturally different

## **THE EFFECT OF THE CLIENT'S DEVELOPMENTAL LEVEL ON THE SOCIAL WORKER-CLIENT RELATIONSHIP**

Social workers must be sensitive to the developmental levels of clients. Development levels refer to the functional abilities at which clients find themselves at given moments. The problem-solving process must take these developmental levels into account. Social workers should not rely on chronological age as clients may be functioning at very different developmental levels. Social workers must use engagement and <sup>306</sup> intervention strategies which are appropriate given clients' developmental functioning. Assessments should include determining the psychosocial levels of clients. Clients' development may be delayed or advanced across all domains or inconsistent with some areas more behind than others. Understanding causes for discrepancies between chronological and developmental age also may be important for insight into clients' problems.

## **THE IMPACT OF DOMESTIC, INTIMATE PARTNER, AND OTHER VIOLENCE ON THE HELPING RELATIONSHIP**

A type of trauma is that resulting from intimate partner abuse (heterosexual, gay, lesbian, dating, married, cohabitating). The common thread in all abusive relationships is the abuser's need for power and control another. Domestic violence occurs across all racial, cultural, and socioeconomic groups and can involve physical, sexual, psychological/emotional, and economic/financial abuse.

Signs of abuse are varied.

- Suspicious injury (not consistent with history of injury, unusual locations, various stages of healing, bites, repeated minor injuries, delay in seeking treatment, and old scars or new injuries from weapons)
- Somatic complaints without a specific diagnosis (such as chronic pain—head, abdomen, pelvis, back, or neck)
- Behavioral presentation (crying, minimizing, no emotional expression, anxious or angry, defensive, fearful eye contact)
- Controlling/coercive behavior of partner (partner hovers, over concerned, won't leave client unattended, client defers to partner, fear of speaking in front of partner, or disagreeing with partner)

## Cycle of Violence

- Phase I: Tension building  
Phase II: Battering incident—shortest period of the cycle, lasts a brief time  
“Loving–contrition” (absence of tension or “honeymoon” phase)—batterer offers profuse apologies; assures attacks will never happen again and declares love and caring  
Phase III:

Batterers often learn abusive behavior from their families of origin, peers, and media, as well as from personal experience of being abused as children. Batterers view their victims as “possessions” and treat them like objects. Victims are dehumanized to justify the battering. Batterers are very self-centered and feel entitled to have their needs (physical, emotional, sexual) met “no matter what.” Batterers have control over their impulses and give themselves permission to be abusive.

Some of the reasons that clients stay in abusive relationships are:

- Hope that the abuser will change. If the batterer is in a treatment program, the client hopes the behavior will change; leaving represents a loss of the committed relationship
- Isolation and lack of support systems
- Fears that no one will believe the seriousness of abuse experience
- Abuser puts up barricades so client won’t leave the relationship (escalates threats of violence, threatens to kill, withholds support, threatens to seek custody of children, threatens suicide, etc.)
- Dangers of leaving may pose a greater danger than remaining with the batterer
- Client may not have the economic resources to survive independently

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Leaving is a process. Over time, the client comes to the conclusion that the abuser will not change; each time the client tries to leave, the client gathers more information that is helpful.

Social exchange theory is based on the idea of totaling potential benefits and losses to determine behavior. People make decisions about relationships based on the amount of rewards they receive from them. A client remains in an abusive relationship because the high cost of leaving lowers the attractiveness (outweighs the benefits) of the best alternative. A client will leave when the best alternative promises a better life (rewards outweigh the costs).

## Guidelines for Interventions

- **According to most literature on domestic violence traditional marital/couples therapy is not appropriate addressing abuse in the family. It puts victims greater danger of further abuse.**
- Medical needs and safety are priorities. Note: Consider domestic violence in the context of Maslow's hierarchy of needs.
- In working with a victim of abuse, trust is a major issue establishing a therapeutic alliance.

## VERBAL AND NONVERBAL COMMUNICATION TECHNIQUES

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In order to facilitate change through the problem-solving process, a social worker must use various verbal and nonverbal communication techniques to assist clients to understand their behavior and feelings. In addition, to ensure clients are honest and forthcoming during this process, social workers must build trusting relationships with clients. These relationships develop through effective verbal and nonverbal communication. Social workers must be adept at using both forms of communication successfully, as well as understanding them, because verbal and nonverbal cues will be used by clients throughout the problem-solving process. Insight into their meaning will produce a higher degree of sensitivity to clients' experiences and a deeper understanding of their problems.

There are many verbal and nonverbal communication methods, including:

- **Active listening**, in which social workers are sitting up straight and leaning toward clients in a relaxed and open manner. Attentive listening can involve commenting on clients' statements, asking open-ended questions, and making statements that show listening occurring.
- **Silence** by social workers, which can show acceptance of clients' feelings and promotes introspection or time to think about what has been learned (*very effective when used with a client who is displaying a high degree of emotion*).<sup>308</sup>
- **Questioning** using open- and closed-ended formats to gather relevant information in a nonjudgmental manner.
- **Reflecting** or **validating** to show empathetic understanding of clients' problems. These techniques can also assist clients in understanding negative thought patterns.
- **Paraphrasing** and **clarifying** by social workers to rephrase what clients are saying in order to join together information. Clarification uses questioning, paraphrasing, and restating to ensure full understanding of clients' ideas and thoughts.
- **Reframing** by social workers shows clients that there are different perspectives and ideas that can help to change negative thinking patterns and promote change.
- Exhibiting desirable **facial expressions**, which include direct eye contact if culturally appropriate, warmth and concern reflected, and varied facial expressions.
- Using desirable **postures or gestures**, which include appropriate arm movements and attentive gestures.

There are many methods that social workers use to facilitate communication with clients. Central to the formation of a therapeutic alliance is displaying empathy. Empathy is distinguished from sympathy as the latter denotes pity or feeling bad for a client, whereas the former means that a social worker understands the ideas expressed, as well as the feelings of a client. To be empathetic, a social worker must

accurately perceive a client's situation, perspective, and feelings, as well as communicate this understanding in a helpful (therapeutic) way.

A social worker should also display *genuineness* in order to build trust. Genuineness is needed in order to establish a therapeutic relationship. It involves listening to and communicating with clients without distorting their messages, as well as being clear and concrete in communications.

Another method is the use of *positive regard*, which is the ability to view a client as being worthy of caring about and as someone who has strengths and achievement potential. It is built on respect and is usually communicated nonverbally.

Communication is also facilitated by *listening*, *attending*, *suspending value judgments*, and *helping* clients develop their own resources. A social worker should always use culturally appropriate communication.

It is also essential to clearly establish *boundaries* with clients to facilitate a safe environment for change.

## **THE CONCEPT OF CONGRUENCE IN COMMUNICATION**

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Communication can be verbal and nonverbal, so an assessment of clients' communication skills must involve both. Role playing is a good way to assess and enhance clients' communication skills. It also allows a social worker to see if there is congruence between nonverbal and verbal communication.

Congruence is the matching of awareness and experience with communication. It is essential that a client is able to communicate freely and that this communication is reflective of the client's feelings. *Congruence is essential for the vitality of a relationship and to facilitate true helping as part of the problem-solving process.*

## **METHODS TO OBTAIN AND PROVIDE FEEDBACK**

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Social workers interface with professionals and others in order to achieve the best possible outcomes for clients. Feedback is essential in order to learn what works and what can be done better.

There is no single method for social workers to seek feedback. Many factors may impact on how such feedback is solicited and

incorporated into practice. However, there are some important principles that social workers should adhere to when obtaining or providing feedback.

1. Feedback may be either verbal or nonverbal, so social workers must make efforts to see what clients are trying to convey verbally or via their behavior and nonverbal cues in order to see whether interventions should be altered.
2. When social workers involve consultants or others in the feedback process related to client care, clients should provide consent.
3. Social workers should ask for feedback in difficult circumstances not just when circumstances appear neutral or positive. It can be tempting only to ask for feedback from people who will say something positive. Sometimes the best learning can be from those who will be critical. Talking through difficult feedback in supervision is important.
4. Feedback is especially critical at key decision points (such as when transferring or terminating with clients).
5. It is important to guard against influencing people to respond in a particular way; this influence may be unintentional, because a social worker may have more influence or power than the individual from whom feedback is sought.
6. Confidentiality should be respected if the informant wants it.
7. Always be clear about why feedback is needed and what will be done with the information.
8. Documentation of feedback is essential.
9. Be aware that the feedback may be very different depending upon when it is solicited. It is critical to realize how recent events may have influenced information received. Getting feedback repeated at several different times may be needed to see if responses differ.
10. A social worker must make sure that the communication method is appropriate. For a younger person, texting, email, or an online questionnaire may work, whereas a face-to-face conversation may be needed for others. The language should be jargon free and accessible.

issues such as language, culture, and disability may affect the ways in which people both understand and react to requests for feedback. A social worker may want to use closed-ended questions and/or open ones to capture needed data.

There are varied methods for feedback. It can be formal or informal,<sup>310</sup> mutual or one-way, written or verbal, personal or impersonal, and/or requested or unsolicited. Feedback can even be anonymous.

The following are some common feedback methods.

## **One-on-One Feedback**

An individual delivering feedback to another, face-to-face, is probably the most common form. Such feedback needs to be delivered sensitively and according to the principles of the profession.

## **Intragroup Feedback**

Individuals in a group provide feedback to the group and/or to one or more individuals within the group. If the feedback is directed to the performance of the group, it can be particularly effective.

## **Group-to-Group Feedback**

This might take place between two groups that are working together. The feedback may go in one direction or both. The feedback might be directed at particular individuals or at the group as a whole.

## **Consultative Feedback**

An individual or group serves as a formal or informal consultant to another (usually to a group, but occasionally to an individual). The individual or group receiving the feedback may be more apt to accept and consider the feedback, given the expertise of the consultative entity, but has no obligation to do so.

## **360° Feedback**

This method involves feedback from all directions—supervisors, peers, subordinates, the community, and so forth. The idea is that the feedback reflects multiple viewpoints and gives a complete picture.

All models of feedback in social work practice should be supportive, use a strengths perspective (emphasizing the positives), not “attack,” and focus on actions needed for change.

# CHAPTER

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# 8

## The Intervention Process

### **THE PRINCIPLES AND TECHNIQUES OF INTERVIEWING (E.G., SUPPORTING, CLARIFYING, FOCUSING, CONFRONTING, VALIDATING, FEEDBACK, REFLECTING, LANGUAGE DIFFERENCES, USE OF INTERPRETERS, REDIRECTING)**

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In social work, an interview is always purposeful and involves verbal and nonverbal communication between a social worker and client, during which ideas, attitudes, and feelings are exchanged. The actions of a social worker aim to gather important information and keep a client focused on the achievement of the goal.

A social work interview is designed to serve the interest of a client; therefore, the actions of a social worker during the interview must be planned and focused. Questions in a social work interview should be tailored to the specifics of a client, not generic, “one size fits all” inquiries. The focus is on the uniqueness of a client and the client’s unique situation.

The purpose of the social work interview can be informational, diagnostic, or therapeutic. The same interview may serve more than one purpose.

Communication during a social work interview is interactive and interrelational. A social worker’s questions will result in specific responses by a client that, in turn, lead to other inquiries. The message is formulated by a client, encoded, transmitted, received, processed, and decoded. The importance of words and messages may be implicit (implied) or explicit (evident). A *social worker should listen, being nonjudgmental, throughout a social work interview.*

There are a number of techniques that a social worker may use during an interview to assist clients.

- *Clarification*—reformulate problem in a client's words to make sure the social worker is on the same wavelength
- *Confrontation*—calling attention to something
- *Interpretation*—pulling together patterns of behavior to get a new understanding
- *Reframing and relabeling*—stating problem in a different way so a client can see possible solutions
  - *Summarization*—identifying key ideas and themes regarding <sup>312</sup> client problems to provide focus and continuity to an interview
  - *Universalization*—the generalization or normalization of behavior

*Summarization* seeks to bring together the important points of a discussion and to give a client and social worker awareness of the progress made. It can give a client a sense that a social worker understands and/or brings a sense of closure. It omits irrelevant information and organizes pertinent aspects of the interaction. It allows a social worker and a client to leave an interaction with the same ideas in mind and provides a sense of closure at the completion of a discussion. Summarizing can be done periodically throughout the discussion or only at its close. But no matter who does it or how frequently it occurs, summarization is a valuable intervention technique.

During summarization, a social worker and a client strive to grasp the significance of what has been said, to formulate the meaning of the information, and to achieve new understandings. Summarization is helpful in pulling together what seems to be disorganized or unrelated material.

There are a variety of summarization approaches. A social worker can summarize the content and essential feelings expressed at any point or at the end of an interaction. A social worker can ask a client to review what has been accomplished or the status of the presenting problem. Finally, a social worker and a client may jointly look at what has been achieved.

Summarization statements can include a social worker saying, “Have I got this correct...?,” “You have said that...,” and/or “During the past hour, you and I have discussed. ...”

Social workers must be proficient in the languages spoken by clients or use qualified interpreters. *It is not appropriate to use family members to*

*interpret or provide services in which social workers are not linguistically competent as valuable information may be missed during social work interviews.* When working with interpreters, social workers should face clients and speak directly to them—not the interpreters. Social workers also should not ask for the opinions of the interpreters or have conversations with them as their focus must be on clients.

## **THE PHASES OF INTERVENTION AND TREATMENT**

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The use of timing in social work interventions is critical. Both verbal expressions and nonverbal communication by a social worker, if timed appropriately, can cause a client to feel joined with a social worker, resulting in a stronger therapeutic alliance that can lead to enhanced outcomes. However, the same expressions or communication at the wrong time can result in a client thinking that a social worker is not aligned or relating to a client's experiences.

Social workers must examine cues provided by clients to determine the appropriateness of communication styles and strategies, as well as when clients are ready to move forward in the problem-solving process. In addition, sometimes a social worker must reassess, with a client, the continued appropriateness of an agreed upon intervention because factors have made it no longer feasible or desirable.

Maslow's hierarchy of needs can help identify which client problems need immediate attention and should be prioritized for intervention first. Often clients have multiple service needs that must be prioritized. Social workers should consider Maslow's hierarchy of needs when working with clients. Clients will need services that address "deficiency needs"<sup>313</sup> (such as those related to physiological, security, social, and esteem concerns) prior to accessing support to promote their "growth needs" (such as self-actualization).

In addition, making sure that psychological and social issues are not caused, and cannot be subsequently addressed, by medical and/or substance use issues is paramount. Social workers should always address these problems first.

Interventions and services are intended to aid clients in alleviating problems impeding their well-being. The interventions used by social workers and the services available to clients are those that are identified as potentially helpful on the basis of the ongoing assessment of clients.

The selection and prioritization of service needs may be driven by many factors, including client desires and motivation, treatment modality

selected, agency setting, available resources, funding and time constraints, and so forth. A social worker should focus on ensuring that service needs chosen are outlined in the intervention or treatment plan and are reevaluated on a regular basis. A social worker should also make sure that the needs are based on an unbiased assessment and client wishes. They should *not* be solely driven by funding and time constraints.

Social workers should *not* recommend only services that are familiar or provided by their employing agencies because this is a “cookie cutter” or “one size fits all” approach.

Social work aims to assist with making change on the micro, mezzo, or macro levels to enhance well-being. Despite the level of intervention, the steps that a social worker takes are similar.

#### Step 1: Engagement with client, group, or community

In *engagement*, a social worker should be actively involved in determining why change is sought, what has precipitated the desire to change now, and the parameters of the helping relationship, including defining the roles of a social worker and the expectations for treatment (what will occur and when it will happen).

#### Step 2: Assessment of strengths and needs

In *assessment*, essential information is collected upon which to define the problem and solutions, as well as identify collateral contacts from which gaps in data can be collected.

#### Step 3: Planning or design of intervention

In *planning*, an understanding of the problem is developed. Goals are developed from this understanding in order to provide a direction to help or assist. Specific action plans are developed and agreed upon in order to specify who will do what, what resources will be needed and how they will be used, and timelines for implementation and review.

#### Step 4: Intervention aimed at making change

In *intervention*, there is active involvement to realize continued progress and sustainable change. Issues that may threaten goal attainment must be addressed. Progress must be tracked and plans and timelines adjusted accordingly.

#### Step 5: Evaluation of efforts

In *evaluation*, subjective reports, in conjunction with objective indicators of progress, should be used to determine when goals and objectives have been met and whether new goals or objectives should be set.

#### Step 6: Termination and anticipation of future needs

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In *termination*, progress that has been achieved should be reviewed and supports anticipated to be needed in the future should be identified.

Usually change does not occur easily and there are stages of change that occur. Understanding these stages can help achieve goals.

Precontemplation	Denial, ignorance of the problem
Contemplation	Ambivalence, conflicted emotion
Preparation	Experimenting with small changes, collecting information about change
Action	Taking direct action toward achieving a goal
Maintenance	Maintaining a new behavior, avoiding temptation
Relapse	Feelings of frustration and failure

In order for real change to occur, all intervention steps must occur and change must be understood in these sequential stages.

To achieve this goal, social workers must engage in interactions at three levels of intervention—micro, mezzo, and macro.

## Micro

At the micro level of intervention, social workers concentrate on helping clients solve their problems. These problems may relate to difficulties with partners/spouses, children, other family members, coworkers, and/or neighbors. At the micro level, social workers help clients to access needed services from other agencies, as well as provide direct support and counseling. This type of social work intervention is often the focus of clinical practice in social work and clients can include individuals, couples, and/or families.

## Mezzo

The second level of intervention for social workers is mezzo (also known as meso). Mezzo interventions apply to larger groups or communities. At the mezzo intervention level, social workers attempt to make connections between the micro and macro levels.

## Macro

The third level of intervention for social workers is macro. This level stresses the importance of economic, historical, sociopolitical, and environmental influences on client well-being and functioning. Social workers determine how these factors can facilitate growth and/or create problems for clients.

Social workers are charged with making systems-level changes that can lead to opportunities and/or reduce barriers. Macro interventions can include creating or changing policies, procedures, regulations, and laws. They are aimed at not only assisting individual clients, but others who are experiencing the same difficulties. The focus of social work to engage in broader macro-level changes is what distinguishes it from other allied professions.<sup>315</sup>

## **PROBLEM-SOLVING MODELS AND APPROACHES (E.G., BRIEF, SOLUTION-FOCUSED METHODS OR TECHNIQUES)**

The problem-solving approach is based on the belief that an inability to cope with a problem is due to some lack of motivation, capacity, or opportunity to solve problems in an appropriate way. Clients' problem-solving capacities or resources are maladaptive or impaired.

The goal of the problem-solving process is to enhance client mental, emotional, and action capacities for coping with problems and/or making accessible the opportunities and resources necessary to generate solutions to problems.

A social worker engages in the problem-solving process via the following steps:

1. Engaging
2. Assessing (includes a focus on client strengths and not just weaknesses)
3. Planning
4. Intervening
5. Evaluating
6. Terminating

## **Short-Term Interventions**

The growing need for time-limited treatment, fueled by the widening influence of managed care in the behavioral health field, has produced a renewed focus on short-term therapy. Short-term interventions vary greatly in their duration.

Research has suggested that a social worker's and client's views on the time of treatment are more important than the duration of treatment itself. Sometimes these approaches are used because of organizational or financial constraints. In other instances, clients are choosing them over open-ended approaches. Although some have been wary of the effectiveness of these techniques to instill long-lasting change, they are being used more broadly than ever before. Some short-term interventions include a crisis intervention model and a cognitive behavioral model.

Although psychoanalysis is often thought of as long term, this was not the case with Freud's early work, and psychoanalysis did not start out this way. A number of short-term psychodynamic approaches focus on the belief that childhood experiences are the root of adult dysfunction.

## THE CLIENT'S/CLIENT SYSTEM'S ROLE IN THE PROBLEM-SOLVING PROCESS

Clients often tend to think of themselves and their problems as unique. A client may think difficulties are so different from those of others that no one else could ever understand them. The client may even enjoy this <sup>316</sup> feeling of uniqueness. It may be a defense against the discomfort of exploring fears of being like others. At this point, a client may not be ready to look at the problem. It is hard to admit difficulties, even to oneself.

There may also be concerns as to whether social workers can really be trusted. Some people, because of unfortunate experiences in their childhoods, grow up with distrust of others. Furthermore, people are generally afraid of what others will think of them.

*A client may only be looking for sympathy, support, and/or empathy, rather than searching for a new way to solve difficulties.* A client may not see that change must occur. When a social worker points out some of the ways in which a client is contributing to a problem, the client may stop listening. Solving the problem often requires a client to confront issues that have been avoided in the past and the client wants to avoid thinking about in the future.

A client may have struggled very hard to achieve independence. The thought of depending on or receiving help from another individual seems to violate something. A client must constantly defend against a sense of

weakness and may have difficulty listening to and using the assistance of another person.

There are also many clients who have strong needs to lean on others. Some spend much of their lives looking for others on whom they can be dependent. In the helping situation, they may constantly and inappropriately seek to repeat this pattern.

## METHODS TO ENGAGE AND MOTIVATE CLIENTS/CLIENT SYSTEMS

A motivational approach aims to help clients realize what needs to change and to get them to talk about their daily lives, as well as their satisfaction with current situations. Social workers want to create doubt that everything is “OK” and help clients recognize consequences of current behaviors or conditions that contribute to dissatisfaction.

It is much easier if clients believe goals can be achieved and life can be different. Sometimes clients are incapacitated by conditions that need to be addressed first (i.e., depression). Social workers can help clients think of a time when things were better or create a picture of what their lives could look like with fewer stresses.

The role of a social worker is to create an atmosphere that is conducive to change and to increase a client’s intrinsic motivation, so that change arises from within rather than being imposed from without.

Motivation is a state of readiness or eagerness to change, which may fluctuate from one time or situation to another.

Some additional techniques include:

- Clearly identifying the problem or risk area
- Explaining why change is important
- Advocating for specific change
- Identifying barriers and working to remove them
- Finding the best course of action
- Setting goals
- Taking steps toward change
- Preventing relapse

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Empathy is a factor that increases motivation, lowers resistance, and fosters greater long-term behavioral change.

## **METHODS TO ENGAGE AND WORK WITH INVOLUNTARY CLIENTS/CLIENT SYSTEMS**

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Social workers often find themselves providing services to those who did not choose to receive them, but instead have to do so as mandated by law, including families in the child protection system, people in the criminal justice system, and so on. Working with involuntary clients can be challenging because they may want to have no contact or may only participate because they feel that they have no other choice.

Often these situations require social workers to receive peer support or supervision to process struggles encountered, as well as reassert their professionalism, because clients may try to test and exhibit anger at social workers, who represent the mandates placed upon them.

Some methods that can be helpful in working with involuntary clients include:

- Acknowledging clients' circumstances and understanding how they came about given clients' histories
- Listening to clients' experiences in order to try to understand how they feel about intervention
- Engaging in clear communication because involuntary clients struggle to understand what is happening to them
- Making clear what the purpose of the intervention is, what clients have control over and what they do not, what is going to happen next, and what the likely consequences will be if they do not participate
- Assisting at an appropriate pace as progress may be slow
- Building trust, even on the smallest scale, by consistently being honest and up-front about the situation and why a social worker is involved
- Giving clients practical assistance when needed to help them fight for their rights
- Paying attention to what is positive in clients' behavior and celebrating achievements

- Showing empathy and viewing clients as more than the problems they brought them into services

## LIMIT-SETTING TECHNIQUES

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Clients of all ages are frequently desperate for an environment with consistent boundaries. For this reason, it is helpful if social workers can learn limit-setting skills. Limit setting is facilitative as clients do not feel safe or accepted in a completely permissive environment.

In addition, although compassion is important for a social worker, it is <sup>318</sup> important to maintain a client–social worker relationship. Understanding boundaries and being able to maintain those boundaries with clients are essential.

## THE TECHNIQUE OF ROLE PLAY

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Role playing is a teaching strategy that offers several advantages. Role playing in social work practice may be seen between supervisor and supervisee or social worker and client.

In all instances, role playing usually raises interest in a topic as clients are not passive recipients in the learning process. In addition, role playing teaches empathy and understanding of different perspectives as clients take on the role of another, learning and acting as that individual would in the specified setting. In role playing, participation helps embed concepts. Role playing gives clarity to information that may be abstract or difficult to understand.

The use of role playing emphasizes personal concerns, problems, behavior, and active participation. It improves interpersonal and communication skills, and enhances communication.

Role playing activities can be divided into four stages:

1. Preparation and explanation of the activity
2. Preparation of the activity
3. Role playing
4. Discussion or debriefing after the role play activity

## ROLE-MODELING TECHNIQUES

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Role modeling emphasizes the importance of learning from observing and imitating and has been used successfully in helping clients acquire new skills, including those associated with assertiveness.

Role modeling works well when it is combined with role play and reinforcement to produce lasting change.

There are different types of modeling, including live modeling, symbolic modeling, participant modeling, or covert modeling.

*Live modeling* refers to watching a real person perform the desired behavior.

*Symbolic modeling* includes filmed or videotaped models demonstrating the desired behavior. Self-modeling is another form of symbolic modeling in which clients are videotaped performing the target behavior.

In *participant modeling*, an individual models anxiety-evoking behaviors for a client and then prompts the client to engage in the behavior.

In *covert modeling*, clients are asked to use their imagination, visualizing a particular behavior as another describes the imaginary situation in detail.

Models in any of these forms may be presented as either a coping or a mastery model. The coping model is shown as initially fearful or incompetent, and then is shown as gradually becoming comfortable and competent performing the feared behavior. The mastery model shows no fear and is competent from the beginning of the demonstration.

## TECHNIQUES FOR HARM REDUCTION FOR SELF AND OTHERS

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A harm reduction approach refers to any program, policy, or intervention that seeks to reduce or minimize the adverse health and social consequences associated with an illness, condition, and/or behavior, such as substance use, without requiring a client to practice abstinence, discontinue use, or completely extinguish the behavior. This definition recognizes that many clients are unwilling or unable to abstain from behaviors or use at any given time and that there is a need to provide them with options that minimize the harm caused by their condition to themselves, to others, and to the community.

Harm reduction complements prevention approaches because it is based on the acceptance that, despite best efforts, clients will engage in

behaviors such as substance use, and are unable or unwilling to stop using substances at any given time.

In addition, clients who use substances may prefer to use informal and nonclinical methods to reduce their consumption or reduce the risks associated with use. Harm reduction is practical, feasible, effective, safe, and cost-effective. Most harm reduction approaches are inexpensive, easy to implement, and have a high impact on individual and community health.

Harm reduction acknowledges the significance of ANY positive change that clients make in their lives; these interventions are designed to “meet clients where they are” currently.

Harm reduction recognizes that intervention can be seen as a continuum with the more feasible options at one end and less feasible, but desirable, ones at the other end. Though desirable, abstinence can be considered difficult to achieve. Thus, social workers should partner with clients to identify actions that can be taken to minimize impacts of their illnesses, conditions, and/or behaviors.

## **METHODS TO TEACH COPING AND OTHER SELF-CARE SKILLS TO CLIENTS/CLIENT SYSTEMS**

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Social workers assist clients in realizing how their lives can improve and/or how they can learn from mistakes that they have made. The techniques that social workers employ are a form of informal or didactic teaching.

For example, social workers may help clients see:

- How their histories have shaped them
- Needs associated with medical and/or behavioral health conditions
- Developmental issues related to various phases across the lifespan
- The workings of systems in which they operate
- Ways of coping in various situations

A social worker must use the problem-solving process to teach clients skills needed to make changes in their lives.

In addition, social workers may collaborate with or inform clients of colleagues who may also assist with more formal teaching, such as

learning to read, obtaining a driver's license, and so on.

## **CLIENT/CLIENT SYSTEM SELF-MONITORING TECHNIQUES**

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Clients are encouraged to pay attention to any subtle shift in feelings. Clients frequently keep thought or emotion logs that include three components: (a) disturbing emotional states, (b) the exact behaviors engaged in at the time of the emotional states, and (c) thoughts that occurred when the emotions emerged. In cognitive behavioral therapy (CBT), homework is often done between sessions to record these encounters. This homework involves client self-monitoring, which is central to this approach.

## **METHODS OF CONFLICT RESOLUTION**

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Management of conflict entails four steps:

1. The recognition of an existing or potential conflict
2. An assessment of the conflict situation
3. The selection of an appropriate strategy
4. Intervention

When previous attempts to resolve a conflict have only escalated the conflict, a useful technique is to structure the interactions between the parties. Structuring techniques include:

1. Decreasing the amount of contact between the parties in the early stages of conflict resolution
2. Decreasing the amount of time between problem-solving sessions
3. Decreasing the formality of problem-solving sessions
4. Limiting the scope of the issues that can be discussed
5. Using a third-party mediator

## **CRISIS INTERVENTION AND TREATMENT APPROACHES**

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A state of crisis is time limited. Brief intervention during a crisis usually provides maximum therapeutic effect. Crisis intervention is a process of actively influencing the psychosocial functioning of clients during a period of disequilibrium or crisis. A *crisis does not need to be precipitated by a major life event*. The goals are to alleviate stress and mobilize coping skills, psychological capabilities, and social resources.

The goals of crisis intervention are to (a) relieve the impact of stress with emotional and social resources, (b) return a client to a previous level of functioning (regain equilibrium), (c) help strengthen coping mechanisms during the crisis period, and (d) develop adaptive coping strategies.

Crisis intervention focuses on the here and now, is time limited (most crises last from 4 to 6 weeks), is directive, and requires high levels of activity and involvement from a social worker. A social worker sets specific goals and tasks in order to increase a client's sense of mastery and control.

## **ANGER MANAGEMENT TECHNIQUES**

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Although everyone gets angry, clients may come to social workers because they are not able to control their anger, causing problems. Anger can also increase risk for developing physical health problems, such as heart disease, stress-related illnesses, insomnia, digestive issues, and/or headaches.

Social workers can assist clients to develop action or treatment plans to change these behaviors. Techniques for assisting clients can include one or more of the following.

### **Relaxation Exercises**

- Deep breathing
- Meditation or repeating calming words/phrases
- Guided imagery
- Yoga
- Stretching or physical exercise

Assisting clients to practice these techniques regularly will result in using them automatically in tense situations.

## Cognitive Techniques

- Replacing destructive thoughts, such as “This is the end of the world” with healthy ones like “This is frustrating, but it will pass”
- Focusing on goals as a way of finding solutions to problems
- Using logic to get a more balanced perspective
- Not using an “all or nothing” approach
- Putting situations into perspective

## Communication Skills

- Slowing down speech to avoid saying something not meant or that one will regret
- Listening to what others are saying
- Thinking about what to say before speaking
- Avoiding defensiveness
- Using humor to lighten the situation

## Environmental Change

- Walking away or leaving situation
- Avoiding people or situations in the future that evoke anger
- Not starting conversations or entering situations that may cause anger when tired or rushed

## **STRESS MANAGEMENT TECHNIQUES**

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Stress is a psychological and/or physical reaction to life events, with most people experiencing it regularly in their own lives. When a life event is seen as a threat, it signals the release of hormones aimed at generating a response. This process has been labeled the “fight-or-flight” response.

Once the threat is gone, clients should return to typical relaxed states, but this may not happen if other threats are presented immediately

thereafter. Thus, stress management is important because it provides tools to deal with threats and minimize the impacts of psychological and/or physical reactions.

The first step in stress management is for clients to monitor their stress levels and identify their stress triggers. These can be major life events, but also those associated with day-to-day life, such as job pressures, relationship problems, or financial difficulties. Positive life events, such as getting a job promotion, getting married, or having children, also can be stressful.

The second step in stress management is to assist clients in identifying what aspects of a situation they can control. Clients can make these changes, as well as benefit from stress-reduction techniques, such as deep breathing, exercise, massage, tai chi, or yoga, to manage those aspects of a situation that cannot be altered. Maintaining a healthy lifestyle is essential to helping manage stress.

Stress will always be a part of life, but assisting clients to manage it can increase their ability to cope with challenges and enhance their psychological and/or physical well-being.

## **THE IMPACT OF OUT-OF-HOME DISPLACEMENT (E.G., NATURAL DISASTER, HOMELESSNESS, IMMIGRATION) ON CLIENTS/CLIENT SYSTEMS**

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The homes in which clients live are part of their self-definition. They are decorated to reflect likes or dislikes, telling others about their occupants and accommodating interests such as gardening, cooking, and others. Homes are seen as extensions of their residents and distinguish people from each other.

Behavior is also cued by the physical environment. Homes remind inhabitants of experiences which took place in the past, as well as what to do in the future. Homes are familiar and are often viewed as safe havens where clients can behave without being judged.

Thus, involuntary displacement outside the home due to hospitalization, incarceration, needed safety, or long-term care needs can be traumatic for many reasons. First, such movement may be associated with losses such as those due to health issues, financial concerns, or safety problems. These losses alone can cause depression, anxiety, confusion, and/or other emotional reactions, which are compounded from having to move from the communities or homes in which clients live.

In out-of-home placements, clients may have changes in roles, causing them to develop poor self-image. For example, the roles of neighbor, community leader, gardener, and so on, which provided fulfillment and recognition, may be lost and no longer possible. Since there is also status attached to these roles, their loss can negatively affect self-image.

There also may be a loss of possessions associated with displacement. Precious items that represent a lifetime of memories may have been destroyed, such as by a natural disaster, or sold/given away as there <sup>323</sup> may be no room to keep them in the new settings—especially if they are shared with others.

There also may be a cost associated with involuntary displacement. For example, long-term care can drain client assets and make clients feel guilty about spending money on themselves or fearful about running out of funds for sustained care and housing.

Out-of-home displacement also often accompanies loss of relationships. Relatives and friends who interfaced with clients in their homes may find it inconvenient or impossible to see them in the new settings. Sometimes the lack of private space in which to visit puts up barriers. Visitors may also be intimidated by the sights and sounds of hospitals, jails, or nursing homes.

Clients frequently do not have the same freedom or control that they had when they were at home. In congregate settings, meals, activities, room cleaning, and bathing may be overseen and scheduled for the sake of organization and efficiency, and there are usually numerous rules, policies, and procedures to follow with less individual autonomy and choice.

## **METHODS TO CREATE, IMPLEMENT, AND EVALUATE POLICIES AND PROCEDURES THAT MINIMIZE RISK FOR INDIVIDUALS, FAMILIES, GROUPS, ORGANIZATIONS, AND COMMUNITIES**

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Social workers should create, implement, and evaluate policies that minimize risk for clients, workers, and practice settings. One critical feature of implementing a comprehensive risk management strategy is conducting a comprehensive ethics audit. An ethics audit entails examining risks through the following steps:

1. Appointing a committee or task force of concerned and informed staff and colleagues
2. Gathering information from agency documents, interviews with staff and clients, accreditation reports, and other sources to assess risks associated with client rights; confidentiality and privacy; informed consent; service delivery; boundary issues; conflicts of interest; documentation; client records; supervision; staff development and training; consultation; client referral; fraud; termination of services; professional impairment; misconduct, or incompetence; and so on
3. Reviewing all collected information
4. Determining whether there is no risk, minimal risk, moderate risk, or high risk in each area
5. Preparing action plans to address each risk, paying particular attention to policies that need to be created to prevent risk in the future and steps needed to mitigate existing risk
6. Monitoring policy implementation and progress made toward reducing existing risk, as well as ensuring that procedures adhere to social work's core ethical principles

Risk management is an ongoing process and must consist of preventive strategies as well as corrective actions that result from audits done routinely or in response to particular concerns or complaints.

## PSYCHOTHERAPIES

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Psychotherapy aims to treat clients with mental disorders or problems by helping them understand their illness or situation. Social workers use verbal techniques to teach clients strategies to deal with stress, unhealthy thoughts, and dysfunctional behaviors. Psychotherapy helps clients manage their symptoms better and function optimally in everyday life.

Sometimes, psychotherapy alone may be the best treatment for a client, depending on the illness and its severity. Other times, psychotherapy is combined with the use of medication or a psychopharmacological approach.

There are many kinds of psychotherapy, so social workers must determine which is best to meet a client's need. A social worker should not use a "one size fits all approach" or a particular type of psychotherapy

because it is more familiar or convenient. Some psychotherapies have been scientifically tested more than others for particular disorders.

For example, cognitive behavioral therapy (CBT), a blend of cognitive and behavioral therapy, is used for depression, anxiety, and other disorders. Dialectical behavior therapy (DBT), a form of CBT developed by Marsha Linehan, was developed to treat people with suicidal thoughts and actions. It is now also used to treat people with Borderline Personality Disorder. A social worker assures a client that the client's feelings are valid and understandable, but coaches him or her to understand that they are unhealthy or disruptive and a balance must be achieved. A client understands that it is the client's personal responsibility to change the situation.

Some psychotherapies are effective with children and adolescents and can also be used with families.

## **PSYCHOANALYTIC AND PSYCHODYNAMIC APPROACHES**

Psychodynamic theories explain the origin of the personality. Although many different psychodynamic theories exist, they all emphasize unconscious motives and desires, as well as the importance of childhood experiences in shaping personality.

Psychodynamic approaches aim to help clients review emotions, thoughts, early life experiences, and beliefs in order to gain insight into their lives and their present-day problems. Recognizing recurring patterns helps clients see the ways in which they avoid distress and/or develop defense mechanisms as methods of coping so that they can take steps to change these patterns.

In order to keep painful feelings, memories, and experiences in the unconscious, clients tend to develop defense mechanisms, such as denial, repression, rationalization, and others. Social workers using psychodynamic approaches encourage clients to speak freely about their emotions, desires, and fears in order to reveal vulnerable feelings that have been pushed out of conscious awareness. According to psychodynamic theory, behavior is influenced by unconscious thought; vulnerable or painful feelings are resolved by the use of defense mechanisms.

The therapeutic relationship is central to psychodynamic approaches because it takes an intimate look at interpersonal relationships so that clients can see relationship patterns. It also empowers clients, through insight and self-awareness, to transform dysfunctional dynamics.

## Psychoanalytic Theory

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Originally developed by Sigmund Freud, a client is seen as the product of his past and treatment involves dealing with the repressed material in the unconscious. According to psychoanalytic theory, personalities arise because of attempts to resolve conflicts between unconscious sexual and aggressive impulses and societal demands to restrain these impulses.

Freud believed that behavior and personality derive from the constant and unique interaction of conflicting psychological forces that operate at **three different levels of awareness:** the preconscious, the conscious, and the unconscious.

The **conscious** contains all the information that a client is paying attention to at any given time.

The **preconscious** contains all the information outside of a client's attention but readily available if needed—thoughts and feelings that can be brought into consciousness easily.

The **unconscious** contains thoughts, feelings, desires, and memories of which clients have no awareness but that influence every aspect of their day-to-day lives.

Freud proposed that personalities have three components: the id, the ego, and the superego.

- **Id:** A reservoir of instinctual energy that contains biological urges such as impulses toward survival, sex, and aggression. The id is unconscious and operates according to the **pleasure principle**, the drive to achieve pleasure and avoid pain.
- **Ego:** The component that manages the conflict between the id and the constraints of the real world. Some parts of the ego are unconscious whereas others are preconscious or conscious. The ego operates according to the reality principle—the awareness that gratification of impulses has to be delayed in order to accommodate the demands of the real world. The ego's role is to prevent the id from gratifying impulses in socially inappropriate ways.

### *Ego-Syntonic/Ego-Dystonic:*

- Syntonic = behaviors “insync” with the ego (no guilt)
- Dystonic = behavior “dis-n-sync” with the ego (guilt)

The ego's job is to determine the best course of action based on information from the id, reality, and the superego. When the ego is comfortable with its conclusions and behaviors, a client is said to be ego-syntonic. However, if a client is bothered by some behaviors, the client would be ego-dystonic (ego alien).

Inability of the ego to reconcile the demands of the id, the superego, and reality produces conflict that leads to a state of psychic distress known as anxiety.

**Ego strength** is the ability of the ego to effectively deal with the demands of the id, the superego, and reality. Those with little ego strength may feel torn between these competing demands, whereas those with too much ego strength can become too unyielding and rigid. Ego strength helps maintain emotional stability and cope with internal and external stress.

- **Superego:** The moral component of personality. It contains all the moral standards learned from parents and society. The superego forces the ego to conform not only to reality, but also to its ideals of morality. Hence, the superego causes clients to feel guilty when they go against society's rules.

## Psychosexual Stages of Development

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Freud believed that personality solidifies during childhood, largely before age 5. He proposed five stages of psychosexual development: the oral stage, the anal stage, the phallic stage; the latency stage, and the genital stage. He believed that at each stage of development, children gain sexual gratification or sensual pleasure from a particular part of their bodies. Each stage has special conflicts, and children's ways of managing these conflicts influence their personalities.

If a child's needs in a particular stage are gratified too much or frustrated too much, the child can become fixated at that stage of development. **Fixation** is an inability to progress normally from one stage into another. When the child becomes an adult, the fixation shows up as a tendency to focus on the needs that were overgratified or overfrustrated.

Freud believed that the crucially important **Oedipus complex** also developed during the phallic stage. The Oedipus complex refers to a male child's sexual desire for his mother and hostility toward his father, whom

he considers to be a rival for his mother's love. Freud thought that a male child who sees a naked girl for the first time believes that her penis has been cut off. The child fears that his own father will do the same to him for desiring his mother—a fear called **castration anxiety**. Because of this fear, the child represses his longing for his mother and begins to identify with his father. The child's acceptance of his father's authority results in the emergence of the superego.

Stage	Age	Sources of pleasure	Result of fixation
Oral	Birth to roughly 12 months	Activities involving the mouth, such as sucking, biting, and chewing	Excessive smoking, overeating, or dependence on others
Anal	Age 2, when the child is being toilet trained	Bowel movements	An overly controlling (anal-retentive) personality or an easily angered (anal-expulsive) personality
Phallic	Age 3–5	Genitals	Guilt or anxiety about sex
Latency	Age 5 to puberty	Sexuality is latent, or dormant, during this period	No fixations at this stage
Genital	Begins at puberty	The genitals; sexual urges return	No fixations at this stage

In psychoanalytic psychotherapy, the primary technique used is analysis (of dreams, resistances, transferences, and free associations).

## Individual Psychology

Alfred Adler, a follower of Freud and a member of his inner circle, eventually broke away from Freud and developed his own school of thought, which he called “individual psychology.” Adler believed that <sup>327</sup> the **main motivations for human behavior are not sexual or aggressive urges, but striving for perfection**. He pointed out that children naturally feel weak and inadequate in comparison to adults. This normal feeling of inferiority drives them to adapt, develop skills, and master challenges. Adler used the term “**compensation**” to refer to the attempt to shed normal feelings of inferiority.

However, some people suffer from an exaggerated sense of **inferiority**. Such people overcompensate, which means that, rather than

try to master challenges, they try to cover up their sense of inferiority by focusing on outward signs of superiority such as status, wealth, and power.

Healthy individuals have a broad social concern and want to contribute to the welfare of others. Unhealthy people are those who are overwhelmed by feelings of inferiority.

The aim of therapy is to develop a more adaptive lifestyle by overcoming feelings of inferiority and self-centeredness and to contribute more toward the welfare of others.

## Self Psychology

This approach defines the self as the central organizing and motivating force in personality. As a result of receiving empathic responses from early caretakers (self-objects), a child's needs are met and the child develops a strong sense of selfhood. "Empathic failures" by caretakers result in a lack of self-cohesion.

The objective of self psychology is to help a client develop a greater sense of self-cohesion. Through therapeutic regression, a client reexperiences frustrated self-object needs.

Three self-object needs are:

- **Mirroring:** behavior validates the child's sense of a perfect self.
- **Idealization:** child borrows strength from others and identifies w someone more capable.
- **Twinship/Twinning:** child needs an alter ego for a sense belonging.

## Ego Psychology

Ego psychology focuses on the rational, conscious processes of the ego. Ego psychology is based on an assessment of a client as presented in the present (here and now). Treatment focuses on the ego functioning of a client, because healthy behavior is under the control of the ego. It addresses:

- Behavior in varying situations
- Reality testing: perception of a situation

- Coping abilities: ego strengths
- Capacity for relating to others

The goal is to maintain and enhance the ego's control and management of stress and its effects.

## Object Relations Theory

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Object relations theory, which was a focus of Margaret Mahler's work, is centered on relationships with others. According to this theory, lifelong relationship skills are strongly rooted in early attachments with parents, especially mothers. Objects refer to people, parts of people, or physical items that symbolically represent either a person or part of a person. Object relations, then, are relationships to those people or items.

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Age	Phase	Subphase	Characteristics
0–1 month	Normal autism		First few weeks of life. The infant is detached and self-absorbed. Spends most of time sleeping. Mahler later abandoned this phase, based on new findings from her infant research.
1–5 months	Normal symbiotic		The child is now aware of the mother, but there is not a sense of individuality. The infant and the mother are one, and there is a barrier between them and the rest of the world.
5–9 months	Separation/ Individuation	Differentiation/ Hatching	The infant ceases to be ignorant of the differentiation between him or her and the mother. Increased alertness and interest for the outside world. Using the mother as a point of orientation.
9–15 months		Practicing	Brought about by the infant's ability to crawl and then walk freely; the infant begins to explore actively and becomes more distant from the mother.
15–24 months		Rapprochement	The infant once again becomes close to the mother. The child realizes that physical mobility demonstrates psychic separateness from the mother. The toddler may become tentative, wanting the mother to be in sight so that, through eye contact and action, the toddler can explore the world. The risk is that the mother will misread this need and respond with impatience or unavailability. This can lead to an anxious fear of abandonment in the toddler.

Age	Phase	Subphase	Characteristics
24–38 months	Object Constancy		Describes the phase when the child understands that the mother has a separate identity and is truly a separate individual. Provides the child with an image that helps supply him or her with an unconscious level of guiding support and comfort. Deficiencies in positive internalization could possibly lead to a sense of insecurity and low self-esteem issues in adulthood.

## COGNITIVE AND BEHAVIORAL INTERVENTIONS

Cognitive behavioral therapy (CBT) is a hands-on, practical approach to problem solving. Its goal is to change patterns of thinking or behavior that are responsible for clients' difficulties, and so change the way they feel. CBT works by changing clients' attitudes and their behavior by focusing on the thoughts, images, beliefs, and attitudes that are held (cognitive processes) and how this relates to behavior, as a way of dealing with emotional problems.

CBT can be thought of as a combination of psychotherapy and behavioral therapy. Psychotherapy emphasizes the importance of the personal meaning placed on things and how thinking patterns begin in childhood. Behavioral therapy pays close attention to the relationship between problems, behaviors, and thoughts.

This approach is active, collaborative, structured, time limited, goal oriented, and problem focused. This approach lends itself to the requirements posed by managed care companies, including brief treatment, well-delineated techniques, goal and problem oriented, and empirically supported evidence of its effectiveness.

### Steps in Cognitive Restructuring

Assist clients in:

1. Accepting that their self-statements, assumptions, and beliefs determine or govern their emotional reaction to life's events
2. Identifying dysfunctional beliefs and patterns of thoughts that underlie their problems
3. Identifying situations that evoke dysfunctional cognitions
4. Substituting functional self-statements in place of self-defeating thoughts
5. Rewarding themselves for successful coping efforts

Foundational to this treatment is client self-monitoring. Clients are encouraged to pay attention to any subtle shift in feelings. Clients frequently keep thought or emotion logs that include three components: (a) disturbing emotional states (b) the exact behaviors engaged in at the time of the emotional states and (c) thoughts that occurred when the emotions emerged. Homework is often done between sessions to record these encounters.<sup>330</sup>

## **STRENGTHS-BASED AND EMPOWERMENT STRATEGIES AND INTERVENTIONS**

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The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (*NASW Code of Ethics—Preamble*).

Empowerment aims to ensure a sense of control over well-being and that change is possible. A social worker can help to empower individuals, groups, communities, and institutions.

On an individual level, social workers can engage in a process with a client aimed at strengthening self-worth by making a change in life that is based on personal desires (self-determination).

To facilitate empowerment, a social worker should:

- Establish a relationship aimed at meeting a client's needs and wishes such as access to social services and benefits or to other sources of information.
- Educate a client to improve skills, thereby increasing the ability for self-determination.

help.

- Help a client to secure resources, such as those from other organizations or agencies, as well as natural support networks, to meet needs.
- Unite a client with others who are experiencing the same issues who needed to enable social and political action.

Social workers should also use an empowerment process with groups, communities, and institutions so they may gain or regain the capacity to meet human needs, enhance overall well-being and potential, and provide individuals control over their lives to the extent possible.

A social worker needs many skills that focus on the activation of resources, the creation of alliances, and the expansion of opportunities in order to facilitate empowerment.

## **CLIENT/CLIENT SYSTEM CONTRACTING AND GOAL-SETTING TECHNIQUES**

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A social worker and client work together to develop a contract (intervention or service plan), including an agreement on its implementation or the activities used to help a client attain identified goals. Modification of the contract may be required as new information about a client's situation emerges and/or as the situation changes.

When clients seek to attain their goals, changes may need to be made to themselves, groups, families, and/or systems in the larger environment. This choice of targets is an even more complex issue than it first appears because the process of changing one system may bring about changes in others.

### **Change Strategies**

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- *Modify systems:* The decision to help a client on a one-to-one basis in the context of a larger system must take into consideration a client's preferences and previous experiences, as well as the degree to which a client's problem is a response to forces within the larger system and whether change can be readily attained by a change in the larger system.
- *Modify individual thoughts:* A social worker may teach how to problem

solve, alter self-concepts by modifying self-defeating statements and/or make interpretations to increase a client's understanding about the relationship between events in the client's life.

- *Modify individual actions:* A social worker may use behavior modification techniques, such as reinforcement, punishment, modeling, role playing, and/or task assignments. *Modeling and role modeling are very effective methods for teaching. They should be used whenever possible.*
- Thoughts can be modified by *feedback from others* and behaviors can be modified through the *actions of others* in a system (by altering reinforcements).
- A social worker can also *advocate* for a client and seek to secure change in a system on the client's behalf.
- A social worker can be a *mediator* by helping a client and another individual or system to negotiate with each other so that each may attain their respective goals.

## PARTIALIZING TECHNIQUES

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During the problem-solving process, a social worker may need to assist a client to break down problems or goals into less overwhelming and more manageable components. This is known as partialization and aims to break complex issues into simpler ones.

Partialization is useful because it may assist a social worker and a client to identify the goals that are easier to achieve first, enabling a client to see results more quickly and gain some success in making harder changes. Partialization can also help individuals to order the problems or goals that need more immediate help from those that can be addressed later. A social worker can use Maslow's hierarchy of needs as one tool to assist in making decisions about more pressing needs. In addition, a client should be asked to prioritize concerns or goals.

When outlining the goals for treatment, it is important that the broad overarching aims of treatment are broken down by a social worker and client into smaller, more tangible items that must be achieved in order to reach the overall goal. Behavioral objectives are the smaller, observable, and measurable intermediate steps that lead to broader long-term goals. Behavioral objectives help a social worker and client understand whether

the strategies they are using to achieve the goal are resulting in change or whether they need to modify their efforts to improve the likelihood of accomplishing the desired outcome.

There are several important elements of behavioral objectives:

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1. Good behavioral objectives are client-oriented and place the emphasis upon what a client will need to do in order for change to occur.
2. Good behavioral objectives are clear and understandable and contain a clearly stated verb that describes a definite action or behavior.
3. Good behavioral objectives are observable and describe an action that results in observable products.
4. Good behavioral objectives contain the behavior targeted for change, conditions under which a behavior will be performed, and the criteria for determining when the acceptable performance of the behavior occurs.

## **ASSERTIVENESS TRAINING**

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Assertiveness training is when procedures are used to teach clients how to express their positive and negative feelings and to stand up for their rights in ways that will not alienate others.

Assertiveness training typically begins with clients thinking about areas in their life in which they have difficulty asserting themselves. The next stage usually involves role plays designed to help clients practice clearer and more direct forms of communicating with others. Feedback is provided to improve responses, and the role play is repeated. Clients are asked to practice assertive techniques in everyday life.

Assertiveness training promotes the use of "I" statements as a way to help clients express their feelings. "I" statements tell others how their actions may cause clients to be upset, but are in contrast with "you" statements, which are often seen as blaming or aggressive.

Learning specific techniques and perspectives, such as self-observation skills, awareness of personal preferences, and assuming personal responsibility, are important components of the assertiveness training process.

## **TASK-CENTERED APPROACHES**

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A task-centered approach aims to quickly engage clients in the problem-solving process and to maximize their responsibility for treatment outcomes. In this modality, the duration of treatment is usually limited due to setting constraints, limitations imposed by third-party payers, or other reasons. Thus, at the outset, the expectation is that interventions from learning theory and behavior modification will be used to promote completion of a well-defined task to produce measurable outcomes. The focus is on the “here and now.” This type of practice is often preferred by clients, as they are able to see more immediate results.

The problem is partialized into clearly delineated tasks to be addressed consecutively (assessment leads to goals, which lead to tasks). A client must be able to identify a precise psychosocial problem and a solution confined to a specific change in behavior or a change of circumstances. A client must also be willing to work on the problem. It is essential that a social worker and client establish a strong working relationship quickly.<sup>333</sup> A social worker’s therapeutic style must be highly active, empathic, and sometimes directive in this approach.

Assessment focuses on helping a client identify the primary problem and explore the circumstances surrounding the problem. Specific tasks are expected to evolve from this process. Consideration is given to how a client would ideally like to see the problem resolved. Termination, in this modality, begins almost immediately upon the onset of treatment.

## **PSYCHOEDUCATION METHODS (E.G., ACKNOWLEDGING, SUPPORTING, NORMALIZING)**

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One of the ways that social workers provide information to clients is through psychoeducation. This model allows a social worker to provide clients with information necessary to make informed decisions that will allow them to reach their respective goals. In addition to focusing on clients’ education, it also provides support and coping skills development.

Psychoeducation is delivered in many service settings and with many types of client populations. It is provided to those who are experiencing some sort of issue or problem with the rationale that, with a clear understanding of the problem, as well as self-knowledge of strengths, community resources, and coping skills, clients are better equipped to deal with problems and to contribute to their emotional well-being.

The core psychoeducational principle is that education has a role in emotional and behavioral change. With an improved understanding of the

causes and effects of problems, psychoeducation broadens clients' perception and interpretation of them, positively influencing clients' emotions and behavior. In other words, clients feel less helpless about the situation and more in control of themselves.

## **GROUP WORK TECHNIQUES AND APPROACHES (E.G., DEVELOPING AND MANAGING GROUP PROCESSES AND COHESION)**

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Group work is a method of working with two or more people for personal growth, the enhancement of social functioning, and/or for the achievement of socially desirable goals.

Social workers use their knowledge of group organization and functioning to affect the performance and adjustment of individuals. Individuals remain the focus of concern and the group is the vehicle of growth and change. *When individual problems arise, they should be directed to the group for possible solutions as the group is the agent of change. Social workers must remind group members that confidentiality cannot be guaranteed—though seeing an agreement among group members concerning preserving the confidentiality of information shared should be an initial goal of any group process.*

**Contraindications for group:** client who is *in crisis; suicidal; compulsively needy for attention; actively psychotic; and/or paranoid*

There are different kinds of groups.

### **Open Versus Closed**

Open groups are those in which new members can join at any time. Closed groups are those in which all members begin the group at the same time.

### **Short-Term Versus Long-Term**

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Some groups have a very short duration, whereas others meet for a longer duration.

A social worker takes on different roles throughout the group process, which has a beginning, middle, and end.

### **Beginning**

A social worker identifies the purpose of the group and the social worker's role. This stage is characterized as a time to convene, to organize, and to set a plan. Members are likely to remain distant or removed until they have had time to develop relationships.

### **Middle**

Almost all of the group's work will occur during this stage. Relationships are strengthened as a group so that the tasks can be worked on. Group leaders are usually less involved.

### **End**

The group reviews its accomplishments. Feelings associated with the termination of the group are addressed.

## **FAMILY THERAPY MODELS, INTERVENTIONS, AND APPROACHES**

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Working with families has always been central to social work practice. Family interventions require treating not just an individual but all those within a family unit, with the focus of assessment and intervention directed at the interaction of family members.

In order to work effectively with families, social workers must:

1. Understand the development of, as well as the historical, conceptual and contextual issues influencing, family functioning.
2. Have awareness of the impact of diversity in working with families particularly race, class, culture, ethnicity, gender, sexual preferences, aging, and disabilities.
3. Understand the impact of a social worker's family of origin, current family structure, and its influence on a social worker's interventions with families.
4. Be aware of the needs of families experiencing unique family problems (domestic violence, blended families, trauma and loss, adopted families, etc.).

Social workers use a variety of techniques to work with families. Family therapy treats the family as a unified whole—a system of

interacting parts in which change in any part affects the functioning of the overall system. The family is the unit of attention for diagnosis and treatment. Social roles and interpersonal interaction are the focus of treatment. Real behaviors and communication that affect current life situations are addressed. The goal is to interrupt the circular pattern of pathological communication and behaviors and replace it with a new pattern that will sustain itself without the dysfunctional aspects of the original pattern.

Key clinical issues include:

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- Establishing a contract with the family
- Examining alliances within the family
- Identifying where power resides
- Determining the relationship of each family member to the problem
- Seeing how the family relates to the outside world
- Assessing influence of family history on current family interactions
- Ascertaining communication patterns
- Identifying family rules that regulate patterns of interaction
- Determining meaning of presenting symptom in maintaining family homeostasis
- Examining flexibility of structure and accessibility of alternative action patterns
- Finding out about sources of external stress and support

## Recognition of Functional Roles in Family Dynamics

Roles are extremely important in family functioning, with the establishment of clear roles directly connected to family well-being and the ability to handle crises.

Family members have both instrumental and affective functions that are essential for positive well-being. Instrumental functions are concerned with the provision of physical resources (i.e., food, clothing, and shelter) and decision making. Affective functions involve the provision of emotional support to family members.

In order for families to maintain emotional and physical health, family members must fulfill essential roles. Sometimes these roles are assumed by multiple family members; in other instances, separate family members may meet each of these needs. Often individuals have multiple roles within family units.

## **Roles in Healthy Families**

### *Provision of Resources*

The provision of resources is an instrumental role that fulfills the most basic needs of the family unit: having money, food, clothing, and shelter.

### *Emotional Support*

Supporting other family members is primarily an affective role and includes providing comfort and support.

### *Life Skills Development*

One of the functions of families is the physical, emotional, educational, and social development of children. This role ensures that life skills development of members occurs.

### *Family System Management*

Decision making, handling finances, and maintaining appropriate boundaries and behavioral standards are critical to maintaining a healthy family dynamic.

### *Intimate Relationship Maintenance*

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Intimate relationships, including sexual ones, are critical between partners and couples. Ensuring that quality intimate relationships are maintained is essential to meeting the emotional needs of partners and spouses.

In dysfunctional families, such as those with members who have substance use problems, members may assume codependent roles, including functioning as the *Family Hero*, the *Scapegoat*, the *Mascot*, and/or the *Lost Child*.

The *Family Hero*, often the oldest child, devotes time and attention to minimizing or masking problems. By overachieving and being successful in school or work, the Family Hero tries to make up for a dysfunctional home life.

The *Scapegoat* is defiant, hostile, and angry, and gets in trouble at school or work. The behavior turns the focus away from dysfunction in the family.

The *Mascot* tries to get people to laugh as a way of improving the atmosphere and drawing attention away from the dysfunctional household.

The *Lost Child* becomes a loner or is very shy. The Lost Child draws away from interactions with family members and becomes invisible in order to avoid adding to the dysfunction or stain.

The following are some types of family therapy.

## Strategic Family Therapy

In strategic family therapy, a social worker initiates what happens during therapy, designs a specific approach for each person's presenting problem, and takes responsibility for directly influencing people.

It has roots in structural family therapy and is built on communication theory.

It is active, brief, directive, and task-centered. Strategic family therapy is more interested in creating change in behavior than change in understanding.

Strategic family therapy is based on the assumption that families are flexible enough to modify solutions that do not work and adjust or develop. There is the assumption that all problems have multiple origins; a presenting problem is viewed as a symptom of and a response to current dysfunction in family interactions.

Therapy focuses on problem resolution by altering the feedback cycle or loop that maintains the symptomatic behavior. The social worker's task is to formulate the problem in solvable, behavioral terms and to design an intervention plan to change the dysfunctional family pattern.

## Concepts/Techniques

- Pretend technique—encourage family members to “pretend” a encourage voluntary control of behavior
- First-order changes—superficial behavioral changes within a system that do not change the structure of the system
- Second-order changes—changes to the systematic interaction pattern

so the system is reorganized and functions more effectively

- Family homeostasis—families tend to preserve familiar <sup>337</sup> organization and communication patterns; resistant to change
- Relabeling—changing the label attached to a person or problem from negative to positive so the situation can be perceived differently; it is hoped that new responses will evolve
- Paradoxical directive or instruction—prescribe the symptom behavior so a client realizes control over it; uses the strength of the resistance to change in order to move a client toward goals

## Structural Family Therapy

This approach stresses the importance of family organization for the functioning of the group and the well-being of its members. A social worker “joins” (engages) the family in an effort to restructure it. Family structure is defined as the invisible set of functional demands organizing interaction among family members. Boundaries and rules determining who does what, where, and when are crucial in three ways.

1. Interpersonal boundaries define individual family members and promote their differentiation and autonomy, yet interdependent functioning. Dysfunctional families tend to be characterized by either a pattern of rigid enmeshment or disengagement.
2. Boundaries with the outside world define the family unit, and boundaries must be permeable enough to maintain a well-functioning open system, allowing contact and reciprocal exchanges with the social world.
3. Hierarchical organization in families of all cultures is maintained through generational boundaries, the rules differentiating parent and child roles, rights, and obligations.

Restructuring is based on observing and manipulating interactions within therapy sessions, often by enactments of situations as a way to understand and diagnose the structure and provide an opportunity for restructuring.

## Bowenian Family Therapy

Unlike other models of family therapy, the goal of this approach is not symptom reduction. Rather, a Bowenian-trained social worker is interested in improving the intergenerational transmission process. Thus, the focus within this approach is consistent whether a social worker is working with an individual, a couple, or the entire family. It is assumed that improvement in overall functioning will ultimately reduce a family member's symptomatology. Eight major theoretical constructs are essential to understanding Bowen's approach. These concepts are differentiation, emotional fusion, multigenerational transmission, emotional triangle, nuclear family, family projection process, sibling position, and societal regression. These constructs are interconnected.

**Differentiation** is the core concept of this approach. The more differentiated, the more a client can be an individual while in emotional contact with the family. This allows a client to think through a situation without being drawn to act by either internal or external emotional pressures.

**Emotional fusion** is the counterpart of differentiation and <sup>338</sup> refers to the tendency for family members to share an emotional response. This is the result of poor interpersonal boundaries between family members. In a fused family, there is little room for emotional autonomy. If a member makes a move toward autonomy, it is experienced as abandonment by other members of the family.

**Multigenerational transmission** stresses the connection of current generations to past generations as a natural process. Multigenerational transmission gives the present a context in history. This context can focus a social worker on the differentiation in the system and on the transmission process.

An **emotional triangle** is the network of relationships among three people. Bowen's theory states that a relationship can remain stable until anxiety is introduced. However, when anxiety is introduced into the dyad, a third party is recruited into a triangle to reduce the overall anxiety. It is almost impossible for two people to interact without triangulation.

The **nuclear family** is the most basic unit in society and there is a concern over the degree to which emotional fusion can occur in a family system. Clients forming relationships outside of the nuclear family tend to pick mates with the same level of differentiation.

**Family projection process** describes the primary way parents transmit their emotional problems to children. The projection process can impair child functioning and increase vulnerability to clinical symptoms.

**Sibling position** is a factor in determining personality. Where a client is in birth order has an influence on how the client relates to parents and siblings. Birth order determines the triangles that clients grow up in.

**Societal regression**, in contrast to progression, is manifested by problems such as the depletion of natural resources. Bowen's theory can be used to explain societal anxieties and social problems, because Bowen viewed society as a family—an emotional system complete with its own multigenerational transmission, chronic anxiety, emotional triangles, cutoffs, projection processes, and fusion/differentiation struggles.

## COUPLES INTERVENTIONS AND TREATMENT APPROACHES

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There are often reasons that couples experience problems including, but not limited to:

- Retriggering emotional trauma and not repairing it
- An inability to bond or reconnect after hurting or doing damage to one another
- Lack of skills or knowledge

Many treatment techniques are used with individuals that can be adapted in work with couples, including:

*Behavior modification*—Successful couples counseling methods will address and attempt to modify any dysfunctional behavior so that couples can change the way each individual behaves with the other.

*Insight-oriented psychotherapy*—A good deal of time is spent studying interactions between individuals in order to develop a hypothesis concerning what caused individuals to react to each other in the way they do.<sup>339</sup>

There are also specific couples therapy approaches, including the *Gottman Method*, which is based on the notion that healthy relationships are ones in which individuals know each other's stresses and worries, share fondness and admiration, maintain a sense of positiveness, manage conflicts, trust one another, and are committed to one another.

The Gottman Method focuses on conflicting verbal communication in order to increase intimacy, respect, and affection; removes barriers that create a feeling of stagnancy in conflicting situations; and creates a heightened sense of empathy and understanding within relationships.

With all approaches, there are actions that a social worker can take to facilitate effective couples' treatment.

For example, when developing a collaborative alliance with each person, a social worker should validate the experience of each and explore each person's reservations about engaging in couples therapy. In addition, when developing an alliance with the couple as a unit, a social worker can reframe individual problems in relationship terms and support each person's sense of self as being part of a unit, as well as a separate individual.

## PERMANENCY PLANNING

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Permanency planning is an approach to child welfare that is based on the belief that children need permanence to thrive. Child protection services should focus on getting children into, and maintaining, permanent homes.

In permanency planning, the first goal is to get children back into their original homes. This can be achieved with a thorough investigation into child protection situations to determine if homes are safe and, if needed, exploring ideas for making them safer or more enriching for children.

Supports can include getting caregivers services for meeting needs or providing education, if needed, to ensure adequate and quality care. If children cannot return to their original homes, steps need to be made so that they can get into permanent living situations as quickly as possible with adults with whom they have continuous and reciprocal relationships, including those made available through adoption.

Family preservation helps keep families together and children out of foster care or other out-of-home placements. Efforts focus on family reunification or adoption if children are removed from homes. Plans for children involved in protection services must be reviewed regularly and "reasonable efforts" must be made to keep families together via prevention and family reunification services. There are often financial

subsidies to assist with facilitating the adoption of children with complex needs or disabilities.

## MINDFULNESS AND COMPLEMENTARY THERAPEUTIC APPROACHES

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Social workers continue to provide the bulk of mental health services. A significant number of persons seek services expecting providers to be aware and knowledgeable about alternatives and complements to <sup>340</sup> Western medical approaches for symptom relief and healing when their medical or behavioral health is disrupted and/or compromised. An ever increasing number of people are seeking complementary and alternative medicine (CAM) or integrated health care (IHC) to address health/behavioral health issues. Not only are clients receptive to the use of complementary approaches, they often request diverse approaches that go beyond medications and psychotherapy to address their overall concerns. Thus, social workers must have knowledge of mindfulness and complementary therapeutic approaches.

Interventions and remedies that some cultures and populations consider conventional, others view as alternative, and what some clients assess as successful outcomes, some professionals may not concur.

**Mindfulness** is the practice of paying close attention to what is being experienced in the present, both inside the body and mind and in the external world. It is a conscious effort to be with whatever is going on right now, without judging or criticizing what we find. In each moment, mindfulness invites being awake, aware, and accepting of ourselves.

The practice of mindfulness is integral to efforts to reduce stress and to increase capacity to cope. Mindfulness can stand alone as a treatment tool or may be incorporated with other treatment modalities. Most settings where social workers practice would be conducive to mindfulness practice.

Social workers and other health/behavioral health providers are increasingly including the practice of mindfulness as a useful tool, not only in building a self-care routine, but also in addressing the needs of their clients.

The multitude of complementary approaches to maintaining health are vast and it is unrealistic for social workers to be informed and knowledgeable about all of them, but it is expected that social workers will be aware of the predominant practices and methods being used among

the populations they are serving. Just as important, social workers need to be instilled with a respect for clients' authority in determining the best method to treat their problems when there are no indications of harm to self and/or others. Knowing how to integrate empirically tested and validated medical interventions, along with indigenous approaches preserved for generations, is essential to ensuring culturally competent, holistic treatment.

## **TECHNIQUES USED FOR FOLLOW-UP**

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The standard of practice is that social workers must involve clients and their families (when appropriate) in making their own decisions about follow-up services or aftercare. Involvement must include, at a minimum, discussion of client and family preferences (when appropriate).

Follow-up meetings are often important to ensure change maintenance. Many clients continue to progress after termination and follow-up meetings provide opportunities to acknowledge these gains and encourage continuation of such efforts.

Follow-up meetings also provide valuable interactions which can mitigate any unanticipated difficulties. Follow-up meetings provide clients with reassurance that they are not alone as they implement what they have learned. They allow for longitudinal evaluation of practice effectiveness.

It is important that social workers explain to clients that follow-up meetings may be important in the problem-solving process. Social workers must not be intrusive or send messages that clients cannot function on their own. Clients who have difficulty terminating may use follow-up meetings as <sup>341</sup> ways to prolong social worker-client relationships beyond what is needed. Social workers must set clear boundaries and treat follow-up meetings with professionalism—having clearly stated goals for these sessions.

*Clients who tell social workers during follow-up about new problems that have arisen should be seen for assessment.* Social workers who have already assisted clients resolve issues are often the first ones to which clients disclose new problems which have emerged.

## **TIME MANAGEMENT APPROACHES**

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Time management is planning and consciously controlling the amount of time spent on specific activities, especially to increase effectiveness, efficiency, or productivity. Though time management initially focused on business or work activities, it is now increasingly used to control personal activities as well.

Most time management approaches focus on creating conducive or effective environments, modifying behaviors, setting priorities, and/or reducing time spent on nonpriorities.

The approaches to time management have evolved. Initially, approaches consisted of checklists and notes to recognize the demands on time. These then evolved into calendars and appointment books that focused on looking ahead to anticipate future events. The third approach, often used today, examines efficiency with the focus on prioritizing, planning, controlling, and taking steps toward a goal.

The last approach requires the categorization of daily activities by importance and urgency. Those activities that are urgent and important can be stressful and require immediate action; those who deal with these exclusively will think they are just “putting out fires.” Activities that are not urgent or important require little or no attention, and time spent on these activities will result in feelings of disengagement. Activities that are urgent but not important often take up a lot of attention but tend to yield little difference or progress. The last grouping—those things that are important but not urgent—are likely to be put aside yet are critical to personal fulfillment. Time management should include minimizing time spent on activities that are not important and ensuring those that are not urgent but are important, such as building relationships, recreation and leisure, and so on, are also prioritized.

## **COMMUNITY ORGANIZING AND SOCIAL PLANNING METHODS**

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**Community organizing** is focused on harnessing the collective power of communities to tackle issues of shared concern. It challenges government, corporations, and other power-holding institutions in an effort to tip the power balance more in favor of communities.

It is essential for social workers to understand sources of power in order to access them for the betterment of the community. Organizing members to focus these sources of power on the problem(s) and mobilizing resources to assist is critical.

Community organization enhances participatory skills of local citizens by working with and not for them, thus developing leadership with particular emphasis on the ability to conceptualize and act on problems. It strengthens communities so they can better deal with future problems; community members can develop the capacity to resolve problems.

**Social planning** is defined as the process by which a group or <sup>342</sup> community decides its goals and strategies relating to societal issues. It is not an activity limited to government, but includes activities of the private sector, social movements, professions, and other organizations focused specifically on social objectives.

Models of social planning in social work practice include those that are based on community participation. Rather than planning “for” communities, social workers as planners engage “with” community members. Social planning does not merely examine sociological problems that exist, but also includes the physical and economic factors that relate to societal issues.

All issues confronting those who are served by social workers are really human or social issues. Social workers can help facilitate the process of planning through all stages: organizing community members; data-gathering related to the issue—including identifying economic, political, and social causes; problem identification; weighing of alternatives; policy/program implementation; and evaluation of effectiveness.

## **METHODS TO DEVELOP AND EVALUATE MEASURABLE OBJECTIVES FOR CLIENT/CLIENT SYSTEM INTERVENTION, TREATMENT, AND/OR SERVICE PLANS**

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When social workers are creating intervention or service plans, it is essential that goals are written in observable and measurable terms. In order to achieve this aim, the following should be included in each goal contained in the intervention or service plan.

- *Criteria:* What behavior must be exhibited, how often, over what period of time, and under what conditions to demonstrate achievement of the goal?
- *Method for evaluation:* How will progress be measured?
- *Schedule for evaluation:* When, how often, and on what dates

intervals of time will progress be measured?

There may also be benchmarks or the intermediate knowledge, skills, and/or behaviors that must be learned/achieved in order for a client to reach an ultimate goal.

Objectives break down the goals into discrete components or subparts, which are steps toward the final desired outcome.

## **PRIMARY, SECONDARY, AND TERTIARY PREVENTION STRATEGIES**

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There are three major types of prevention strategies—primary, secondary, and tertiary. Optimally, all three types are needed to create comprehensive strategies of prevention and protection.

### **Primary Prevention**

The goal is to protect people from developing a disease, experiencing an injury, or engaging in a behavior in the first place.

Examples:

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- Immunizations against disease
- Education promoting the use of automobile passenger restraints a bicycle helmets
- Screenings for the general public to identify risk factors for illness
- Controlling hazards in the workplace and home
- Regular exercise and good nutrition
- Counseling about the dangers of tobacco and other drugs

Since successful primary prevention helps avoid the disease, injury, or behavior and its associated suffering, cost, and burden, it is typically considered the most cost-effective.

### **Secondary Prevention**

Secondary prevention occurs after a disease, injury, or illness has occurred. It aims to slow the progression or limit the long-term impacts. It

is often implemented when asymptomatic, but risk factors are present. Secondary prevention also may focus on preventing reinjury.

Examples:

- Telling those with heart conditions to take daily, low-dose aspirin
- Screenings for those with risk factors for illness
- Modifying work assignments for injured workers

## Tertiary Prevention

Tertiary prevention focuses on managing complicated, long-term diseases, injuries, or illnesses. The goal is to prevent further deterioration and maximize quality of life because disease is now established and primary prevention activities have been unsuccessful. However, early detection through secondary prevention may have minimized the impact of the disease.

Examples:

- Pain management groups
- Rehabilitation programs
- Support groups

## THE INDICATORS OF CLIENT/CLIENT SYSTEM READINESS FOR TERMINATION

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Readiness for termination may be marked when meetings between a social worker and client seem uneventful and the tone becomes one closer to cordiality rather than challenge, as well as when no new ground has been discovered for several sessions in a row.

In termination, a social worker and client (a) evaluate the degree to <sup>344</sup> which a client's goals have been attained, (b) acknowledge and address issues related to the ending of the relationship, and (c) plan for subsequent steps a client may take relevant to the problem that do not involve a social worker (such as seeking out new services, if necessary).

The process of evaluation helps a client determine if goals have been met and if the helping relationship was beneficial. As a result of the

evaluation process, a social worker can become a more effective practitioner and provide better services. There must always be a method to evaluate the effectiveness of the services received. Evaluation measures, when compared with those taken at baseline, assist in determining the extent of progress and a client's readiness for termination.

A social worker helps a client cope with the feelings associated with termination. This process may help a client cope with future terminations.

By identifying the changes accomplished and planning how a client is going to cope with challenges in the future, a social worker helps a client maintain these changes.

# CHAPTER

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# 9

# Service Delivery and Management of Cases

## **THE EFFECTS OF POLICIES, PROCEDURES, REGULATIONS, AND LEGISLATION ON SOCIAL WORK PRACTICE AND SERVICE DELIVERY**

Client functioning must be viewed using a “person-in-environment” (PIE) perspective. The “rules” that govern society are critical to the way in which the environment is structured, operates, and changes. They can both facilitate and hinder client functioning across time. Social workers can think of clients as part of a larger system with many layers of influence. Clients are most immediately impacted by their families, who are members of neighborhoods and communities. However, each of these contextual influences—families, neighborhood, and communities—are affected by state, national, and international forces, such as policies, procedures, regulations, and laws. They dictate who may be eligible for programs, the amount of funding received, and/or which programs are established or eliminated.

Their influence is dynamic because, using a systems perspective, changes to any one “rule” impacts all others. The creation or modification of a societal “rule” also impacts on individuals, and vice versa.

At different times, state, national, and international forces may be more or less prominent. For example, international policies may influence businesses and communities because multinational corporations make decisions about job location, outsourcing, and other

restructuring. In addition, international unrest may restrict travel to other countries. Thus, policies, procedures, regulations, and laws at different levels interact with one another and can create both the opportunities and the barriers for clients in their family units, neighborhoods, and communities.

Social workers must be aware of this dynamic and the relationship of “rules” on client functioning, as well as their own professional practice, to make sure that they are delivering effective and efficient services to clients in accordance with existing rules and best practices.

Many laws affect social work practice. Although social workers may not be responsible for implementing these pieces of legislation, they provide protections or programs that are critical to those served. Social workers are also expected to keep up-to-date with new public laws and policies.

For example, social workers must be familiar with and fully informed of policies, procedures, regulations, and legislation related to confidentiality, living wills/advance directives, special education<sup>346</sup> services, child abuse and neglect, discrimination, public benefits/welfare, disability rights and accommodations, domestic violence, and other special populations or areas of practice.

Policies, procedures, regulations, and legislation shape practice and service delivery as they exert influence on the social contexts of clients and delivery systems. Policies can optimize or hinder well-being. There are unintended consequences of policies, procedures, regulations, and legislation that are not anticipated and can adversely impact clients and the delivery of social services. Social workers are uniquely positioned to identify policies that promote relationships and improve the well-being of those who may be marginalized or oppressed.

Clients’ lives are directly impacted by policies, procedures, regulations, and legislation in systems such as child protection, criminal justice, and/or mental health. Social workers need to be aware of the laws that regulate each system in order to help clients navigate their way through these systems more effectively, and to be able to advocate for reform to improve the goodness of fit between clients and their socio-legal environments.

Policies, procedures, regulations, and legislation govern many relationships of interest to social work clients, including landlord/tenant,

employer/employee, physician/patient, spouse/spouse, and parent/child relationships. Thus, knowledge of policies, procedures, regulations, and legislation, as well as their effects, provides social workers with an understanding of their clients' rights and responsibilities in a broad range of social relationships.

Social work is rooted in strong assumptions about rights, fairness, and justice. A focus on poverty and other sources of adversity are essential to eliminating disparities and improving well-being. Social justice is a necessary value for social work practice, research, and pedagogy. Social welfare policies may be an effective means to accomplish this aim.

Policies, procedures, regulations, and legislation are important mechanisms for promoting justice and ultimately health. Advocacy is needed to ensure that the rights of those who may not have power or privilege are respected.

Social workers serve clients in hospitals, schools, correctional facilities, mental health agencies, and other settings. Policies, procedures, regulations, and legislation dictate who is eligible for services, standards for record keeping, confidentiality, and other client rights. Social workers need to understand policies, procedures, regulations, and legislation to ensure that agencies are in compliance with them. Social work must advocate for changes in these settings to promote greater social and economic justice.

Social work practice itself is regulated by policies, procedures, regulations, and legislation. Most states/jurisdictions have licensing or accreditation laws that regulate the practice of social work, including who may practice and what standards of practice are legally enforceable. Social workers must be aware of malpractice laws that identify when they may be legally responsible for causing harm to clients if they perform their professional duties in a manner that falls below a reasonable standard of care.

## **THE IMPACT OF THE POLITICAL ENVIRONMENT ON POLICY-MAKING**

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Social work is unique in its dual focus on assisting clients on an individual level while also working to change the policies that adversely impact them. The personal troubles of clients are linked to the <sup>347</sup>

public policies which can help to prevent or address them. Social workers are charged with working with and helping individuals and their families directly, but also working within decision-making bodies to promote these policies.

Social workers must be knowledgeable about the political environment if they are to shape public policy based upon the core values of the profession. As there are always competing interest groups who would like to influence policy-makers in their favor, political advocacy is seen as an important and necessary skill.

Advocacy can be defined as attempting to influence public policy through education, lobbying, or political pressure. Social workers are often called upon to educate the general public as well as public policy-makers about the nature of problems, the legislation needed to address problems, and the funding required to provide services or conduct research.

Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop to their full potential. They should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice (*NASW Code of Ethics—Social and Political Action*).

## **THEORIES AND METHODS OF ADVOCACY FOR POLICIES, SERVICES, AND RESOURCES TO MEET CLIENTS'/CLIENT SYSTEMS' NEEDS**

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Advocacy is one of a social worker's most important tasks. Social workers may advocate when working with an individual client to ensure that the client's needs are met. However, social workers have an ethical mandate to make systemic changes to address the problems experienced by groups of individuals who are vulnerable and/or who are unable to speak for themselves.

A social worker may engage in advocacy by convincing others of the legitimate needs and rights of members of society. Such work can occur on the local, county, state, or national levels. Some social

workers are even involved in international human rights and advocacy for those in need in other countries.

Fundamental to social work is advocating to change the factors that create and contribute to problems.

Sometimes advocacy can be achieved by working through the problem-solving process as it relates to a problem, including acknowledging the problem, analyzing and defining the problem, generating possible solutions, evaluating each option, implementing the option of choice, and evaluating the outcomes.

In other instances, social workers may engage in obtaining legislative support or using the media to draw attention to a concern.

In all instances, social workers should be working with clients to have their voices heard and should not be speaking for them. *Often social workers need to help clients to advocate with third-party payers to have their needs met when resources are not adequate.* Social workers must inform clients of appeal processes when services are denied and support them as they advocate to meet their needs. When clients feel that they have not been treated fairly, social workers should empower them by providing education about appeal processes and other methods to change policies, fix services, and/or increase services to meet their needs.

The goal of social work advocacy is to assist clients to strengthen <sup>348</sup> their own skills in this area. Social workers may assist by locating sources of power that can be shared with clients to make changes.

## **METHODS OF SERVICE DELIVERY**

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The context of social work practice clearly has a profound influence on the quality and standards of professional activities and the ability of social workers to practice ethically and effectively. Social work takes place in a wide variety of settings, including, but not limited to, private practices, public sector organizations (government), schools, hospitals, correctional facilities, and private nonprofit agencies.

To meet the needs of clients, social workers must have work environments that support ethical practice and are committed to standards and good-quality services. A positive working environment is created where the values and principles of social workers are reinforced in agency policies and procedures.

To achieve this aim, employers must understand social work practice and provide supervision, workload management, and continuing professional development consistent with best practices.

Policies setting out standards of ethical practice should be written and clear. Social workers should never be required to do anything that would put at risk their ability to uphold ethical standards, including those in the areas of confidentiality, informed consent, and safety/risk management.

The public, including clients, should be regularly informed of agency policies and procedures and provided with information about how to raise concerns or make complaints about them.

Policies that do not tolerate dangerous, discriminatory, and/or exploitative behavior must be in place so that social workers and their clients are safe from harm.

The adoption and implementation of policies and procedures on workload and caseload management contribute greatly to the provision of quality services to clients. In addition, policies and procedures for confidential treatment and storage of records should be established.

Continuing professional development and further training enable social workers to strengthen and develop their skills. Orientation and other relevant training provided to social workers upon hire and when assuming other jobs within the setting are essential.

Good quality, regular social work supervision by professionals who have the necessary experience and qualifications in social work practice is a critical tool to ensure service quality.

Rates of pay for social workers need to be comparable with similar professionals, and the skill and qualifications of social workers must be recognized, while ensuring services are affordable to clients.

## **THE COMPONENTS OF CASE MANAGEMENT**

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Case management has been defined in many ways. However, all models are based on the belief that clients often need assistance in accessing services in today's complex systems, as well as the need to monitor duplication and gaps in treatment and care.

Although there may be many federal, state, and local programs <sup>349</sup> available, there are often serious service gaps. A client might have a specific need met in one program and many related needs ignored

because of the lack of coordination. Systems are highly complex, fragmented, duplicative, and uncoordinated.

Social workers provide case management services to different client populations in both nonprofit and for-profit settings.

The primary goal of social work case management is to optimize client functioning and well-being by providing and coordinating high-quality services, in the most effective and efficient manner possible, to individuals with multiple complex needs.

Five case management activities are (a) assessment, (b) planning, (c) linking, (d) monitoring, and (e) advocacy.

Fragmentation presents one of the biggest service delivery challenges for clients and those who are assisting them, such as social workers. Clients can fall through the cracks because the connections between services are either absent or problematic, or needed services are missing altogether.

The purpose of coordinating services for clients is to improve outcomes. The assumption is that collaborative activity can facilitate access to services, reduce unnecessary duplication of effort, and produce a more effective and efficient social service system.

Social workers are uniquely positioned to coordinate services.

Coordination is achieved through the *integration of services* in which services are combined and provided simultaneously. Such an approach is often used with mental health and substance use interventions in which they are combined within a primary treatment relationship or service setting.

Another method of coordination is *wrap-around services* in which multiple providers and services may overlap in some ways, but are not combined to the same degree as integrated services.

In addition, “round tables” or *interdisciplinary team approaches* also are useful in ensuring that all professionals are brought together to stay informed of total client care and work together to avoid fragmentation and/or duplication.

## **THE PRINCIPLES OF CASE RECORDING, DOCUMENTATION, AND MANAGEMENT OF PRACTICE RECORDS**

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Documentation in social work practice is critical because it forms the basis of assessment, planning, intervention, and evaluation of services. It is used to memorialize what has occurred and to hold social workers accountable for their services to clients, third-party payers, employers, and others. It also is used for supervision to ensure that clients receive the most effective and efficient services possible. Social workers should always document services appropriately and must never tamper with or alter records to mislead, omit, or falsify information.

There are many issues with regard to the management of practice records, including, but not limited to, that they have sufficient and credible content, they are prepared and stored correctly, and they are protected and accessed only by those who are authorized to do so. It is essential that there are written protocols with regard to the management of practice records and that these protocols are reviewed and revised regularly. Training on these protocols should be regularly conducted so that social workers know what is expected and how to address routine situations, as well as those that are not anticipated, <sup>350</sup> such as the receipt of a subpoena or court order.

Management of practice records must be in accordance with all laws and agency policies. Funders may also have requirements with regard to necessary documentation and/or the retention of records. Social workers should be knowledgeable about standards related to practice records that appear in the *NASW Code of Ethics*.

Social workers should store records following the termination of services to ensure reasonable future access and maintain them for the number of years required by laws, agency policies, and contracts (*NASW Code of Ethics—Client Records*).

The protection of confidential information requires great care. Social workers should know the exceptions to confidentiality and how to handle practice records when working with court-ordered clients or those who are involved in divorce or child custody proceedings. Social workers who are providing treatment to children whose parents are divorced should be aware of legal custody determinations and the respective rules that govern release of information in these arrangements.

The proper documentation of client services is paramount to competent practice. Without proper case recording or record keeping, the quality of service may be compromised, the continuity of service

may be disrupted, there may be misinterpretation that can cause harm, client confidentiality may be breached, and a client's confidence in the integrity of a social worker may be impacted.

In addition to client harm, a social worker, as well as the social worker's agency, if applicable, may be at risk of liability due to malpractice, negligence, and/or breach of confidentiality.

In order to ensure that all communications are written in a professional manner that will assist clients, social workers should ensure that:

- The purpose of the written communication is clear and concise
- Arguments and opinions are logical, with recommendations well supported
- Client confidentiality is addressed ethically
- Grammar is correct
- Assessments and recommendations are not based on assumptions or generalizations
- The format is clear and headings are appropriate
- The content is easily understood
- Jargon is not included
- Person-first language is used
- Language is culturally appropriate
- Content is based on value-free, objective descriptions

Written communications of social workers may be harmful to clients if they are not prepared correctly with care and skill. Social workers should understand the "audience" for documents that are prepared and ensure that they are written so that they can be used effectively.

It should also include only information that is directly relevant to the delivery of services.

The release and storage of case recordings is also critical. Social workers must make sure that records are not released without proper client consent and records are properly stored during and following

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the termination of services. Records should be maintained for the number of years required by laws, statutes, regulations, and relevant contracts.

## **METHODS TO ESTABLISH SERVICE NETWORKS OR COMMUNITY RESOURCES**

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The need for services to not be duplicative and complement one another is central to meeting client needs. Social workers are often called upon to assist with developing or navigating service networks, as well as creating community resources where they are lacking. Integrating services takes sustained effort and hard work. Though the concept of service integration may seem simple, it is not and usually takes several administrative and operational strategies. Strong leadership and sound management are critical.

In order to effectively meet client needs, organizations are increasingly recognizing collaborations, networks, alliances, and/or partnerships. There are two distinct network forms—mandated network arrangements and self-organizing networks.

Within each of these forms, there may be a lead organization or a model in which all organizations share decision-making power. The former is often associated with a centralized structure, whereas the latter is more indicative of a decentralized one. Networks can also have strong and weak arrangements in which the parameters of integration may or may not be highly regulated.

The willingness and ability of social service organizations to form networks often depends on organizational size, resource dependency, and collaborative experience.

## **EMPLOYEE RECRUITMENT, TRAINING, RETENTION, PERFORMANCE APPRAISAL, EVALUATION, AND DISCIPLINE**

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Employment and human resources law can be very complicated. Social work administrators should be familiar with federal, state, and local regulations. They must ensure that human service organizations operate legally and they must make ethical decisions with regard to

employee recruitment, training, retention, performance appraisal, evaluation, and discipline. Social work administrators must also ensure that employment policies and practices are not discriminatory based on race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

Employee recruitment can be difficult as it involves finding the best candidates for positions. Bad recruitment practices may lead to unqualified people being selected. Although there is no perfect method for hiring, it is best to start well in advance of a hiring need. A pool of candidates should be recruited using a detailed job description and an established background check policy. Interviews should use standard questioning which complies with legal and ethical standards.

Once hired, employees need to be initially trained and should receive ongoing development opportunities to ensure that they have the skills needed to fulfill the mission of an organization. There are several options for training and education related to employees' official duties. These include doing training within an agency or having employees go to other entities to be trained. Training may be paid solely by an employer or an employee, or split between the two parties. In addition, time spent in training may or may not be compensated by an employer, depending upon the policy of an agency.

Once employees are hired and trained, retaining them should also <sup>352</sup> be a top priority. Many good retention practices are inexpensive to implement. Employee retention is positively linked to career development opportunities and a chance to advance within an agency, opportunities for regular feedback and recognition, flexible work schedules that recognize the need for work/life balance, and good salaries and benefits.

Employee performance should be periodically evaluated to ensure that employees are meeting expected standards, as well as to inform them of their status. In order to ensure the delivery of effective and efficient client services, social workers' performance should be reviewed and evaluated. Such reviews and evaluations should occur regularly as part of the administrative task of supervision. Performance appraisal should be both formal and informal so that employees can get immediate feedback if they are doing something good or bad.

Evaluations provide information to facilitate sound administrative decision making on employment matters (pay increases, promotions, terminations), as well as contribute to social workers' professional development and job performance.

*The most important objective, however, is to ultimately improve the outcome of service delivery, thereby being accountable to a client and the public at large.*

Evaluations should include a review of both the quality and quantity of the work performed. Some of the areas to be included in a social work appraisal or evaluation are:

- The ability to establish and maintain meaningful, effective appropriately professional relationships with clients
- Knowledge and skills (i.e., data-gathering, diagnostic treatment/intervention, interviewing, and recording skills)
- Ability to adhere to agency objectives, policies, and procedures
- Use of supervision
- Staff and community relationships
- Professional attributes and attitudes, including adherence to the *NASW Code of Ethics*
- Cultural awareness

Evaluations should identify both strengths and weaknesses and should be specific and individualized. Evaluations should focus on recurrent patterns of behavior, not atypical, isolated examples. Supervisors should consider factors that may have affected performance, such as a heavy caseload or the unavailability of needed support.

Social workers are responsible for conducting evaluations on their employees in a responsible and ethical manner. They also should ensure that evaluations of their services are completed in order to provide feedback on their work.

Supervisors should notify supervisees in advance of when evaluations will occur, what information and standards will be used, who will see the results, and how the results will be used. When conducting

evaluations, supervisors and supervisees should prepare by reviewing all materials, including evaluation tools, supervision notes, and employee reports. Supervisors and supervisees should have a chance to discuss their perceptions, followed by written documentation of the supervisee performance and suggestions for improvement. This documentation should be given to the supervisee with the opportunity for revision if the supervisor agrees with objections raised.<sup>353</sup> Objections that the supervisor does not accept should be documented and placed in the supervisees file.

There are a number of evaluation formats/methods including, but not limited to, the use of ordinal rating scales and evaluation outlines.

Supervisors need to be aware of and guard against biases, such as a central tendency bias, halo effect, and leniency bias, which may impact on ratings.

Positive reinforcement is a powerful force for employees who are doing a good job. For problem employees, specific work-quality issues can be pointed out. Evaluations should make employees feel empowered, not micromanaged. After employees have been evaluated, goals for development and/or improvement should be established.

Sometimes discipline, including termination, becomes necessary. Social work administrators must be knowledgeable about both laws and agency policies that impact disciplinary actions. When employees have performed illegal acts, termination is justified. Breaking agency policies can also be grounds for termination. However, there are situations where termination can be considered “wrongful” or inappropriate, such as when an employee is fired for reporting wrongdoing or for taking time off when covered by the Family Medical Leave Act (FMLA).

## **CASE RECORDING FOR PRACTICE EVALUATION OR SUPERVISION**

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Case records are often an excellent source of information for evaluating the impacts of services. They are existing sources of data, so there is no additional cost or time associated with their collection. However, there are a few limitations. If looking at records completed by multiple workers, there may be inconsistencies in recording styles or

details that may impact on the evaluation. Also, information of interest may not be contained in the records; evaluations would need to be limited to only information that is explicitly stated, which may not reflect all progress that has been made.

In addition, the opinions about how a client views both the process and outcome of service delivery are also critical and may not be fully captured in the record. Ensuring that a client's views are the center of any practice evaluation is critical. Thus, a social worker may want to use the case record as one source of information, but include others as well, to ensure all aspects of a client's care, including satisfaction with services.

Social workers engaged in formal evaluation beyond that used to determine individual client progress should obtain voluntary and written informed consent from clients regarding the use of their records without any penalty for refusal to participate or undue inducement to participate (*NASW Code of Ethics—Evaluation and Research*).

Review of case records by supervisors is also essential. This review will ensure that a social worker is documenting properly and recording information in an unbiased manner. Clients must understand and consent to supervisory review of records.

When reviewing information, supervisors should adhere to the same standards of confidentiality as a social worker. The supervisor should not review the records unless it is for the betterment of a client and only within the supervisory context to ensure the quality of services. If the supervisor is a consultant, a client must consent unless there is a compelling need for such disclosure.

## **METHODS TO EVALUATE AGENCY PROGRAMS (E.G., NEEDS ASSESSMENT, FORMATIVE/SUMMATIVE ASSESSMENT, COST-EFFECTIVENESS, COST-BENEFIT ANALYSIS, OUTCOMES ASSESSMENT)**

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Program evaluation is the systematic assessment of the processes and/or outcomes of a program with the intent of furthering its development and improvement. There are many types of program evaluation including, but not limited to, the following.

- A **cost-benefit analysis** determines the financial costs operating a program as compared with the fiscal benefits of outcomes. A *cost-benefit ratio* is generated to determine whether and the extent to which, the costs exceed the benefits. Program decisions can be made to eliminate or modify the program (reducing program expenditures) based upon the findings.
- A **cost-effectiveness analysis** is similar to a cost-benefit analysis, but distinct. *It considers the benefits that are not measured in monetary terms*, such as illnesses prevented and/or lives saved. It does not produce a cost-benefit ratio, but may focus on the most financially efficient way to achieve a defined outcome or the cost of producing a specific nonmonetary outcome.
- An **outcomes assessment** is the process of determining whether a program has achieved its intended goal(s). It involves collecting evidence through assessment, analyzing the data, and then *using the findings to make programmatic changes if needed*. This is an iterative process with continual feedback loops.

## THE EFFECTS OF PROGRAM EVALUATION FINDINGS ON SERVICES

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One of the most significant benefits that a program evaluation communicates is the need to make service improvements. Some examples of improvements that may need to be made include:

- Eliminating services that do not achieve program outcomes
- Adding services that are better designed to achieve outcomes
- Acquiring more adequate resources to support effective services
- Targeting a different group of participants to receive services

Evaluation findings should be viewed and communicated as an opportunity to make programs better. Evaluation results that indicate the need for improvement should not be communicated as an indictment of the failure of a program. Program evaluation findings

should be viewed with an excitement about the possibilities of developing an even stronger set of service offerings and improving already successful efforts. An action plan aimed at improvement should be developed, based on evaluation results, and communicated widely to key stakeholders.

## **QUALITY ASSURANCE, INCLUDING PROGRAM REVIEWS AND AUDITS BY EXTERNAL SOURCES**

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Historically, quality assurance systems have focused on auditing records to monitor and report on the extent of compliance with laws and grant requirements. Usually a small number of quality assurance staff within organizations focused on this auditing function, and their reports often had minimal impact on the services delivered by the agency.

Today, many agencies are developing systems that move beyond compliance monitoring. These systems attempt to gather and assess a range of information on quality, and they work to implement needed improvements on an ongoing basis. As a way of differentiating these efforts from traditional compliance monitoring, the new approaches are often called continuous quality improvement systems. These systems require that agencies adopt the following steps:

Step 1: Adopting outcomes and standards

Step 2: Incorporating quality assurance standards and processes throughout their work

Step 3: Gathering data and information

Step 4: Analyzing data and information

Step 5: Using analyses and information to make improvements

Funders and accreditors support and encourage the move toward continuous quality improvement processes. This new approach improves upon compliance monitoring in three ways. First, quality improvement programs are broader in scope, assessing practice and outcomes, as well as compliance. Second, they attempt to use data, information, and results to effect positive changes in policy and practice, along with compliance with federal, state, and agency

requirements. Third, these programs engage a broad range of internal and external partners in the quality improvement process, including top managers, staff at all levels, clients, and other stakeholders.

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# Consultation and Interdisciplinary Collaboration

## LEADERSHIP AND MANAGEMENT TECHNIQUES

There are many different definitions of leadership and management, with little consensus about the differences between the two terms. However, there is agreement that successful organizations need both good leadership and management. Some suggest that leadership can be viewed as a subset of management because a leadership role is inherent in a management position. Leadership is related to being focused on the future, dealing with uncertainty and instability, and prospectively considering the ways in which organizational operations need to change. Leadership also includes initiating, sustaining, and helping to maintain a certain amount of momentum through the change process. Leaders must be attentive to and help to balance stability and change. Management, on the other hand, focuses on efficiency, effectiveness, and planning.

Social work leaders need management skills and social work managers need leadership skills in order to be effective. The skill sets of leaders focus on inspiration, transformation, empowerment, trust, innovation, and creativity whereas managers are concerned with performance, planning, accountability, monitoring, evaluation, cooperation, and teamwork. Managers must govern resources and oversee the tensions between controlling, rationing, and providing needed services.

There is typically little distinction between managers and leaders because leaders are often appointed to management positions. Thus, managers and leaders within organizations are usually the same individuals.

## **MODELS OF SUPERVISION AND CONSULTATION (E.G., INDIVIDUAL, PEER, GROUP)**

There are many and varied supervision models, each with its own benefits and limitations. In order for supervision to be effective, it is necessary to take into account both the needs of social workers and the requirements and constraints of organizations when considering the model to be utilized.

Individual supervision has traditionally been the cornerstone of professional skill development. Supervision can be provided in groups, peer-led, or facilitated by professional leaders. Group and peer supervision, as well as intensive consultation on a case-by-case basis, are useful and less costly additions to individual supervision, but they may be inadequate as substitutes for one-on-one support.<sup>358</sup>

### **Individual**

#### ***Benefits***

- Full attention on the skill development, strengths, challenges, and professional enhancement of the individual supervisee
- More time and potentially safer environment in which to explore supervisee's interpersonal dynamics with clients and the impact the work (e.g., countertransference issues, secondary trauma, compassion fatigue, burnout)
- Less exposure to poor practices of peers, which could be inappropriately modeled or interfere with supervision process

#### ***Challenges***

- Potential for supervisee to feel intimidated by the supervisor, with i

one else present to observe, or break up the intensity of the one-on-one focus

- Costly and time consuming
- No input from others outside the dyad
- No opportunity for supervisee to compare self with others, or gain support from peers

## Peer Group

### *Benefits*

- Each group member can offer and receive wisdom, experience, and ideas (i.e., enjoy both “teacher” and “student” roles)
- Shared influence and responsibility regarding how the group is run
- Avoids chance of getting stuck with an unwanted supervisor
- Opportunities for personal growth via group dynamics
- Participants as equals encourages lateral help and peer support

### *Challenges*

- Potential for unconscious designation of more experienced/skilled members as “de facto” supervisors
  - Success is dependent upon how group members exercise their responsibilities
- Mutual trust, openness, and respect are essential
- Usually requires that groups remain closed, at least for a period of time
- Competition, defensiveness, and criticism between peers can occur
- Discussion frequency, depth, and intensity are limited by the time available and the number of members participating in the group

## Facilitated Group

### ***Benefits***

- Learning occurs from others' practice examples and ways of working
- Self-confirmation occurs through giving feedback
- Opportunities for role play and other action techniques are present
- Less expensive and time consuming than individual supervision
- Opportunities for personal growth via group dynamics

### ***Challenges***

- Supervisor must be skilled in working systemically with groups and must be able to facilitate while also supervising (dual tasks)
- Supervisor's anxiety about the supervisor's own competence may pose a barrier, as there is greater exposure of the supervisor's abilities and experience
- Less time for each supervisee, as the group must balance the needs of each member
- Group needs to have a high level of trust in order for supervisees to feel safe

## **EDUCATIONAL COMPONENTS, TECHNIQUES, AND METHODS OF SUPERVISION**

There are three components of supervision—administrative, educational, and supportive. *Administrative supervision* aims to ensure that a social worker is accountable to the public as well as to organizational policies. The major responsibility is to make sure that the work is performed in an acceptable manner. *Educational supervision* establishes a learning alliance between a supervisor and a social worker with the aim of teaching new skills or refining existing ones.

*Supportive supervision* is focused on increasing performance by decreasing job-related stress that interferes with functioning.

For a social worker to learn job-related material and develop as a skilled professional, the social worker must make appropriate and effective use of educational supervision. The educational component of supervision is concerned with teaching a social worker what the social worker needs to know in order to do the job and helping the social worker through the learning process. In essence, the educational component relates to the transmission of knowledge, skills, attitudes, and values needed by social workers.

In order for learning to occur, a supervisee must be cooperative <sup>360</sup> (willing to work and learn new skills), willing to follow directions (initially doing what is told until able to complete routines without direction), and knowledgeable (about agency procedures). A supervisee also must show initiative (seeking out learning opportunities and applying new knowledge) and accepting of criticism (trying to improve and accepting feedback when it is justified and constructive).

Supervisors also have responsibilities in educational supervision. They must provide education and training (formal and informal opportunities to ensure supervisees have the knowledge and skills needed to do their jobs competently) and feedback (explanations on what is going well and what needs improvement). Identifying the learning needs of supervisees should be done at hire and regularly thereafter. Changes in the field must always be considered. Lastly, supervisors should be aware of supervisees' learning styles and ensure that education is delivered via methods that are most effective. There are three main cognitive learning styles: visual (uses visual objects such as graphs and charts to learn), auditory (retains information through hearing and speaking), and kinesthetic (likes to use hands-on approaches to acquire knowledge).

## **THE SUPERVISEE'S ROLE IN SUPERVISION (E.G., IDENTIFYING LEARNING NEEDS, SELF-ASSESSMENT, PRIORITIZING, ETC.)**

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The short-term objectives of supervision are to increase a social worker's capacity to work more effectively, to provide a work context conducive to productivity, and to help a social worker take satisfaction

in work. The ultimate objective is to assure the delivery of the most effective and efficient client services.

Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

Competence is essential for ethical social work practice and social workers must be competent in the services that they are providing (*NASW Code of Ethics—Competence*). In order to be competent, they must keep abreast of new developments in the field and obtain supervision.

Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience (*NASW Code of Ethics—Competence*).

Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques (*NASW Code of Ethics—Competence*).

When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm (*NASW Code of Ethics—Competence*).

If a supervisor needs to talk with a social worker about a problem situation, the supervisor should meet privately with the social worker to discuss the matter.

## **METHODS TO IDENTIFY LEARNING NEEDS AND DEVELOP LEARNING OBJECTIVES FOR SUPERVISEES**

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Supervision is an essential way in which social workers acquire knowledge and skills needed for professional practice. It is often the bridge between the classroom and the field. Supervision is necessary to improve client care, develop professionalism, and maintain ethical

standards in the field. Supervision has also become the cornerstone of quality improvement and assurance.

Quality supervision is founded on a positive supervisor-supervisee relationship that promotes client welfare and the professional development of the supervisee. A supervisor is a teacher, coach, consultant, mentor, evaluator, and administrator. *Ultimately, effective supervision ensures that clients are competently served.* Supervision ensures that social workers continue to increase their skills, which in turn increases service effectiveness.

Some of the skills that social work supervisors must have in order to effectively teach supervisees include the ability to:

- Identify learning needs and styles.
- Write learning goals and objectives.
- Devise instructional strategies to accommodate needs and learning styles.
- Present material in a didactic manner, using modeling.
- Match learning styles to developmental levels (e.g., provide more instruction to junior supervisees and use guided discovery for those who are senior).
- Explain the rationales for interventions.
- Evaluate supervisees' learning.
- Give constructive feedback to supervisees.

Learning needs of supervisees may result from gaps in knowledge about practice modalities; effective communication strategies; setting, funding, or legal requirements; self-care strategies; and so on. Social work supervisors should be knowledgeable about the skills supervisees acquired from previous professional training and experience, as well as gaps in learning, such as those related to diagnostic assessment and treatment; ethical standards of practice; laws and rules; record keeping; cultural awareness; methods for establishing treatment relationships with clients; methods for including family members in clients' treatment when appropriate; communication with other professionals in developing diagnosis and treatment plans and assuring continuity of

care; and so on. Lastly, social work supervisors should solicit input from supervisees about what they view as their greatest learning needs and develop learning objectives to meet these needs in partnership with supervisees. Identifying learning needs and developing learning objectives is a collaborative process between social work supervisors and supervisees.

## **THE ELEMENTS OF CLIENT/CLIENT SYSTEM REPORTS**

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There is no one way to organize information or client files. Some client information and files are obtained and stored in paper format. However, increasingly client records are kept electronically with software to assist professionals in organizing and accessing data.

Whether paper or electronic, client files are usually stored with the <sup>362</sup> following in separate sections or folders:

1. Demographic information and intake materials
2. Assessments, quarterly reviews, and reassessments
3. Service plan(s) with goals
4. Discharge plan
5. Releases of information and referrals
6. Correspondence

Social workers should keep psychotherapy notes in a secure location outside of client files to provide added confidentiality protection.

Often agency policies or requirements imposed by funders dictate the organizational structure for client files. However, regardless of the schema, it is essential that files are secure, up-to-date, and complete, with a format that makes locating information easy and evident.

Social workers are expected to communicate effectively, including in the preparation of written reports for external organizations. Poorly written reports or the inclusion of irrelevant or inappropriate information can have an adverse impact on a client. In the preparation of reports, including those for the courts, social workers are expected to

communicate accurately and professionally. Reports generated by social workers must be taken seriously and will not be treated legitimately if there are spelling or grammatical mistakes, or the content is not based on critical thought and analysis.

Social workers also must develop reports as requested or needed, adhering to the standards of confidentiality, as failure to provide professional observations may hinder opportunities for clients. Often, social workers are reluctant to generate reports even when requested by clients and legally allowed to do so.

Critical to developing reports is the knowledge that they must be understandable and useful to recipients with a wide range of educational backgrounds and literacy levels. In addition, social workers must have a keen awareness of the purposes of reports, who they are being written for, and how they should be presented differently depending on the purposes and the audience.

Social workers should avoid irrelevant and inappropriate information, meaningless phrases or slang words, and illogical conclusions in the preparation and writing of reports. Social workers should plan what should and should not be included in the final documents prior to starting to develop them. It is also helpful to prepare drafts for later editing. Having others review draft reports can help catch errors and ensure the clarity of all material.

Social workers' competence and the value of social work services are often judged by the quality of written reports. Thus, it is essential that thought and care be taken in their preparation, and that they adhere to best practices and standards.

Administrative reports, such as annual reports from public and private social service organizations, are critical to the fulfillment of the social work mission. They provide accountability to the public about the number of people served, the services delivered, and how funds were allocated. They also may be used by social workers to document unmet needs which should be addressed.

Social workers may be required to prepare grant reports,<sup>363</sup> evaluations, program proposals, and accreditation reports. While each of these documents serves a different purpose, they all require social workers to use their written communication skills and critical thinking/analysis to help clients directly or indirectly.

For example, a program proposal sets forth a plan of activities needed to begin or modify services in order to (better) meet clients' needs. It includes recommendations to organize or arrange a program in an effective and efficient manner. It describes and recommends procedures and ways to organize services for maximum client benefit. To ensure that it is implemented as intended, it must be clear, accurate, and well-written.

## **THE ELEMENTS OF A CASE PRESENTATION**

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When a social worker communicates with others in order to ensure comprehensive and complete care for clients, the social worker completes a case presentation. Case presentations are also used in professional development and learning to provide input into options for treatment and to ensure services are being delivered effectively and efficiently.

There is no universal format for a case presentation in social work practice. However, there are some standard elements, including:

- Identifying data (demographics, cultural considerations)
- History of the presenting problem (family history)
- Significant medical/psychiatric history (diagnoses)
- Significant personal and/or social history (legal issue academic/work problems, crisis/safety concerns)
- Presenting problem (assessment, mental status, diagnosis)
- Impressions and summary (interview findings)
- Recommendations (treatment plan/intervention strategies, goa theoretical models used)

Content areas can be added or eliminated based on the reasons for the case presentation and input sought. Information for a case presentation is usually information that a social worker has obtained directly from a client during an interview and/or observation, as well as that collected from collateral contacts, other professionals, and/or case records.

## **THE PRINCIPLES AND PROCESSES FOR DEVELOPING FORMAL DOCUMENTS (E.G., PROPOSALS, LETTERS, BROCHURES, PAMPHLETS, REPORTS, EVALUATIONS)**

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Social workers are expected to communicate effectively and be able to prepare formal documents. Being able to provide quality services is not the only important aspect of social work; all work is undermined by poor recording or documentation.

A good document begins with careful planning—jotting down the report's purpose and some notes about key content to be contained. Many times, drafts need to be made to ensure that the formal <sup>364</sup> document meets its purpose and is written clearly, without punctuation and other mistakes. Editing is usually required before finalizing for dissemination. Typing reports is always preferred for a more professional appearance and to avoid “illegible” handwriting.

From court reports, to grant proposals, to public relations pamphlets, social workers are expected to communicate accurately with others. Poor English skills can affect the quality of reports. Social workers need to be able to write reports that can be taken “seriously” by others.

Quality of content is just as critical as spelling and punctuation. Time must be allotted to be able to do critical analyses, which many formal reports require. It is easy to describe something, but much harder to indicate its significance. Repeating facts may not provide needed professional opinions and observations.

Formal documents will only count if they get to the right people. Social workers must be aware of the purpose of documents to be prepared, and to whom they are being written, and then write accordingly. Social workers should avoid irrelevant, inappropriate information; meaningless phrases; and illogical conclusions.

Social workers should expect that their documents may be scrutinized. Thus, they should write just enough to make their points, but not “overdocument” with irrelevant details. Social workers should be specific and avoid characterizations, such as “poor outcome,” “good result,” “moderate compliance,” “drunk,” “aggressive,” and “combative.” They should also avoid acronyms and abbreviations and use precise description and specific language (not “it seems,” “I suppose,” “it appears,” “I believe,” “I feel,” and so on).

Social workers must prepare documents in a timely fashion and consider ethical issues that can be related to their preparation and distribution. Documents should not contain bias wording. Social workers should not alter documents after they are written unless it is appropriate to do so. Social workers must know when communication is “privileged” and should not share information with those without a need to know.

## **CONSULTATION APPROACHES (E.G., REFERRALS TO SPECIALISTS)**

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Social workers are often called upon to seek consultation for a problem related to a client, service, organization, and/or policy. Consultation is the utilization of an “expert” in a specific area to assist with developing a solution to the issue. Consultation is usually time limited and the advice of the consultant can be used by a social worker in the problem-solving process. Although a consultant does not have any formal authority over a social worker, a consultant has informal authority as an “expert.” However, a social worker is not required to follow the recommendations of a consultant.

Four things are critical in consultation:

1. Defining the purpose of the consultation
2. Specifying the consultant’s role
3. Clarifying the nature of the problem
4. Outlining the consultation process

Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients, but should only do so from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation (*NASW Code of Ethics—Consultation*).<sup>365</sup>

When seeking consultation, social workers need to get the permission of clients if any identifying or specific information will be shared. In addition, social workers should only disclose information that is absolutely necessary when interacting with consultants.

Social workers may also provide consultation in-person or remotely. They should have the appropriate knowledge and skill to do so and should follow all ethical standards, including avoiding conflicts of interest and maintaining boundaries (*NASW Code of Ethics—Supervision and Consultation*).

## **METHODS OF NETWORKING**

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The importance of networking has been stressed heavily in business, but it has received far less attention in social work practice. This void is interesting, because it is critical to the effective delivery of services. Networking involves building relationships with other professionals who share areas of interest. It is about creating a community around common interests and building alliances. It is also about creating opportunities to work with others toward the achievement of mutual goals.

Although networking in business is a way to attract patrons/customers or to get jobs, it has a broader, and more altruistic, focus in social work.

For example, learning about others who do similar or complementary work can result in a sharing of resources and expertise, which could be beneficial to clients by keeping the cost of services contained and/or increasing the skills of practitioners. Learning about the skills of others and establishing professional relationships through networking can also provide resources for clients who may need referrals to other professionals.

Networking helps improve social skills and the ability to relate to others in a variety of settings. It puts social workers “out there” so that others can be aware of the important work that they do. Educating others about social problems is an important part of making systematic changes. Lastly, networking can identify individuals who would be good candidates for jobs. Recruiting qualified individuals into the agencies where social workers are employed results in clients receiving quality care.

## **THE PROCESS OF INTERDISCIPLINARY AND INTRADISCIPLINARY TEAM COLLABORATION**

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Social workers often work together with others from various professions. This is known as an interdisciplinary approach. Some interdisciplinary teams interface daily, whereas others may only meet periodically. Sometimes social workers form interdisciplinary relationships that do not constitute team practice but are nevertheless necessary for effective service. These relationships may be with legal or educational professionals. To practice effectively, social workers must be prepared to work with professionals from all other disciplines that may be needed by a client. In turn, social work knowledge is influenced by, and in turn influences, other disciplines, including family studies, medicine, psychiatry, sociology, education, and psychology. Interdisciplinary teams are often seen as advantageous to clients <sup>366</sup> because they do not have the burden of navigating multiple service systems and communicating to multiple professionals involved in their care. Interdisciplinary teams can also be cost effective and can increase positive outcomes.

An interdisciplinary approach may also have benefits for social workers as they:

1. Provide peer support, especially when working with stress problems associated with involuntary service delivery, violence, suicide, and so on.
2. Allow for work to be assigned across multiple professionals.
3. Fulfill professional goals by ensuring all aspects of a client biopsychosocial-spiritual-cultural care are delivered.
4. Create cross-fertilization of skills between professionals.
5. Facilitate decision making related to all aspects of client care, which can lead to increased job satisfaction.
6. Streamline work practices through sharing of information.

Interdisciplinary collaboration is a rewarding, yet challenging, social work activity. Collaboration, a learned skill that can be improved through practice, is a vehicle for improving services for all clients. It means working with others for the betterment of a client. Collaborative teams are more likely to develop important new and innovative approaches to dealing with problems.

Collaboration goes beyond people sitting around a table. It includes premeeting work (i.e., making telephone calls), how members typically conduct themselves (i.e., being friendly), and how meetings proceed (i.e., choosing to ignore minor irritations in order to get on with the agenda).

Social workers must understand their own styles and focus on their own behavior as part of a group, rather than on how other members should change.

Collaboration involves strong interpersonal communication and group process skills, as well as being able to understand the perspectives of others. It can be discrete (distinct or separate; limited to single occurrence or action) or continuous (ongoing or repetitive).

The following list provides some guidelines that can be helpful when social workers participate in such collaboration.

1. Social workers should clearly articulate their roles on interdisciplinary teams.
2. Social workers should understand the roles of professionals from other disciplines on these teams.
3. Social workers should seek and establish common ground with these professionals, including commonalities in professional goals
4. Social workers should acknowledge the differences within the field and across other disciplines.
5. Social workers should address conflict within teams so that it does not interfere with the collaborative process and the team outcomes.
6. Social workers should establish and maintain collegial relationships.

There are also ethical guidelines that must be followed when social workers are part of interdisciplinary collaboration (*NASW Code of Ethics—Interdisciplinary Collaboration*).<sup>367</sup>

1. Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations

the interdisciplinary team as a whole and of its individual members should be clearly established.

2. Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistently with client well-being.

Intradisciplinary teams are composed exclusively of social workers who may have different levels of training and skill within the profession. Intradisciplinary teams are often referred to as unidisciplinary. An interdisciplinary approach differs from a multidisciplinary one due to its holistic nature. Professionals in an interdisciplinary team are charged with working together and a treatment plan is usually developed by the entire group. In service provision, the work of each professional group can and often does overlap. Interdependence throughout the problem-solving process is stressed. Each member contributes to the group's goals. In multidisciplinary teams, the steps are often conducted in isolation and outcomes are later shared with other team members. Intradisciplinary teams in social work practice can be useful in professional development, mentorship, and the provision of supervision. However, working on a team with others in the profession has advantages and disadvantages. Members share the same professional orientation and values, which can facilitate consensus and cohesion within the group, but the ability to generate alternative solutions to problems when viewing problems from multiple professional perspectives can be reduced.

## **THE BASIC TERMINOLOGY OF PROFESSIONS OTHER THAN SOCIAL WORK (E.G., LEGAL, EDUCATIONAL)**

Social workers should maintain access to professional consultation. Often, this consultation may be from qualified professionals in other disciplines. Each discipline has its own set of assumptions, values, and priorities; in order to ensure that the assessment of a client's problems consider all possible root causes (including medical) and all needs of a

client are met, the social worker should consult with experts in other fields, as well as refer a client to them when needed.

Social workers often work together with others from various professions. This is known as an interdisciplinary approach. Some interdisciplinary teams interface daily, whereas others may only meet periodically.

Sometimes social workers form interdisciplinary relationships that do not constitute team practice, but are nevertheless necessary for effective service. These relationships may be with legal or educational professionals. To practice effectively, social workers must be prepared to work with professionals from all other disciplines that may be needed by a client.

In turn, social work knowledge is influenced by, and in turn <sup>368</sup> influences, other disciplines, including family studies, medicine, psychiatry, sociology, education, and psychology.

## **TECHNIQUES TO INFORM AND INFLUENCE ORGANIZATIONAL AND SOCIAL POLICY**

Social policy is influenced by many factors, such as the following.

### **Knowledge/Innovation**

Knowledge and innovation create new opportunities to change, as well as information that current practices may need to be reformed. Technological advances are often drivers of changes in policy.

### **Social, Political, and Economic Conditions/Resources**

Good policies are often not adopted because they are proposed without the social, political, or economic resources to move them through the policy process and/or implement them.

Social norms change over time and foster or impede social policy development or revision.

Political and/or economic conditions can also promote or hinder the creation and/or revision of policy, as well as whether policy alternatives are suggested or considered for adoption.

### **Legal Issues/Laws**

Understanding how new policies will influence or interact with existing laws is essential. Policies may not be supported if they are believed to negatively impact on existing policies that are seen as beneficial.

## Institutional Influences

The structure of institutions, such as government agencies, private sector organizations, and so on, can also impact the ability to influence and efficiently or effectively implement social policies. Sometimes policies are so complex or integrated into the practices of complex institutional systems that it is difficult to understand them; therefore, change is less likely.

## External Influences

The media and other external influences can be very influential. Media can be used to call attention to a problem. More media coverage of one policy alternative may influence its support as it is more familiar. Public opinion is a very salient influence as to whether policies will be proposed and/or adopted.

Social workers who want to promote certain social policies must be aware of these influences and use methods to support policies as they relate to these areas. Contrarily, social workers can decrease the <sup>369</sup> desirability of policies by creating barriers or removing positive influences in these areas.

Problems are also often associated with policy implementation. Policies may not be clearly communicated, leaving implementers and others at a loss as to how to follow them in order to achieve the intended goals. Negative attitudes of service personnel, lack of resources to carry out policies, and/or the conflict with previously established procedures or structures can also be obstacles to implementation.

**Cooptation** has many meanings, but may be used as a strategy to influence social policy as leaders will try to quiet dissention or disturbances not only by dealing with immediate grievances, but by making efforts to channel the energies and angers of dissenters into more legitimate and less disruptive activities. When coopting, incentives are offered and other efforts are made aimed at complacency.

## **METHODS TO ASSESS THE AVAILABILITY OF COMMUNITY RESOURCES**

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Social workers must respect the rights to self-determination of clients. In order for clients to make informed decisions, it is critical that they understand the range of services available and be informed about any opportunities they have to obtain services from other service providers. Clients should also understand their right to be referred to other professionals for assistance, as well as their right to refuse services and possible consequences of such refusals.

Throughout the problem-solving process, social workers should be assisting clients to access available resources, as well as create new ones if they do not exist or are not appropriate. In order for clients to choose between alternative resources, social workers must review the advantages and disadvantages of using each.

There are important steps, as well as ethical concerns, that must be taken when referring clients for services.

### **Step 1: Clarifying the Need or Purpose for the Referral**

Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that other services are required (*NASW Code of Ethics—Referral for Services*).

### **Step 2: Researching Resources**

When making a referral, it is critical that a social worker refers to a competent provider, someone with expertise in the problem that a client is experiencing. When researching resources, a client's right to self-determination should be paramount. In addition, if a client is already receiving services from an agency, it may be advisable to see if there are available services provided by this agency in order to avoid additional coordination and fragmentation for a client.

### **Step 3: Discussing and Selecting Options**

Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring

social worker (*NASW Code of Ethics—Referral for Services*).

### **Step 4: Planning for Initial Contact**

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Social workers may want to work with a client to prepare for the initial meeting. Preparation may include helping a client to understand what to expect or reviewing needs and progress made so that it can be discussed with the new provider.

### **Step 5: Initial Contact**

Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers (*NASW Code of Ethics—Referral for Services*).

### **Step 6: Follow-Up to See If Need Was Met**

Social workers should always follow-up to ensure that there was not a break in service and that the new provider is meeting a client's needs.

## **TECHNIQUES FOR MOBILIZING COMMUNITY PARTICIPATION**

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Community participation is critical in social work practice. Community participation informs others about needed changes that must occur. Policies, programs, and services that were effective or appropriate previously may have become ineffective or inappropriate.

Community participation also creates relationships and partnerships among diverse groups who can then work together, but may not usually do so.

Community participation puts decision-making power partly or wholly with the community, ensuring that individuals will remain interested and involved over time.

When engaging in community-based decision making, individuals will typically go through various stages.

Orientation stage—Community members may meet for the first time and start to get to know each other.

Conflict stage—Disputes, little fights, and arguments may occur. These conflicts are eventually worked out.

Emergence stage—Community members begin to see and agree on a course of action.

Reinforcement stage—Community members finally make a decision and justify why it was correct.

Community members are far more likely to buy into policy that has been created with their participation. Their support over time will lead to permanent change.

Community participation energizes communities to continue to change in positive directions. Once involved in a successful change effort, community members see what they can accomplish collectively and take on new challenges.

Lastly, community members must inform policy-makers and planners of the real needs of the community, so that the most important problems and issues can be addressed. They must also provide information about what has been tried before and worked or not worked.

## METHODS TO ESTABLISH PROGRAM OBJECTIVES AND OUTCOMES

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The terms “mission,” “goals,” “objectives,” and “outcomes” are often used interchangeably without being clearly defined.

A *mission statement* is a general, concise statement outlining the purpose guiding the practices of an organization. Outcomes eventually flow from the mission statements of an agency. *Goals* are broad, general statements of what the program intends to accomplish. Goals describe broad outcomes and concepts expressed in general terms (e.g., clear communication, problem-solving skills). Goals should provide a framework for determining the more specific objectives of a program and should be consistent with the mission of the agency. A single goal may have many specific subordinate objectives.

*Objectives* are brief, clear statements that describe the desired outcomes. They are distinguished from goals by the level of specificity.

Goals express intended outcomes in general terms and objectives express them in specific terms.

*Outcomes* may be knowledge, abilities (skills), and/or attitudes (values, dispositions) that have been obtained. Outcomes are *achieved* results.

## **GOVERNANCE STRUCTURES**

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Governance concerns those structures, functions, processes, and customs that exist within an organization to ensure it operates in a way that achieves its objectives, and does so in an effective and transparent manner. It is a framework of accountability to clients, stakeholders, and the wider community, within which organizations make decisions and control their functions and resources to achieve their objectives.

Good governance adds value by improving the performance of an organization through more efficient management, more strategic and equitable resource allocation and service provision, and other improvements that lend themselves to improved outcomes and impacts.

Social workers should advocate within and outside their agencies for adequate resources to meet clients' needs and for resource allocation procedures that are open and fair (*NASW Code of Ethics—Administration*). When not all clients' needs can be met, an allocation procedure should be developed that is nondiscriminatory, appropriate, and consistent. Social workers should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision and that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*.

## **THE RELATIONSHIP BETWEEN FORMAL AND INFORMAL POWER STRUCTURES IN THE DECISION-MAKING PROCESS**

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Formal power is received in accordance with position in an organization and the authority associated with that position. Conversely, informal

power stems from the relationships built and respect earned from coworkers.

## Formal Power

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Organizations typically have organizational charts that list the relationship and ranks of positions. The charts detail the lines of authority and responsibilities and outline the formal power structures of the organizations. Formal power may refer to position in the organizational hierarchy, corporate structure, or even job function. A chief executive officer, for example, has decision-making power in many areas. Even in small agencies without official organizational charts, employees can easily recognize formal power because of job roles, titles, and functions.

## Informal Power

The most powerful person in an organizational unit is not necessarily a supervisor. Instead, persons with the most influence, who can lead others to achieve goals or accomplish tasks, may have the greatest influence. Informal power refers to the ability to lead, direct, or achieve without official authority. It is derived from relationships that are built. Employees with informal power may be the most experienced or knowledgeable or the most respected because of personality traits.

All forms of power within an organization are beneficial when used appropriately. Formal power is necessary to achieve goals. Informal power can be equally useful. Workers may be more apt to accept criticism or take direction when they receive guidance from a colleague that is respected and trusted. It is often easier to get employee “buy-in” when suggestions come from those with informal power.

## **ACCREDITATION AND/OR LICENSING REQUIREMENTS**

Administrative reviews, such as annual reviews from public and private social service organizations, are critical to the fulfillment of the social work mission. They provide accountability to the public about the number of people served, the services delivered, and how funds were allocated. They also may be used by social workers to document unmet needs that should be addressed.

Social workers may be required to engage in grant monitoring, evaluations, program inspections, and accreditation reviews. Although each of these reviews serves a different purpose, they all require social workers to use critical thinking/analysis to help clients directly or indirectly.

## Content Area III: Practice Questions

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The following section has 46 unique practice questions that assess retention of material related to psychotherapy, clinical interventions, and case management. The number of questions reflects the approximate proportion of a typical exam (27%) devoted to this content.

- 1.** During the first session, a client becomes very upset and hostile about his need to seek treatment. He blames others for his situation and yells in a loud manner. In order to facilitate the problem-solving process, the social worker should **FIRST:**

  - A.** Listen to the client as he explains his concerns
  - B.** Tell the client that he needs to calm down so the social worker can understand his issues
  - C.** Assess why the client is so upset and unwilling to accept responsibility for his problems
- 2.** A client in a group facilitated by a social worker has a red face and appears visibly upset when he talks about his current relationship with his family. When the social worker comments how the client appears unhappy about his current situation, the client says, “Everything is fine.” How can the behavior of the client **BEST** be explained?

  - A.** Lack of congruent communication
  - B.** Denial of an underlying psychic conflict
  - C.** Resistance to address the situation
- 3.**

How is positive regard **BEST** defined?

- A.** Exploring with clients the protective factors that are present in their lives
- B.** Working with clients to establish goals that will improve their quality of life
- C.** Accepting clients regardless of their actions or statements

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A client comes to see a social worker because she is having multiple issues with her job. During the initial session, she tells the social worker that she “can’t wait for advice on how to fix the problems.” In this situation, the social worker should:

- A.** Help the client to prioritize the issues so that the most urgent are addressed first
  - B.** Ask the client why she feels that the social worker’s advice would be so valuable
  - C.** Clarify the responsibilities of the client and social worker with regard to the change process
- 5.** The social worker ends a family session with, “During the last hour, each of you has had a chance to discuss your frustrations with one another and how sometimes your own actions have been perceived by each other as hurtful, though they were not intended to be so.” The social worker’s statement **MOST** likely aims to:
- A.** Clarify to the family that the social worker is objective since each member got a chance to speak
  - B.** Summarize what occurred so family members can gain a new understanding of their actions
  - C.** Praise the family members for their openness and participation in the session
- 6.** Which of the following must a social worker consider when obtaining formal feedback from others about social work

practice delivery?

- A. Client consent is needed if consultation is related to client care
- B. The best insight can often be gained from those who are critical of care
- C. Feedback is important at key decision points in service development and implementation

**7.** When a social worker and client are not from the same ethnic or racial group, a social worker should:

- A. Recognize the differences and understand how they may impact on the treatment process
- B. Engage in supervision and/or consultation with a member of that ethnic or racial group
- C. Understand the customs and beliefs that are universal to those from that ethnic or racial group

**8377**

- During the first session, a young woman sobs as she states that she does not think that she will ever get through the recent dissolution of her marriage. She ends by saying that she “is alone and nobody understands how I feel.” In order to **BEST** instill hope, the social worker should:

- A. Talk about how the social work had the same feelings during a marital breakup
- B. Assure her that many women in similar situations are able to work through this isolation
- C. Refer her to a support group with other women who are going through divorce

**9.** Which of the following is a primary prevention strategy?

- A. Regular screenings of those with risk factors for an illness or disease

- B. Regular exercise and good nutrition
- C. Taking low doses of aspirin for those with heart conditions

**10.** Which of the following is the **FIRST** goal of assisting clients who have suffered life crises?

- A. Linking clients with others who have experienced similar crises to build a network of support
- B. Identifying the cause of the crises in order to prevent the crises from reoccurring in the future
- C. Assisting clients to establish a sense of equilibrium and return to prior levels of functioning

**11.** Which of the following contains thoughts, feelings, desires, and memories of which a client has no awareness even though they influence the client's daily life?

- A. Preconscious
- B. Superego
- C. Unconscious

**12.** After a client assessment is completed, what is expected to follow according to the problem-solving process?

- A. Intervention
- B. Planning
- C. Engagement

<sup>379</sup> **13.** Which of the following is a level of awareness as defined by Freud?

- A. Id
- B. Preconscious
- C. Preconventional

**14.** Which **BEST** describes the role of a social worker when engaged in crisis intervention?

- A. Short-term support focused on restoring clients' psychological capacities
- B. Long-term support to ensure clients are able to address trauma experienced
- C. Highly involved support focused on meeting the clients' basic needs

**15.** Which of the following is a key concept in individual psychology?

- A. Striving for perfection
- B. Aggressive urges
- C. Repressed sexual fantasies

**16.** A social worker is seeing a 69-year-old client who is a former cigarette smoker and has chronic obstructive pulmonary disease (COPD), interfering with normal breathing. The client takes several medications, including one to regulate her blood pressure. Which of the following is a primary prevention need of the client?

- A. Receiving an annual influenza immunization
- B. Monitoring her blood pressure to modify her medications as needed
- C. Reducing strenuous activity that causes heavy breathing

**381**      **17.** Which is the **MOST** important reason that self-monitoring is used as a social work technique?

- A. Clients are the most reliable sources of information
- B. Clients better understand the causes and frequency of the problem behaviors
- C. Clients collecting data is based on the principles of self-determination

**18.** A social worker receives a referral to provide case management to a family who just immigrated from another

country and needs to be linked to services to meet their basic needs. The 13-year-old daughter in the family speaks English in addition to her native language, which is exclusively spoken by the parents. The social worker, who only understands and speaks English, accepts the referral. Which **BEST** describes this action by the social worker?

- A. Ethical because the daughter will be available to translate for the parents
  - B. Ethical because the services are time-limited and nonclinical in nature
  - C. Unethical because the social worker cannot speak to or understand all family members
- 19.** A client reports to a social worker that he is having problems with his wife because he feels that she does not care about him. The social worker discovers that this belief by the husband stems from his belief that she is always distracted when he speaks. The social worker challenges and helps him replace this thought with an alternative one that she “does care, but just has a lot of other demands for her attention.” Which approach is the social worker using to address the husband’s issues?
- A. Operant conditioning
  - B. Cognitive behavioral therapy
  - C. Ego psychology
- 20.** A social worker observes that a client is having trouble communicating with her husband, so she often confides in her sister-in-law about her fears and concerns, hoping that the sister-in-law will be able to assist. The sister-in-law finds that she is becoming increasingly “in the middle” of the problems that exist between her brother and his wife. Which term **BEST** describes this family situation?
- A. Triangulation
  - B. Differentiation

**C. Familial regression**

2383

**1**

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A married couple comes in to see a social worker because they are having problems in their relationship. They report feeling disconnected and having little intimacy. The husband admits that his drinking recently caused him to be fired from his job and he is currently unemployed. The wife reports that she is fearful of her husband because he often is loud when he drinks. She spends a lot of time out of the house. They have not had sex for several months and are behind in their mortgage payments. In order to assist the couple, the social worker should **FIRST**:

- A.** Help the couple with their lack of emotional intimacy
  - B.** Determine the reasons for the wife's absence from the home
  - C.** Identify the extent of the husband's alcohol use
- 22.** In which of the following phases of child development is rapprochement a subphase?
- A.** Normal symbiotic
  - B.** Object constancy
  - C.** Separation-individuation
- 23.** When engaging in structural family therapy, social workers may use which of the following techniques to understand and diagnose structures that maintain families' dysfunctional interactions?
- A.** Confrontation
  - B.** Journaling
  - C.** Enactments
- 24.** When working with an involuntary client, which of the

following actions is likely to be **MOST** effective during engagement?

- A. Reviewing the court order so the client understands why services are mandated
- B. Discussing mandates of confidentiality as per the ethical code
- C. Listening to understand the client's current feelings and situation

<sup>385</sup>  
**25.** During what ages does "latency" usually occur within the psychosexual stages of development?

- A. First year of life
  - B. Between 3 and 5 years old
  - C. From age 5 until puberty
- 26.** Upon intake, a single mother admits to binge drinking on the weekends. She states that she is not going to stop this behavior. Using a harm reduction approach, a social worker should:
- A. Help the mother to prearrange for alternative childcare on the weekends when she is drinking
  - B. Recommend that the mother go to a physician to assess if she has any medical problems
  - C. Refer the mother for a drug and alcohol evaluation to determine the extent of her drinking
- 27.** Which action by a social worker will be **MOST** effective in addressing resistance during engagement?
- A. Clarifying the social worker's role and the problem-solving approach
  - B. Completing a biopsychosocial assessment to better understand the situation
  - C. Partializing the problem to identify action steps

**28.** A man is court ordered to receive an evaluation by a social worker. Although initially agreeable to participating, the client states at the conclusion of his meetings with the social worker that he “changed his mind” and wished that he had never agreed to be interviewed. He asks the social worker not to release any information to the court. The social worker should:

- A. Respect the client’s wishes and not provide any information to the court
- B. Inform the court that the client rescinded his consent
- C. Complete the evaluation based on all of the information gathered

**29.** Which of the following is a critical part of termination in social work practice?

- A. Identifying other concerns that may need to be addressed in the future
- B. Reviewing the nature of the support systems that are available to help
- C. Anticipating how to address subsequent reoccurrences of the problem

387 What is the primary goal of permanency planning?

**30.**

- A. Living in stable and long-term homes
- B. Improving educational outcomes
- C. Ensuring treatment decisions are individually based

**31.** A man comes to see a social worker because he is sexually attracted to those of the same gender and is deeply distressed by the thought that he may be homosexual. Which of the following **BEST** describes the feelings experienced by this client?

- A. Ego alien

**B.** Ego-syntonic

**C.** Fixations

**32.** When determining whether a task-centered approach is appropriate for a client, which of the following must the social worker consider?

**A.** The client takes a very active role in making change

**B.** The treatment is highly structured and time limited

**C.** Termination usually begins in the first session

**33.** Which of the following statements is accurate regarding confidentiality in group work?

**A.** Group members have the same protection of confidentiality received in individual counseling

**B.** Group members have a legal duty not to disclose information that is shared

**C.** Social workers cannot guarantee that information disclosed in groups will be kept confidential

3389

**4**

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A client tells a social worker that she “feels like a failure” because she cannot seem to meet the multiple daily demands of working and parenting. The social worker states that “many people in your situation experience the same feelings.” Which of the following techniques is being used by the social worker?

**A.** Validating

**B.** Reflecting

**C.** Clarifying

**35.** When conducting a social work interview, what must a social worker consider about these interactions?

**A.** These interviews can be informational, diagnostic, or

- therapeutic
- B. These interviews are uniform in nature to collect consistent information on all clients
  - C. These interviews collect important information to be used in the problem-solving process

**36.** What is the **BEST** definition of empowerment?

- A. Helping clients obtain services needed to solve their problems
- B. Providing clients with training and education to improve their coping skills
- C. Assisting clients to realize that they have strengths and resources to solve their own problems

**37.** According to self-psychology, which is an essential child need that caregivers must meet to ensure healthy development?

- A. Cultural
- B. Biological
- C. Twinship

<sup>391</sup> According to object relations theory, at about which age  
**38.** does the normal symbiotic phase of development end?

- A. 5 months
- B. 2 years
- C. 2 weeks

**39.** A client starts to miss appointments with a social worker after achieving goals. Prior to these absences, the client had very good attendance and had made substantial progress. What is the **MOST** likely reason for these missed appointments?

- A. Readiness to terminate from services
- B. Emergence of a new problem that needs to be addressed
- C. Dissatisfaction with achieved outcomes

**40.** A client has just been diagnosed with stage 4 cancer and is referred to a pain management group to minimize the discomfort associated with her illness. Which of the following types of prevention is being recommended for the client?

- A. Tertiary prevention
- B. Primary prevention
- C. Secondary prevention

**41.** When making level of care determinations, which criterion is primarily used in behavioral health settings?

- A. Capitation
- B. Medical necessity
- C. Managed risk

4393

**2**

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A couple comes to see a social worker because they feel that they have suffered discrimination. They are blind and would like to adopt a child but have been told by an adoption agency that it is not possible because of their visual impairments. They are distraught and do not think that they will be able to fight the agency bias. In order to **BEST** assist this couple, the social worker should:

- A. Assist them to identify other methods to become parents
- B. Help them cope with their disappointment from being denied
- C. Support them in fighting the agency bias

**43.** A social worker in a mental health agency is very upset by the passage of legislation that, in his opinion, will be detrimental to some clients. He is asked by an advocacy organization to join a protest; he does so on his own time and without identifying his employer. His agency director is very upset by his participation because the board of directors of the mental

health agency supported this legislation. Which of the following **BEST** describes the social worker's actions?

- A. Unethical because the social worker is considered a representative of his employer
- B. Ethical because he acted as a private individual
- C. Unethical because he should have gotten permission from his agency director first

**44.** Which of the following **BEST** describes the benefit of peer supervision in social work practice?

- A. Peer supervision is less expensive than individual supervision
- B. Peer supervision can occur as needed, anytime and anywhere
- C. Peer supervision is a reciprocal learning relationship aimed at skill acquisition

**45.** An agency is concerned with the recidivism of its clients and hires a consultant to provide recommendations about service modifications that have to occur. The consultant has a doctorate and extensive experience in the field. After several weeks, the consultant generates a report advising of service changes that, in the social worker's professional opinion, would be detrimental to clients. In this situation, the social worker should:

- A. Agree to the service changes as the consultant is an "expert" in the field
- B. Refuse to implement the service changes, citing the reasons for the concerns
- C. Identify the feelings of others in the agency about the proposed service changes

A social worker is struggling with treating a client diagnosed with pica. This disorder is not common among those served by her agency. The social worker believes that it is in the best interest of the client for the social worker to obtain consultation. A colleague in the agency has shown interest in the situation and agrees to advise because she has known the social worker for many years and they both became employed at the agency immediately after graduation. In this situation, the social worker should:

- A.** Decline the offer in order to find a consultant with more experience in treating this disorder
- B.** Accept the offer because the colleague is immediately available to assist
- C.** Decline the offer as it is a conflict of interest to use a colleague employed by the same agency

#### Practice Questions

Content Area III: Psychotherapy, Clinical Interventions, and Case Management (27%)

Competency	Question Numbers	Number of Questions	Number Correct	Percentage Correct	Area Requiring Further Study?
1. Therapeutic Relationship	1, 2, 3, 4, 5, 6, 7, 8	8	____/8	____%	
2. The Intervention Processes	9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40	32	____/32	____%	
3. Service Delivery and Management of Cases	41, 42, 43	3	____/3	____%	
4. Consultation and Interdisciplinary Collaboration	44, 45, 46	3	____/3	____%	

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- A.** The client's actions are occurring during the first session. There is no indication that his outbursts are dangerous to himself or the social worker. Upon intake, clients are often upset and angry (even at themselves) for their current situations. The problem-solving process starts with engagement.

As the question is asking what the social worker should do FIRST, the answer should be directly related to engagement. Listening to the client as a way of building rapport will help facilitate change. The other answers will interfere with development of the therapeutic alliance and/or may come later in the process.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); The Principles and Techniques for Building and Maintaining a Helping Relationship (KSA)

- 2. A.** Congruence is the matching of awareness and experience with communication. It is essential that a client is able to express feelings and that verbal communication is consistent with nonverbal expressions of feelings. Congruence is essential for the vitality of a relationship and to facilitate true helping as part of the problem-solving process. The client states that the relationship is "fine," but his physical symptoms clearly indicate that it is not. This is an example of a lack of congruence in his communication. There is no way to know if the client is resistant or is in denial but clearly the client is not communicating his feelings based upon his facial expressions.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); The Concept of Congruence in Communication (KSA)

- 3. C.** Positive regard was a term used by Carl Rogers for the critical

need to view clients as worthy, accepting and supporting them without judgment. It is believed to be essential for therapeutic treatment according to the humanistic approach. Social workers should set aside their own opinions and biases in order to show acceptance of clients and believe that they are capable of change while still having value and worth without changing.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); Verbal and Nonverbal Communication Techniques (KSA)

4376

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**C.** Social work roles in the problem-solving process include consultant, advocate, case manager, catalyst, broker, mediator, facilitator, instructor, mobilizer, resource allocator, and so forth.

Problems can arise when a client is not clear about a social worker's role. Initial clarification should be made during engagement and should be discussed during the therapeutic process if the role of a social worker changes. The social worker must address the client's misconception that the social worker will be fixing the problem. The other response choices may be helpful but do not relate to the comment by the client.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); The Social Worker's Role in the Problem-Solving Process (KSA)

**5. B.** Summarization seeks to bring together the important points of a discussion and to heighten awareness of progress made. It omits irrelevant information and organizes pertinent aspects of the interaction. It provides a sense of closure at the completion of a discussion. During summarization, social workers and clients strive to grasp the significance of what has been said, to formulate the meaning of the information, and to achieve new understandings.

The social worker uses summarization at the end of a session to pull together the meaning of what has been said by each family member. This technique allows the family to better understand the common theme in session discussions and perhaps gain a new understanding about the behaviors of others.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); Verbal and Nonverbal Communication Techniques (KSA)

- 6. A.** When social workers involve consultants or others in the feedback process related to client care, clients should provide consent. While sometimes the best learning can come from those who are critical, feedback should be obtained from those with specific expertise—not just because they have concerns. Feedback is especially important at key decision points, but this response choice does not directly focus on client well-being which is paramount.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); Methods to Obtain and Provide Feedback (KSA)

- 7. A.** Social workers' self-awareness about their own attitudes, values, and beliefs concerning cultural differences and a willingness to acknowledge racial/cultural differences are critical factors in working with diverse populations. Supervision and consultation are important, but clients are the experts of their own experiences. There are more intragroup differences than intergroup ones, so no customs or beliefs are universal.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); The

## Dynamics of Diversity in the Social Worker–Client/Client System Relationship (KSA)

8378

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- B.** Most practice situations are best handled with no self-disclosure by social workers. Social workers should not discuss their own marital breakups. Instead, social workers can normalize feelings generally and let clients know that they will have the opportunity to address their feelings. The woman may benefit from meeting others who are going through similar experiences but referring her at this point in the problem-solving process is not an appropriate method for instilling hope.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Therapeutic Relationship (Competency); The Principles and Techniques for Building and Maintaining a Helping Relationship (KSA)

- 9. B.** Regular exercise and good nutrition are actions that are classified as primary prevention, helping to avoid developing diseases, injuries, and/or illnesses. The other response choices are secondary prevention strategies that occur after diseases, injuries and/or illnesses have developed to mitigate or slow their progression/impacts.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Primary, Secondary, and Tertiary Prevention Strategies (KSA)

- 10. C.** The immediate goal is to relieve the stress experienced, return clients to previous levels of functioning, and assist them with regaining equilibrium. A social worker may want to work with clients to identify precursors and/or link with others for mutual

support, but these actions would occur after the crisis has subsided.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Crisis Intervention and Treatment Approaches (KSA)

- 11. C.** The unconscious contains thoughts, feelings, desires, and memories of which clients have no awareness, but that influence every aspect of their day-to-day lives. The preconscious contains all the information outside of a client's attention, but that is readily available, if needed. The superego is the moral component of personality. It causes clients to feel guilty when they go against society's rules.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

- 12. B.** The problem-solving process consists of engaging, assessing planning, intervening, evaluating, and terminating. Thus, planning is done after an assessment is complete.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Problem-Solving Models and Approaches (e.g., Brief, Solution-Focused Methods or Techniques) (KSA)

**1380**

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- B.** Freud believed that behavior and personality derives from the constant and unique interaction of conflicting psychological forces

that operate at three different levels of awareness: the preconscious, the conscious, and the unconscious.

The preconscious contains all the information outside of a client's attention, but that is readily available, if needed. Preconscious thoughts and feelings can be brought into the consciousness easily if needed.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

- 14. C.** Crisis intervention focuses on the here and now, is time limited (most crises last from 4–6 weeks), is directive, and requires high levels of activity and involvement from social workers. Social workers' primary goal is to return clients to equilibrium and meet their immediate needs. Although the first response choice indicates that the support is short term, it is incorrect because social workers focus on meeting basic needs, not "restoring clients' psychological capacities."

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Crisis Intervention and Treatment Approaches (KSA)

- 15. A.** Individual psychology is a theory of human behavior emphasizing the drive to overcome feelings of inferiority by compensation and the need to achieve personal goals that have value for society. Alfred Adler believed that the main motives of human thought and behavior were a striving for superiority and power, partly in compensation for feelings of inferiority. Adler believed that the main motivations for human behavior were not sexual or aggressive urges but striving for perfection.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

- 16.** **A.** The receipt of an influenza immunization is the only response choice aimed at disease prevention. Reducing strenuous activity is associated with managing or living with chronic obstructive pulmonary disease (COPD). Such actions are tertiary prevention. Monitoring medication is an activity aimed to slow the progression or long-term impacts of conditions, including high blood pressure. Thus, medication monitoring is a secondary prevention activity.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Primary, Secondary, and Tertiary Prevention Strategies (KSA)

**1382**

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- B.** Self-monitoring consists of clients systematically observing their own behavior. Most clients are not entirely aware of the extent to which they engage in various behaviors and/or antecedents or consequences of their actions. When clients are provided with the opportunity to observe their own behaviors carefully, dramatic changes often occur by the mere monitoring of the behaviors themselves. The incorrect response choices are important but are not directly linked to use of client self-monitoring.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Client/Client System Self-Monitoring Techniques (KSA)

- 18.** **C.** Because the parents do not speak or understand English, the social worker should arrange for a qualified interpreter or

translator. The use of the daughter to translate for her parents is not appropriate because the parents may be apprehensive to identify the family's true needs to their daughter. In addition, the social worker will only learn what the parents say through the daughter. Valuable information may be omitted or lost. Lastly, the daughter also may not communicate what the social worker is saying in a manner that is appropriate or accurate.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); The Principles and Techniques of Interviewing (e.g., Supporting, Clarifying, Focusing, Confronting, Validating, Feedback, Reflecting, Language Differences, Use of Interpreters, and Redirecting) (KSA)

- 19. B.** Cognitive behavioral therapy aims to change patterns of thinking or behavior that are responsible for clients' difficulties. In this approach, the social worker assists clients to change attitudes and behaviors by focusing on thoughts, images, beliefs, and attitudes that are held (cognitive processes) and replacing distorted thinking patterns with healthy ones (cognitive restructuring).

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Cognitive and Behavioral Interventions (KSA)

- 20. A.** Triangulation occurs when there is anxiety and tension between two individuals that may cause them not to communicate directly. In this situation, they communicate through a third person, leading to the formation of a triangle. Often the two people try to get the third to take each of their sides when disagreements arise.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Family Therapy Models, Interventions, and Approaches (KSA)

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- C.** Many of the problems reported by the couple appear to be caused by the alcohol use of the husband, including his unemployment and their financial problems. The social worker should FIRST determine the extent of the husband's drinking and his willingness to address this issue because many of the reported problems will not change if this behavior continues. Treating substance misuse and medical issues always is prioritized because they are often the etiological causes of negative impacts on psychosocial well-being.

**Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Couples Interventions and Treatment Approaches (KSA)

- 22. C.** Rapprochement occurs between 15 and 24 months. In this subphase of separation-individuation, the child once again becomes close to the mother. The child realizes that physical mobility demonstrates psychic separateness from the mother and may want her in sight.

**Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

- 23. C.** Structural family therapy is based on the premise that there is an overall structure or organization that maintains family dysfunction. Restructuring is based on observing and manipulating interactions within therapeutic sessions. Enactments are

suggested by social workers as ways to diagnose structure and provide openings for restructuring interventions.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Family Therapy Models, Interventions, and Approaches (KSA)

- 24. C.** Engagement is aimed at starting to build the therapeutic alliance. When a client is involuntary, the client may be reluctant to trust the social worker and may think that the social worker does not understand the client's feelings or current situation. Thus listening is the most effective action because it begins to build rapport. It shows the client that the social worker cares about what is being said and is nonjudgmental.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Methods to Engage and Work With Involuntary Clients/Client Systems (KSA)

2386

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- C.** The oral stage occurs during the first year of life, followed by the anal stage, which occurs during toilet training (2–3 years old). The phallic stage is from ages 3 to 4 and is followed by latency, which begins at about age 5 and lasts until puberty. The genital stage begins in puberty with the source of pleasure being the genitals.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

**26. A.** Although more than one of the response choices may be appropriate actions to be taken by a social worker, assisting the mother to find alternative childcare is the answer that directly relates to “a harm reduction approach” as directed in the question.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Technique for Harm Reduction for Self and Others (KSA)

**27. A.** Partialization is a good technique to assist clients in breaking down problems or goals into less overwhelming and more manageable components. However, it does not happen during engagement, but rather planning and/or intervention. Completing a biopsychosocial assessment also does not happen during engagement. Helping the client to understand the social worker’s role and the nature of helping does occur during engagement and is useful for helping alleviate the fears of resistant clients.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Partializing Techniques (KSA)

**28. C.** The evaluation is court ordered and, therefore, the social worker does not need to get the consent of the client to perform services and/or release information to the court. However, it is essential that the social worker inform the client at the onset about what he has control over and what information will/will not be released. The client not wanting the social worker to release the information does not change the legal duty to do so.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Methods

to Engage and Work With Involuntary Clients/Client Systems (KSA)

- 29. C.** Termination is focused on reviewing accomplishments, anticipating how to address the problem if it arises in the future, and recognition of the loss on the part of the client and social worker because the relationship is ending. Identifying new problems or available support systems is not appropriate during termination.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); The Indicators of Client/Client System Readiness for Termination (KSA)

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- A.** Permanency planning is an approach to child welfare that is based on the belief that children need permanence to thrive. Child protection services should focus on getting children into and maintaining permanent homes.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Permanency Planning (KSA)

- 31. A.** When the ego is comfortable with feelings and/or behaviors, a client is said to be ego-syntonic. However, if a client is bothered by feelings and/or behaviors, the client would be ego-dystonic (egc alien).

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

- 32. A.** A task-centered approach aims to quickly engage clients in the problem-solving process and to maximize their responsibility for treatment outcomes. The focus is on the “here and now.” The problem is partialized into clearly delineated tasks to be addressed consecutively (assessment leads to goals, which lead to tasks). Termination, in this modality, begins almost immediately upon the onset of treatment. All the response choices are hallmarks of task-centered treatment but only determining if the client is capable of taking such an active role needs to be considered before the onset of treatment. The remaining choices impact service delivery once the modality is selected.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Task-Centered Approaches (KSA)

- 33. C.** When social workers engage in group work, they should seek agreement among group members concerning preserving the confidentiality of information shared. However, social workers should inform members that they cannot guarantee that all group members will honor such agreements. Group members do not have the same legal obligations that social workers do to keep information private and protected. However, social workers engaged in group work should use the same professional standards regarding their own conduct.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Group Work Techniques and Approaches (e.g., Developing and Managing Group Processes and Cohesion) (KSA)

3390

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**A.** Validation shows empathetic understanding of the client's problems. Validation lets the client know that she is not alone, and others are experiencing the same feelings or difficulties. By realizing that her belief is one that is shared by those in similar situations, the client feels less isolated and gains strength by the realization that others have worked through the problem(s) that she is experiencing.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); The Principles and Techniques of Interviewing (e.g., Supporting, Clarifying, Focusing, Confronting, Validating, Feedback, Reflecting, Language Differences, Use of Interpreters, and Redirecting) (KSA)

**35. C.** Social work interviews are always purposeful and involve verbal and nonverbal communication between social workers and clients during which ideas, attitudes, and feelings are exchanged. The aim is to gather important information used in the problem-solving process. Social work interviews are designed to serve the interest of clients. Questions in a social work interview should be *tailored* to the specifics of a client, *not generic*, "one size fits all" inquiries. The purpose of the social work interview can be informational, diagnostic, or therapeutic, but the intent should be decided prior to conducting the interview. The question asks about what a social worker should consider when doing the interview.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); The Principles and Techniques of Interviewing (e.g., Supporting, Clarifying, Focusing, Confronting, Validating, Feedback,

Reflecting, Language Differences, Use of Interpreters, and Redirecting) (KSA)

- 36. C.** Empowerment is a multidimensional social work process that helps clients gain control over their lives. Empowerment fosters clients to use their strengths and skills to make changes that they desire. The correct answer focuses on clients solving their own problems, a fundamental concept in empowerment.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Strengths-Based and Empowerment Strategies and Interventions (KSA)

- 37. C.** According to Kohut, caregivers are not always responsive, which leads to poor self-cohesion. It is essential that children receive *mirroring* that confirms children's sense of greatness and perfection, *idealizing* of others through which children take in strength and calmness, and *twinship* or alter-ego that provides children with a sense of being human and a likeness to others.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

3392

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- A.** The normal symbiotic phase ends at about 5 months of age. The child is now aware of the mother, but there is not a sense of individuality. The child and mother are one, and there is a barrier between them and the rest of the world.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Psychoanalytic and Psychodynamic Approaches (KSA)

- 39.** **A.** Sometimes missing appointments after achieving stated goals can be an indicator that the client is ready to terminate. The client may want to practice new skills independently and does not think that there is a need to continue to see the social worker. There is no indication that a new problem has emerged or the client is dissatisfied. The client's behavior most likely means that the client is ready to stop seeing the social worker.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); The Indicators of Client/Client System Readiness for Termination (KSA)

- 40.** **A.** Tertiary prevention focuses on managing complicated, long-term diseases, injuries, or illnesses. The goal is to prevent further deterioration and maximize quality of life because the disease is now established. Other types of prevention strategies are aimed at preventing the development of a disease and/or slowing its progression or minimizing its long-term impacts.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; The Intervention Process (Competency); Primary, Secondary, and Tertiary Prevention Strategies (KSA)

- 41.** **B.** Medical necessity is a criterion used to determine whether treatments and services are justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Payment for services, as well as whether levels of care are justified, uses medical necessity to assess whether treatment and service requests are “reasonable and necessary” given clients diagnoses and/or presenting problems.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Service Delivery and Management of Cases (Competency); The Effects of Policies, Procedures, Regulations, and Legislation on Social Work Practice and Service Delivery (KSA)

4394

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**C.** Social workers are charged with helping clients who have experienced discrimination by making policy and/or system changes. The social worker should not be seeking alternative methods to assist the couple to become parents because they have the right to adopt and desire to do so. Although they may need support, developing coping skills will not BEST assist the couple because these actions do not help them ultimately realize parenthood through adoption which is their goal.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Service Delivery and Management of Cases (Competency); Theories and Methods of Advocacy for Policies, Services, and Resources to Meet Clients'/Client Systems' Needs (KSA)

**43. B.** Social workers should make clear distinctions between statements made and actions engaged in as private individuals as opposed to those as representatives of their employing agencies. The social worker did not protest on agency time or identify himself in any way as an employee of the agency. He acted as a private individual and, therefore, his actions are ethical.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Service Delivery and Management of Cases

(Competency); Theories and Methods of Advocacy for Policies, Services, and Resources to Meet Clients'/Client Systems' Needs (KSA)

- 44. C.** The primary benefit of peer supervision is the reciprocal learning through the sharing of experiences. Peer supervision is based on the use of feedback to assist with self-directed learning and evaluation. Peer supervision is not always associated with cost savings and this is not its biggest benefit if they do occur. In order for peer supervision to be effective, it should occur regularly and be scheduled, not just happen "on the fly."

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Consultation and Interdisciplinary Collaboration (Competency); Models of Supervision and Consultation (e.g., Individual, Peer, Group) (KSA)

- 45. B.** If the social worker has concerns about the consultant's recommendations and thinks they will be detrimental to clients, the social worker cannot ethically implement them, but must make clear why such a decision is being made. The social worker should not implement them because of the consultant's educational background and expertise. The social worker may want to find out the opinions of others but regardless of these views, the social worker cannot implement recommendations that the social worker feels are not in the best interest of clients.

### **Question Assesses**

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Consultation and Interdisciplinary Collaboration (Competency); Consultation Approaches (e.g., Referrals to Specialists) (KSA)

**4396**

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**A.** Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients but should only do so from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation. Although willing, the colleague probably does not have expertise and competence related to the disorder because both social workers began working at the agency upon graduation and this disorder is not commonly treated in this setting. There is no conflict of interest in having a colleague in the same agency provide consultation if the colleague has the requisite knowledge and skills.

### ***Question Assesses***

Content Area III—Psychotherapy, Clinical Interventions, and Case Management; Consultation and Interdisciplinary Collaboration (Competency); Consultation Approaches (e.g., Referrals to Specialists) (KSA)

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## **Content Area IV: Professional Values and Ethics (19%)**

400

# Professional Values and Ethical Issues

## **LEGAL AND/OR ETHICAL ISSUES RELATED TO THE PRACTICE OF SOCIAL WORK, INCLUDING RESPONSIBILITY TO CLIENTS/CLIENT SYSTEMS, COLLEAGUES, THE PROFESSION, AND SOCIETY**

Social workers frequently encounter ethical and legal issues. In most instances, ethical and legal standards complement each other. However, in some circumstances, ethical and legal standards conflict. The ethical standards for social workers are outlined in the *NASW Code of Ethics*. With regard to legal mandates, social workers must be aware of five distinct sets of requirements: constitutional law, statutory law, regulatory law, court-made/common law, and executive orders.

Ethical and legal issues encountered by social workers fall into four distinct categories:

1. Actions that are compatible with both legal and ethical standards in social work (legal and ethical)
2. Actions that are neither legal nor ethical in social work according to prevailing standards (not legal and not ethical)
3. Actions that are legal, but not ethical according to prevailing standards (legal, but not ethical)
4. Actions that are ethical, but not legal according to standards in

laws (ethical, but not legal)

When there are conflicts between ethical and legal standards, a social worker should identify the mandates that conflict. A social worker should also identify the individuals, groups, and organizations that are likely to be affected by the outcome of the conflict. All possible courses of action and the benefits and risks of each alternative should be considered, including the reasons supporting and in opposition to each possibility. Resolution of conflicts should not be done in a vacuum and a social worker should consult with colleagues and appropriate experts. All steps in the decision-making process should be documented. Once a decision is made, the results should be monitored and evaluated.

The *NASW Code of Ethics* states that all ethical standards are <sup>402</sup> applicable to interactions, relationships, or communications, whether they occur in person or with the use of technology (*NASW Code of Ethics—Purpose of the NASW Code of Ethics*). Technology-assisted social work services include all aspects of practice involving the use of computers, mobile or landline telephones, online social media, chat rooms, text messaging, email, and emerging digital applications.

Social workers who use technology in the provision of social work services should ensure that they have the knowledge and skills to provide such services competently, including understanding the special communication challenges when using technology and implementing strategies to address these challenges. Additionally, these social workers should comply with the laws governing technology and social work practice in the jurisdictions in which they are regulated and located and, as applicable, in the jurisdictions in which clients are located (*NASW Code of Ethics—Competence*).

## **TECHNIQUES TO IDENTIFY AND RESOLVE ETHICAL DILEMMAS**

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An ethical dilemma is a predicament when a social worker must decide between two viable solutions that seem to have similar ethical value. Sometimes two viable ethical solutions can conflict with each other. Social workers should be aware of any conflicts between personal and professional values and deal with them responsibly.

In instances where social workers' ethical obligations conflict with agency policies or relevant laws or regulations, they should make a responsible effort to resolve the conflict in a manner that is consistent with the ethical values, principles, and standards.

In order to resolve this conflict, ethical problem solving is needed.

## Essential Steps in Ethical Problem Solving

1. Identify ethical standards, as defined by the professional code of ethics, that are being compromised (always go to the *NASW Code of Ethics*. First—do not rely on supervisor or coworkers).
2. Determine whether there is an ethical issue or dilemma.
3. Weigh ethical issues in light of key social work values and principles as defined by the *NASW Code of Ethics*.
4. Suggest modifications in light of the prioritized ethical values and principles that are central to the dilemma.
5. Implement modifications in light of prioritized ethical values and principles.
6. Monitor for new ethical issues or dilemmas.

## **THE CLIENT'S/CLIENT SYSTEM'S RIGHT TO REFUSE SERVICES (E.G., MEDICATION, MEDICAL TREATMENT, COUNSELING, PLACEMENT, ETC.)**

Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions (*NASW Code of Ethics—Informed Consent*).

In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of

services and about the extent of clients' right to refuse service (*NASW Code of Ethics—Informed Consent*).

## **PROFESSIONAL BOUNDARIES IN THE SOCIAL WORKER–CLIENT/CLIENT SYSTEM RELATIONSHIP (E.G., POWER DIFFERENCES, CONFLICTS OF INTEREST, ETC.)**

Many standards speak to the professional boundaries that social workers should maintain with clients. These include those related to sexual relationships, physical contact, and sexual harassment.

The standards that govern social work practice address the use of physical contact with clients. Setting clear, appropriate, and sensitive boundaries that govern physical contact are essential for professional practice (*NASW Code of Ethics—Physical Contact*). Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to a client as a result of the contact (such as cradling or caressing clients).

Physical contact or other activities of a sexual nature with clients are clearly not allowed by social workers.

Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced (*NASW Code of Ethics—Sexual Relationships*).

Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to a client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to a client and may make it difficult for a social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom a client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries (*NASW Code of Ethics—Sexual Relationships*).

Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to a client.

If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally (*NASW Code of Ethics—Sexual Relationships*).

Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for a social worker and <sup>404</sup> individual to maintain appropriate professional boundaries (*NASW Code of Ethics—Sexual Relationships*).

In addition, social workers should not sexually harass supervisees, students, trainees, colleagues, or clients, including sexual advances, sexual solicitation, requests for sexual favors, and other verbal, written, electronic, or physical conduct of a sexual nature (*NASW Code of Ethics—Sexual Harassment*).

Social workers should avoid communication with clients using technology (such as social networking sites, online chat, e-mail, text messages, telephone, and video) for personal or non-work-related purposes and be aware that posting personal information on professional websites or other media might cause boundary confusion, inappropriate dual relationships, or harm to clients. Social workers should avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media (*NASW Code of Ethics—Conflicts of Interest*).

Clients may discover social workers' posts and interactions on websites, social media, and other forms of technology. Such involvement may affect the ability of social workers to work effectively with some clients (*NASW Code of Ethics—Conflicts of Interest*).

## **ETHICAL ISSUES RELATED TO DUAL RELATIONSHIPS**

Social workers must ensure that they do not engage in dual or multiple relationships that may impact on the treatment of clients. The standards related to this area provide guidelines that can assist social workers if such relationships emerge (*NASW Code of Ethics—Conflicts of Interest*).

Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of clients (*NASW Code of Ethics—Conflicts of Interest*).

Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests (*NASW Code of Ethics—Conflicts of Interest*).

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to a client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively (*NASW Code of Ethics—Conflicts of Interest*).

When social workers provide services to two or more people who have a relationship with each other (e.g., couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially <sup>405</sup> conflicting roles (e.g., when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest (*NASW Code of Ethics—Conflicts of Interest*).

In addition, social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in

a manner that makes participants' interests primary (*NASW Code of Ethics—Evaluation and Research*).

## **SELF-DISCLOSURE PRINCIPLES AND APPLICATIONS**

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The decision about whether to disclose personal information by a social worker often arises in practice because the social worker–client relationship involves the discussion of intimate topics. Some self-disclosure by a social worker may be harmless and even therapeutically useful as it can help clients connect during engagement and/or realize that they are not the only ones who have experienced similar problems.

However, some self-disclosure is exploitative, self-serving, and harmful to clients. Many boundary violations begin as a result of social workers discussing personal information with clients. Though not intended to be the start of friendships or more intimate relationships, self-disclosure by social workers, perhaps well meaning, can blur the boundaries between professional and personal relationships.

Sometimes social workers disclose personal information because they have experienced trauma or other problems which have not been adequately addressed and they are looking to connect with others in order to cope with their own challenges. Social workers may also self-disclose about problems because they think that clients can help them in some way, such as giving them legal advice if the clients are lawyers.

Sometimes clients learn personal information about social workers unexpectedly. For example, a social worker may run into a client at a community activity. These events cannot be anticipated and provide personal information to a client about a social worker that the social worker would prefer not to have been revealed.

Most therapeutic situations require no self-disclosure by a social worker. In fact, a client having information about a social worker's family, personal interests, and/or relationship status can be an indication of a potential boundary violation.

Prior to disclosing any information about themselves, social workers should engage in consultation or supervision about why such disclosure is being considered and why it is professionally justified in this instance. Only when it will clearly assist clients and there are no

other methods for achieving the same outcome should it be contemplated. Better understanding by social workers about their own desire to self-disclose is necessary in order to prevent boundary crossings which are harmful to clients.

## THE PRINCIPLES AND PROCESSES OF OBTAINING INFORMED CONSENT

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In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This <sup>406</sup> may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible (*NASW Code of Ethics—Informed Consent*).

In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with clients' level of understanding. In such instances, social workers should seek to ensure that the third party acts in a manner consistent with the clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent (*NASW Code of Ethics—Informed Consent*).

Social workers who provide services using technology should inform recipients of the limitations and risks associated with such services (*NASW Code of Ethics—Informed Consent*).

Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party (*NASW Code of Ethics—Informed Consent*).

Social workers should obtain client consent before conducting electronic searches on clients except when needed to protect clients or others from serious, foreseeable, and imminent harm, or for other compelling professional reasons (*NASW Code of Ethics—Informed Consent*).

Social workers should discuss policies with clients concerning the use of technology in the provision of professional services. Social workers who use technology to provide social work services should assess the clients' suitability and capacity for electronic and remote services. Social workers should consider the clients' intellectual,

emotional, and physical ability to use technology to receive services and the clients' ability to understand the potential benefits, risks, and limitations of such services. If clients do not wish to use services provided through technology, social workers should help them identify alternate methods of service (*NASW Code of Ethics—Informed Consent*).

Social workers who use technology to provide social work services should obtain informed consent from clients prior to initiating services. Social workers should assess clients' capacity to provide informed consent and, when using technology to communicate, verify the identity and location of clients (*NASW Code of Ethics—Informed Consent*).

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients (*NASW Code of Ethics—Clients Who Lack Decision-Making Capacity*).

In order to obtain informed consent, social workers must use clear and understandable language related to service purpose, risks, limits due to third-party payers, time frame, and right of refusal or withdrawal. If the client lacks capacity or is a minor informed **consent** must be obtained by a responsible third party and **assent** must be obtained from the client.

## **LEGAL AND/OR ETHICAL ISSUES REGARDING DOCUMENTATION**

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In addition to maintaining confidentiality of client records, there are many other obligations related to documentation that social workers must consider in order to follow legal and/or ethical standards.

It is important to document the purpose, goals, plans, services,<sup>407</sup> interventions, and referrals offered and provided to clients. Assessments, evaluations, recommendations, and circumstances of termination should also be documented in the client record. Consultations with supervisors and other professionals and rationale for practice decisions should be documented as well. Client records should include informed consent and release of information documents. All information relevant to client contact should be stated in clear, accurate terms. False, inaccurate, or misleading information in a client

record is unethical and may be potentially harmful to clients and pose a liability risk to social workers. It is unethical to alter case notes after the fact. If necessary, social workers should add new notes with current dates indicating that, in review, past entries were found to be inaccurately documented and correction of those inaccuracies should be clearly stated.

In an effort to ensure continuity of service, it is imperative that client contact be documented in a timely, thorough, and accurate manner. Timely documentation is required for optimal service continuity when clients are transferred from one staff member to another in an agency or when clients are referred out of the agency to collaborating agencies. In addition, accurate and timely records are required by insurers, funding agencies, and so on. Lastly, documentation of significant aspects of client contact is also critical to protecting social workers in the event of lawsuits or ethics complaints.

Client contact documentation should include social history, assessment, treatment plans, intervention strategies, dates and times of contacts, methods of evaluation of progress, reasons for termination, documentation of informed consent and release of information signatures, contacts with all third parties, consultation with collaborating professionals, explanation of social worker's reasoning regarding decisions, recommendations, interventions, and referrals and documentation of any critical incidents. Documentation should be completed as soon as possible after contact so as to ensure accuracy and to maintain up-to-date information in the record in the event of an emergency or the social workers' absence or incapacitation that would require another professional to intervene.

Social workers should only include relevant information that is directly related to client issues for the purpose of service provided. Client records should not include subjective or speculative observation, or any extraneous and irrelevant information.

Social workers must be familiar with legal and ethical protections available for clients—including keeping psychotherapy notes in locations which are secure, but separate from clients' files to provide additional confidentiality protections.

## **LEGAL AND/OR ETHICAL ISSUES REGARDING TERMINATION**

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Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve client needs or interests (*NASW Code of Ethics—Termination of Services*).

Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary (*NASW Code of Ethics—Termination of Services*).

Social workers in fee-for-service settings may terminate services to <sup>408</sup> clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to a client, if a client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with a client (*NASW Code of Ethics—Termination of Services*).

Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client (*NASW Code of Ethics—Termination of Services*).

Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to client needs and preferences (*NASW Code of Ethics—Termination of Services*).

Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options (*NASW Code of Ethics—Termination of Services*).

It is unethical to continue to treat clients when services are no longer needed or in their best interests.

Another standard also relevant to termination of services mandates that social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death (*NASW Code of Ethics—Interruption of Services*).

## **LEGAL AND/OR ETHICAL ISSUES RELATED TO DEATH AND DYING**

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There are many legal and/or ethical issues related to death and dying. Some legal issues involved with dying include, but are not limited to, clients' right to have informed consent to receive or refuse treatment, advance directives, and establishing living wills. Treating professionals, by law, must give clients the opportunity for informed consent. It involves explaining the options for treatment, the possible benefits as well as risks for each treatment, and any recommendations, with rationales, for one treatment over another. Furthermore, clients must know that they have the right to choose whatever treatment they want or to choose to refuse treatment. Particularly when discussing chronic or terminal illness, conditions over which there is little control over the ultimate outcome of care provided, having clients feel as much control over their treatment options as possible is of great importance.

Clients can give written directions, called advance directives, about the type of care they do and do not want to receive when dying. Advance directives are legal written agreements that will be honored in the future when people can no longer communicate their wishes. For example, advance directives can prohibit resuscitation (the act of trying to revive a person whose heart has stopped) or tube feeding, if clients wish.

Advance directives are legal documents which indicate who has the right to make decisions when clients are incapable physically or mentally of making their wants known. The purpose of advance directives is to respond to judicial decisions that have been made indicating that if clients have not made others aware of their wishes, the decision to remove them from life supports or place them on life supports cannot be made. Therefore, it has become increasingly imperative that advance directives be established to memorialize clients' wishes and identify individuals to make these decisions if needed.

Advance directives have been paired with living wills to give clients <sup>409</sup> control over what happens to them in a severe illness or injury. A living will allows individuals to retain some control over what happens at the end of their lives, even if they are then no longer competent to make personal choices for terminal care, by specifying their wishes

while they are still healthy and at a time when there is no doubt of their mental competence.

Clients whose death may occur soon should also have Physician Orders for Life-Sustaining Treatment (POLST) documents. These documents are written doctors' orders that reflect preferences for medical care (particularly whether to receive care or not). The documents are kept in clients' medical records and in the home and are used to direct emergency medical personnel in following the clients' preferences. For example, these documents may contain the doctors' orders as to whether people should receive cardiopulmonary resuscitation (CPR), transportation to hospitals, or aggressive treatments (such as blood transfusions or chemotherapy) to relieve symptoms even if death is inevitable.

Although very few people actually take any steps toward causing their own death, many clients who are dying at least consider suicide. Discussing suicide may help sort out the issues and often correct certain problems that prompted consideration of suicide. Pain medicine can be prescribed if clients are uncomfortable and spiritual guidance can help clients find meaning in the remainder of their lives. Making decisions to forgo life-sustaining treatment, forgo food and fluids when near death, or take many drugs or large doses of drugs to relieve symptoms is not considered suicide. Several states have passed laws which allow those who are terminally ill to receive lethal combinations of drugs to take when they decide to die.

## **RESEARCH ETHICS (E.G., INSTITUTIONAL REVIEW BOARDS, USE OF HUMAN SUBJECTS, INFORMED CONSENT)**

Social workers have an ethical mandate to monitor and evaluate policies, the implementation of programs, and practice interventions. They also must promote and facilitate evaluation and research to contribute to the development of knowledge. In addition to doing research themselves, social workers must keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

When doing research and evaluation, social workers must consider possible consequences and should follow guidelines developed for the

protection of evaluation and research participants. Social workers must protect participants from unwarranted physical or mental distress, harm, danger, or deprivation (*NASW Code of Ethics—Evaluation and Research*). Appropriate institutional review boards should be consulted.

For example, social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate or without undue inducement to participate. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research (*NASW Code of Ethics—Evaluation and Research*).

When using electronic technology to facilitate evaluation or research, social workers should ensure that participants provide informed consent for the use of such technology. Social workers should assess whether participants are able to use the technology and, when appropriate, offer reasonable alternatives to participate in the <sup>410</sup> evaluation or research (*NASW Code of Ethics—Evaluation and Research*).

When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy (*NASW Code of Ethics—Evaluation and Research*).

Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible (*NASW Code of Ethics—Evaluation and Research*).

Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty (*NASW Code of Ethics—Evaluation and Research*).

Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate

supportive services (*NASW Code of Ethics—Evaluation and Research*).

Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed (*NASW Code of Ethics—Evaluation and Research*).

Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary (*NASW Code of Ethics—Evaluation and Research*).

## **ETHICAL ISSUES IN SUPERVISION AND MANAGEMENT**

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Social workers must follow all ethical standards when providing and receiving supervision, as well as engaging in management tasks. These include, but are not limited to, those regarding commitment to clients, self-determination, informed consent, competence, cultural awareness and social diversity, conflicts of interest, privacy and confidentiality, access to records, sexual relationships, physical contact, sexual harassment, derogatory language, payments, clients who lack decision-making capacity, and interruption or termination of services.

Social workers who provide supervision should have the necessary knowledge and skill to supervise or consult appropriately, and they should do so only within their areas of competence. They should also evaluate supervisees' performance in a manner that is fair and respectful (*NASW Code of Ethics—Supervision and Consultation*). Social workers who are in managerial roles should take reasonable steps to ensure that adequate agency resources are available to provide appropriate staff supervision (*NASW Code of Ethics—Administration*).

Social workers who provide supervision are responsible for setting clear, appropriate, and culturally sensitive boundaries. They should not engage in any dual or multiple relationships with supervisees when

there is a risk of exploitation of or potential harm to the supervisee,<sup>411</sup> including dual relationships that may arise while using social networking sites or other electronic media (*NASW Code of Ethics—Supervision and Consultation*).

Social workers in managerial roles should advocate within and outside their agencies for adequate resources to meet clients' needs and ensure resource allocation procedures are open, fair, and nondiscriminatory. Social work managers should ensure that working environments are consistent with the *NASW Code of Ethics* and eliminate conditions which are not (*NASW Code of Ethics—Administration*).

Sometimes in practice, ethical issues can arise related to the payment of services. These standards indicate what rules social workers should follow in these situations.

When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay (*NASW Code of Ethics—Payment for Services*).

Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at a client's initiative and with a client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to a client or the professional relationship (*NASW Code of Ethics—Payment for Services*).

Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through social workers' employers or agencies (*NASW Code of Ethics—Payment for Services*).

Social workers should obtain information on procedures for using insurance coverage when a client wants to use an employee benefit

package for behavioral health services.

## **METHODS TO CREATE, IMPLEMENT, AND EVALUATE POLICIES AND PROCEDURES FOR SOCIAL WORKER SAFETY**

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Social workers provide services in increasingly complex, dynamic social environments with many client populations. The number and variety of people to whom social workers provide services and the variety of settings in which these services are provided contribute to an increasingly unpredictable, and often unsafe, environment for social work practice. Social workers have been the targets of verbal and physical assaults in agencies, as well as during field visits with clients. Tragically, some social workers have also been permanently injured or have lost their lives.

Most clients and families that social workers serve do not present threats or pose danger. In instances where threats are present, most employers address these issues appropriately. There are, however, social work settings where social workers face increased risks of violence.

Social workers have the right to work in safe environments and to advocate for safe working conditions. Social workers who report concerns regarding their personal safety, or who request assistance in assuring their safety, should not fear retaliation, blame, or <sup>412</sup> questioning of their competency from their supervisors or colleagues. Social workers should routinely practice universal safety precautions in their work. Violence occurs in every economic, social, gender, and racial group. To avoid stereotyping particular groups of people and to promote safety, social workers should practice safety assessment and risk reduction with all clients and in all settings. A thorough understanding of the risk factors associated with elevated risk for violence can inform safety assessments. Social workers should also be aware of the potential that their personal information on the Internet, particularly social networking sites, can be accessed by anyone. Universal safety precautions also include the establishment of safety plans as a matter of routine planning. The adoption of universal safety precautions should not preclude agencies from establishing particular safeguards when social workers are asked to perform dangerous tasks.

In those situations, agencies should establish specific policies to reduce the risk of harm.

# Confidentiality

## THE USE OF CLIENT/CLIENT SYSTEM RECORDS

Social workers should provide clients with reasonable access to their records. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to a client should provide assistance in interpreting the records and consultation with a client regarding the records. **Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to a client.** Both clients' requests and the rationale for withholding some or all of the records should be documented in clients' files (*NASW Code of Ethics—Access to Records*).

Social workers should develop and inform clients about their policies on the use of technology to provide clients with access to their records. These policies must be consistent with prevailing social work ethical standards (*NASW Code of Ethics—Access to Records*).

When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

**The NASW Code of Ethics states that a social worker should only solicit information essential for providing**

**services (minimum necessary to achieve purpose). Once private information is shared, standards of confidentiality apply.**

## **LEGAL AND/OR ETHICAL ISSUES REGARDING CONFIDENTIALITY, INCLUDING ELECTRONIC INFORMATION SECURITY**

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Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible, before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review circumstances with clients where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in a social worker-client relationship and as needed throughout the course of the relationship (*NASW Code of Ethics—Privacy and Confidentiality*).

When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. This agreement should include consideration of whether confidential information may be exchanged in person or electronically. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should inform clients involved in family, couples, marital, or group counseling of a social worker's, employer's, and agency's policy concerning a social worker's disclosure of confidential information among the parties involved in the counseling (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to a client, social workers should request that the court withdraw the order or limit the order as

narrowly as possible or maintain the records under seal, unavailable for public inspection (*NASW Code of Ethics—Privacy and Confidentiality*).

A subpoena and court order are not the same. When receiving a subpoena, a social worker should respond and claim privilege, but not turn over records unless the court issues a subsequent order to do so. As stated, when a social worker gets a court order, the social worker should try to limit its scope and/or ask that the records be sealed.

Social workers should protect the confidentiality of clients when responding to requests from members of the media (<sup>415</sup> *NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should take reasonable steps to protect the confidentiality of electronic communications, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages. In addition, social workers should develop and disclose policies and procedures for notifying clients of any breach of confidential information in a timely manner. In the event of unauthorized access to client records or information, including any unauthorized access to the social worker's electronic communication or storage systems, social workers should inform clients of such disclosures, consistent with applicable laws and professional standards (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should develop and inform clients about their policies on the use of electronic technology to gather information about clients. Social workers should avoid searching or gathering client information electronically unless there are compelling professional reasons, and when appropriate, with the client's

informed consent (*NASW Code of Ethics—Privacy and Confidentiality*).

**Social workers should avoid posting any identifying or confidential information about clients on professional websites or other forms of social media (*NASW Code of Ethics—Privacy and Confidentiality*).**

Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should take reasonable precautions to protect client confidentiality in the event of a social worker's termination of practice, incapacitation, or death (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless a client has consented to disclosure of confidential information (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should not disclose identifying information when discussing clients with consultants unless a client has consented to disclosure of confidential information or there is a compelling need for such disclosure (*NASW Code of Ethics—Privacy and Confidentiality*).

Social workers should protect the confidentiality of deceased clients consistent with the preceding standards (*NASW Code of Ethics—Privacy and Confidentiality*).

If a client sues a social worker, a social worker has the right to a defense and may need to release client information as part of this defense. A social worker should limit this disclosure only to information required for defense.

Confidentiality of minor records can be challenging, especially if a parent wants access to them and/or consents to their release. Social workers must be knowledgeable about ethical standards and laws that relate to the protection and release of minor records. Parents may have access to these records depending upon the age of the minor and the type of treatment or setting. Social workers <sup>416</sup>

treating minors with parents who may have joint or limited custody must also be aware of the rights of all parties to access and/or consent to their release.

## **LEGAL AND/OR ETHICAL ISSUES REGARDING MANDATORY REPORTING (E.G., ABUSE, THREAT OF HARM, IMPAIRED PROFESSIONALS, ETC.)**

Social workers are required to disclose confidential information, sometimes against a client's wishes, to comply with mandatory reporting laws. Laws not only require social workers to report suspected cases of abuse and neglect, but there can be varying levels of civil and criminal liability for failing to do so.

This mandate causes ethical issues for social workers who have a commitment to their clients' interests as well as a responsibility to the larger society.

The majority of all reports of abuse and/or neglect came from professionals including medical personnel, law enforcement agents, educators, lawyers, and social workers.

Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action. Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations (*NASW Code of Ethics —Impairment of Colleagues*).

# Professional Development and Use of Self

## **PROFESSIONAL VALUES AND PRINCIPLES (E.G., COMPETENCE, SOCIAL JUSTICE, INTEGRITY, AND DIGNITY AND WORTH OF THE PERSON)**

The mission of the social work profession is rooted in a set of core values. These core values are the foundation of social work practice:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

Professional ethics are based on these basic values and guide social workers' conduct. These standards are relevant to all social workers, regardless of their professional functions, the settings in which they work, or the populations they serve.

Professional ethics are "rules" based on the core values of the profession that should be adhered to by social workers. They are statements to the general public about what they can expect from a social worker. These standards tell new social workers what is essential

for practice based on the profession's core values. Social workers are judged with regard to competency based on these standards.

Professional standards are also helpful in guiding social workers when they are unsure about a course of action or conflicts arise.

The social work profession is based on the belief that every person has dignity and worth. It is essential that social workers respect this value and treat everyone in a caring and respectful fashion. Social workers should also be mindful of individual differences, as well as cultural and ethnic diversity.

Social workers should promote clients' right to self-determination and act as a resource to assist clients to address their own needs. Social workers have a dual responsibility to clients and to the broader society and must resolve any conflicts, in a socially responsible and ethical manner, that arise due to this dual mandate.

## **PROFESSIONAL OBJECTIVITY IN THE SOCIAL WORKER–CLIENT/CLIENT SYSTEM RELATIONSHIP**

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Social worker communication should not be burdened with emotional investment; instead, social workers should be interested, genuinely concerned, and encouraging, while neither condemning nor praising.

The relationship between a social worker and a client must be productive, and must have certain characteristics. There must be mutual acceptance and trust. A client must feel understood and valued as a person, though personal performance may be unsatisfactory. If a client feels judged, the client will not speak freely, and will find way to defend current and past actions.

A social worker accepts and understands a client's problems, recognizes the demands and the requirements of the situation, and assists a client to examine alternatives and potential consequences. A social worker does not tell a client what to do. Only a client can decide to change because the client acts upon personal feelings and insights, and has a unique view of the problem.

The social worker–client relationship is a social microcosm where clients' interpersonal behavioral and conditioned patterns of perceiving and feeling are manifested. This relationship allows social workers to see for themselves the interaction patterns and methods of

communication that have caused difficulties for clients in their everyday lives.

Social workers should use various intervention techniques to assist clients in identifying distorted perceptions and communication patterns and replacing them with healthy, more constructive ones.

For example, social workers who observe that clients have poor boundaries with them and/or engage in behaviors that interfere with productive interactions during the problem-solving process can use limit setting. Limit setting can be facilitative because clients do not feel safe or accepted in a completely permissive environment. In addition, it is important for clients to learn the importance of appropriate boundaries.

Social workers may also observe in the helping relationship that clients are not assertive. Thus, they may use assertiveness training to teach clients how to express their positive and negative feelings and to stand up for their rights in ways that will not alienate others.

Learning self-observation skills and awareness of personal preferences, as well as assuming personal responsibility, are important components of the assertiveness training process.

One of the best ways that a social worker can assist a client when observing a maladaptive behavior is by modeling, along with role play and reinforcement, to produce behavioral change.

Social workers and clients should view the therapeutic environment as a place to learn and practice new skills and relationship patterns that can be used outside of this setting with others.

## **TECHNIQUES FOR PROTECTING AND ENHANCING CLIENT/CLIENT SYSTEM SELF-DETERMINATION**

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination <sup>419</sup> when, in social workers' professional judgment, clients' actions or potential actions pose serious, foreseeable, and imminent risk to themselves or others (*NASW Code of Ethics—Self-Determination*).

### **CLIENT/CLIENT SYSTEM COMPETENCE AND SELF- DETERMINATION (E.G., FINANCIAL DECISIONS,**

## **TREATMENT DECISIONS, EMANCIPATION, AGE OF CONSENT, PERMANENCY PLANNING)**

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Self-determination, the concept that clients are qualified to make their own decisions about their lives, is a central concept in the social work profession. It is described in the *NASW Code of Ethics* as one of a social worker's primary ethical responsibilities. Using a strengths-based perspective, all clients are assumed to be competent to make their own decisions, including those about financial matters and treatment options.

When working with clients, there may be, at times, some concerns about their cognitive or functional abilities to perform life tasks. For example, clients who are not able to complete activities of daily living independently may need services to assist them in these areas. The need to rely on others to assist may limit clients' independence. An assessment which can assist social workers in determining assistance needed in functional life domains is the *World Health Organization's Disability Assessment Schedule (WHODAS)*.

When limitations are not physical, but involve mental processes, there may be some unease about clients' abilities to provide consent related to financial, medical, and/or legal treatment. All those over the age of majority (adults) are presumed to be competent to provide consent unless legal proceedings have found otherwise. When clients lack the capacity to provide consent, social workers should protect clients' interests by seeking permission from an appropriate third party and informing clients in a manner consistent with the clients' level of understanding. In such instances, social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent (*NASW Code of Ethics—Informed Consent*).

### **Emancipation and Age of Consent**

Treating minors requires social workers to be well versed in state and federal laws related to consent and confidentiality. The age at which minors can obtain services without parental/guardian permission varies by state and the type of service being delivered. Minors also do not have the same legal rights to confidentiality in some instances because parents/guardians may have access to minors' records.

Even when parental/guardian consent is needed for treatment, social workers should provide explanations to minors of all elements required in a consent procedure, using language that can easily be understood. Social workers should also seek the minor's assent or willingness to participate.

During the problem-solving process, social workers treating minors must make clear to them all the limits to their self-determination imposed by legal, financial, and other constraints.

Within our society, minors do not have the same rights as adults.<sup>420</sup> Emancipation is a legal process that ends the rights and responsibilities of parents or guardians over minor children. However, there can be either a partial or complete emancipation. Emancipation involves decision-making authority. Upon achieving emancipation, the minor assumes the rights, privileges, and duties of adulthood before actually reaching the "age of majority" (adulthood). An emancipated minor can enter into a contract, sue others, make health care decisions, and so on. However, the emancipated minor still has to follow other laws and still cannot get a driver's license or drink alcohol prior to the legal age to do so.

All states have laws dealing with the emancipation of minors; that is, laws that specify when and under what conditions children can become independent of their parents or guardians for important legal purposes. Approximately half of the states regulate emancipation by statutes specifically designed for that purpose. These statutes set forth the conditions required or the procedures for seeking emancipation. Statutes vary considerably from state to state, but most states allow for the possibility of court-reviewed emancipation. The age at which minors can apply for or petition for emancipation varies between states.

Under normal circumstances, a minor is presumed to become emancipated from parents/guardians upon reaching the age of majority. In most states, the age of majority is 18.

## **THE INFLUENCE OF THE SOCIAL WORKER'S OWN VALUES AND BELIEFS ON THE SOCIAL WORKER– CLIENT/CLIENT SYSTEM RELATIONSHIP**

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Social workers must recognize values that may inhibit the therapeutic relationship.

- 1. Universalism—There is one acceptable norm standard for everyone** versus there are other valid standards that have been developed by people that they have determined to be most useful to them.
- 2. Dichotomous “either-or” thinking; differences are inferior, wrong, bad** versus differences are just different and coexist.
- 3. Heightened ability/value on separating, categorizing, numbering, “left-brain”** versus “right-brain” or “whole picture.” Mental activity is highly valued to the exclusion of physical and spiritual experiences. Persons are studied in isolation, not as part of a group or interrelated with their environment.
- 4. High value on control, constraint, restraint** versus value on flexibility, emotion/feelings, expressiveness, spirituality. What can be controlled and definitively defined is deemed nonexistent; unimportant, unscientific, or deviant/inferior. Reality is defined with the assumption of objectivity; subjective reality is viewed as invalid because it cannot be consistently replicated by many people.
- 5. Measure of self comes from outside, and is only in contrast to others** versus value comes from within—you are worthwhile because you were born, and you strive to live a life that is in harmony with others and the environment. Worth is measured by accumulation of wealth or status (outside measures)—therefore, one can only feel good if one is better than someone else, or accumulates more than someone else, or has a higher status.
- 6. Power is defined as “power over” others, mastery over environment** versus “power through” or in harmony with others; sharing power, power can be expanded, and each becomes more powerful.

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## THE INFLUENCE OF THE SOCIAL WORKER'S OWN VALUES AND BELIEFS ON INTERDISCIPLINARY COLLABORATION

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Social workers are increasingly recognized as beneficial members of interdisciplinary teams in addressing the complex needs of clients. A social worker may be on the team because the social worker is a direct service provider (counselor, case manager), an administrator, and/or a consultant.

Interdisciplinary teams can include those from many professions including law, psychology, and education. When working collaboratively, social workers can work “hand-in-hand” or “side-by-side” with others. In the former, social workers and others work together on most issues, whereas in the latter, each discipline works separately to accomplish what needs to be done.

Often when working with others, there can be potential conflicts in both personal and professional values of the team members. In order to mitigate these conflicts, it is important to:

- Outline the parameters that will govern the functioning of the collaborative team, including frequency of contact, other forms of communication, delineation of responsibilities, and leadership positions.
- Understand and define the roles of those who are collaborating.
- Understand and articulate the professional values of each member.
- Agree upon methods of decision making.
- Determine means for resolving disagreements.

The importance of role boundaries, role maintenance, and role clarity are essential in collaborative relationships. These issues should be openly discussed among team members, and obstacles to effective team functioning should be identified and addressed.

In all instances, it is the responsibility of a social worker to understand and reflect upon their own values, ensure that they do not interfere with the collaborative process, and that they are always aligned with ensuring outcomes in the best interest of a client. Areas of sensitivity that require self-reflection include beliefs about differing status among team members, unequal benefits for participation, different levels of personal and time commitments, insecurity about the value of the team approach, and/or lack of administrative support.

## **THE IMPACT OF TRANSFERENCE AND COUNTERTRANSFERENCE IN THE SOCIAL WORKER-CLIENT/CLIENT SYSTEM RELATIONSHIP**

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Transference refers to redirection of a client's feelings for a significant person to a social worker. Transference was first described by Sigmund Freud, who acknowledged its importance for a better understanding of a client's feelings.

Transference is often manifested as an erotic attraction toward a <sup>422</sup> social worker, but can be seen in many other forms such as rage, hatred, mistrust, parentification, extreme dependence, or even placing a social worker in an esteemed status.

When Freud initially encountered transference in his therapy with clients, he felt it was an obstacle to treatment success. But what he learned was that the analysis of the transference was actually the work that needed to be done. The focus in psychoanalysis is, in large part, a social worker and a client recognizing the transference relationship and exploring the relationship's meaning.

Since the transference between a client and a social worker happens on an unconscious level, a social worker doing psychoanalysis uses transference to reveal unresolved conflicts a client has with childhood figures.

Countertransference is defined as redirection of a social worker's feelings toward a client, or more generally, as a social worker's emotional entanglement with a client. A social worker's recognition of countertransference is nearly as critical as understanding a client's transference. Not only does this help a social worker regulate emotions in the therapeutic relationship, but it also gives a social worker valuable insight into what a client is attempting to elicit.

For example, a social worker who is sexually attracted to a client must understand this as countertransference, and look at how a client may be eliciting this reaction. Once it has been identified, a social worker can ask a client about the client's feelings toward a social worker, and/or explore how they relate to unconscious motivations, desires, or fears.

## **THE IMPACT OF TRANSFERENCE AND COUNTERTRANSFERENCE WITHIN SUPERVISORY RELATIONSHIPS**

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Transference and countertransference within supervisory relationships can be a parallel process of what is occurring between a social worker and a client. The transference occurs when a social worker recreates, within a supervisory relationship, a presenting problem and emotions occurring in a therapeutic relationship. Countertransference occurs when a supervisor responds to a social worker in the same manner that a social worker responds to a client. Thus, a supervisory interaction replays, or is parallel with, a social worker– client interaction. In essence, the processes at work in the relationship between a social worker and a client are reflected in the relationship between a social worker and the supervisor's supervisor.

Parallel process is an unconscious identification with a client and can be used as an important part of the supervisory process. Examining it will assist a social worker and the social worker's supervisor in identifying issues that exist in a therapeutic relationship and allow for techniques to resolve these issues to be identified and discussed.

## **THE COMPONENTS OF A SAFE AND POSITIVE WORK ENVIRONMENT**

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To practice effectively and ethically, social workers need a working environment that upholds ethical practice and is committed to standards and good quality services. A positive working environment is created where the values and principles of employers and social workers are consistent with each other and mutually reinforcing. There is substantial evidence that the most effective social work services are provided in <sup>423</sup> situations where employers understand social work practice, respect their employees, and are committed to implementing professional values.

A framework for supporting good practice needs to take account of ethical principles and ensure effective induction, supervision, workload management, and continuing professional development.

The following are some elements which enable social workers to practice ethically:

- Written policies setting out standards of ethical practice provide clarity and protection for clients, social workers, and agencies. Social workers should never be required to do anything that would put at risk

their ability to uphold such ethical standards, including policies on confidentiality, equal opportunities, and risk management.

- Quality social work services draw on research and practice evidence. Policies should be informed by research and practice evidence.
- The public, including clients, should be regularly informed about the standards, policies, and procedures and provided with information about how to raise concerns or make complaints about standards of practice.
- People employed as social workers must be suitable to enter the workforce, hold appropriate recognized qualifications that entitle them to practice as social workers, provide references (including evidence that they are not a risk to clients), and demonstrate that they understand their roles and responsibilities, including their ethical duties.
- Dangerous, discriminatory, or exploitative behavior and practice must be dealt with promptly through the implementation of policies and procedures. Such policies should provide measures to prevent and minimize violence, making it clear to staff, social workers, and clients that violence, threats, or abusive behavior is not acceptable.
- Social workers have a right for their health and occupational safety to be protected. Social workers frequently experience trauma or violence in their work and they are vulnerable to work-related stress and burnout due to the nature of their work.
- The adoption and implementation of policies on workload management make a major contribution to the provision of quality services to clients. Workload practices must consider the basic tenets of social work intervention, including the centrality of human relationships, the need to manage risk and complexity, and the duty to highlight unmet need.
- The physical working environment has an important part to play in the support of effective and ethical practice including, for example, the physical arrangements and procedures required for confidential interviewing and storage of confidential records.
- Continuing professional development and further training enable social workers to strengthen and develop their skills and

knowledge and ensure that agencies adapt to the changing needs of clients and changing organizational realities. Orientation and induction training provided to new employees and those changing jobs are essential, including the management of risk, making complex professional judgments, and the fulfillment of statutory obligations such as the protection of minors and vulnerable adults.

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- Good quality, regular social work supervision by people who have the necessary experience and qualifications in social work practice is an essential tool to ensure accountable and ethical practice. Research has confirmed that supervision is an important vehicle for supporting the management function in promoting creative and reflective practice, supporting staff resilience and well-being, and continuing professional development.
- Systematic reviews of services and practice, led by social workers who have experience of the field, should be held regularly. The activities identify needed support, training, and action when poor or unethical practice is identified.
- Career development opportunities for social workers wishing to develop advanced practice skills need to be available. These not only meet the individual needs of social workers, but can also constitute an effective tool for retaining valuable practice knowledge and experience and for preventing high staff turnover and difficulties in recruitment that are typical challenges constantly being faced by social work services.
- Rates of pay or fees for social work practice need to be comparable with similar professionals and recognize the skill and qualifications of social workers.

## **SOCIAL WORKER SELF-CARE PRINCIPLES AND TECHNIQUES**

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Self-care is essential for social workers so that they can practice effectively and honor their professional and personal commitments. Self-care refers to activities and practices that are done on a regular basis to reduce stress and maintain and enhance short- and longer-term health and well-being.

Practicing self-care helps social workers:

- **Identify and manage the general challenges** that health care professionals face such as the potential for stress and burnout or interpersonal difficulties.
- **Become aware of personal vulnerabilities** such as the potential for retraumatization (if trauma history exists), vicarious secondary traumatization (if working with individuals who report their own traumatic experiences), and compassion fatigue (which can develop from a combination of burnout and vicarious traumatization).
- **Achieve balance in life** by maintaining and enhancing the attention paid to different domains of life in a way that meets personal needs.

Self-care is not simply about limiting or addressing professional stressors. It is also about **enhancing overall well-being**. There are common aims to almost all self-care efforts including:

- Taking care of physical and psychological health
- Managing and reducing stress
- Honoring emotional and spiritual needs
- Fostering and sustaining relationships
- Achieving an equilibrium between meeting personal needs and school/work demands

## **BURNOUT, SECONDARY TRAUMA, AND COMPASSION FATIGUE**

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Burnout, secondary trauma, and compassion fatigue have been used interchangeably to express adverse impacts that result from constantly working with those who are experiencing problems or trauma or are in crisis.

*Burnout* is a state of physical, emotional, psychological, and/or spiritual exhaustion. It can be manifested by cynicism or a lack of satisfaction in working with clients to resolve their problems. Burnout is characterized by emotional fatigue and feeling inadequate due to not being able to change clients' life circumstances. Many factors can contribute to burnout, including client, organizational, and/or contextual variables.

*Secondary trauma* relates to the behaviors and emotions that result from knowledge about traumatizing events experienced by clients and the stress resulting from helping or wanting to help them. Secondary trauma results from engaging in empathic relationships with clients who have had traumatic experiences and witnessing the effects of those experiences. The symptoms of secondary trauma mirror those experienced by the primary victim of trauma, including, but not limited to, insomnia, chronic irritability or angry outbursts, fatigue, difficulty concentrating, and/or avoidance.

*Compassion fatigue* is best defined as a syndrome consisting of a combination of the symptoms of secondary trauma and burnout. It usually represents the overall experience of emotional and physical fatigue that social workers can experience due to the prevalent use of empathy when treating clients who are distraught and experiencing emotional pain. Social workers also encounter bureaucratic hurdles that exacerbate agency stress and upset the balance between practice and administrative demands. Much like burnout, compassion fatigue tends to occur cumulatively over time, whereas secondary trauma may have a more immediate onset. Social workers may develop empathy or compassion fatigue as they repeatedly see little or no improvement in client situations. Social workers who treat victims of trauma can find that secondary trauma may contribute to overall compassion fatigue. However, social workers who do not treat those who have experienced trauma may experience compassion fatigue without experiencing secondary trauma.

In order to manage the effects of burnout and secondary trauma, and in an attempt to prevent compassion fatigue, social workers must engage in *self-care* activities which should include, but not be limited to, receiving support from mentors or peers, obtaining therapy, engaging in relaxation and personal endeavors that are nonprofessional activities, and balancing work demands with one's personal life.

## EVIDENCE-BASED PRACTICE

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Evidence-based social work practice combines research knowledge, professional/clinical expertise, social work values, and client preferences/circumstances. It is a dynamic and fluid process whereby social workers seek, interpret, use, and evaluate the best available information in an effort to make the best practice decisions.

The promotion of evidence-based research within social work is widespread. Evidence-based research gathers evidence that may be informative for clinical practice or clinical decision making. It also involves the process of gathering and synthesizing scientific evidence from various sources and translating it to be applied to practice.

The use of evidence-based practice places the well-being of clients <sup>426</sup> at the forefront, desiring to discover and use the best practices available. The use of evidence-based practice requires social workers to only use services and techniques that were found effective by rigorous, scientific, empirical studies—that is, outcome research.

Social workers must be willing and able to locate and use evidence-based interventions. In areas in which evidence-based interventions are not available, social workers must still use research to guide practice. Applying knowledge gleaned from research findings will assist social workers in providing services informed by scientific investigation and lead to new interventions that can be evaluated as evidence-based practices.

Decisions are based on the use of many sources, ranging from systematic reviews and meta-analyses to less rigorous research designs.

Social workers often use “evidence-based practice” to refer to programs that have a proven track record. However, it takes a long time for a program or intervention to be “evidence based.” Thus, most interventions in social work need more empirically supported research in order to accurately apply the term. “Evidence-informed practice” may be more appropriate.

Some questions guide the selection of intervention modalities:

- How will the recommended modality assist with the achievement of the treatment goal and will it help get the outcomes desired?
- How does the recommended treatment modality promote client

strengths, capabilities, and interests?

- What are the risks and benefits associated with the recommended modality?
- Is there research or evidence to support the use of this modality for this target problem?
- Is this modality appropriate and tested on those with the same or similar cultural background as the client?
- What training and experience does a social worker have with the recommended modality?
- Is the recommended modality evidence-based or consistent with available research? If not, why?
- Was the recommended modality discussed with and selected by the client?
- Will the use of the recommended modality be assessed periodically? When? How?
- Is the recommended treatment modality covered by insurance? What is the cost? How does it compare to the use of other options?

## **PROFESSIONAL DEVELOPMENT ACTIVITIES TO IMPROVE PRACTICE AND MAINTAIN CURRENT PROFESSIONAL KNOWLEDGE (E.G., IN-SERVICE TRAINING, LICENSING REQUIREMENTS, REVIEWS OF LITERATURE, WORKSHOPS)**

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Professions enjoy a high social status, regard, and esteem conferred upon them by society. This high esteem arises primarily from the higher social function of their work, which is regarded as vital to society as a whole and, thus, special and valuable in nature. All professions involve technical, specialized, and highly skilled work, often referred to as “professional expertise.” Training for this work involves obtaining degrees and professional qualifications (i.e., licensure) without which entry to the profession is barred. Training also requires regular updating of skills through continuing education.

Professional development refers to skills and knowledge attained for effective service delivery and career advancement. Professional development encompasses all types of learning opportunities, ranging from formal coursework and conferences to informal learning opportunities situated in practice. There are a variety of approaches to professional development, including consultation, coaching, communities of practice, mentoring, reflective supervision, and technical assistance.

Social workers often go through various stages of professional development, including:

1. Orientation and job induction
2. Autonomous worker
3. Member of a service team (independence to interdependence)
4. Development of specialization
5. Preparation to be a mentor or supervisor

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## Content Area IV: Practice Questions

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The following section has 32 unique practice questions that assess retention of material related to professional values and ethics. The number of questions reflects the approximate proportion of a typical exam (19%) devoted to this content.

- 1.** A social worker receives a call from a former girlfriend who is now married and is having trouble dealing with the recent death of her mother. The former girlfriend would like to see the social worker for counseling. The social worker has not seen the former girlfriend in more than 10 years. In order to handle this situation appropriately, the social worker should:

  - A.** Begin treatment immediately as more than a decade has passed since the relationship
  - B.** Contact the social work licensing board to determine if regulation allows this treatment

**C.** Inform the former girlfriend that the social worker cannot treat her

**2.** For which of the following reasons are social workers allowed to terminate services?

- A.** Social workers wish to pursue social relationships with clients
- B.** Social workers are leaving employment settings to pursue other opportunities
- C.** Social workers believe that clients are making poor choices that negatively affect their well-being

**3.** A social worker in private practice is providing therapy to a client. The client has not paid the social worker for many weeks, accumulating a substantial balance, despite receiving and acknowledging the social worker's payment policy. The social worker has told the client repeatedly that he will be terminated if he does not pay his bill and decides to do so at the next session. The client comes into this session visibly upset and crying because he doesn't think "he can go on" without the social worker. The social worker tells the client that he can come back to see her once the balance is paid. Which **BEST** describes the actions of the social worker?

- A.** Unethical because the client may be a danger to himself
- B.** Ethical because the social worker is allowing the client to return when the balance is paid
- C.** Unethical because termination is not allowed based upon nonpayment of services

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A school social worker is employed part-time in a mental health agency. A mother brings her daughter into the agency and asks that the social worker provide counseling because she has been impressed by the social worker's ability to "relate to" her daughter in school. The school social worker has taken the lead

in developing her daughter's Individual Education Plan (IEP) and meets with the daughter regularly in school to assess her progress. In this situation, the social worker should:

- A. Refuse to serve the daughter in the mental health agency as this situation represents a conflict
  - B. Serve the daughter in both settings to ensure continuity of treatment outside of the school setting
  - C. Agree to be a consultant as needed while referring the daughter to another professional
5. A social worker has joined the board of directors of a domestic violence agency where she was formerly a volunteer. Which of the following activities can the social worker engage in ethically?
- A. Raising money for the agency through direct solicitation
  - B. Serving agency clients at a reduced rate in her private practice
  - C. Working part-time at the agency if needed due to staff shortages
6. A social worker asks her current clients to write testimonial endorsements to assist with attracting others to her private practice. Which **BEST** describes these requests by the social worker?
- A. Ethical because clients can decide whether they will write them
  - B. Ethical if she agrees not to identify clients by name
  - C. Unethical because clients are vulnerable due to their circumstances
7. A social worker believes that there may be an ethical dilemma in his agency. According to steps in ethical problem solving, the social worker should **FIRST** consult:
- A. A supervisor
  - B. The professional ethical code

### C. The policies and procedures of the agency

8. Therapy sessions conducted by social workers in an agency are frequently audiotaped for review by their supervisors. These tapes are destroyed upon client terminations and are used only for supervisory purposes, not shared with others outside the agency. The standard consent form used by the agency states that social workers will receive supervision and client information may be disclosed with supervisors to ensure service quality. To avoid making clients feel uncomfortable, taping is not discussed with them, but consent forms are read by the social worker to clients who sign them. Which of the following statements **BEST** describes this situation?
- A. Ethical because it is done as part of supervision to ensure service quality
  - B. Unethical because informed consent for audiotaping has not been obtained
  - C. Ethical because the tapes are destroyed upon termination

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- A social worker finds that she has a lot in common with a client. The client suggests seeing another professional because the client feels she "would be a better friend than client." The social worker agrees, but states that she cannot have contact with the client for several months after termination to allow time for her to get engaged in treatment with a new social worker. Which **BEST** describes the actions of the social worker?
- A. Ethical because contact will not occur until several months after ending of the therapeutic relationship
  - B. Ethical because the social worker is respecting the client's self-determination
  - C. Unethical because the social worker cannot terminate services for this reason

10. After several months of treating a client, a social worker learns

that the client goes to the same church as the social worker. The social worker continues to go to the church, seeing the client occasionally across the room. The social worker has no contact with the client at church. Which **BEST** describes the actions of the social worker?

- A. Unethical because a referral should have been made to another social worker
  - B. Ethical because the conflict was not known initially and has been minimized by avoiding contact
  - C. Unethical because the social worker should have started attending another church
- 11.** A social worker regularly refers clients to a colleague because he has expertise in treating substance-related and addictive disorders. The colleague is very appreciative of the social worker's confidence in his abilities and offers his season football tickets to the social worker each time a referral is received. The social worker takes the tickets so as not to "hurt his feelings," but donates them to a local charity. Which **BEST** describes the actions of the social worker?
- A. Ethical because the tickets are donated to charity
  - B. Unethical because the social worker should not accept the tickets
  - C. Ethical because there is no additional cost to the colleague for the tickets
- 12.** An agency is required by its funder to make extensive modifications to its human resource policies. The agency director is worried about the financial health of the agency and reports that the agency does not have the money to hire someone to complete this task. The social worker's wife is a human resource manager at a large corporation and agrees to work with the agency for a few weeks at a deeply discounted rate to meet the requirements. Which of the following **BEST** describes this situation?

- A.** Ethical because the wife is being hired as a consultant and not an employee of the agency
- B.** Unethical because it represents a conflict of interest
- C.** Unethical because the wife is charging for her services

1435

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A social worker in a substance abuse treatment facility is attracted to one of her supervisees and asks him out on a date. After several months of dating, they get married and the supervisee finds a job at another agency. Which **BEST** describes the actions of the social worker?

- A.** Unethical because she engaged in a dual relationship with a supervisee
- B.** Ethical because the supervisee found another job once they were married
- C.** Ethical because the sexual contact prohibition only applies to social workers and clients

14. A client in treatment with a social worker has made substantial progress. She loses her job and no longer has insurance that will pay for services. Both the social worker and the client think that continued treatment would be beneficial. In order to assist the client in an ethical manner, the social worker should:

- A.** Terminate services until she is reemployed and has insurance coverage
- B.** Identify services that can be performed by the client in exchange for treatment
- C.** Arrange to see the client on a sliding scale or pro bono until she is reemployed

15. Which of the following actions by a social worker is considered ethical according to established practice standards?

- A.** Writing a recommendation for a current adult client

- B.** Giving a monetary gift to a current adult client
- C.** Having a business relationship with a current adult client

- 16.** Which of the following statements is accurate about assent and consent in social work practice?
- A.** Assent and consent both give legal authorization to participate in treatment
  - B.** Assent and consent procedures are similar, each requiring clients to be informed about risks
  - C.** Assent and consent are required of all clients, even those who are court mandated

1437

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A couple is receiving marriage counseling from a social worker. After several months, the couple decides to end their marriage and ask the social worker to make a child custody recommendation to the court because they feel that the social worker is best suited to make suggestions. The social worker should:

- A.** Decline because it is not appropriate since they are both current counseling clients
  - B.** Accept because both clients agree that the social worker is appropriate to make recommendation
  - C.** Decline until the social worker is contacted by the court directly
- 18.** Which of the following statements is accurate regarding physical contact between social workers and clients?
- A.** Contact should be culturally sensitive, considering the customs, beliefs, and traditions of clients
  - B.** Contact should only occur with adult clients and not children
  - C.** Contact should only occur after rules for such contact have been established

19. A client abruptly stopped coming to sessions with a social worker after 6 weeks. About a month later, the client calls the social worker and asks for a copy of his record. There is nothing in the record that is harmful to the client, but the social worker refuses to give the copy to the client. Which **BEST** describes the actions of the social worker?

- A. Ethical because he did not terminate with the social worker appropriately
- B. Ethical because the request must come in writing with the reason that a copy is needed
- C. Unethical because the social worker has a duty to give the client a copy of the record

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20. When a social worker has direct knowledge of a social work colleague's impairment that interferes with effective practice, the social worker should **FIRST**:

- A. Consult with the colleague when feasible to take remedial action
  - B. Notify the agency director so that employee assistance services can be accessed
  - C. Report the situation to the social work licensing board
21. A social worker suspects that a child receiving services from her agency is being psychologically abused and neglected. She discusses the reasons for her belief and her serious concerns about the child's home environment with her social work supervisor. After a lengthy conversation, the social work supervisor does not agree with the social worker and tells the social worker to monitor the situation for a while before deciding whether to make a report to the child protection agency. In order to handle the situation in an ethical manner, the social worker should:
- A. Regularly follow up with the supervisor to seek direction
  - B. Contact the child protection agency immediately
  - C. Make another appointment to speak to the agency director

22. A social worker is providing therapy to a family. During a session, the 17-year-old daughter states that her father molested her when she was 6 years old. She says that the molestation happened twice and has not occurred since that time. The father confirms the daughter's account and says that he is remorseful about his actions. In this situation, the social worker should:

- A. Ask the daughter about what should happen to the father due to his actions
- B. Make a note in the file, but not contact the child protection agency given the time that has passed
- C. Contact the child protection agency after telling the family of the need to do so

23. What are a social worker's ethical obligations for record release when sued by a client for malpractice?

- A. A social worker should never release any information about treatment
- B. A social worker should claim privilege so the courts understand that the information is confidential
- C. A social worker should release only information related to the nature of the lawsuit

441      Which of the following actions constitute an unethical use  
24.      of identifying client data?

- A. Incorporating data in a grant application for emergency funding due to budget cuts
  - B. Notifying child protective services of suspected neglect
  - C. Seeking assistance from a supervisor or consultant concerning critical treatment issues
25. A social worker is completing an intake with a family who recently immigrated from another country. They need help with basic needs such as rental and nutrition assistance. The children appear neat and clean. The social worker observes

the mother mixing a small amount of alcohol into her infant's bottle and is told that this "soothes" the child as she is teething. During the intake, the family discloses that they do not believe in Western medicine and think sickness is caused by the presence of evil demons. They report that they spend much of their day engaged in prayer and meditation because one of their children is gravely ill. In order to **BEST** assist this family, the social worker should:

- A. Prioritize them for services provided by the agency
  - B. Respect their cultural traditions while working with them to meet their basic needs
  - C. Inform them that a report to the child protection agency is necessary
26. A social worker receives a request from a client's insurance company for detailed treatment summaries. The correspondence makes clear that the insurance company will cease funding for treatment unless these summaries are received immediately. In order to best assist, the social worker should:
- A. Contact the client to see if this information can be released
  - B. Provide only the diagnosis and prognosis, citing confidentiality mandates
  - C. Send the treatment summaries as soon as possible
27. A social worker is providing therapy to a mother and her 6-year-old child. They have made substantial progress and the social worker is seeing dramatic improvements in their relationship. During a session, the social worker observes what appear to be burns on the child's neck and arm. She asks the mother about what caused these injuries and the mother's explanation does not seem plausible. The social worker is concerned and feels that physical abuse may have occurred. In order to **BEST** address this situation, the social worker should:
- A. Express her concerns to the mother and ask the mother to come back with the child in a few days so that the social

- worker can assess the situation
- B. Wait until the mother and child leave the office and contact the child protection agency
  - C. Tell the mother that the social worker will need to contact the child protection agency immediately and involve her in making the report

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28. A social worker receives a subpoena for a former client's record. The social worker should **FIRST**:

- A. Respond to the court by claiming privilege
  - B. Provide the record since the request relates to a former client
  - C. Inform the court that the client is no longer receiving services
29. A school social worker is seeing a 14-year-old girl who confides that she is struggling with gender identity issues and is being teased by peers. Several weeks later, the principal asks the social worker what is "going on" with her client because she was involved in an altercation with other students. The principal asks to see her file to better understand her issues because she is facing out-of-school suspension for her behavior. The principal thinks that the information contained in the file will help reduce her punishment. In this situation, the social worker should:
- A. Share the file with the principal to assist the client with avoiding punishment
  - B. Summarize the client's struggles in a conversation with the principal
  - C. Inform the principal that the information is confidential
30. A social worker is contacted by a man who is very distraught. He is aware that his mother was a client of the social worker because he has found bills for services in her belongings after she recently passed away. He had little contact with her in the last years of her life as she seemed "to pull away." He is trying

to understand her behavior and would like to make an appointment to see the social worker. The social worker should:

- A. Schedule a session with the son to try to assist him in understanding his mother's behavior
  - B. Explain to the son that the social worker cannot talk to him about his mother
  - C. Ask him to put his questions in writing so the social worker can determine their nature
- 31.** Which of the following is a core value in the social work profession as stated in the preamble of the professional ethical code?
- A. Reliability
  - B. Loyalty
  - C. Service
- 32.** Which of the following is accurate about transference in social work practice?
- A. Transference is more likely with clients with certain personality features
  - B. Transference does not have any therapeutic value
  - C. Transference is always sexual in nature

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- C. Social workers should not provide clinical services to individuals with whom they have had prior intimate relationships. Providing clinical services to a former girlfriend has the potential to be harmful to her and the past relationship may be difficult for the social worker and the former girlfriend to maintain appropriate professional boundaries.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Professional Boundaries in the Social Worker–Client/Client System Relationship (e.g., Power Differences, Conflicts of Interest, etc.) (KSA)

- 2. B.** Social workers should not terminate services to pursue social financial, or sexual relationships with clients or when they believe that clients are making poor choices. Social workers who are leaving employment settings can terminate with clients after informing them of appropriate options for the continuation of services and the benefits and risk of the options.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Legal and/or Ethical Issues Related to Termination (KSA)

- 3. A.** Social workers in fee-for-service settings may terminate services to clients who are not paying overdue balances if the financial contractual arrangements have been made clear to clients, *if clients do not pose an imminent danger to self or others*, and if the clinical and other consequences of the current nonpayment have been addressed and discussed. The client appears upset and states that he cannot “go on.” Such a statement may be an indication of suicide risk. The social worker must assess this risk and provide appropriate supports/referrals prior to termination.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Legal and/or Ethical Issues Related to Termination (KSA)

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- A.** The *NASW Code of Ethics* states that social workers should take appropriate action to minimize any conflict of interest. An agreement for the social worker to be a consultant from the onset is

also a conflict because the school social worker will then be serving her in different roles in both settings.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

- 5. A.** Raising money is routinely expected of board members of human service organizations. The social worker cannot provide services to agency clients in her private practice as this arrangement is a conflict of interest. Additionally, the social worker should not work at an agency in which she is on the board of directors. These dual roles in the organization also serve as a conflict.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

- 6. C.** Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Professional Boundaries in the Social Worker–Client/Client System Relationship (e.g., Power Differences, Conflicts of Interest, etc.) (KSA)

- 7. B.** The first step in ethical problem solving is to identify ethical standards, as defined by the professional *NASW Code of Ethics*, which may be compromised. The social worker should not rely on his supervisor to determine whether there is an ethical issue or dilemma. The supervisor may not even be a social worker. By referring directly

to the *NASW Code of Ethics*, the social worker can better weigh ethical issues in light of key social work values and principles, which are explicitly stated in this document.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Techniques to Identify and Resolve Ethical Dilemmas (KSA)

8. **B.** Social workers should obtain clients' informed consent before audio or video recording clients or permitting observation of services to clients by a third party. The consent forms should explicitly state that the sessions will be audiotaped and have information about who will listen to the recordings, how they will be stored, what will happen to the tapes after treatment has ended, and so forth. The risks and benefits associated with audio or video recording should also be reviewed with clients to get their informed consent. The permission of the client to make these recordings cannot be assumed or taken for granted as part of standard language about supervision on a consent form.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); The Principles and Processes of Obtaining Informed Consent (KSA)

- <sup>434</sup> **C.** Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.  
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### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

10. **B.** The social worker was not aware of this potential conflict of interest upon the start of treatment. Once it was discovered, steps, such as minimizing contact and sitting across the room, were taken

to mitigate its existence. The client does not have to be referred to another social worker unless it is more comfortable for the client to do so. In addition, the social worker does not have to leave the church. However, the existence of this unanticipated conflict should be discussed so that the client is aware of its existence and strategies for minimizing its impact can be established.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

- 11. B.** Because the receipt of the tickets by the social worker is clearly linked to the referrals, this is a form of “fee splitting,” which is not allowed in social work practice. Social workers cannot receive incentives or remuneration for making referrals. The donation of the tickets to a local charity does not justify acceptance of these gifts. Although there is no additional cost to the colleague, the football tickets clearly have monetary value.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

- 12. B.** The *NASW Code of Ethics* indicates that consultation should follow all ethical standards, including avoiding conflicts of interest and maintaining boundaries. The social worker’s wife making changes to the agency’s personnel policies that impact her husband is clearly a conflict of interest. Breaching this standard should not be justified because the situation appears desperate and other resources are not evident. It remains a conflict of interest whether the wife charges for her services or not.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to

## Dual Relationships (KSA)

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- A.** The *NASW Code of Ethics* prohibits social workers who function as supervisors or educators from engaging in sexual activities or contact (including verbal, written, electronic, or physical contact) with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

The social worker engaged in a dual relationship with her supervisee, which is unethical.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

- 14. C.** Social workers are only allowed to barter under very limited circumstances. The content in this vignette does not justify the use of bartering or exchanging services for treatment. Terminating services also does not assist the client. The response choice that assists “the client in an ethical manner” is the one that arranges to see the client for a sliding scale or pro bono.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Legal and/or Ethical Issues Related to the Practice of Social Work, Including Responsibility to Clients/Client Systems, Colleagues, the Profession, and Society (KSA)

- 15. A.** Social workers should not give money to or have a dual (business) relationship with clients according to the *NASW Code of Ethics*. Social workers can certainly write a recommendation for a current (or even former) client as long as the content is based on information collected as part of service delivery and social workers

are not making assertions or drawing conclusions beyond the scope of therapeutic relationships.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Legal and/or Ethical Issues Related to the Practice of Social Work, Including Responsibility to Clients/Client Systems, Colleagues, the Profession, and Society (KSA)

- 16. B.** Assent and consent are not the same. Consent is the agreement of clients or their authorized representatives, who have legal authority to make decisions for them, to participate in treatment. Assent is a term used to express willingness to participate in treatment by clients who are too young to give consent or have been deemed by the courts as incapable of making legal decisions. Assent by itself is not sufficient. If assent is given, social workers must still obtain consent from clients' parents or guardians. Court-mandated services do not require clients' consent, but clients should be advised at the onset what they have control over and what they do not in these situations. Both assent and consent require informing clients of the risks and benefits of services to be received.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); The Principles and Processes of Obtaining Informed Consent (KSA)

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- A.** The process and goals for completion of a child custody evaluation are vastly different than those used in marriage counseling. Making child custody recommendations would be inappropriate because both parties were not informed from the onset that discussions and information collected would be used for this purpose. In addition, both parties are current counseling

clients. Often child custody evaluation recommendations are not favorable and/or acceptable to both parents. Providing such a recommendation may, therefore, not be in the best interest or promote positive well-being for one or both of the parties.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Ethical Issues Related to Dual Relationships (KSA)

- 18. A.** The standards that govern social work practice address the use of physical contact with clients. Social workers should not engage in physical contact with clients when there is a possibility of psychological harm as a result of the contact (such as cradling or caressing clients). Physical contact or other activities of a sexual nature with clients are clearly not allowed by social workers.

The *NASW Code of Ethics* does not limit physical contact to only adult clients. However, social workers must clearly evaluate the appropriateness of having physical contact with children, especially because many of the youth served have experienced trauma. There do not need to be “rules” established to govern physical contact though setting clear, appropriate, and culturally sensitive “boundaries” that govern physical contact are essential for professional practice.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Values and Ethical Issues (Competency); Professional Boundaries in the Social Worker–Client/Client System Relationship (e.g., Power Differences, Conflicts of Interest, etc.) (KSA)

- 19. C.** Social workers should provide clients with reasonable access to their records. Social workers who are concerned that clients’ access to their records could cause serious misunderstanding or harm to a client should provide assistance in interpreting the records and consultation with a client regarding the records. Social workers should limit clients’ access to their records, or portions of their

records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to a client. There was not a risk of harm due to the release, so the social worker should have provided access; however, information can be withheld in some circumstances, as described, as long as the request and the reason for the denial is documented in the client's file.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); The Use of Client/Client System Records (KSA)

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- A.** The *NASW Code of Ethics* states social workers who have direct knowledge of colleague impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties that interfere with practice effectiveness should consult with the colleague when feasible and assist the colleague in taking remedial action. Going to the agency director may be appropriate, but only after the social worker has gone to the colleague FIRST. Reporting the issue to the social work licensing board would also not be the initial response as the social work colleague needs to take action to avoid treating clients until the issues are resolved. Licensing board actions often take considerable time to implement.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Mandatory Reporting (e.g., Abuse, Threat of Harm, Impaired Professionals, etc.) (KSA)

- 21. B.** Social workers are mandated reporters. Despite the supervisor's assessment not reaching the same conclusion, the social worker still must make a report because she has "a reasonable suspicion."

It would not be appropriate to delay to meet with the supervisor or agency director.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Mandatory Reporting (e.g., Abuse, Threat of Harm, Impaired Professionals, etc.) (KSA)

22. **C.** Social workers are mandated reporters. In this instance, the social worker should not be making an assessment about these being isolated incidents or the likelihood that they would happen again. The *NASW Code of Ethics* states that clients should be informed whenever possible of such reports. The social worker's behavior should not solely be dictated by what the daughter wants as the father may be continuing to engage in inappropriate acts with children.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Mandatory Reporting (e.g., Abuse, Threat of Harm, Impaired Professionals, etc.) (KSA)

23. **C.** Social workers are allowed to defend themselves when sued by clients. Such a defense usually involves releasing information related to treatment. However, social workers should limit the information released to that which is relevant to the allegations in the lawsuit.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Confidentiality, Including Electronic Information Security (KSA)

2442

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**A.** Releasing information is mandated for child abuse and neglect protections. A social worker should inform the client when seeking supervision and/or consultation and get the client's permission to release information. However, in instances in which disclosure is needed to prevent serious, foreseeable, and imminent harm to a client, the social worker can release only the minimum amount of information necessary to prevent such harm. A social worker should never use identifying client data in a grant application, and to do so is unethical because it is not directly tied to client safety.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Confidentiality, Including Electronic Information Security (KSA)

**25. C.** Although the beliefs and behaviors of the family may be culturally based, there may be some adverse impacts to the children that threaten their well-being. It is not the responsibility of the social worker to determine the reasons for or impact of their actions. The social worker should get the child protection agency involved so they can investigate the situation further. There also may be some resources available to this family by the child protection agency.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Mandatory Reporting (e.g., Abuse, Threat of Harm, Impaired Professionals, etc.) (KSA)

**26. A.** Social workers should not disclose confidential information to third-party payers, including insurance companies, unless clients have authorized such disclosures. The request must be discussed with the client. Additionally, best practice includes reviewing the

summaries with the client prior to submission even if permission is granted to release them.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Confidentiality, Including Electronic Information Security (KSA)

- 27. C.** The “reasonable suspicion” of the social worker makes reporting to the child protection agency necessary. This report should not be delayed to monitor the situation. The social worker should tell the mother of the need to report and support the mother and child through the process. Having the mother present when the social worker contacts the child protection agency may alleviate the mother’s fears about what is being disclosed and the social worker can help the mother to understand the next steps after such a report is made.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Mandatory Reporting (e.g., Abuse, Threat of Harm, Impaired Professionals, etc.) (KSA)

2444

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- A.** A subpoena is a request by the court for information. The social worker must respond. When receiving a subpoena, a social worker should claim privilege and not turn over records unless the court issues a subsequent court order to do so or the client grants permission to release the information. A subpoena and a court order are not the same. Social workers who receive court orders should try to limit their scope and/or ask that records be sealed.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Confidentiality, Including Electronic Information Security (KSA)

29. **C.** The client file cannot be shared with the principal even if the information will assist the client. Social workers should not be sharing information without consent unless necessary to prevent harm to self or others.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Confidentiality, Including Electronic Information Security (KSA)

30. **B.** Social workers should protect the confidentiality of deceased clients consistent with the same standards that apply to those who are living. The social worker should not disclose any information about the client. There is no reason to have the son put his questions in writing or to schedule a session to see him.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Confidentiality (Competency); Legal and/or Ethical Issues Regarding Confidentiality, Including Electronic Information Security (KSA)

31. **C.** The mission of the social work profession is rooted in a set of core values. These core values are the foundation of social work's unique purpose and perspective. The values stated in the preamble of the *NASW Code of Ethics* are service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Development and Use of Self (Competency); Professional Values and Principles (e.g., Competence, Social Justice, Integrity, and Dignity and Worth of the Person) (KSA)

- 32. A.** Clients with borderline personality disorder or its associated features are more likely to engage in transference. Transference-focused psychotherapy is, therefore, often used with clients who have borderline personality disorder. Transference can be used therapeutically and does not have to be sexual in nature.

### **Question Assesses**

Content Area IV—Professional Values and Ethics; Professional Development and Use of Self (Competency); The Impact of Transference and Countertransference in the Social Worker–Client/Client System Relationship (KSA)

445

Practice Questions Content Area IV: Professional Values and Ethics (19%)					
Competency	Question Numbers	Number of Questions	Number Correct	Percentage Correct	Area Required Further Study
1. Professional Values and Ethical Issues	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18	18	____/18	____%	
2. Confidentiality	19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30	12	____/12	____%	
3. Professional Development and Use of Self	31, 32	2	____/2	____%	

446

447

# Full-Length Practice Test

448

# 170-Question Practice Test

This practice test contains 170 questions but remember that your score on the actual examination will be based on 150 questions because 20 items are being piloted. As you won't know which items will be scored and determine whether or not you pass, you will need to complete all 170 questions. Thus, this test has 170 questions so that you can gauge the length of time that it takes you to complete an equivalent number of questions. The questions in each domain or area are in random order on this practice test, as they are on the actual examination, and there is a similar distribution of questions from each section as will appear on your actual examination.

Human Development, Diversity, and Behavior in the Environment

41 Questions

Assessment, Diagnosis, and Treatment Planning

51 Questions

Psychotherapy, Clinical Interventions, and Case Management

46 Questions

Professional Values and Ethics

32 Questions

The best way to use this practice test is as a mock examination,  
which means:

- a. Take it AFTER you have completed your studying—do not memo answers to these questions.
- b. Do not apply the answers to these questions to the actual examination or you may miss subtle differences in each question that can distinguish the correct from the incorrect response choices.

- c. Take it in its entirety during a 4-hour block of time to show yourself you can finish in the allotted time period for the examination.
- d. Do not look up the correct answers until you are completely finished with the entire practice test, and do not worry if you get questions incorrect. Remember, this examination is not one in which you can expect to get all of the answers correct. **The number of questions that you will need to answer correctly generally varies from 90 to 107 correct of the 150 scored items.**

- 451 When a social worker is engaged in reunification therapy with a parent and child, which is the **MOST** important factor to consider?
- A. Parent-child bond prior to separation
  - B. Comfort and needs of the child
  - C. Court-involvement in family matters
2. Which of the following is **MOST** likely the cause of risk-taking behavior in teenagers?
- A. Greater number of social contexts
  - B. Peer pressure and acceptance
  - C. Romanticization of harmful relationships
3. A social worker is meeting with an adult client who witnessed the violent death of a friend a month ago. The client experienced recurrent, distressing memories of the incident immediately after the incident occurred, causing an inability to return to work. However, the client reports that these negative troubling memories subsided in the last week. Based on this report, with which of the following is the client **MOST** likely to be diagnosed?
- A. Acute stress disorder
  - B. Post-traumatic stress disorder
  - C. Repressed memories
4. Which of the following is the **MOST** important psychosocial aim for adolescence?

- A. Development of greater independence
- B. Movement from egocentric to altruistic views
- C. Recognition of complexity in intimate connections

**5.** When building resilience in adolescence, which of the following is **MOST** important for a social worker to remember?

- A. Resilience should be viewed within a community context rather than an individual framework
- B. Adolescents can have good outcomes despite threats to their healthy development
- C. A focus on resiliency should aim to reduce levels of exposure to risk factors

**6.** A social worker is meeting with an adult client who has a loss of appetite and problems sleeping in addition to a depressed mood. The client reports that the symptoms have persisted for the last decade despite attempts to remedy them. Which of the following diagnoses **BEST** fits the client's condition?

- A. Major depressive disorder
- B. Persistent depressive disorder
- C. Low self-esteem

**7.** A social worker has just been hired at a high school and is concerned about correctly maintaining the confidentiality of the students. Which of the following will be **MOST** helpful in identifying the proper protocols?

- 452      Obtaining a copy of the school policies and procedures
- A.
  - B.      Arranging a meeting with a supervisor
  - C.      Reviewing the laws of the state or jurisdiction

**8.** Which of the following **BEST** differentiates the difference between schizopreniform disorder and schizophrenia?

- A. Severity of symptoms
- B. Duration of symptoms

### C. Types of symptoms

- 9.** A White social worker is supervising an employee who is Black/African American in a human service agency in the United States. Using an antiracist approach, what will be **MOST** appropriate for the social worker to remember when interacting with the employee?
- A. Current management practices are likely rooted in oppressive and racist structures
  - B. The social worker will need to work harder to engage the employee
  - C. The social worker will need to examine inherent positions of privilege within the relationship
- 10.** A social worker, who is only proficient in English, receives a referral for a couple whose child has recently been placed in a residential facility for adults with developmental disabilities. One partner has limited English proficiency. The other partner offers to assist with translation so that the social worker can assist with a problem that emerged due to the placement. In this situation, the social worker should:
- A. Accept the referral once all parties agree that one partner will be translating for the other
  - B. Refuse the referral as the social worker is not able to communicate proficiently with both partners
  - C. Commence services once a qualified translator is identified
- 11.** A social worker is meeting with a single mother and her three children for an initial session. The social worker learns that one of the children, a 14-year-old son, is sneaking out at night and experiencing truancy at school. When speaking with the son, he states that he does not have to listen to his mother and is treated like a baby even though he is the “man of the house.” The other two children rarely speak, instead comforting the mother who sobs throughout the interview. After engaging with family members, the social worker should **NEXT**:
- A. Identify the roles expectations of family members for themselves

and others

- B. Explore the impact of the son's behavior on family functioning and communication
- C. Request school records for the children to understand their performance outside the family unit

**12.** Which of the following is **BEST** practice in disclosing clinical diagnoses to clients as part of social work practice?

- 453 Social workers should only discuss the names of and rationales for clinical diagnoses with clients if they ask about them
- A. rationales for clinical diagnoses with clients if they ask about them
  - B. Clients should be fully informed of the names of and rationales for their clinical diagnoses if the information does not cause harm
  - C. Clients should be fully informed of the names of and rationales for their clinical diagnoses in all instances

**13.** A client tells a social worker that he has stopped taking his medication and is experiencing delusional thoughts. He states that he will never be taking this medication again. The social worker should **FIRST**:

- A. Speak to the client about maladaptive feelings and behaviors that will likely emerge
- B. Identify what factors in the client's life may have contributed to this recent decision
- C. Suggest that the client try a different medication to address his delusional thoughts

**14.** Which of the following theories provides the **BEST** evidence for the mind-body connection?

- A. Person-in-environment theory
- B. Systems theory
- C. Psychodynamic theory

**15.** A social work manager discovers that the agency is operating at a 30% client vacancy rate with most programs operating under

capacity. When speaking with the staff, the social work manager learns that new referrals have been turned away due to staff vacancies. Existing staff are not sure that they can handle increased demand due to the number of job openings. Many of the staff vacancies result from low pay. Which of the following actions is **MOST** likely to reduce client vacancies?

- A. Agreeing to proportionally increase the pay of all existing agency staff
- B. Creating a performance-based incentive plan linked to staff compensation
- C. Increasing the starting salary for all new personnel hired

**16.** A social worker is working with a 17-year-old girl who has a strong acuity for and interest in computer programming but does not want to pursue it as a career as she “does not see a future in it for me.” She makes many comments about how she is the only female in many of her computer courses in high school. The client has delayed looking at college programs which the social worker feels is due to an inner desire by the client to pursue computer programming despite what she states. Which of the following will be **MOST** helpful in assisting the client?

- A. Exploring the client’s feelings about gender stereotypes and past female role models
- B. Identifying colleges with the client that have a wide variety of majors
- C. Arranging meetings for the client to interact with women who have careers in computer programming

**17.** A non-profit agency board of directors identifies the lack of racial diversity in its management staff. Persons of color are then hired for senior management positions but are often excluded from key decision making. The board of directors praises the increased <sup>454</sup> efforts made at hiring more diverse staff, but do not review the management practices or policies of the organization to ensure that they are antiracist. Which **BEST** describes the hiring actions of the board of directors?

- A. Systematic discrimination

- B. Tokenization
- C. Bigotry

- 18.** A social worker is working with a client who identifies as “gender fluid.” What is **MOST** likely the meaning of the client’s use of this language?
- A. Ambivalence about personal gender identity
  - B. Open to changing gender expression or identity
  - C. Living as the gender opposite of that assigned at birth
- 19.** A social worker suspects that a client may either have cyclothymic disorder or bipolar I disorder. Which of the following will **BEST** help in making the differential diagnosis?
- A. Age of the client
  - B. Severity of the symptoms
  - C. Biopsychosocial functioning
- 20.** A social worker at a homeless shelter for adult women is contacted by a 14-year-old girl as she was evicted from her home by her parents who no longer have any contact with her. She reports that the parents were not abusive but were upset with her substance use and truancy from school. She states that she may be able to stay with a friend next week so only needs short-term housing in the shelter. The social worker should **FIRST**:
- A. Facilitate a referral of the girl to the child protection agency
  - B. Ask the agency director whether the girl can be served given her short-term need
  - C. Arrange to meet with the girl to complete an intake assessment
- 21.** A social worker meets with a 20-year-old client who is having trouble functioning at home and in the community. For the last year, the client has had severe verbal outbursts and an angry mood daily. The social worker diagnoses the client with disruptive mood dysregulation disorder, which has never been assigned to this client before. The supervisor disagrees with the diagnosis. Which of the following is the basis of the supervisor’s objection?

- A.** Symptomology presented
- B.** Age of the client
- C.** Chronicity of symptoms

**22.** A social worker is meeting with a 26-year-old client for the first time. During the meeting, the client tells the social worker about events that happened yesterday which include being fearful as someone was “trying to get him.” The client states that he has been “followed for years” and he fears for his safety. In order to meet the needs of the client, the social worker should **FIRST**:

- 455      Assess the client for paranoia and other psychotic disturbance
- A.** Complete a biopsychosocial evaluation with the client
  - B.** Ask the client more about incidents of concern which have occurred over the years

**23.** A social worker has been working with a teen for several years before learning that the client will be attending college out of state and would like to receive services from the social worker using electronic methods. The social worker is licensed in the client’s home state, but not the state where the client will be attending college. Which statement **MOST** likely describes the social worker’s legal authority in this situation?

- A.** The social worker is authorized by the home state regulatory board to serve the client at college as long as only electronic services are provided out of state
- B.** Most states do not have regulations that govern such situations, allowing social workers to use their professional discretion
- C.** The social worker needs a regular or telehealth license in the state in which the client is attending college

**24.** Which of the following are the **MOST** distinguishing indicators of toxic stress?

- A.** Prolonged duration
- B.** Adverse health outcomes
- C.** Intensity of stimuli

- 25.** A social worker employed in an substance use treatment agency notices a 17-year-old client appears to be in distress in the common area. The client recently completed a detoxification program for opioid use and is attending day treatment. The client is unresponsive and has labored breathing. After calling for emergency assistance, the social worker should **NEXT**:
- A. Ask others about the client's behavior
  - B. Contact the client's parents
  - C. Administer naloxone to the client
- 26.** A social worker is charged with developing a new service program. Which of the following will be **MOST** critical for informing program design?
- A. Provider competition
  - B. Agency resources
  - C. Needs assessment
- 27.** A social worker is working with a client who has recently been evicted due to underemployment. The client appears to qualify for subsidized housing which is means tested. The client has experienced many adversities due to the lack of stable housing including depression, anxiety, and isolation. In order to **BEST** assist the client, the primary focus of intervention should be to:
- A. Help the client obtain fiscal records and asset verification
  - B. Address the client's current emotional state
  - C. Support the client in finding another job
- 456**  
**28.** A social worker believes that a client has antisocial personality disorder. On which of the following behaviors or feelings is the social worker likely to base the assessment?
- A. Poor descriptions of self-worth and competency
  - B. Difficulty starting a new task and working independently
  - C. Conning others for pleasure or personal profit
- 29.** A social worker has been providing teletherapy via video

conferencing to a single mother for several months. The social worker notices that the client is very distracted in sessions by her children fighting in the background and a lot of people moving about the house. In order to **BEST** address the situation, the social worker should:

- A. Recognize the distractions and their impact on the client's current well-being
- B. Request that the client find a private place to speak to the social worker
- C. Suggest coping skills that can assist the client with stressors in her environment

**30.** A social worker wants data on the causes and prevalence of heart disease in a geographic region for a grant application to help prevent and manage the disease. What type of research is the social worker interested in conducting?

- A. Experimental
- B. Epidemiological
- C. Explanatory

**31.** A social worker is hired at a day treatment program for people with psychotic disorders. The social worker is responsible for collecting data on the mental status of clients daily. What data collection method will be **MOST** effective in collecting the needed information?

- A. Interviews
- B. Self-administered screening
- C. Observations

**32.** A client reports that she was brutally raped as a child and has difficulty connecting with others. She often has difficulty expressing her emotions. The client would like to have more friends but feels that relationships are not formed as others do not get a chance to get to know her. Which of the following interventions by the social worker will **BEST** assist the client?

- A. Modeling social interactions when meeting with the client

- B. Ensuring that the client understands that her past trauma impacts all aspects of functioning
  - C. Helping the client to identify ways to meet others socially
- 33.** Which of the following social work values is **MOST** critical to consider when doing motivational interviewing with a client?
- A. Self-determination
  - B. Confidentiality
  - C. Consent
- 3457**
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- A social worker employed at a community action agency learns about a long-standing problem that has not been addressed. Central to filling the need is program development and fundraising. When speaking individually to clients, each recognizes the need but states, "I am not sure what I can do about it." Which of the following roles will be **MOST** critical for the social worker to help engage clients in addressing the issue?
- A. Advocate
  - B. Mobilizer
  - C. Broker
- 35.** A social worker, employed in a large governmental human service organization, notices that there is little racial diversity within upper administration with few people of color in decision-making positions. The direct services staff workforce is quite diverse with many people of color providing services to clients. Which of the following statements **MOST** likely describes the reason for this disparity?
- A. Few people of color seek management positions within the organization
  - B. Recruitment efforts lack attention to attract a diverse candidate pool
  - C. Promotional practices and policies are institutionally biased

- 36.** Based on the onset of symptoms, when in the life course is autism spectrum disorder **MOST** likely to be diagnosed?
- A. Adolescents
  - B. Early childhood
  - C. School age
- 37.** A social worker provides a managed care company with a psychiatric diagnosis needed to authorize services. The managed care company asks for more information, such as case notes and other records, to support the assessment. What is **MOST** likely the concern of the managed care company request?
- A. Validity of the diagnosis
  - B. Prognosis for treatment
  - C. Cost of care
- 38.** A social worker must make a differential diagnosis between obsessive-compulsive disorder and obsessive-compulsive personality disorder. Which of the following will be **MOST** helpful in making the distinction?
- A. Examination of the client's personal relationships
  - B. Determination of client's distress due to thoughts, feelings, and/or actions
  - C. Review of client's past history of mental health treatment
- 39.** After several meetings, a 23-year-old client confesses to a social worker that someone has hacked into his computer and speaks to him through the device about embezzling his money. He is fearful as he has also noticed that people are loitering on the street outside his house, leaving him to wonder if they are planning to rob him. To assist the client, the social worker should **FIRST**:
- 458      Determine whether the client has experienced similar events
- A. in the past
  - B. Assess the client for psychosis
  - C. Assure the client that he is not in danger

- 40.** In psychoanalysis, what does dream analysis attempt to understand?
- A.** Delusional tendencies
  - B.** Unconscious desires
  - C.** Sexual drives
- 41.** A client of a social worker is a long-time illicit barbiturate user, but now tells the social worker that she will be quitting “cold turkey.” Which of the following supports will be **MOST** important during this process?
- A.** Medical monitoring
  - B.** Social support
  - C.** Psychological counseling
- 42.** A social worker is working with a 35-year-old client who is in the early stages of recovery from addiction. The client is feeling alone and hopeless but is concerned about connecting with others due to confidentiality given professional status. Which of the following treatments will **MOST** likely be appropriate for this client?
- A.** Medication assisted treatment intervention
  - B.** Group therapy
  - C.** Individual therapy
- 43.** A social worker is working with a couple who has struggled with infertility and has decided to pursue surrogacy. They express nervousness about the process and the rights of all parties. Their anxiety has been fueled by relatives, aware of their decision, who ask them questions which they are not able to answer. In order to **BEST** assist the couple, the social worker should:
- A.** Recommend that the couple review federal laws and protections afforded to surrogates and parents
  - B.** Assure the couple that many people have the same feelings when they begin the surrogacy process
  - C.** Review state/jurisdictional laws related to surrogacy with the couple to identify specific concerns

**44.** A social worker has received consent from the parent of a 14-year-old girl to provide therapy to address her depression and anxiety. After several months, the parent contacts the social worker and would like a copy of the record. In accordance with legal and ethical guidelines, the social worker should:

- A. Provide the parent with a copy of the record and let the client know that the release has occurred
- B. Ask the client whether the parent can have access to the record
- C. Refuse to provide a copy of the record as the information is confidential

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A social worker has a client who lives with a large extended family. The family is a critical support system, with the client reporting the importance of family gatherings centered around food and activities related to the client's culture. During a home visit, the client invites the social worker to join the family in tasting ethnic food that are being prepared for an upcoming celebration. In this situation, the social worker should:

- A. Refuse the invitation as it jeopardizes the boundaries associated with professional roles
- B. Agree to taste the food as it is central to the client's cultural traditions
- C. Ask the client why the request to join the family in tasting the food was made

**46.** A client who left the agency many years ago contacts the social worker for a copy of an assessment. The social worker finds that the agency retained the record even though the length of time exceeds its record retention policy. In order to properly address the situation, the social worker should:

- A. Provide the client with a copy of the assessment after explaining that it was kept longer than usual
- B. Deny the client's request as it is beyond the record retention policy

C. Ask the client why the assessment is being requested

**47.** An agency provides face-to-face and remote services via technology to clients. A social worker finds that a client is frequently missing appointments due to his work schedule and cannot attend remotely as he does not have a computer. He states that remote access would be much more convenient, but it will be several months until he can save the money for the appropriate technology.

In order to **BEST** meet the client's needs, the social worker should:

- A. Suggest to the client that he wait until he has purchased a computer to continue services
- B. Explore with the client any possible accommodations that can be made by the employer
- C. Advocate with the agency director for the client to be given a computer to use for remote services

**48.** Which of the following describes best practice when obtaining client consent for release of information?

- A. Social workers should ask clients during the first session to designate which documents can be released to which third parties
- B. Social workers should meet with clients to review each third-party request and document to be released to obtain consent separately for each release
- C. Social workers should obtain client consent at intake and at least yearly thereafter for releasing information to third parties

**49.** A social worker is meeting with the parents of a 4-year-old who drowned in their swimming pool 2 years ago. Treatment planning focused on the need for the parents to address their unresolved grief. To help the parents cope with the loss of their child, the social worker should:

- A. Educate the parents about the stages of mourning after traumatic events
- B. Refer the parents to a support group focused on grief and loss
- C. Facilitate expression of the parent's grief and its impact on their daily lives

<sup>460</sup>  
50. When using a Bowenian family therapy approach, which of the following is a critical factor in determining an individual's differentiation of self?

- A. Sibling position
- B. Gender roles
- C. Repressed urges

51. A social worker is working with an adult client who is incarcerated. The client was recently found with illicit drugs while in prison after attesting vehemently to the social worker that she did not have them. Based on the client's assertion, the social worker had attested the client's innocence to the prison administration. The social worker shares with the client how the client's lying made the social worker feel betrayed. The sharing of these feelings by the social worker is **MOST** likely done to:

- A. Engage in authentic responding to help the client understand the importance of honesty in the helping relationship
- B. Assist the client to understand that the social worker is nonjudgmental and would have kept the information about the drugs confidential
- C. Inform the client that the social workers cares about the client and needs to be part of the client's support system

52. A social worker, who is conducting a mental status examination, asks a client to name as many articles of clothing as possible in a minute. What is the social worker **MOST** likely assessing by this client request?

- A. Appearance
- B. Cognition
- C. Speech

53. Which of the following situations **BEST** describes the presence of preconventional moral reasoning?

- A. A client does not come late to an appointment for fear of being reprimanded by the social worker

- B. A client disagrees with a social worker's assessment but does not speak up to not offend the social worker
  - C. A client reports to a social worker that a friend made an offensive comment but the comment was ignored to maintain the relationship
- 54.** A client reports employment changes that will likely impact her income. She is worried about her ability to meet her monthly expenses. In this situation, the social worker should **FIRST:**
- A. Refer the client to financial assistance programs to assist with meeting needs
  - B. Ask the client to identify her regular bills and expenses
  - C. Determine the nature of the employment changes

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- A social worker in a child welfare organization is working with a family in which abuse and neglect against a child has been substantiated. The social worker is identifying a resource family for the child to stay with long-term while also simultaneously referring the parents to psychotherapy and parenting skills groups. What **BEST** describes the approach being used by the social worker?
- A. Harm reduction
  - B. Concurrent planning
  - C. Kinship care
- 56.** A former client comes to see a social worker several months after the death of the client's child. The social worker met the child many times and has lots of positive memories about the interactions. The former client seems eager to speak about her child, engaging the social worker in conversation about the child. When speaking with the former client about the child, the social worker should:
- A. Recall meaningful stories about the child when appropriate
  - B. Stress the need to deal with current issues
  - C. Express sympathy and respect for loss experienced by the

former client

- 57.** A social worker is very concerned as a colleague is experiencing symptoms of unresolved grief due to the death of a spouse. The colleague is distracted when meeting with clients and has missed several program meetings due to fatigue caused by sleep disturbance. The colleague appears unaware of the impact of the grief. The social worker should **FIRST**:
- A. Report the concerns to a supervisor so the colleague can be properly supported
  - B. Speak to the colleague directly about observed problems in job performance
  - C. Document concerns about the colleague's behavior as related to employment duties
- 58.** A social worker is working with 15-year-old transgender client who is being bullied at school. The client is isolated and displays behaviors associated with poor self-esteem. The client would like to have friends but states that classmates are guarded and avoid interactions. Which of the following is **MOST** likely the root cause of the client's problems?
- A. Lack of social and coping skills needed in new gender roles
  - B. Fear and discrimination against those who are transgender
  - C. Psychosocial stress associated with assuming a different gender
- 59.** A social worker is seeing a 14-year-old client whose parents are concerned about his level of isolation. The client reports that the parents are exaggerating and that he has friends, but often prefers to be alone. When doing an assessment with the client, which of the following tools will be **MOST** helpful to the social worker in identifying whether a problem exists?
- A. School records
  - B. Genogram
  - C. Ecomap

**60.** A social worker is referred a 17-year-old woman for counseling due to anxiety and depression. Though she is a high school honor student, the client is questioning whether she wants to attend college. She recently broke up with her boyfriend of many years and has “sworn off dating men.” She has gained weight and begun to dress differently. What should the social worker **FIRST** ask the client about in this situation?

- A. Mental health challenges that have occurred in the past
- B. Identity formation and views of self-concept
- C. Social pressures from friends and family

**61.** A client, who lives alone and is morbidly obese, tells a social worker that he would like to lose weight as his size is interfering with his daily functioning. After referring the client to a physician who says that there are no medical problems, the social worker should **FIRST**:

- A. Evaluate whether the client is a candidate for weight loss surgery
- B. Focus on the clients' use of overeating as a coping mechanism
- C. Assess the clients access to nutritious foods

**62.** A social worker is working with an elderly couple. The husband has Alzheimer's disease and needs significant support from the wife who has been his primary caregiver for years. In the last week, the wife has been found disoriented in the neighborhood with obvious signs of neglect. Which of the following factors is **MOST** likely the cause of the wife's condition?

- A. Chronic stress associated with caregiving for the husband
- B. Aggressive behavior of the husband that resulted in abuse of the wife
- C. Degenerative disease due to the wife's own aging process

**63.** A social worker realizes when a client shows up for an initial appointment that she is deaf and communicates through the use of American Sign Language (ASL). The social worker is not proficient

in ASL but has had some basic training in its use. To **BEST** address this situation, the social worker should:

- A. Exchange written notes with the client during the session to get the information needed
- B. Communicate with the client using ASL to the maximum extent possible to complete the intake
- C. Explain to the client that the session needs to be rescheduled so an interpreter can be accessed

**64.** A social worker has a client who is a person of color but has a very light complexion, causing her to be frequently mistaken as White. The client reports that people often make racist statements in front of her as they do not realize that she is a person of color. When she explains to them the offensiveness of their comments, they are always apologetic. In which of the following ways will these experiences **MOST** likely impact the client?

- A. The client will likely have better expressive communication skills due to her advocacy efforts
- B. The client's identity development will likely be adversely impacted by exposure to racism
- C. The client will likely be more marginalized and oppressed due to feelings of isolation

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A social worker is providing therapy to a mother and her 10-year-old child due to emotional issues resulting from a contentious divorce. The father of the child recently petitioned the court to receive sole custody. The social worker has observed positive interactions between the mother and child, noting the strong attachment that the child has to the mother. The mother asks the social worker to write a letter to the court recommending joint custody. To handle this situation ethically, the social worker should:

- A. Provide a letter with the recommendation to the court as it is in the best interest of the child
- B. Inform the mother that a child custody recommendation cannot

be made due to a conflict of interest

- C. Ask to meet with the daughter individually to determine her views about custody arrangements

**66.** After working for a child welfare agency for several years, a social worker experiences moral distress rooted in the working conditions. In order to **BEST** handle this situation ethically, the social worker should:

- A. Seek supervision and consultation to increase coping skills associated with work stressors
- B. Consider changing positions within the agency to alleviate burnout and secondary trauma
- C. Advocate to increase resources and/or modify oppressive practices or policies

**67.** A social worker is charged with ordering supplies for an agency's social service programs. The social worker learns that the vendor gives reward points for each purchase that can be used toward self-care promotions such as massages, fitness instruction, and sportswear. The supplier tells the social worker that the points are for the personal use of the employee ordering the products. In this situation, the social worker should:

- A. Inform the vendor that the reward points cannot be used personally
- B. Review human resource documents outlining agency policies about use of such promotions
- C. Identify how the points were utilized in the past by other employees in this role

**68.** During pregnancy, a couple learn through prenatal testing that their child will be born with significant disabilities. The couple decides to terminate the pregnancy based on this diagnosis. Which type of result would threaten the basis of their decision?

- A. False positive
- B. Curvilinear
- C. False negative

**69.** A social worker is working with a client who reports significant sleep disturbance during the past year. The client has been seen by a physician who can find no medical reason for the sleeplessness. The client is having difficulty concentrating on the job and has fallen asleep at work. The client states that he will be fired if the behavior continues. In order to assist the client, the social worker should

**FIRST:**

- 464 Identify complementary therapies such as meditation and
- A. mindfulness to assist him
  - B. Determine if changes in the client's life may have resulted in sleeping problems
  - C. Refer the client to a physician to see if medication can be prescribed to assist with sleeping

**70.** Which of the following is the **MOST** significant problem associated with reversal designs in single-subject research?

- A. Lack of generalizability to other clients and situations
- B. Poor internal validity demonstrating cause-effect
- C. Ethical challenges associated with withdrawing the treatment

**71.** A social worker is notified by the court about the need to testify about a client who has been receiving substance use services for the last 6 months. The client was involved in an assault prior to treatment but was not mandated by the court to receive services. The client has made substantial progress and has not been using substances. The social worker has no experience in forensic practice. The social worker should **FIRST:**

- A. Seek consultation from a lawyer
- B. Notify the client about the need to testify
- C. Write to the court stating that all information is confidential

**72.** A 20-year-old client is concerned as she failed several college courses last semester that were paid for by her parents. The parents have threatened to call the university, after the daughter has failed to show them her transcript but have not done so. While the client feels bad about keeping the information from her parents,

she does not want them to know. What is the **BEST** response when the client asks the social worker about what the university will tell her parents if they call?

- A. Universities vary in their policies about releasing information to parents of students
- B. Federal law protects her educational record from being released to anyone without her permission
- C. The transcript will be sent to the parents since they are the ones paying for the courses

**73.** A social worker employed at an inpatient psychiatric hospital has deemed a client severely depressed using the Beck Depression Inventory. The social worker notices that the rating is consistent with observed behaviors seen by staff on the inpatient unit so feels confident in this diagnosis. Upon which of the following research concepts is the social worker basing this confidence?

- A. Internal validity
- B. Test-retest reliability
- C. Criterion-related validity

**74.** A social worker and client agree that the current intervention is not working as no substantial progress has been made in several months. The social worker should **NEXT**:

465 Revise the goals set forth in the client's treatment plan

- A.
- B. Explore with the client the root cause of the presenting problem
- C. Seek consultation and supervision for new techniques to use with the client

**75.** A social worker finds that a client, who was convicted of sexual assault of a minor, is at high risk of reoffence. Which of the following considerations is **MOST** important when treating this client?

- A. Restricting access to potential victims
- B. Education of the client's support system about the risks

C. Ability of client to engage in cognitive behavioral therapy

**76.** Which **BEST** characterizes the behavior of a client who exaggerates an illness to gain external benefit?

- A. Malingering
- B. Hypochondriacal
- C. Grandiose

**77.** A social worker who works in a psychiatric hospital is told by a client that a staff person in another unit is having sex with a client. To appropriately handle this situation, the social worker should **FIRST**:

- A. Report the allegation to the social worker's supervisor
- B. Evaluate the validity of the client's report based on diagnosis and treatment history
- C. Ask the client reporting the incident to document the allegation in writing

**78.** After meeting with a social worker for several therapy sessions, a client states that several years ago she gave her mother excessive pain medication that caused her death as the mother was terminally ill and suffering greatly. The client feels guilty but is convinced that she made the correct decision. The client has difficulty relating to her father, who is in good health, due to the circumstances of her mother's death which have never been revealed. The social worker should **FIRST**:

- A. Inform the client that the situation needs to be reported to the authorities
- B. Help the client to identify measurable goals for her relationship with her father
- C. Determine the vulnerability of the father to potential harm by the client

**79.** During the fifth meeting with a social worker, a client mentions her place of employment and the name of her boss. The boss is the parent of a very close friend of the social worker's daughter. In this situation, the social worker should:

- A. Refrain from mentioning the relationship between the social worker and boss as it is irrelevant
- B. Refer the client to another social worker in the agency to avoid any conflict of interest
- C. Disclose the nature of the relationship between the social worker and boss to the client

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A social worker who recently divorced due to infidelity by a spouse becomes increasingly upset with a client who is having an affair. The client has been dating a coworker for a year, being careful to hide the relationship. In order to **BEST** meet the needs of the client, the social worker should:

- A. Disclose the feelings to the client to determine if a referral to another social worker is warranted
- B. Encourage the client to be honest with her spouse
- C. Acknowledge the feelings and discuss them with a supervisor

81. Which of the following is **MOST** likely to determine whether a marriage ends after infidelity of one spouse?

- A. Whether the affair involved sexual contact by the spouse who was unfaithful
- B. Culture of the spouse who was not having the affair
- C. Age of the spouse who was unfaithful

82. A social worker is meeting with a 20-year-old college student who is unhappy due to his major. He admits that his current choice of study was heavily influenced by his parents. He is unsure of his career plans but knows that he would be much happier studying another subject. The client is worried that his parents will be angry with him. The social worker asks him to identify ten things that are personally important regarding future employment. The social worker is **MOST** likely making this request to:

- A. Prepare the client for a conversation with his parents about his

career choice

- B. Assess the client's ability to make decisions independent of his parents
- C. Help the client to determine a major that is more suited to his interests

**83.** A social worker is meeting with a client whose mother has recently entered a nursing home. The client talks at length about the event, expressing both sadness at her mother's loss of independence and relief due to the strain of caring for her at home. The social worker comments, "I am not sure that I am clear about what you are feeling." The intent of the social worker's statement is **MOST** likely to:

- A. Demonstrate to the client that the social worker is listening
- B. Ensure that the social worker understands what the client is saying
- C. Help the client to better understand the emotions that are impacting this transition

**84.** Which is the primary aim of summarizing progress with a client at the beginning of weekly meetings?

- A. Providing continuity of treatment since the last session
- B. Identifying the social worker's treatment goals for the current meeting
- C. Ensuring that the client understands the progress made to date

**85.** A social worker is meeting with a client who is reluctant to leave his job though he is miserable at work. The social worker asks, "What do you think would happen if you resigned?" The social worker is **MOST** likely asking this question to:

- 467      Determine the coping skills that the client has to handle stress
- A. Help the client identify the restraining forces for employment change
  - C. Assess the emotional attachment that the client has to his boss and colleagues

- 86.** The primary purpose of a social worker using attending behaviors during the problem-solving process is to:
- A. Provide alternative viewpoints to enhance a client's understanding of a problem
  - B. Convey empathy for the client's situation
  - C. Strengthen the therapeutic alliance between a social worker and client
- 87.** Which of the following is the **MOST** significant risk of using a standardized client intake form during an initial meeting with a client?
- A. Gathering information that is not tailored to the presenting problem of a client
  - B. Appearing uncaring about a client's individual needs
  - C. Ignoring the value of open-ended questioning to better understand a client's life circumstances
- 88.** The **BEST** reason for doing post-discharge telephone follow up with a client is to:
- A. Assess whether client has maintained progress obtained during treatment
  - B. Ensure that client participates in any after-care services
  - C. Determine if the client is having other issues or problems
- 89.** A social worker asks the client a leading question during the assessment phase of the planned change process. The intent of this question is **MOST** likely to:
- A. Help the client to stay focused on issues to be discussed during treatment
  - B. Obtain specific information from the client about the presenting problem
  - C. Explore whether the client is motivated to make needed changes
- 90.** A woman contacts a social worker as her spouse had an ongoing affair that ended more than 2 years ago. The couple have

reconciled and have been getting along well. However, but the woman states that she still feels betrayed and angry. Which of the following treatment modalities will **BEST** assist the woman?

- A. Individual counseling
- B. Couples therapy
- C. Mutual aid support

**91.** A client is complaining that she has little patience with her children when they are not in school. The client feels that she has grown distant from them, and the parent-child relationship is dysfunctional. The social worker asks, "What could you do to make the situation with your children even worse?" The social worker asked this question **MOST** likely to:

- A. Identify whether the client is listening or showing detachment in this setting as well
- <sup>468</sup>Assess the level of commitment that the client has to change the  
B. situation with the children
- C. Generate ideas about how to improve the relationship between the client and her children

**92.** During an initial meeting with a client, he talks at length about the problems that he is experiencing and how he is "overwhelmed." The social worker asks the client, "How can I help you?" This question is being used by the social worker is to:

- A. Focus the client on solutions rather than problems
- B. Demonstrate to the client that the social worker is there to assist
- C. Determine if the client has specific expectations for treatment

**93.** A social worker observes a play session in which a couple interact with their small children. The social worker sees that the couple encourage a child to "go play with the toys," but then reprimand the same child for leaving the couple's side. Which of the following communication issues is involved in this interaction between the couple and child?

- A. Metacommunication
- B. Double bind

**C. Negative feedback loop**

**94.** A social worker is providing services to a client who is involved in a contentious divorce. The client is worried about the therapy records being court ordered in the child custody dispute as they were in the past. In order to **BEST** protect confidentiality of the client, the social worker should:

- A.** Maintain psychotherapy notes in a separate file than the client record
- B.** Only put material in the case file that will reflect positively about the client
- C.** Minimize documentation made about client problems or issues

**95.** An elderly client is being discharged from the hospital to the home of his son. The client was hospitalized for diverticulitis though he was unaware that he had the condition before admission. Which of the following is going to be **MOST** important for the social worker to include in discharge planning?

- A.** Goals for the client after leaving the hospital
- B.** Education for the client and his son about the condition and the client's ongoing dietary needs
- C.** Summary of the treatments that have been provided to the client after admission

**96.** A social worker employed at a homeless shelter receives a referral for a 23-year-old woman and her two children. The family has significant hardships including chronic poverty and homelessness. The mother reports being hospitalized for mental health in the past and one of the children has developmental disabilities which greatly impair functioning. There is some concern about the risk of the children for abuse and neglect. Which of the following factors should be assessed **FIRST** in determining risk to the children?

- 469      Ability of the family to secure and maintain housing
- A.**
- B.**      Level of need of the child with developmental disabilities
- C.**      Mother's mental health status

- 97.** A social worker contemplating developing a sliding scale fee for his private practice that is based on the client's income. Which of the following is the **MOST** significant concern about this approach?
- A. The fee structure does not account for the expenses of the client
  - B. All clients should be treated the same regardless of income
  - C. Clients' fees may change during the course of treatment if their earnings change
- 98.** A social worker begins therapy with a 13-year-old girl who has divorced parents. Both parents wanted treatment for the daughter, but the father called after several weeks to indicate that he does not consent and wants the social worker to discontinue services. The social worker feels that the daughter greatly benefitted from services, and the child's other parent is very supportive of the treatment. In this situation, the social worker should:
- A. Meet with the daughter one more time to develop a termination plan
  - B. Inform all parties that treatment must end immediately given the lack of consent by both parents
  - C. Contact the other parent about the situation with a request to see the child custody agreement
- 99.** A client tells a social worker that she does not want to receive a vaccination required for her job. The client learns that her employer makes her attest to her vaccination, but she does not have to show her vaccination card. The client plans to be deceitful. The client lives with her two small children and her elderly parents. What will be **MOST** important for the social worker to discuss with the client?
- A. She will likely be fired from her job if her employer discovers that she lied
  - B. Her vaccination may protect her children and parents from becoming ill
  - C. Vaccinations are thoroughly tested for safety, and she will have no adverse effects
- 100.** A social worker employed by a child welfare organization

responds to a complaint by a concerned relative about domestic violence within the household. When arriving at the house, both parents and the children seem reluctant to speak to the social worker. In this situation, the social worker should **FIRST**:

- A. Interview the family together to ensure consistency of responses
- B. Speak to each parent and child separately to obtain their views about family life
- C. Assure all family members that they have done nothing wrong

**101.** A social worker is helping a client using a cognitive behavioral approach. The social worker asks the client to keep a journal and briefly describe any situations that lead to unpleasant feelings. The client is instructed to include any initial thoughts that first <sup>470</sup> entered the client's mind in these situations. In order to assist the client, the social worker should **NEXT**:

- A. Assist the client to avoid these situations in the future so the thoughts do not reemerge
- B. Help the client to identify patterns and root causes of negative thinking
- C. Work with the client to determine the consequences of these thoughts

**102.** A client confesses that she is very angry with a friend over an incident that happened the night before. The social worker asks the client to rate her anger on a scale from 1 to 10. The social worker is **MOST** likely using this scaling technique to:

- A. Determine the intensity of the emotion that the client is feeling
- B. Help the client to be more accurate in describing her feelings
- C. Encourage the discussion of a sensitive issue for the client

**103.** A social worker who is meeting a new client for the first time uses the incorrect pronoun to refer to the client. The client corrects the social worker. To appropriately handle the situation, the social worker should **NEXT**:

- A. Apologize to the client for the mistake
- B. Help the client to understand the reasons for the mistake

C. Praise the client for correcting the social worker

**104.** A social worker has been doing teletherapy with a client for many months. During a session, the social worker notices that the client, who appears fully clothed, is lying in bed. The social worker feels uncomfortable speaking with the client while the client is in bed. In this situation, the social worker should:

- A. Ask the client to move to another location that is more appropriate
- B. Reflect on why the social worker is having these feelings
- C. Acknowledge that there is likely a reason that the client is in bed

**105.** A social worker obtains a job at an agency delivering therapy to older adults. At the time of employment, the agency wants the social worker to sign a document that states that the social worker will not provide services to clients after leaving the agency for any reason. When the social worker asks about the reason for the document, the social worker is told that it is used as there was a problem in the past with a social worker soliciting clients in order to start a private practice. In order to handle this situation ethically, the social worker should:

- A. Sign the document as it is inappropriate for a social worker to solicit clients for a private practice
- B. Consult with an attorney to determine if this policy is legally allowed
- C. Inform the agency that such an agreement cannot be signed as it limits self-determination of clients

**106.** A social worker, who is dating another agency employee, learns that she will be promoted to be the director of the unit to which the employee is assigned. The couple have not made <sup>471</sup> their relationship public so no one is aware that they are in a personal relationship. In order to **BEST** address the issue, the social worker should:

- A. Determine whether any conflicts of interest exist before accepting promotion to the new role
- B. Inform human resources about the relationship so that an

independent evaluation can occur

- C. Decline the promotion without stating the reason for decision

**107.** A social worker would like to use a data collection method which has high validity but is not as concerned about reliability. Given these concerns, which of the following methods is **MOST** appropriate?

- A. Self-administered questionnaire
- B. Unstructured interview
- C. Structured interview

**108.** A social worker is working with a couple, who is undocumented, and their three children who are living in a basement apartment. The apartment is in disrepair causing a poor life quality for the family. The social worker has been urging the couple to speak to the landlord about making some needed repairs but they have not done so. To appropriately handle the situation, the social worker should **FIRST**:

- A. Acknowledge that the couple may be hesitant due to discrimination
- B. Help the couple to see the urgency of the situation
- C. Encourage the couple to stop paying rent until the repairs are completed

**109.** While driving, a social worker sees a woman and two children in the median of a highway asking for money. They are holding a sign describing their situation which uses both English and Spanish words. The spot where they are standing is dangerous and the social worker fears for their welfare. The social worker wants to call the police but is worried about doing so. What is **MOST** likely the basis of the social worker's concern?

- A. The police do not have access to social services that the family appears to need
- B. There may be difficulty with the family communicating with law enforcement officials
- C. The family's behavior may result in separation and/or

criminalization

- 110.** A social worker, raised in a religious household that condemns the legalization of abortion, feels strongly that she would never choose to terminate a pregnancy. The social worker has been offered a job in a college counseling agency and is told that students often raise issues about reproductive options in therapy. In this situation, the social worker should **FIRST**:

- A. Decline the position as there are potentially too many conflicts of interest
- B. Assess her ability to educate and support students on all reproductive options including abortion
- C. Disclose her personal beliefs about reproductive rights to determine if they conflict with agency policy

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A social worker learns that a client has been involuntarily committed to a psychiatric hospital after being brought to an emergency room by the police due to an injury resulting from an altercation with another person. Based on these actions, which of the following can be assumed by the social worker?

- A. The incident was caused by the client's aggression
- B. The client is a danger to self or others
- C. Hospitalization is likely to be lengthy given the severity of the client's mental and physical problems

- 112.** A child welfare social worker must visit the home of a Hmong family who emigrated from Laos to the United States in the past 2 years. The allegation involves neglect by the parents toward their five children, aged 2 months through 16 years, and there is a concern about the family's 16-year-old daughter who is pregnant. When the social worker arrives at the home, he finds little food in the cupboards. The parents state everything is fine, but the older daughter must find another place to live. In order to appropriately address the situation, the social worker should **FIRST**:

- A. Identify resources to get food for the family to address malnutrition
- B. Investigate whether the children have experienced physical or sexual abuse
- C. Inquire how the members of the family care for one another according to customs and traditions

**113.** Which of the following is the **MOST** important reason that social workers should be educated about sexuality and sexual health?

- A. Clients may be reluctant to talk about sexual intimacy due to their traditions and customs
- B. Sexual health impacts emotional, social, and physical well-being
- C. Sexual orientation can be the root cause of family problems and discriminatory practices

**114.** Which of the following is the **MOST** critical threat to efficacy when social workers in agency settings consistently serve clients with the same identified problems?

- A. New evidence-based practices to treat client problems will not be identified
- B. Differences in client circumstances that impact assessment and treatment will not be considered
- C. Social work burnout is more likely to occur due to repeatedly listening to the same client problems

**115.** A social worker is meeting with a new client for the first time who reports having erectile dysfunction in the last 6 months. Recently, he has been fighting with his wife constantly and is worried that they will soon separate. The client reports feelings of self-doubt and rejection which have caused him to feel inadequate. In this situation, the social worker should **FIRST**:

- A. Recommend that the client see a specialist who treats sexual dysfunction
- B. Refer him to his primary care physician for medical screening and treatment

473 Refer him to his primary care physician for medical screening

**C.**Determine whether the problems with erectile dysfunction are caused by marital problems

- 116.** The **MOST** important reason that a social worker documents as a critical component of practice is to:
- A.** Allow both client and social worker to track progress and use data in treatment decision-making
  - B.** Protect the social worker and agency from malpractice claims that are unfounded
  - C.** Memorialize the services provided for future reference in case the problem re-emerges
- 117.** A social worker learns that “in vivo supervision” will be provided in his new employment. Which of the following **BEST** describes the nature of this supervision type?
- A.** The supervisor is in the room with the social worker and client to be available for consultation
  - B.** Taped sessions between a social worker and client are listened to during supervision for feedback
  - C.** The social worker is observed by the supervisor behind a one-way mirror to ensure appropriate care
- 118.** Which of the following is the **MOST** significant limitation of using process recordings as the basis of social work supervision?
- A.** Information on the client is confidential so additional consent needs to be obtained
  - B.** Process recordings depend upon social workers accurately observing interactions and occurrences
  - C.** Social workers are not able to ask supervisors questions about clinical treatment in real time
- 119.** A social worker has decided to co-facilitate a group with another mental health professional. Which of the following would be **MOST** critical to ensuring the efficacy of this approach?
- A.** The two facilitators are recognized by group participants as having equal responsibility for change

- B. The two facilitators spend time outside of the group to coordinate and process group activities
- C. The two facilitators agree to use the same therapeutic techniques when working with clients

**120.** A social worker is hired by an agency to address problems with the burnout of their direct care staff. The social worker learns that these employees, consisting mostly of people of color, often have several jobs given their low pay and feel stressed as they do not have enough administrative support. Their morale is low and impacts on client care. Using a social justice approach, which of the following actions should the social worker recommend?

- 474 Enhancing the organizational structure so that these
- A. employees have more administrative support
  - B. Raising compensation for these employees so they can reduce their work hours to make a living wage
  - C. Implementing training initiatives to enhance the morale and reduce stress of these employees

**121.** A client comes to a social worker as she is having difficulty juggling multiple demands and is consistently missing deadlines. The social worker and client determine the need for better time management strategies. In order to develop an effective treatment plan, the social worker will need to **FIRST**:

- A. Understand the psychological reasons that the client has not budgeted her time appropriately
- B. Help the client understand that there is only so much that can be accomplished in a single day
- C. Determine client responsibilities according to their level of importance so they can be prioritized

**122.** For which of the following diagnoses is a total lack of motivation a common characteristic?

- A. Schizophrenia
- B. Trichotillomania
- C. Borderline personality disorder

**123.** A school social worker is asked to join an administrative committee as there is a desire to update forms that ask about student gender. The administrator recognizes that the way that gender is currently assessed on the forms may not include those with all types of identities. The goal is to have these forms ready for students to fill out in the upcoming school year. Which of the following will be **MOST** important for the social worker to help the group understand when revising the forms?

- A. Gender identity is a very difficult construct to assess using forms
- B. Some youth may not be familiar with the terms used on the forms
- C. Youth who are gender nonconforming are often stigmatized, bullied, and discriminated against

**124.** A social worker agrees to work with a client using a qualified interpreter as the social worker and client do not speak the same language. During the first meeting, the client is very upset by the recent death of her father and cries throughout the interview. During the initial session, the social worker should **FIRST**:

- A. Work with the client to understand the roles of the social worker and interpreter in the helping process
- B. Review confidentiality standards so the client feels comfortable speaking openly with the interpreter
- C. Ask about the cultural practices and mourning rituals of the client's family

**475**

Which type of medication include benzodiazepines?

**125.**

- A. Antianxiety agents
- B. Antidepressants
- C. Antipsychotic drugs

**126.** A school social worker learns that a client has been diagnosed with attention-deficit/hyperactivity disorder. Which of the following medications is the client **MOST** likely to be prescribed?

- A. Stimulant

- B. Mood stabilizer
- C. Antianxiety

- 127.** A client comes to a social worker for therapy due to the negative impacts of a recent divorce on his well-being. During the initial meeting, the client talks about lots of ways that the social worker can assist him. The client is committed to getting services for “as long as it takes.” Which of the following will be **MOST** important for the social worker to review during the session?
- A. Confidentiality and its limits
  - B. Parameters of the helping process
  - C. Expected length of service
- 128.** During a meeting with a client, a social worker reflects on the feelings and meaning of what the client states rather than the actual spoken words. In this technique, which of the following is the focus of the social worker’s communication?
- A. Summarization
  - B. Clarification
  - C. Latent content
- 129.** Which one of the following phases in the problem-solving process is **MOST** influenced by case formulation?
- A. Planning
  - B. Engagement
  - C. Intervention
- 130.** A social worker fears that an elderly client is being abused as the client has had unexplained bruising in recent months. Which of the following factors places the client at the **MOST** risk?
- A. The client has a degenerative condition that is progressively impairing cognition and mobility
  - B. The client has a home caregiver with substance use and/or mental health problems
  - C. The client has experienced social isolation in recent months due

to the loss of several close friends

476      Which of the following therapies often uses prolonged  
**131.**      exposure to treat posttraumatic stress disorder?

- A. Cognitive behavioral therapy
- B. Existential therapy
- C. Psychoanalytic therapy

**132.** A social worker in private practice learns that he has cancer that will require aggressive treatment in the coming weeks. The social worker plans to continue to work during his radiation and chemotherapy but will not be accepting any new clients. In order to address this situation ethically, the social worker should:

- A. Educate clients about his medical diagnosis and the effects of treatment so they know what to expect
- B. Continue to provide services without disclosing his health status since it will not impact services
- C. Speak with his clients about their available treatment options given his medical condition

**133.** According to standards of competence, which of the following must occur for a social worker to possess cultural awareness and humility?

- A. Ensuring that client assessment forms include questions about culture
- B. Engaging in critical self-reflection of personal biases
- C. Committing to lifelong continuing education about cultural differences

**134.** Which of the following is the **BEST** definition of intersectionality related to those served by social workers?

- A. Interconnection of social categorizations that create interdependent systems of client disadvantage
- B. Interrelatedness of micro, mezzo, and major systems that influence clients' current life status
- C. Repeated patterns of client behavior across the lifespan due to

unresolved issues from childhood

**135.** A new social worker lives in a rural community so he is worried that there may be instances in which those he knows in other contexts present themselves as clients. Which of the following will be **MOST** effective in minimizing the impacts of dual relationships?

- A. Prescreening clients to ensure that they are not known to the social worker before the onset of services
- B. Ensuring that clients are aware during engagement that dual relationships are forbidden in social work practice
- C. Reviewing confidentiality mandates and client-social worker roles throughout the problem-solving process

**136.** A client who has been institutionalized for a long time would like to move to supportive housing. The parents, who are his legal guardians, are hesitant, but want the client to be happy. All <sup>477</sup> agree that finding housing near the parents would be optimal. In order to determine the ability to honor the client's request at this time, the social worker should **FIRST**:

- A. Meet with the client to determine his preferences for housing types and supports
- B. Identify the intensity and scope of the client's service needs
- C. Discuss with the parents any concerns that they may have about the client moving

**137.** A social worker is charged with designing and implementing a parent education program for those who have recently left welfare and are returning back to work. Which of the following delivery methods will likely be **MOST** effective for learning?

- A. Short videos to be accessed via social media
- B. Individual lectures with opportunities for question and answer
- C. Interactive educational exercises with group discussion

**138.** A social worker in private practice receives a subpoena for records of a client who left services over a month ago. The social

worker has had no contact with the client since termination. In order to handle this situation appropriately, the social worker should **FIRST**:

- A. Send a letter stating that the client is no longer receiving services
- B. Seek legal counsel to determine whether disclosure is required
- C. Contact the client to discuss authorization to release the requested information

**139.** When engaging in structural family therapy, which of the following is **MOST** important for a social worker to remember to assist families in making changes?

- A. Families often need social workers to assume an authoritarian role to make needed changes
- B. Reinforcement of positive interactions leads to better role definitions within families
- C. Not all family interactions are easily amenable to change so treatment may need to be long term

**140.** A social worker learns that a client is prescribed disulfiram (Antabuse). Based on this prescription, which of the following is **MOST** likely the client's diagnosis?

- A. Alcohol use disorder
- B. Bipolar disorder
- C. Major depressive disorder

**141.** During a session with a client, a social worker asks the client how life would be different if the problem did not exist. In what part of the problem-solving process will the response be **MOST** helpful?

- A. Planning
- B. Intervention
- C. Assessment

1478

4

2.

A social worker is interested in examining why some youth leaving the detention center never reoffend despite extreme adversity. The social worker is in contact with many former clients and has obtained authorization to engage in a research study. Which of the following data collection techniques will be **MOST** effective?

- A. Focus groups with those who have not reoffended
- B. Surveys of those who have reoffended and not reoffended
- C. Semi-structured interviews with those who have not reoffended

**143.** A social worker is conducting an evaluation to assess the effectiveness of an agency intervention. The social worker collects baseline data and then randomly assigns clients to a group which receives the service and one that does not. After several weeks, the social work readministers the same assessment. Which of the following types of evaluation designs is the social worker employing?

- A. Quasi-experimental
- B. Cohort
- C. Experimental

**144.** A social worker gets a referral for a client with schizoid personality disorder. Based on this diagnosis, which of the following symptoms can the social worker expect the client to exhibit?

- A. Resentfulness that results in explosive anger
- B. Lack guilt over harm to others
- C. Limited emotional expression

**145.** A social worker in private practice has started a website for the general public that provides useful suggested strategies for addressing mental health issues such as anxiety, depression, and fear. Which of the following issues is **MOST** important to consider when the social worker provides this information?

- A. Dual relationships will likely emerge because some of the people who read the site may be people that the social worker knows
- B. The social worker is not a specialist in all these areas so the information may not be up-to-date and current

C. Readers may take this information as treatment recommendations without proper assessment of their individual problems

- 146.** A social worker believes that those with mental health diagnoses are more likely to be justice involved. Representative data obtained by the social worker confirms a correlation, so the social worker concludes that mental health conditions cause justice involvement. Which is the **MOST** significant threat to internal validity with regard to reaching this conclusion?
- A. Other variables that explain both having mental health diagnoses and being justice involved need to be eliminated
  - B. The types of client mental health diagnoses have to be identified and controlled
  - C. The hypothesis needs to be tested on a larger and more diverse group of clients with varied mental health conditions

**1479**

**4**  
**7.**

A social worker recommends that a 19-year-old client play a high-action simulated martial arts video game that he likes to release aggression and tension. Which of the following psychological concepts is this recommendation based?

- A. Catharsis
- B. Harm reduction
- C. Transference

- 148.** A social worker receives a doctorate in literature (PhD) after receiving her social work degree. On her social work business cards, she lists her social work degree and license, as well as uses the title “Dr.” in front of her name. According to ethical standards, which **BEST** describes the actions of the social worker?

- A. Unethical as clients are likely to assume that her doctorate is in social work
- B. Ethical as she has not listed the literature degree, but only used

the appropriate title

- C. Ethical as she has earned all of the degrees listed on her business card

**149.** A social worker notices a change in the appearance of a client with dementia who lives alone. The client appears dirty and unshaven but is evasive when asked about his daily hygiene routine. Which of the following is **MOST** likely the reason for his appearance?

- A. Physical abuse  
B. Exploitation  
C. Self-neglect

**150.** A client, who is a mother, tells a social worker that she is concerned as her 5-year-old son exposed himself while on the bus going to school. He also was pretending that his penis was a gun while playing with his siblings at home. In order to **BEST** assist, the social worker should:

- A. Inform the mother that many children exhibit similar behavior  
B. Identify the contexts in which these incidents with the child occurred  
C. Explain the psychosexual stages of child development to the mother

**151.** Which of the following parenting styles is the **BEST** predictor of positive outcomes for children?

- A. Permissive  
B. Authoritative  
C. Authoritarian

**152.** A social worker in a community housing agency is working with a client who has an ongoing dispute with a landlord. The dispute is focused on the client's responsibility to pay the rent during extensive renovations to the apartment building. The client and landlord agree to have the matter handled by an appointee of the

court who will make a binding determination. Which legal process is being used to resolve this issue?

- A. Pretrial intervention
- B. Mediation
- C. Arbitration

1480

5  
3.

A social worker is working with a couple that is in the process of a high conflict divorce. When intervening with the couple, which of the following roles will the social worker **MOST** likely assume?

- A. Broker
- B. Resource allocator
- C. Mediator

154. An oncology social worker finds that family members often have a lot of anger and fear related to client's cancer diagnoses. The social worker decides to start a group for family members to attend. Based on the social worker's assessment of need, which of the following will **MOST** likely be the focus of the group's goals?

- A. Education
- B. Socialization
- C. Emotional support

155. A school social worker is providing an educational workshop for teachers in the school. One of the teachers expresses frustration as students often challenge rules, questioning "what is in it for them." They report that students seem to respond well to rewards for good behavior but fail to recognize that good behavior is needed to have a productive learning environment. Which of the following levels of moral development should the social worker discuss to help the teacher understand student behavior?

- A. Postconventional
- B. Conventional

### C. Preconventional

- 156.** A client comes to a social worker after the death of his wife of 32 years. Despite the social worker asking about his present coping, the client continues to speak about events that happened in the past. The social worker gets frustrated and annoyed. To address this situation, the social worker should:
- A. Remind the client about the importance of speaking about his current feelings
  - B. Acknowledge that discussing past recollections must be important to the client in some way
  - C. Facilitate discussions about the past so the social worker can learn more about the wife
- 157.** When making which of the following decisions would analyses on cost-effectiveness of interventions be **MOST** important?
- A. Deciding the target populations to receive target treatments
  - B. Selecting between comparable treatment alternatives
  - C. Identifying funding needed to appropriately provide required treatments
- 158.** The **MOST** important aim of enactments in structural family therapy is to:
- A. Root the change effort in the relationships between family members
  - <sup>481</sup>Help engage family members in the problem-solving process
  - B.
  - C. Assist family members with practicing learned skills prior to termination
- 159.** Which of the following is the **MOST** significant limitation of using results from a single subject design to inform social work practice?
- A. External validity
  - B. Internal validity
  - C. Instrumentation

**160.** A social worker in an agency learns of a breach of confidential information related to a client. The social worker reports the issue to a supervisor who is not a social worker. In order to address the issue ethically, the social worker should **NEXT**:

- A. Discuss the issue with a clinical social work supervisor to determine an appropriate course of action
- B. Notify the client about the nature and extent of the confidential information released
- C. Seek legal consultation which may involve notifying the social worker's malpractice insurance carrier

**161.** During an initial meeting with a client who has suffered traumatic loss, a social worker states to the client, "I have hope that you will find some peace over time that will replace some of the pain that you are currently feeling." The social worker is **MOST** likely making this statement to:

- A. Help motivate the client to continue services in the future
- B. Build the therapeutic alliance between the client and social worker
- C. Suggest that the client can have better life quality than is experienced now

**162.** A social worker is receiving clinical supervision from a supervisor in another division of an agency serving clients who have criminal justice involvement. The social worker asks the supervisor to assist with helping locate resources for a client who is moving into a new apartment. During a supervision session, the clinical supervisor mentions that she researched the past criminal history of the client and wants to discuss it so the social worker can better understand the client's situation. In this situation, the social worker should:

- A. Listen attentively so that the information can be used in care planning
- B. Inform the supervisor that client consent should have been obtained to access this information
- C. Ask the supervisor how this history impacts the client's upcoming

move

**163.** Before social workers disclose information about their own lives to clients, which of the following questions is **MOST** important to ask themselves?

- A. "How much personal information should be revealed without crossing boundaries?"
- B. "Whose needs are being met by the personal disclosure?"
- C. "Is the treatment being provided different from that provided to others in any other way?"

1482

6

4.

A social worker in an agency feels remorse because she witnessed and failed to intervene when witnessing behavior that caused moral injury to a client. Which of the following will likely be **MOST** effective in helping the social worker address the feelings?

- A. In-depth supervision provided to the social worker to address ethical responsibilities to clients
- B. A real or imagined apology by the social worker to the client for the act of omission
- C. Reparation by the agency to compensate the client for any trauma caused by the incident

**165.** A social worker is working with a pregnant client who is actively using opioids. The client is very worried about the health of her baby and has decided that she would like to stop using these drugs. In order to assist the client, the social worker should

**FIRST:**

- A. Identify a medication assisted treatment provider for the client
- B. Recommend that the client withdraw or abstain from opioids as soon as possible
- C. Refer the client to a physician knowledgeable about perinatal addiction

**166.** When conducting a mental status exam, which of the following statements **BEST** describes the extent to which a client's cultural background should be considered?

- A. The social worker should determine a client's cultural identity when making all assessments
- B. The role of culture should not be considered to ensure consistent assessment across diverse groups
- C. The influences of a client's cultural identity on all behaviors and thought patterns must be considered

**167.** In social work practice, which of the following is associated with strong ego strength in clients?

- A. Fantasies
- B. Wishful thinking
- C. Emotional regulation

**168.** A social worker gets a referral for a 20-year-old college student who deliberately engaged in social isolation due to beliefs that others are "out to get him." After the behavior persists for three weeks, the client is prescribed antipsychotic medication and appears to be functioning typically. Which of the following is the **BEST** diagnosis for this client?

- A. Brief psychotic disorder
- B. Schizophreniform disorder
- C. Schizophrenia

**169.** A social worker discovers a breach of client confidentiality has occurred. Which of the following will be **MOST** helpful in guiding the social worker's actions?

- A. Review of ethical and legal standards on confidentiality breaches  
483 Conversations with the client involved in the situation
- B.
- C. Consultation with a supervisor

**170.** A social worker is working in a community that has been

marginalized. The social worker finds that members of the community have absorbed negative messages that limit their views about their ability to achieve. Which of the following **BEST** defines these internalized oppressive thoughts?

- A. Direct power blocks
- B. Indirect power blocks
- C. Magical thinking

# Full-Length Practice Test Answers

449

- 1. B.** Family courts increasingly order psychotherapy to resolve issues of alienation and estrangement between parents and children. Reunification therapy is a clinical intervention intended to unite estranged children and parents. There are many considerations when doing this type of treatment. The safety of children should be paramount as a lack of understanding about whether reunification is warranted may result in harm. All of the incorrect response choices should be considered, but children's needs are most important.

## Question Assesses

Psychotherapy, Clinical Interventions, and Case Management

- 2. B.** Several theories have been proposed as to why adolescents engage in risky behaviors. One theory stresses the need for excitement, fun, and novel, intense sensations that override the potential dangers involved in a particular activity. Another theory stresses that many of these risk behaviors occur in a group context and involve peer acceptance and status in the group. A third theory emphasizes that adolescent risk taking is a form of modeling and romanticizing adult behavior. In other words, adolescents engage in some behaviors to identify with their parents and other adults. Larger social networks does not place a youth at greater risk. Also, risk-taking behavior occurs outside of relationships so romanticization of harmful behaviors is also not the greatest risk.

## **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 3. A.** Diagnoses of acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) are based on a history of exposure to severely frightening and horrifying trauma followed by reexperiencing, emotional numbing, and hyperarousal. These symptoms must be severe enough to cause impairment or distress. Symptoms lasting  $\geq 3$  days and  $< 1$  month are considered ASD. Symptoms lasting  $> 1$  month are considered PTSD, which can be a continuation of ASD or may manifest up to 6 months after the trauma. Inability to function after exposure to trauma does not equate to poor coping skills. Also, there is no indication that the memories of the event are repressed or forgotten, only that they are no longer negative or troubling.

## **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 4. A.** There are key foci in adolescence— independence, self-image, and peer relationships. Identity is also critical. The move for independence creates the largest amount of distress for parents. Early adolescents begin to pull away from their parents and show less interest in family activities. Adolescents become aware of their physical development. Most early adolescents are not sure initially what to think of the changes in their body and accompanying hygienic responsibilities. They become more comfortable by the end of adolescence. Peers become extremely important. As children pull away from their family, early adolescents are not strong enough to stand on their own and they turn to their peers for guidance and support.

Recognizing the complexity in intimate relationships usually does not occur until early adulthood—Erikson's next psychosocial stage (intimacy vs. isolation) and movement from

egocentric to altruistic is most closely related to Erikson's stage of generativity versus stagnation.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 5. A.** Social workers use a person-in-environment perspective and recognize the importance of the external environment or context. Thus, social workers should guard against viewing resilience from an individual framework. Instead, resilience should be seen as a function of developmental experiences that are grounded in a community context. Whether a community is able to offer the relationships, resources, and commitment needed to provide the kinds of supports and developmental experiences that produce resilient youth depends on many factors, but primary is whether the needs of youth are given priority by all those which interact with these adolescents.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 6. B.** Persistent depressive disorder (PDD), a psychiatric disorder, was originally known as dysthymia and chronic major depression. PDD involves fewer symptoms but they last longer, at least 2 years. Major depressive disorder (MDD) can be diagnosed if symptoms last for 2 weeks. Both mood disorders are serious. Sometimes PDD can be more disruptive, even with fewer symptoms. Those with PDD have at least two of the following symptoms, along with a depressed mood: loss of appetite or overeating; problems sleeping; low energy or tiredness; low self-esteem; difficulty concentrating or making decisions; or feelings of hopelessness. The symptoms will persist for at least 2 years without much relief.

Those with MDD will have more symptoms, at least five of the following: depressed mood; loss of interest or pleasure in many or all activities; sleep problems; noticeable weight loss or gain; faster or slower movements that others notice; tiredness or low energy; problems thinking or making decisions; thoughts of guilt or worthlessness; or repeated thoughts of death or suicide, or a suicide attempt. They will last at least 2 weeks. Some are like dysthymia symptoms. But they may be worse. There is no indication that the client has low self-esteem.

- 7. C.** A school social worker has a unique role in most schools and may encounter issues that are not explicit in the policies and procedures of the school. Obtaining a copy of policies and procedures does not mean that they were read by the social worker. The supervisor of the social worker may not be another social worker and can be unfamiliar with the ethical/legal issues in the profession. Arranging a meeting with a supervisor also does not mean that it has already occurred. Social workers should be well versed in confidentiality laws within their states or jurisdictions as they are not consistent.

### **Question Assesses**

#### Professional Values and Ethics

- 8. B.** The duration of symptoms is what differentiates schizophreniform disorder from schizophrenia. Schizophreniform disorder symptoms last no longer than 6 months, while schizophrenia is a lifelong condition. If the symptoms do not improve, the diagnosis is schizophrenia, which is a lifelong illness. Most individuals with schizophreniform disorder are eventually diagnosed with schizophrenia.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 9.**

**A.** Critical race theory posits that racism should not be viewed as an individual issue, but rather that it is a willful, institutionalized, and dehumanizing system that is systemically memorialized in policies and systems. Thus, modern business management practices employed by corporations and nonprofits—creating middle managers, performance management, productivity analysis, and workforce planning—can all be traced back to the management of plantation slavery. The incorrect response choices focus on individual barriers and issues, but the correct one transcends the professional relationship between social worker and employee. Supervisors should also ensure that the organizational policies are audited and understood within an antiracist lens. Racism occurs on and is perpetuated by mezzo and macro levels and systems, respectively, so it is MOST important for the supervisor to remember this important principle.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**10. C.** Social workers cannot communicate with one partner in a couple as this creates a power dynamic within the therapeutic relationship. If one partner translates for another, the social worker gets information secondhand and is not able to hear concerns of both partners directly. Social workers can accept clients who speak other languages and do not have to refuse referrals of these clients as long as qualified interpreters are employed.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**11. A.** The question contains a qualifying word—NEXT, indicating that the order in which the responses occur is critical. There is

also no mention of school performance being an issue for any of the children, besides truancy of the son, so requesting school records is not needed. Assessment comes after engagement and identifying and exploring are both assessment tasks. The question mentions the son's behavior as just one indication of problems with family roles. The other children rarely speak and comfort the mother who appears emotionally dependent. The only response choice that mentions family roles is the correct one as it is important to understand the expectations in order to see if there are distorted views. Exploring the impact of the son's behavior may be more relevant once it is understood in light of perception about his place within the family structure.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 12. B.** A critical service component is helping clients understand their problems. Understanding diagnoses can help clients realize the pathology or causes of their behaviors and feelings, as well as learn about treatment options and prognoses. Social workers should not only discuss diagnoses with clients who ask as clients may not understand their ability to inquire and will, therefore, not have the benefit of learning about the causes of their problems. Clients should always be fully informed of the names of and rationales for their clinical diagnoses, but not when knowing could cause harm. Social workers should always adhere to the social work ethic of "do no harm."

### **Question Assesses**

Professional Values and Ethics

- 13. B.** The question has a qualifying word—FIRST, meaning that the order of the response choices is critical. Speaking to the client about the impacts of not taking the medication and suggesting a different medication will likely not be salient

reasons for the client to resume medication compliance and certainly are not initial responses. Central to getting the client to take his medication in the future is understanding the cause of his resistance so that any barriers or challenges can be addressed and removed.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**14. B.** Mind-body connection is the belief that the causes, development and outcomes of a physical illness are determined from the interaction of psychological, social factors and biological factors. The impact of one system on another is BEST supported by systems theory. Person-in-environment theory is focused on the impacts of the environment on behavior which does not directly speak to the mind-body connection. Psychodynamic theory explores deeply rooted drives, needs and desires as behavior is thought to be explained by intrapsychic processes and interpersonal patterns outside conscious awareness and based on childhood experiences.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

**15. B.** All of the response choices focus on compensation linked to staff recruitment and/or retention, but only the correct answer increases pay due to desired performance (accepting more referrals). A performance-based incentive plan clearly identifies objectives and rewards staff financially for reaching these performance indicators. There is no guarantee that compensation focused on recruitment and/or retention will actually “result in reducing client vacancies,” which is the goal, without linking compensation to performance. The pay may not be low for new employees but may cause turnover as employees leave when they get experience.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 16. C.** The question specifically mentions that the client is the only female in her computer programming courses. She also makes a comment in the first sentence about the field not having “a future” for her. Persistent messages about gender roles are critical during adolescence. The correct answer assists the client to expand her perception of who can be computer programmers.

The client may not even realize that her lack of motivation is linked to gender stereotyping so exploring it will not be MOST helpful. The problem in the question is rooted in her views about computer programmers so college identification is not relevant. Helping the client to see women who are working as computer programmers is essential for the client to see herself in one of these positions in the future.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 17. B.** Tokenization is the practice of making only a symbolic effort to do a particular thing, especially by recruiting a small number of people from underrepresented groups in order to give the appearance of racial equality within a workforce. Not including managers of color in decision-making is systematic discrimination, but the question asked specifically about the “hiring actions.” The hiring actions are BEST described as tokenization as they symbolic rather than represent true diversity in practices. Bigotry is having or expressing strong, unreasonable beliefs and disliking other people who have different beliefs or a different way of life.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

**18. B.** A person who is “gender fluid” is flexible in regard to gender identification. Gender can be seen as non-binary, meaning that not all fit squarely into either traditional male or female categories. Being gender fluid means not having a fixed gender or place on the gender spectrum. The term is an acknowledgment that there is a spectrum, and that gender is not binary. Gender can change over time or depending on the situation.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**19. B.** Cyclothymic disorder is a chronic, fluctuating mood disturbance characterized by hypomanic and depressive symptoms that are distinct from one another. The hypomanic and depressive symptoms are insufficient in number, severity, pervasiveness, or duration to meet the full criteria for a hypomanic or depressive episode. The current functioning of a client with cyclothymic and bipolar I disorders may be comparable, depending on the efficacy of psychopharmacological treatment.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**20. A.** When the age of the client is mentioned in a question, it is relevant. The initial sentence in the question states that the girl is 14 years old, and the service is for adult women. The shelter is not authorized to provide services and/or guardian permission is needed. There is no information in the question that indicates that the girl is legally emancipated from her parents. Since the girl has no contact with them, parental permission will be impossible. Even if the agency director says that she can be served, it is not allowed. Thus, completing an intake assessment

is not appropriate since the shelter is not a viable service provider. The social work needs to work with the girl to contact the child protection agency as they will be the ones to thoroughly assess the situation and get her any services needed.

### ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

- 21. B.** Disruptive mood dysregulation disorder (DMDD) is a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts. The symptomology and chronicity of symptoms in the question are appropriate. However, the onset of symptoms must be before age 10, and a DMDD diagnosis should not be made for the first time before age 6 or after age 18.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 22. B.** The report by the client is provided during the first meeting with a social worker. The client's account may be accurate or an indication of delusional thinking. There is not enough information to make an accurate assessment so the response choices are all assessment tasks. Determining whether the client's feelings stem from paranoia and the nature of the incidents is important but cannot be understood without knowing more about the client's current functioning and history. Completing a biopsychosocial evaluation will provide the context needed to address the client's concerns appropriately, so it needs to occur before the other actions.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

**23. C.** States or jurisdictions have the authority to regulate their professionals. Social workers cannot practice in a state without appropriate authority, even if it is done via electronic methods. There is no uniform reciprocity between states and jurisdictions. All states have regulations that govern practice—including the provision of services using technology. The social worker will need a regular or telehealth license in the state in which the client is attending college if the type of service is regulated.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

**24. B.** Stress can become toxic over time, affecting the way brains and bodies grow. It can increase a person's risk of developing high blood pressure, elevating levels of inflammation that can damage the arteries. These conditions can lead to heart disease, stroke, and other serious health issues. Toxic stress can make it harder for bodies to fight off infection and illness. While toxic stress usually involves prolonged activation of the stress response, an individual can have chronic stress that is not toxic. Additionally, people can cope with events that are very stressful but not experience toxic stress.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**25. C.** Naloxone is a life-saving medication used to rapidly reverse opioid overdoses and can be given by intranasal spray (into the nose), intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. Social workers should be trained to administer naloxone as they often work with those at risk of overdose. The question contains a qualifying word—NEXT. Since the social worker has already contacted the authorities, the medication should be administered as it can help save the

client's life. The other response choices are not correct as they do not address safety and can be done later, if appropriate.

### ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

- 26. C.** Program design is a description of the proposed intervention. It addresses process and outcome objectives, timelines, plans for collaboration, evaluation methods, and staffing needs. Planning is driven by assessment findings so the needs assessment will be critical to program design. A needs assessment is an appraisal to determine what services are lacking. It provides information required to prioritize goals. If it is not central to program design, new services may be ineffective.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 27. A.** The question indicates that the client's depression, anxiety, and isolation are rooted in housing instability. The social worker can BEST assist by helping the client get stable housing. As the client is financially unsecure, there is the possibility of means-tested assistance, but it will require producing fiscal records and asset verification. This goal should be primary. The client's emotional state is situational according to the question so should not be a primary focus as it will improve once stable housing is secured. The question does not mention that another job is desired or even realistic, so a job search is not advisable.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 28. C.** Those with antisocial personality disorder do not have difficulty starting tasks or working independently and have a

sense of superiority. They have deeply ingrained, and rigid dysfunctional thought process focused on social irresponsibility with exploitive, delinquent, and criminal behavior with no remorse.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 29. A.** Teletherapy often allows social workers to be able to observe clients in their “natural” environments. The ability to visualize the context in which clients live and/or work is very helpful in understanding their life situations. Social workers should never ignore client behaviors as the distraction is presented in the question as a potential barrier to treatment and perhaps resulting from concerns about what is happening in her surroundings. If the client had a more private location and desired to use it, the client would not be seeing the social worker with the described distractions. The client may want the social worker to directly observe her home life or has no private space. Thus, requesting the client to find a private place is not BEST. The client’s presenting problem and the need for coping skills are unknown so suggesting ways to deal with stressors may not be appropriate. Acknowledging the distractions and helping the client to understand their impact are essential as the social worker has valuable information about the family unit and living arrangement which should be incorporated into the helping process.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 30. B.** Epidemiology is the study of how often diseases occur in different groups of people and why. Epidemiological information is used to plan and evaluate strategies to prevent illness and as a guide to the management of patients in whom disease has already developed. Experimental research is a study that strictly

adheres to a scientific research design as it focuses on explanation or cause/effect.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 31.** **A.** The social worker has to determine the daily mental status of those with psychotic disorders. It will likely not be possible to identify delusional or hallucinating clients by observing them as their thought processes will be unknown. Self-reporting has poor validity as clients may not disclose, or even recognize, their symptoms. The best method of data collection is interviewing clients.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 32.** **A.** The question provides information about the difficulty that the client is having—expressing her emotions and interests—as well as the reason that the problem exists—her rape as a child. The goal is also stated as her desire to have more friends. All the response choices are important, but the question asks for what would be BEST when assisting the client. There is no mention that she does not understand the impacts of her past trauma. The issue is not that she does not meet others socially but she has difficulty with others getting to know her and expressing her emotions so modeling social interactions would be helpful in shaping the desired behaviors.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 33.** **A.** Self-determination, the right to make one's own decisions and be treated with respect, is at the heart of both social work and motivational interviewing. Motivational interviewing

addresses ambivalence, which needs to be resolved for behavior change to occur. It also focuses in on and amplifies change talk to take the focus away from the areas where a person is arguing to stay the same. Thus, it helps clients make different decisions in their lives which is linked to freedom to choose.

### ***Question Assesses***

Professional Values and Ethics

- 34. B.** A mobilizer identifies and convenes community members and resources and makes them responsive to unmet community needs. According to the question, there is a need to drive change within the community and bring citizens together to engage in planning. In an advocacy role, social workers fight for the rights of others, especially those who are marginalized and oppressed—which was not mentioned in the question. Brokering is the process of making referrals to link clients to needed resources. Again, this question does not concern existing service delivery.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 35. C.** The racial diversity within the organization is quite good, indicating that recruitment efforts are sufficient. There is no indication that people of color are not seeking management positions or want promotion. It is likely that there is institutional racism in the policies and practices of the organization that have been perpetuated over time.

### ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

**36. B.** The behavioral symptoms of autism spectrum disorder (ASD) often appear early in development. Many children show symptoms of autism by 12 months to 18 months of age or earlier. While some are diagnosed later, these diagnoses are delayed because parents or providers may ignore the early symptoms. Research shows that early detection and early intervention greatly improve outcomes, so it is important to look for these symptoms when a child is as young as possible. This question asks for the answer to be “based on the onset of symptoms” that are present in early childhood.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

**37. A.** The question states that the managed care company is asking for information “to support the assessment.” The company is questioning its accuracy or validity. The records requested focus on the assessment, not treatment planning or intervention. The prognosis for treatment is unknown at this time. Managed care companies are always concerned with cost. However, the question does not mention cost and cost cannot be determined simply by a client’s diagnosis.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

**38. A.** Obsessive-compulsive disorder (OCD) does not damage personal relationships. Obsessive-compulsive personality disorder (OCPD) drastically impacts interpersonal relationships, to their detriment so examination of personal relationships would be helpful. Clients with both diagnoses will be distressed as these disorders interfere with a person’s thoughts, feelings, and/or actions so this symptom is not helpful when making a differential diagnosis. Past treatment history is not relevant to distinguishing between these disorders.

## **Question Assesses**

### Assessment, Diagnosis, and Treatment Planning

**39. B.** The question describes the presence of auditory hallucinations as he believes that someone is speaking “to him through the device.” Additionally, he appears paranoid about being robbed, believing that others are spying on him. The question has a qualifying word—FIRST—which indicates that the order is important. Assuring the client that he is not in danger will be ineffective as he believes that he is, and the social worker has no additional information to alleviate his fears. The client may be delusional or hallucinating so determining the presence of psychosis is an important first step. Often psychotic disorders, such as schizophrenia, emerge in early adulthood which is why the age of the client was included in the question. The presence or absence of past similar experiences does not impact the client’s current beliefs that are the basis of the presenting problem.

## **Question Assesses**

### Assessment, Diagnosis, and Treatment Planning

**40. B.** Answering this question correctly requires knowledge about psychoanalytic theory. Dreams represent wish fulfillment, unconscious desires, and conflicts. Dreams contain both manifest and latent content. Manifest content includes information from the dream as it is remembered. Latent content represents the repressed, symbolic meaning embedded within the dream. During dream analysis, the client shares the manifest content of the dream. After specific symbols are pulled from the manifest content, a social worker utilizes free association to facilitate the exploration of repressed material.

## **Question Assesses**

## Human Development, Diversity, and Behavior in the Environment

**41. A.** Barbiturates were extremely popular to treat seizures, anxiety, and insomnia, but many doctors stopped using them when misuse and overdoses increased over time. However, barbiturates are still being misused today. Barbiturate withdrawal can be very severe or even deadly. The question states that the client is a long-time barbiturate user. Thus, it is critical for the client to go through medical detoxification. During medical detoxification, a client's dosage of barbiturates can be gradually tapered down.

### **Question Assesses**

## Human Development, Diversity, and Behavior in the Environment

**42. C.** The presenting problem in the client's feeling of being alone and hopelessness which would not be addressed by medication assisted treatment intervention. The client may need such medication to assist with the biological aspects of the addiction, but that is not the focus of the question, and the nature of the addicted substances is unknown. Group therapy is helpful, but the question mentions that the client is worried about confidentiality and confidentiality cannot be guaranteed in groups, making group therapy less desirable for this client though it is effective for the problem. The remaining response choice, individual therapy, would be the correct treatment recommendation for this client given the circumstances.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**43. C.** In the United States, there are no federal surrogacy laws so recommending the couple to review them is irrelevant. Though

the United States is one of the few countries to permit commercial surrogacy, the laws vary considerably state to state so helping to educate the couple on the laws that apply to them is important. Some states have comprehensive surrogacy laws, others are completely silent on the subject. While providing reassurance may be helpful, it is not the BEST response as the question states that their nervousness is fueled by their lack of knowledge about the rights of all parties and not knowing the answers to questions asked. Providing reassurance will not give them the information needed to address the root cause of the problem that will be alleviated with more factual information.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 44. A.** The first sentence of the question states that the social worker obtained consent for treatment from the parent. Thus, the girl is under the age of consent for this service in this state/jurisdiction. The age of consent varies across states/jurisdictions and type of treatment. After age 18, youth automatically become adults legally and consent for their own treatment. The parent is the consenting party so has access to the record unless there is some compelling professional reason why such release should not occur. No such reason is stated in the question. Asking the client whether to release the record is incorrect as the client is under the age of consent and not legally able to make that decision. Refusing a copy of the record is also incorrect as the parent is the consenting legal representative.

### **Question Assesses**

Professional Values and Ethics

- 45. B.** Eating with a client or accepting food from a client does not always jeopardize the boundaries associated with professional roles. In this question, there is no mention that the client is confused about the role of the social worker or trying to test

boundaries. Asking the client about the nature of the request may be culturally offensive as it is clear in the question that food is used as a way of connecting with others. The social worker should taste the food as it is central to the client's culture.

### ***Question Assesses***

#### Professional Values and Ethics

- 46. A.** The records should have been disposed of according to the agency policy, but this did not occur. As the social worker has a copy of the assessment, it should be provided to the client, but the client should be aware that it was not appropriately destroyed. Informing the client of the lack of compliance is important as records that are 7 years old may not be available in the future. It would not be appropriate to deny the request as the records are still available. The reason for the request is not required for record release. Clients always are allowed copies of their records unless social workers feel that releasing this information would cause harm, which is not the situation in this question.

### ***Question Assesses***

#### Professional Values and Ethics

- 47. C.** The presenting problem is that the client is missing appointments due to his work schedule and does not have access to remote services. Suggesting that he wait until he has a computer will not provide him with needed services immediately. The employment of the client is critical as it is clear that the client does not have disposable income since he cannot afford a computer. Thus, suggesting possible accommodation by the employer is not likely and may negatively impact on his job as it is assumed that the client would not be cancelling if it were possible to attend. The lack of access to services is critical and this client does not have the same resources as others. Advocacy is the best way to meet the client's needs so that he

can participate remotely like those with more means. None of the other response choices will help with getting him a computer as soon as possible.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 48. B.** Asking clients during the first session to designate which documents can be released to which third parties is not best practice as clients do not get to review the documents and may not be informed of what and when information is being disclosed. The same is true of obtaining consent at intake and yearly thereafter. Having clients look at each document and request separately provides maximum control and decision-making by clients.

### ***Question Assesses***

Professional Values and Ethics

- 49. C.** The question is asking what the social worker should focus on “to help the parents cope with the loss of their child.” Education about the stages of mourning will not facilitate “coping” which is the goal of intervention. The social worker is supposed to help the parents process the loss. Referring the parents to a support group will result in the group being the agent of change—not the social worker.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 50. A.** Bowen referred to general ideas about sibling position in families when developing his family theory. Sibling position in one's family of origin is considered a major determining influence on differentiation of self and on vulnerability to family projection and multigenerational transmission. Functioning given

sibling position strongly influences the probability of becoming emotionally trapped in a family.

This question requires recall of Bowen's work, but the response choices can be narrowed down when realizing that Bowen focused on families and the only response choice that relates to families is the correct answer.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 51. A.** There are many ways of authentically responding, including giving positive feedback, reacting to client comments, and sharing feelings. Although social workers should be accepting of clients, sometimes social workers experience justifiable feelings of frustration, anger, or even hurt due to clients' actions. Social workers should only share these feelings if they can be shared constructively and this sharing benefits clients. Social workers need to ensure that all actions taken are intended to meet the needs of clients and not their own. In the question, the social worker is MOST likely engaging in authentic responding, using sharing to help the client understand the importance of honesty and strengthen the helping relationship. The shared feeling concerns the client lying and is not related to being nonjudgmental and confidentiality. Social workers should never be the support systems of clients. They can be supportive and help clients mobilize their own supports but clients will be dependent upon social workers if they serve as support systems. Thus, sharing feelings to reinforce that the social worker is part of the support system is incorrect.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 52. B.** Word finding, the task requested of the client, is a great method to assess the client's cognitive abilities. Appearance is

directed at examination of apparent age, cleanliness and grooming, hair/clothing style, and so forth. Speech focuses on fluency, tone, volume, and so forth. While the client is asked to name the clothing articles and will be speaking, the focus of the request is to determine how many can be named in the designated time period. The qualifying word—**MOST**—is there to assist with not focusing on the use of speech.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**53. A.** Preconventional morality is the first stage of moral development. At the preconventional level, there is no personal code of morality, and instead moral decisions are shaped by the standards of others, usually adults, and the consequences of following or breaking their rules. At the conventional level, morality is tied to personal and societal relationships. At the postconventional level, morality is defined in terms of more abstract principles and values. There is now a belief that some laws are unjust and should be changed or eliminated.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**54. B.** The client is worried about expenses given her income so the social worker needs to gather data that can assist with developing a fiscal plan. Referring the client is an intervention and not the FIRST action by the social worker as both assessment and planning are needed prior to taking action. Determining the nature of the employment changes may be part of assessment but does not focus on the crux of the problem which is paying monthly bills. Thus, this action can be done after asking the client about her regular bills and expenses, if appropriate.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**55. B.** Concurrent planning is a type of permanency planning in which reunification services are provided at the same time that alternative permanency plans are made for children, in the event that reunification efforts fail. While concurrent planning is not mandated in every jurisdiction, it is allowed and encouraged as a way expedite permanency for children in the child welfare system. In this question, the social worker is making long-term, out-of-home arrangements for the child while simultaneously strengthening the parenting skills and capacity of the parents to increase the likelihood that the child can eventually return home.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

**56. A.** While people handle grief differently, research indicates strategies that assist when speaking with survivors of a death. The client is eager to speak about the child and conversation can provide a much-needed sense of normalcy at a time when life seems anything but normal. An open exchange of firsthand recollections, and their implied or overt expression(s) of why the person mattered, often proves welcome and beneficial to the bereaved and reinforces that the loved one lived a life worth remembering.

In the question, ignoring the desire for the client to speak about the child would not be “starting where the client is.” Simply being sympathetic does not help to reengage the client. The client may be coming to the social worker as the client needs someone to be able to speak to about the child. Sometimes friends and family members are reluctant to mention the individual who has died for fear of triggering grief responses.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**57. B.** Social workers who have direct knowledge of a colleague's impairment due to personal problems or psychosocial distress should consult with the colleague when feasible and assist the colleague in taking remedial action. Thus, reporting the concerns to a supervisor would not be done FIRST. Also, documenting does not allow for immediate action to address the negative consequences to client services. The question mentions that the colleague is unaware of the impact of the grief so speaking to the colleague directly is needed.

### ***Question Assesses***

#### Professional Values and Ethics

**58. B.** The question describes the client as being isolated, having poor self-esteem, and enjoying few social relationships within the context of school bullying. The behaviors and feelings of the client are not the root cause of the problem. The problem lies in the fear and discrimination against those who are transgender. The lack of social and coping skills is not a cause, though having them is a need of the client. The client is likely experiencing psychosocial stress but it is also an effect rather than a cause. The bullying and lack of friendships that are causing isolation and poor self-esteem result from fear and discrimination by others. This fear and discrimination are why strong protections and policies need to be in place.

### ***Question Assesses***

#### Human Development, Diversity, and Behavior in the Environment

**59. C.** An ecomap is a structural diagram of a client's most important relationships with people, groups, and organizations. A genogram is a graphic portrayal of the composition and

structure of the client's family. School records will focus on academic progress—not the presence or intensity of his friendships.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 60. B.** The answer must be chosen based on the client's behavior. Erikson spoke about adolescence as the period of transition between childhood and adulthood. The question provided the client's age, indicating its importance in reasoning to arrive at the correct answer. While the first sentence states that she has sought counseling for depression, the behaviors that are the focus of the question do not indicate mental health problems. Additionally, there is no family or peer pressure mentioned. The question mentions that client is "questioning" decisions and engaging in new behaviors. These actions are more associated with self-exploration and identity formation, the basis of psychosocial development during late adolescence/early adulthood.

### **Question Assesses**

#### Human Development, Diversity, and Behavior in the Environment

- 61. C.** The question has a qualifying word—FIRST. Evaluating the client for weight loss surgery is premature and should be done by a physician due to the medical risks. The question mentions that the client lives alone. The client may not have access to nutritious healthy foods due to a social justice issue, such as living in a food desert. The need for concrete services such as transportation to stores with fresh foods comes before looking at the weight as a social-emotional response according to Maslow's hierarchy of need.

### **Question Assesses**

## Human Development, Diversity, and Behavior in the Environment

**62. A.** The question does not mention the health of the wife before the onset of the husband's Alzheimer's disease. The context is focused on the wife being the primary caregiver of the husband. Based on the information in the question, degenerative disease is not indicated. There are also no explicit signs of abuse by the husband. Caregiving is associated with stress that can cause these issues and has to be considered given the material in the question.

### ***Question Assesses***

## Human Development, Diversity, and Behavior in the Environment

**63. C.** The first sentence provides important information about the client and her method of communication. It is followed by a sentence that indicates that the social worker is not able to use this method proficiently. Communicating in writing or using basic American Sign Language (ASL) is also not advised as the first appointment is critical to engaging the client and gathering information about why the client is seeking services. Not having the ability to communicate fully with the client during the initial meeting may inhibit the helping process in the future. The meeting needs to be rescheduled so that a trained interpreter can be identified and utilized.

### ***Question Assesses***

## Human Development, Diversity, and Behavior in the Environment

**64. B.** Exposure to racism has individual and system-level implications. It is not the responsibility of a person of color to educate White/Caucasian people about racism. Unfortunately,

this client has had to assume that responsibility. This experience can have profound adverse impact on identity development. There is no indication that the client is feeling isolated, and marginalization and oppression occurs predominately by systemic racism. The experience described in the question is not positive, so it will likely not yield improved functioning or better skills.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 65. B.** The first sentence of the question indicates that the mother and child are the clients. Seeing the daughter individually about future custody is not advised as the daughter is not an individual client and custody was not the original intent of treatment. The social worker is not allowed to make child custody recommendations as there is a conflict of interest as the social worker is providing therapy to the mother and daughter. The social worker cannot be a forensic expert and has never met the father so is not aware of his capacity to parent. Thus, sending the letter recommending joint custody is unethical as the social worker has never assessed and has no relationship with the father.

### **Question Assesses**

Professional Values and Ethics

- 66. C.** Moral distress results from the psychological and emotional effects experienced when social workers and other helping professionals feel institutional constraints block them from operating in a manner perceived as right. Moral conflicts and dilemmas related to limited resources are ever-present in the daily work of social workers. Social workers should advocate for adequate resources and working environments that are consistent with professional ethical principles. Coping with poor

working conditions or changing positions does not address the root cause of the problem, unjust or inadequate systems, making them not the BEST ethical solutions.

### **Question Assesses**

#### Professional Values and Ethics

**67. A.** This question describes a situation in which a social worker would gain personally from a professional responsibility. It is not appropriate for the social worker to use the points personally. This specific situation may not be covered in human resource policy or employment documents so review of them is not critical. Additionally, even if actions are allowed by policy, they may not be consistent with the ethical standards of the profession. Even if another employee used the points for personal use, the social worker should not. In order to handle the situation ethically, the social worker should inform the vendor that the reward points cannot be used personally. The social worker has an unfair advantage over other employees due to this job responsibility and should not use the task for personal gain.

### **Question Assesses**

#### Professional Values and Ethics

**68. A.** The couple's decision is based on the belief that the child will be born with disabilities. If the test yields a false positive then the couple terminated a pregnancy for a child who would not have disabilities. A false negative test result indicates that a person does not have a specific disease or condition when the person actually does have the disease or condition. Curvilinear relationships are those that do not consistently follow an increasing or decreasing pattern but rather change direction over time. The nature of relationships does not apply to this question.

## **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 69. B.** The reason for the sleep disturbance has not been determined so a comprehensive biopsychosocial assessment is needed to identify any changes which may be the cause. Complementary therapies are directed at treating the symptoms—not the underlying reason for sleeplessness. While medication from a physician may be helpful while the issue is being identified, it is not the FIRST way for the social worker to assist.

## **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 70. C.** Reversal designs are powerful methods for demonstrating relationships between independent and dependent variables. Thus, they can have good, not poor, internal validity. While there are benefits to reversal designs (removing interventions to see changes in dependent variables), there are also problems associated with them. For example, many interventions cannot be reversed, due to ethical reasons (involving self-injurious or self-harm behavior) or practical reasons (they cannot be unlearned). It may be unethical to end a treatment if it is beneficial and related to health/safety. While external validity (generalizability) is a concern of single-subject designs generally, it is not a problem for reversal design specifically, eliminating it from also being correct.

## **Question Assesses**

Professional Values and Ethics

- 71. A.** The question states that the social worker has no experience working with the courts (i.e., forensic social work). The social worker may be unclear as to whether there is a mandate to appear before the court based on the notification provided.

There may be a need or perhaps the social worker can claim privilege, but legal consultation is needed before writing to the court. It is important to notify the client, but the client will likely have questions about whether and what information is to be released. Since the social worker is not knowledgeable about forensic work, it would be best to become educated by an attorney during consultation so that this information can ultimately be provided to the client ultimately. The question contains a qualifying word—FIRST—which means that the order of the actions is critical.

### **Question Assesses**

#### Professional Values and Ethics

- 72. B.** When a student reaches 18 years of age or attends a postsecondary institution, rights transfer from the parents to the student. Law prohibits the improper disclosure of personally identifiable information derived from education records without the adult student's permission. All universities need to follow the law so policies cannot vary, and transcripts are not sent to parents without permission even if they are paying for courses.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

- 73. C.** Criterion validity establishes whether the construct is measured with accuracy by comparison one assessment with other measures of the same construct. The consistency between the rating and observed behavior increases confidence that the rating scale is valid. Internal validity is related to cause-effect relationships. Test-retest reliability concerns whether administering the same assessment repeatedly will yield the same result.

### **Question Assesses**

## Assessment, Diagnosis, and Treatment Planning

**74. B.** If intervention is not working, the social worker needs to assess to see if other issues have emerged or if the original determination of the root cause of the problem is incorrect. The goals are based on the assessment so revising them will be needed but is premature. There may be a need for consultation or supervision, but the use of NEXT as a qualifying word in the question makes this response choice incorrect. Again, intervention is implementation of a treatment plan that is based on assessment. If the intervention is not working, additional information from the client is needed.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

**75. A.** Safety is always paramount. If a social worker is concerned about a client who has engaged in sexual offenses against a minor reoffending, then access to potential victims must be limited. Other response choices may be appropriate but are not the MOST important in intervention as they do not directly relate to safety of others.

### **Question Assesses**

#### Human Development, Diversity, and Behavior in the Environment

**76. A.** Malingering is falsification or profound exaggeration of illness (physical or mental) to gain external benefits such as avoiding work or responsibility, seeking drugs, avoiding trial (law), seeking attention, avoiding military services, leave from school, paid leave from a job, among others. Hypochondriacal is abnormal anxiety about health, especially with an unwarranted fear that one has a serious disease. Grandiose is being

impressive and imposing in appearance or style, especially pretentiously so.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 77. A.** The allegation needs to be immediately reported to a supervisor. All reports need investigation regardless of the treatment history of the complainant. Allegations do not need to be in writing. Only the correct answer ensures a timely report to a responsible party.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 78. B.** This information is privileged so the social worker should not contact the authorities. There is no indication of danger to the father in the question as the father is in good health. Treatment should be focused on the client and her feelings of guilt and relationship with her father. Goal setting is critical and should be done FIRST as she reports difficulty “relating” to her father but there is no information about what specifically is meant by this concern or what needs to change.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 79. C.** While the social worker may not directly be friends with the boss, the presence of this relationship can certainly impact treatment. If the client learns of this relationship, it may erode trust as the client may be thinking that the social worker was hiding something. The decision to continue working together is primarily the client’s choice—not the social worker’s decision. Referring the client to another social worker may not be needed.

However, all conflicts of interest or potential conflicts of interest should be discussed with the client when they emerge so a mutually agreed upon solution can be determined.

### **Question Assesses**

Professional Values and Ethics

- 80. C.** This question describes an issue with which the social worker must deal so disclosing it to the client is not appropriate. Social workers are human and naturally may be triggered by clients' attitudes, behaviors, and experiences. Feelings by the social worker should not drive treatment recommendations for the client. Social workers do not give advice and the question does not indicate that the client is interested in disclosing the affair to her spouse.

### **Question Assesses**

Professional Values and Ethics

- 81. B.** Infidelity can involve an emotional connection and is not necessarily sexual in nature. Emotional infidelity is equally damaging and can lead to divorce. The age of the unfaithful spouse is also not directly relevant. While most cultures are disapproving of infidelity, divorce or ending a marriage is not permitted in all cultures. Views about infidelity are also culturally based so will have the MOST impact on whether the marriage ends.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 82. C.** Values clarification exercises are often used by social workers to assist clients with gaining greater understanding of what is important to them. Understanding their values helps

clients make decisions consistent with what makes them happy. In this question, asking the client to identify what is important with regard to future work will help him narrow down his new major as he is unhappy with his current choice and unsure of his career plans. The question is clear that the client wants to change his area of study and has put ample thought into the decision. The question does not state that he will be discussing his career choice with his parents, only that they will be angry with him. Also, the MOST pressing issue is identifying another major. Informing his parents is secondary once a new major has been selected. There is no indication that the client has difficulty making independent decisions generally—only that his current major was influenced by his parents.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 83. C.** Clarification is a useful interviewing technique that has many purposes. The question includes the qualifying word MOST so identifying the essential function is the root of what is being asked. Interviewing is done for the betterment of the client. Demonstrating that the social worker is listening is only useful as it relates to enhancing client well-being, which is not mentioned in this response choice. The social worker understands what the client is explicitly saying, but the client is expressing mixed emotions. The client is communicating clearly but needs to process the varied feelings associated with this transition. The social worker's statement concerns feelings so the answer must also be focused on affective responses.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 84. A.** While summarization usually occurs at the end of a meeting, it can also be used midway through an interaction or even at the beginning. At the start of a session, it is useful to summarize any

previous discussions as it can help to provide focus so there is continuity in care. Treatment goals are not focused on the social worker and should be mutually agreed upon by client and social worker, making identifying the social worker's treatment goals incorrect. Additionally, summarizing specifically at the beginning of a weekly meeting does not focus on enhancing client understanding of progress as understanding progress can occur at any time during meetings.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 85. B.** The social worker is asking a probing question that aims to help the client think more critically about leaving his job. The question does not focus on determining his coping skills or assessing his emotional attachment. While the client may or may not ultimately decide to leave his current employment, understanding the barriers to leaving, which are called restraining forces, are important. Until the restraining forces are identified, little progress can be made to reduce them which is why the social workers is posing the question.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 86. C.** Attending behaviors are verbal and non-verbal behaviors displayed by a social worker throughout the problem-solving process. Examples include referring to a client by name, reframing, paraphrasing, maintaining eye contact (if culturally appropriate), displaying facial expressions that express interest and concern, nodding head to convey affirmation, and so forth. Attending behaviors can be used to describe all actions while attentively listening. Helpful attending behaviors, along with active listening, are considered cornerstones of the therapeutic alliance which is the major agent of change. They are not limited to conveying empathy as they also focus on showing respect for

the client and increasing understanding of client problems. Attending behaviors do not provide alternative viewpoints so this response choice is not primary to their use.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 87. A.** Client questionnaires are surveys that help clients convey personal information, such as address or age, past history, and so forth. Social workers might complete assessment forms during initial interviews to gather client information. Even when asking standard questions, social workers should always appear caring and use attending behaviors. Client intake forms can contain close- and open-ended questions so they do not ignore the value of open-ended inquiry. The use of standardized intakes or assessments are not centered on client's unique problems and may fail to collect information that is relevant while collecting material that is not germane to the presenting issue.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 88. A.** The question concerns post-discharge follow up that occurs subsequent to evaluation and termination. As the client has been discharged, goal attainment has been achieved. Maintaining that progress is critical to continued success. Not all clients need after-care services, so it is not the BEST response. Social workers should not be exploring the presence of other issues or problems when telephoning clients.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 89. B.** Leading questions focus client responses on a particular

topic or area of interest. Examples of leading questions include the following: "You travelled by taxi today, didn't you?" or "You mentioned that you were adopted, correct?" Leading questions during assessment are not focused on treatment discussions. Assessment precedes treatment and focuses on gathering information. Social workers do not need to use leading questions to determine client motivation, which can be assessed verbally and nonverbally. They are leading as the social worker wants to obtain information about a chosen subject or in a specific area.

### ***Question Assesses***

#### **Assessment, Diagnosis, and Treatment Planning**

- 90. A.** Infidelity can leave a partner feeling devastated, alone, and betrayed. Individual counseling can help focus on forgiving, letting go, or moving on. There are many ways to handle feelings that come with infidelity. There is no indication that there are ongoing problems in the relationship so couples therapy is not needed. Mutual aid groups can be helpful for isolation or addressing feelings that one is alone. However, betrayal and anger are BEST handled individually.

### ***Question Assesses***

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 91. C.** Paradox questions are often a surprise for clients, but they get them thinking about new ideas and possible solutions. Paradox questions are a powerful tool whenever clients are stuck, and old patterns or habits need to be replaced with new ones. By understanding what could cause the relationship to deteriorate further, the client, in the question, identifies what needs to be addressed to make improvements. Paradoxical questions are not used to assess listening or level of commitment.

## ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 92. A.** The context described in the question is the client focusing on problems and feeling overwhelmed. The question posed by the social worker is to help him focus on solutions—what can be done rather than what can't be done. The question assists with steering the conversation in a positive direction. The social worker's question also affirms that the social worker is a helper, but the social worker needs to address the presenting problem which is that the client is not being solution focused. The client is just starting to move to goal setting so specific expectations are likely premature.

## ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 93. B.** Double binds have been central to family therapy since its earliest days. This example of a double bind is the parent giving the message: "Be spontaneous" and then scolding the child when doing so. If a child is subjected to this kind of communication over a long period of time, it is easy to see how confusion or erosion of confidence by a child can set in. Metacommunication is the nonverbal cues (tone of voice, body language, gestures, facial expression, etc.) that have meaning but is not manifest. A feedback loop one in which outputs slow down a process and preserve a stable state.

## ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

- 94. A.** Additional protection is provided to the client if psychotherapy notes are kept separately from the client's record. Psychotherapy notes means communication documenting or

analyzing the contents of conversation during a private counseling session. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. They are private notes used by the treating professional. Social workers should never skew their documentation to include only positive content or not document for fear of the need to release information.

### ***Question Assesses***

#### Professional Values and Ethics

**95. B.** Diverticulitis is inflammation (swelling) and infection in the large intestine or colon characterized by pain, nausea, and fever. It requires a high fiber diet, drinking plenty of water, and exercise. Since the client will be living with his son, it is important that they both know on-going care is needed that can prevent problems in the future. Goal setting post discharge is not MOST important. The client will get a summary of care when leaving the hospital, but discharge planning is focused on the future and preventing relapse—not reviewing the past.

### ***Question Assesses***

#### Assessment, Diagnosis, and Treatment Planning

**96. C.** Child abuse and neglect and parental mental health are strongly associated. Though not all parents with mental health issues abuse their children, maternal mental health is a significant risk factor for child abuse, after controlling for poverty, child's intellectual disability and other variables. While all the response choices may be relevant, the FIRST area that needs further assessment is the mother's mental health status as it is the most salient to risk.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 97. A.** Sliding scale fees are common in-service delivery and there are many bases for determining their structure. Income can be used but may not indicate the amount that a client can actually afford to pay. For example, the client who is making more may have a spouse who is not working due to childcare responsibilities. This client may have less discretionary income than a client without children. The ability to pay is distinct from income and is a concern given expenses. All clients do not need to pay the same fee. A client who is being seen pro bono or for a reduced rate can be charged the full cost of services if circumstances change. Thus, the fees can change during the course of treatment. Changing fees is not an issue with using sliding scale fees.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 98. C.** While both parents agreed to treatment of the daughter initially, it is unknown if consent by both parents was needed. Whether both parents have to consent will be stipulated in the child custody agreement which needs to be consulted. The social workers cannot meet with the daughter again if consent by both parents is required. It would be premature to end treatment, given its benefit, if the consent of only one parent is needed. The correct response would be to contact the other parent to determine the legal decision-making requirements per the court order.

### **Question Assesses**

Professional Values and Ethics

**99. B.** Vaccination is an important part of a public health program. The goal of public health is to prevent disease. It is much easier and more cost-effective to prevent a disease than to treat it. Immunizations protect the person who is vaccinated from serious diseases and also prevent the spread of those diseases to others. The importance of her job to her is unknown but it is likely that she is already aware that she may be fired if she is deceitful, so it does not appear to be a salient motivator. There are many people who are wary of the safety of vaccinations and question their efficacy despite scientific evidence. The question mentions that she lives with her children and parents. The well-being of others is often a great motivator for clients to seek treatment or change behaviors. Discussing the benefit of vaccination to the well-being of her family is likely to be the MOST important consideration for the client when making her decision.

### ***Question Assesses***

#### ***Psychotherapy, Clinical Interventions, and Case Management***

**100. B.** According to the question, the social worker is employed by a child welfare agency that is charged with investigating this allegation. It is not appropriate to interview all parties together as it is not likely that the person(s) being hurt will feel comfortable being honest in the presence of the perpetrator. The children will be important sources of information, so they need to be part of the inquiry. If domestic violence is occurring, the perpetrator must be held accountable for actions taken and understand that the behavior is wrong. Assuring all family members that their actions are acceptable may inadvertently send a message that abuse or violence against others is acceptable. Speaking to each family member separately will help the social worker better understand the situation and protect the well-being of those who may be victimized.

### ***Question Assesses***

## Assessment, Diagnosis, and Treatment Planning

**101. B.**Cognitive behavioral treatment is a psychological intervention that is helpful with a wide range of disorders. It helps clients change thinking patterns by learning to recognize distortions in thinking that are creating problems, and then reevaluating them in light of reality. Central to this approach is gaining a better understanding of the behavior. In this question, the client is journaling and has identified situations that invoke unpleasant thoughts. The NEXT step is to identify negative thinking that supports the initial thoughts and attempt to isolate its root causes. Avoiding situations does not help with modifying the client's thinking. Determining the consequences of the thoughts is needed, but only after the patterns and causes are understood.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

**102. A.**Scale questions are good tools to find out things that are difficult to measure. Scale questions help to assess subjective perceptions such as satisfaction, motivation, cognition, impressions, feelings, progress, and anger. They become measurable, helping the client to put feelings in perspective. Their use does not enhance accuracy or encourage discussion. In fact, they may limit discussion as clients need to represent their emotions by a single number, without the ability to explain in more depth their feelings. Pain is often assessed using a scaling question as it is a quick way to assess intensity.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**103. A.**Social workers should not assume a client's preferred pronouns by appearance, name, and so forth. There are many

best practices for creating an inclusive environment for clients such as avoiding specific gender markers if they are unknown—for instance, asking, “How may I help you today?” When a client’s preferred name or pronouns are unknown, it is also good to politely ask, “I would like be respectful—how would you like to be addressed?” or “What name and pronoun would you like me to use?” In the question, the social worker used the incorrect pronoun by accident so the social worker should NEXT acknowledge the mistake and apologize by saying “I apologize for using the wrong pronoun. I did not mean to disrespect you.” Regardless of the reason, the social worker has made a mistake. The problem is rooted in the social worker’s action, so it is not the client’s responsibility to understand why it occurred. The correction by the client did take bravery, but having the social worker take accountability is essential for a therapeutic alliance to be formed.

### ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

**104. C.** There may be therapeutic reasons why clients must be in certain settings for treatment. However, as such a reason is not specified in the question and there is no indication that the client has been informed that being in bed is inappropriate, asking the client to move is not correct. It may be good for the social worker to inquire the reason for lying in bed, but the presenting problem is the uncomfortable feeling by the social worker. While self-reflection may be a good first step, the question is not asking about the order of the response choices, rather what should be done. Acknowledging that the client is exerting self-determination is important even if the other response choices eventually do happen. The correct answer has to occur while the others can but are not mandatory.

### ***Question Assesses***

## Professional Values and Ethics

**105. C.** Social workers who are leaving employment settings should inform clients of appropriate options for the continuation of services. Social workers should review the benefits and risks of each option. Social workers should not solicit clients when leaving agencies and opening private practices, but likewise, clients should have receiving services from such practices as an option for continuity of treatment. Not being able to continue to serve clients limits their treatment options and decision making. Just because a policy is legal does not mean that it is ethical so consulting an attorney is not helpful. The social worker should ultimately not sign the document for this reason.

### **Question Assesses**

## Professional Values and Ethics

**106. B.** Social workers should avoid engaging in sexual relationships with colleagues/coworkers when there is a potential for a conflict of interest. It is assumed that the relationship described in the question began without the presence of or potential for a conflict. However, the promotion of the social worker places her with supervisory responsibility over her partner. The relationship should not remain secret, whether the promotion is taken or not, as the agency needs to ensure that potential conflicts do not occur now and in the future. The social worker should not be the one to determine the conflicts as judgment may be skewed by the relationship and there is no transparency. The social worker should not decline the promotion without stating the reason as the social worker needs to be forthcoming with the employer. There may be ways for the relationship to continue and the social worker to be promoted but an appropriate plan cannot be developed without informing the agency.

### **Question Assesses**

## Professional Values and Ethics

**107. B.** Quantitative methods have high reliability, but often lack validity whereas qualitative methods have high validity, but low reliability. Self-administered questionnaires are used in quantitative research. Structured interviews mirror self-administered questionnaires, but questions are asked by an interviewer instead. They also are focused on reliability, which is why questions are written out. Unstructured interviews allow freedom for the interviewer to probe and to gather more in-depth qualitative information on a chosen topic. They yield qualitative data which will provide an in-depth understanding of the area of concern (high validity).

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**108. A.** People who are undocumented are likely to avoid routine activities out of fear of immigration enforcement. Avoidance of these activities are likely to experience psychological distress. In addition to causing psychological distress, discriminatory policies negatively impact undocumented immigrants access to services and exercising of their rights. Social workers should recognize these realities before assisting families. Given that their life quality is negatively impacted, they likely see the urgency, but their reluctance may be due to real issues associated with potential deportation. If they are not willing to speak to the landlord, the couple will certainly not stop paying rent. The question contains a qualifying word—FIRST. Many of the response choices may be the focus of the intervention, but they have to be considered after recognizing the discrimination against those who are undocumented which is a necessary initial step.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**109. C.**Often those who are immigrants, undocumented, or members of marginalized communities have negative outcomes when interfacing with law enforcement. Instead of seeing this woman's behavior as a way to ask for assistance, it may be viewed as endangering her children. Additionally, she may be undocumented or have past unresolved legal matters that can result in adverse outcomes for her and her children if police are notified. The safety issue caused an ethical dilemma for the social worker as something needed to be done to prevent the family from being injured. However, the social worker needs to be aware that laws often dictate actions that adversely impact families. The rest of the response choices are not the MOST pressing concern.

### ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

**110. B.**The question describes the beliefs of the social worker's family and her own decisions about reproduction. However, there is no indication that the social worker does not support the self-determination of clients and have the ability to inform clients about all options. The social worker should not decline the position until after assessing the ability to fulfill the ethical responsibilities associated with the job duties. The results of this assessment will dictate the ultimate decision of whether to work with the students. Disclosing personal beliefs is not needed if they will not impact job performance and consistency with ethical standards, not agency policy, is paramount.

### ***Question Assesses***

Professional Values and Ethics

**111. B.**Individuals who are a danger to self or others can, under certain conditions, be court ordered to psychiatric hospitals.

This process is often referred to as involuntary commitment. There is an attempt to only hospitalize individuals for a short time until they can be stabilized so there should be no assumption that the hospitalizations will be lengthy. The client may not have been the aggressor in the incident described but still may be a danger to self or others.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 112. C.** The question has a qualifying word—FIRST. It is necessary for the social worker to understand the situation within a cultural context. Such an assessment needs to include exploring the cultural and family's view of pregnancy, including rituals or traditions surrounding the care of females who are pregnant. The family may need assistance with financial and food assistance, but this will not be known without listening and learning by the worker. For example, the cupboards may be bare as food may be grown or raised in the family's backyard. Additionally in this home, the family may follow the Hmong tradition that a pregnant woman must live in another place for 30 days, but after that time, she can return home. The daughter's age may have nothing to do with her needing to leave the house. There is no indication of physical or sexual abuse mentioned in the question.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 113. B.** Sexual health is an important part of total health as sexual problems can disrupt health, quality of life, and general well-being, causing in many instances marital problems or marriage dissolution, and emotional impoverishment. While clients may be hesitant to talk about sexual issues, it is not the MOST important reason for social workers to be educated in this area.

While discussing sexual health with clients may not be necessary, understanding its impact on biopsychosocial function is essential for all clients. Being knowledgeable about sexual health is not just important for social workers addressing issues related to sexual orientation.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 114. B.**When social workers are working with clients who have the same identified problems, there is a risk that individual differences will not be considered, treatment will become rote, and a “one size fits all” approach will emerge. Assessment and treatment strategies should take into consideration client circumstances even if presenting problems of clients are the same. Social workers should always use evidence-based practices. Burnout is not influenced by treating the clients with the same identified problems. The MOST risk is a social worker adopting a “seen that—done that” attitude which can make the social worker less apt to determine important differences between clients which need to be considered in the problem-solving process.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 115. B.**The question contains a qualifying word—FIRST—so the order of the social workers’ actions is critical. A medical etiology should be ruled out before determining other social-emotional causes. Self-doubt, rejection, and feelings of inadequacy are common in those with sexual dysfunction, which is the root cause of the problem. A primary care physician can assist with performing a physical exam and taking a medical history. Based on symptoms, more tests may be ordered, and an oral medication can be prescribed. Social

workers and general medical practitioners should be versed in dealing with problems associated with erectile dysfunction, so specialists are usually not needed, at least not initially.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 116. A.** Social work practice should always be viewed from the perspective of the client. Protecting the social worker and agency are never the primary concern or motivator for practice decisions. While creating a record of what services have been provided is very useful, this response choice justifies documentation only due to the chance that problems will re-emerge, while many do not. Information needs to be readily available to the client and social worker to evaluate the effectiveness of services and ensure that appropriate treatment decisions are made. The correct answer is the basis of evidence-based decision making which is a critical component of social work practice.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

- 117. A.** There are different forms of supervision. They include in-vivo supervision in which the supervisor is in the room with the supervisee and client. The supervisor does not engage in direct therapy, but instead the supervisee consults with the supervisor in the presence of the client. Another type (sometimes referred to as “bug-in-the-ear”) is when a social worker wears a wireless earphone to receive guidance. It can be done while the supervisor watches the social worker behind a one-way mirror which allows the supervisor to observe the social workers’ interactions with clients as well.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**118. B.**There are many terms used to refer to documentation that a social worker makes as a result of meeting with or monitoring clients, including case notes, progress notes, progress recordings, client log, and so forth. Often these documents are used in supervision as they summarize the services that the social worker has provided. The discussion of these notes in supervision can create a productive and meaningful supervisory environment. However, like other self-report methods, it is dependent on the supervisee's ability to accurately observe interactions and occurrences. Clients should always be asked to consent when discussing clients' situations with supervisors. The use of process recordings in supervision does not mean that supervisors cannot provide real time feedback.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**119. B.**Co-therapy can be very beneficial but facilitators are not responsible for change in groups. Peer support is the agent of change. Co-facilitation takes more time and coordination than running a group alone so facilitators must be available for discussion and coordination. It is often beneficial when the facilitators use divergent, not the same therapeutic, approaches as clients can benefit from varied expertise and techniques.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**120. B.**The answer must be related to use of “a social justice approach.” The direct care workforce consists of mostly of people of color who are receiving low pay for their work.

Raising compensation is the response choice that would assist by structurally and systematically helping those who may lack the educational and other opportunities afforded to those in management positions within the agency. The other response choices may be helpful, but they do not address the root cause of the problem which is that the direct care workers have to have several jobs to make a living wage. Working long hours and not having adequate time off will lead to burnout regardless of the provision of additional administrative support or training aimed at raising morale.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

**121. C.** The question contains a qualifying word—FIRST—that indicates that the order of the response choices is critical. The goal of treatment—the need for better time management strategies—has been established so understanding why they are needed is not currently relevant. There is no indication that the client is trying to accomplish too much and helping the client to understand the parameters of available time is not related to the issue of difficulty juggling demands. Prioritization of the client’s responsibilities is a necessary initial step in treatment planning.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**122. A.** This question is based on the recall of clinical terminology and associated mental disorders. Avolition is a term used to describe the lack of motivation or ability to do tasks or activities that have an end goal, such as paying bills or attending a school function. Avolition occurs most commonly in schizophrenia, depression, and bipolar disorder. Examples of avolition in schizophrenia might be the inability to care for personal hygiene or participate in work or recreational

activities. People experiencing avolition may withdraw from social contact and normal activities. They often have no enthusiasm and get little enjoyment from life. Their emotions may become dull and conversations may be disjointed.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**123. C.** Making forms represent the broad diversity of gender identities is important so that all feel included and are adequately represented. School personnel need to understand that gathering this information comes with the responsibility of having policies and protections in place so that youth who disclose non-binary gender identities or are non-conforming are safe from bullying and discrimination. The other response choices are not the MOST important and can be addressed. The safety and treatment of youth is paramount so discussions of why this information is being collected and how it will be used to create a more inclusive school must occur immediately.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**124. A.** While confidentiality is important, there is nothing in the question that indicates that the client does not feel comfortable speaking to the social worker and interpreter. Essential to engagement is the client understanding the role of the social worker. This role definition is further complicated by the use of an interpreter. Establishing the roles of the social worker and interpreter must be discussed during the initial session. Understanding the client's mourning rituals is important, but rapport has not yet been established so asking, which is part of assessment, should not be the done FIRST.

## **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 125.** **A.**This question requires recall knowledge about psychotropic medications. Benzodiazepines are a class of drugs primarily used for treating anxiety and other conditions such as insomnia. They also are used for sedation prior to surgery or diagnostic procedures, muscle relaxation, alcohol withdrawal and drug-associated agitation, and so forth.

## **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 126.** **A.**Stimulants are an effective way of managing symptoms associated with attention-deficit/hyperactivity disorder, such as short attention span, impulsive behavior, and hyperactivity. Mood stabilizers are used to treat disorders characterized by intense and sustained mood shifts, such as bipolar disorder. Antianxiety medications are used to prevent or treat anxiety related to several disorders.

## **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 127.** **B.**The beginning phase of service delivery is important as it is when engagement occurs. Additionally, vital information is exchanged. Clients do need to know about confidentiality and its limits, but they are not MOST important in the situation described in the question. The client has made comments that indicate a potential lack of clarity about the problem-solving process and the role of the social worker, which will be important to review. It is not possible to know the expected length of service as the nature of the problem is not yet

understood and goals have not been established. However, the client must understand as services are time limited.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 128. C.**Manifest content is evidence that is directly seen such as the words in an interview. Latent content refers to the underlying meaning of content which is unspoken. In this question, the social worker is identifying feelings which are implicit in the client's verbal and non-verbal communication. In the question, there is no evidence of summarization—briefly describing the main points—or clarification, when concepts are described in an easier to understand manner.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 129. A.**Case formulation, sometimes referred to as clinical formulation when issues involve mental disorders, is an explanation or a conceptualization of the information obtained during assessment. It constitutes a hypothesis about the nature of the presenting symptoms. It can include, but is more expansive than, a single diagnosis. Case formulation provides a framework for planning. While all phases of the problem-solving process are interrelated, planning is MOST impacted by case formulation.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 130. B.**This question requires recall of knowledge about elder abuse. There are different ways that substance use and/or mental health conditions can cause or exacerbate elder abuse.

Elder abuse usually takes place in homes and is committed by adult family members. If the caregiver has substance abuse and other problems, elder abuse is more likely or may be more severe. For example, some caregivers may also begin to steal money or financially abuse the elderly patient in order to pay for their drug use. Individuals who abuse drugs are also more likely to suffer from personality disorders and depression and this may make them more likely to commit abuse or neglect.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 131. A.** Exposure is an intervention strategy commonly used in cognitive behavioral therapy to help clients confront fears. Prolonged exposure is a specific type of cognitive behavioral therapy that teaches clients to gradually approach trauma-related memories, feelings, and situations. Most clients want to avoid anything that reminds them of the trauma they experienced but doing so reinforces their fear. By facing what has been avoided, a client can decrease symptoms of posttraumatic stress disorder by actively learning that the trauma-related memories and cues are not dangerous and do not need to be avoided.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 132. C.** Ethical standards dictate that social workers should make reasonable efforts to ensure continuity of services in the event of illness. While the social worker plans to work during his treatment, there may be unexpected interruptions or lack of availability due to appointments, fatigue, side effects, and so forth. The clients do not need to be educated on his medical diagnosis. They only need to know how it will impact service delivery and their available options. Not informing clients about

changes in availability or risks of disruption due to the changing health status of the social worker would be irresponsible as clients may want to see another practitioner temporarily or on an ongoing basis.

### ***Question Assesses***

#### Professional Values and Ethics

- 133. B.** There is no provision that states that client assessment forms include questions about culture. In fact, assessing culture may be best completed via interviews and observations so that social workers can hear and see the impact of culture on behaviors, attitudes, appearance, and so forth. Self-reflection is paramount to cultural awareness and humility. Social workers do not need lifelong continuing education. If they are not engaged in professional practice, such as after retirement, such education cannot be required and may not be needed. Also, growth results from methods other than continuing education.

### ***Question Assesses***

#### Human Development, Diversity, and Behavior in the Environment

- 134. A.** This question requires recall of knowledge about a critical social work term “intersectionality” which is the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups.

### ***Question Assesses***

#### Human Development, Diversity, and Behavior in the Environment

**135. C.**Social workers in rural areas face the real possibility of knowing their clients prior to the onset of services or having the possibilities of dual relationship present themselves. Prescreening clients is not effective as dual relationships may emerge or become evident later in the process. Educating clients about dual relationships is advisable, but dual relationships should be discussed throughout the problem-solving process, not just during engagement. Central to “minimizing the impacts of dual relationships” as they often exist in rural setting is having clarity about confidentiality mandates and client-social worker roles. This response choice is also optimal as it describes a collaborative process with the social worker and client working together on this important issue.

### **Question Assesses**

#### Professional Values and Ethics

**136. B.**Many of the response choices listed will be important, but the order in which they occur is important. The question is asking about the FIRST task that must be completed. Meeting with the client to determine his preferences and discussing parental concerns are essential, but the feasibility of having community supports in place needs to be assessed. Without proper support, the client may not be safe. Current needs will drive whether the client is stable and can be discharged. Thus, client needs should be identified so that they can be used to address parental concerns and be considered in light of client preferences later in the process.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**137. C.**This question requires recall knowledge about the efficacy of instructional methods. When designing a parent education

program, it is important to include parenting skills, network-building, and stress management. The latter two may seem less relevant, but parents who are low-income tend to experience social isolation and frustration at work (or in the job search), which can negatively affect outcomes in terms of their children's learning and development. The same insightful and sensitive approach must be applied to program implementation. A classroom-style lecture, for example, is shown to be fairly ineffective with low-income parents. Short videos also do not allow for interaction and group discussion, which are critical.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 138. C.** Subpoenas may be issued by judges, clerks of the court, or attorneys. A social worker should not assume that an attorney's subpoena requesting client records has legal authority requiring the release of records unless it is accompanied by a court order signed by a judge—not the judge's clerk. A social worker cannot ignore a subpoena, even if it is not signed by a judge.

The question contains a qualifying word—FIRST—so the order of the response choices is critical. The social worker should also not send a letter to the court without the consent of the client. While legal consultation is always advisable, the social worker should initially contact the client to determine the client's desire to share the information. The social worker cannot assume that the client does not want the information released. In fact, it may have been the client's attorney who is requesting it for a legal matter on the client's behalf. If the client does not want it released, there are likely going to be much discussion with lawyers and the client to ensure that the information is protected to the extent possible by law.

### **Question Assesses**

## Professional Values and Ethics

**139. B.** Social workers help families and family members become more functional by highlighting positive behaviors. It is critical that social workers recognize that change is incremental and will be seen gradually over time. Shaping competence is a matter of social workers not acting as experts but instead reinforce family members for doing things right or making their own appropriate decisions. Family interactions are always seen as relationships which can be changed and improved, even without long-term treatment. Structural family therapy focuses on roles and hierarchy in families which must be remembered when deliberating between response choices.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

**140. A.** A medication that may be prescribed to inhibit alcohol use is disulfiram (antabuse), which is classified as an aversion drug. The medication will cause the client to experience uncomfortable, but not ultimately harmful, side effects when drinking. The medication is meant to condition the mind and body to develop an aversion to alcohol. Some side effects that might be experienced include feeling nausea, headaches, hot sweats, and vomiting. As little as half a drink is all that is needed for side effects to occur, and they may last up to 2 hours.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**141. A.** The social worker is asking a client the “miracle question” which focuses the mind on the desired outcome. Focusing on future goals is the essence of solution focused therapy. This approach gets clients to focus on what they want to become

and how they will get there. This process is the essence of planning. Asking the client about life without problems is not intervening or actually taking action to address the situation—rather it is determining what is possible. This exercise should come after engagement so the client feels comfortable being honest with the social worker. The focus is more on identification of solutions, rather than gathering information which is the essence of assessment.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 142. C.** While having a comparison group would be helpful to compare the experiences of those who have reoffended with those who have not, use of surveys will yield superficial data. The social worker needs to understand the lived experiences of those who have not reoffended. Focus groups will not provide in-depth information. The MOST effective technique is semi-structured interviews which will produce qualitative data on key areas of interest but allow the social worker the opportunity to probe as needed.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 143. C.** The question describes the classic experimental design, also known as the pretest-posttest control group design, in which clients are randomly assigned to treatment and control groups. Experimental designs are needed to demonstrate cause-effect as they account for threats to internal validity. Quasi-experimental designs lack randomization, thereby having more threats to internal validity. Cohort studies are types of longitudinal studies in which those who are examined share a common characteristic or characteristics.

### **Question Assesses**

## Assessment, Diagnosis, and Treatment Planning

**144. C.** Schizoid personality disorder can severely limit making social connections and emotional expression. People with this disorder may be viewed as odd or eccentric preferring to being alone; having difficulty expressing emotions and reacting appropriately to situations; and appearing humorless, indifferent, or emotionally cold to others. They do not lack guilt or cause harm to others. Clients with schizoid personality disorder are aloof but are not often overly resentful and do not demonstrate explosive anger like those with paranoid personality disorder.

### **Question Assesses**

## Assessment, Diagnosis, and Treatment Planning

**145. C.** Providing written material to the general public about mental health is certainly within the purview of social workers. Using current, evidence-informed information is critical, but the social worker does not need to be a specialist in addressing all issues as the social worker may simply be relaying research done by others (with proper citations of course). As readers are not clients, there is no risk of dual relationships. The MOST significant concern is that the social worker has not assessed the specific needs of readers. Thus, readers may choose to use the information to take actions that are not helpful or advisable. It is important that readers understand becoming educated by reading about conditions and their treatment generally is not a substitute for professional assessment and intervention.

### **Question Assesses**

## Professional Values and Ethics

**146. A.** There are three criteria required for identifying a causal

effect: (1) two variables need to be related; (2) the independent variable must precede the dependent variable in time; and (3) the independent and dependent variable cannot both be explained by a third variable that causes both of them. The third criterion has not been met in the question. There are many factors that may result in both being diagnosed and getting involved in the justice system. Diagnoses do not have to be identified and controlled because the social worker may be interested in mental health conditions generally. The question states that the data is representative so testing on larger and more diverse client groups is not the MOST significant threat. Additionally, the representative of the sample relates to external validity—generalizability—not internal validity that focuses on cause-effect.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 147. A.** Sigmund Freud first used catharsis as a therapeutic method of releasing negative emotions to reduce frustration and feelings of aggression. Catharsis is the process of venting aggression as a way to release or get rid of emotions. Catharsis theory is based on the premise that releasing emotions decreases pressure or tension, so clients have fewer negative emotions and are less aggressive. Harm reduction is an approach designed to reduce the adverse effects of risky behaviors (e.g., alcohol use, drug use, and indiscriminate sexual activity), rather than to eliminate the behaviors altogether. Transference is a client's displacement or projection onto a social worker of those unconscious feelings and wishes originally directed toward other individuals in the client's life, such as parents.

### **Question Assesses**

#### Human Development, Diversity, and Behavior in the Environment

**148. A.** The question indicates that the business card is for social work services. A social worker needs to clearly represent credentials, education, and qualifications to clients. The literature degree is not directly relevant to the provision of social work services. By just using the title “Dr.,” clients are likely to inappropriately assume that the doctorate is in social work, making the action unethical. A social worker can list her PhD, such as on her resume, but must make it known that it is in literature. Just using “Dr.” on a social work business card may lead to confusion by clients.

### **Question Assesses**

#### Professional Values and Ethics

**149. C.** Self-neglect is the inability or unwillingness to attend to personal needs or hygiene. It may manifest in different ways, such as not attending to nutrition, hygiene, clothing, or acting appropriately to care for medical conditions. Self-neglect can occur as a result of dementia, brain damage, or mental illnesses. There is no indication in the question that the client’s condition is caused by or the result of the actions of others, which are required for physical abuse and exploitation.

### **Question Assesses**

#### Human Development, Diversity, and Behavior in the Environment

**150. C.** When age is provided in a question, it generally has relevance to selecting the correct answer. The client is describing the actions of her son, which are concerning to her. According to Freud, every “healthy” child evolves through five different psychosexual stages—oral, anal, phallic, latent, and genital. Each stage is associated with a specific part of the body, or more specifically, erogenous zone. Each zone is a source of pleasure and conflict during its respective stage. This

boy appears to be in the phallic stage based on his age and actions. Educating the mother about these developmental stages will help her understand the behavior and anticipate future actions by the child. Educating her is BEST as it increases her capacity to understand her child's development.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 151. B.** This question requires recall knowledge about parenting styles. The authoritative parenting style has been identified as the best approach to parenting with children raised using this style being more capable, happy, and successful. Authoritative parents act as role models and exhibit the same behaviors they expect from their children. Consistent rules and discipline also allow children to know what to expect. These parents tend to exhibit good emotional understanding and control. Their children also learn to manage their emotions and learn to understand others. Authoritative parents also allow children to act independently. This freedom teaches kids that they are capable of accomplishing things on their own, helping to foster strong self-esteem and self-confidence. Permissive parenting fails to set firm limits, to monitor children's activities closely or to require appropriately mature behavior of their children. Authoritarian parenting is characterized by high demandingness and low responsiveness, with strict rules enforced with little consideration of children's feelings or social-emotional and behavioral needs.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 152. C.** Arbitration, a form of alternative dispute resolution, is a process in which disputing parties agree that one or several

individuals can decide about the dispute after receiving evidence and hearing arguments. Arbitration is different from mediation because the neutral arbitrator has the authority to decide about the dispute. Pre-trial intervention is a program to have non-violent, first time offenders avoid incarceration or other serious consequences so that focus on future positive actions and avoiding more serious infractions in the future.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 153. C.**When a social worker acts as a mediator, a problem-solving intervention is used to assist and guide others toward resolution. The mediator does not decide the outcome, but helps clients understand and focus on the important issues needed to reach a resolution. In a high-conflict divorce, intervention will be directed at compromise to address important issues related to both person and property. The broker role involves the process of making referrals to link others to needed resources. When doing resource allocation, social workers are establishing or implementing rules that allows fair allocation of resources or funding to be made to those who need extra support.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 154. C.**Groups can be beneficial for a variety of purposes, including mutual aid and education. This question identifies the emotions of family members (i.e., anger and fear) being the primary concerns. Based on this assessment, emotional support will MOST likely be the benefit of participation. There is no indication in the question that family members need education or socialization. While these areas of focus may be helpful, it is important to choose an answer that is justified by question wording.

## **Question Assesses**

### Assessment, Diagnosis, and Treatment Planning

**155. C.** Kohlberg reviewed people's responses and placed them in different stages of moral reasoning. According to Kohlberg, an individual progresses from the capacity for preconventional morality (before age 9) to the capacity for conventional morality (early adolescence), and toward attaining postconventional morality (once Piaget's idea of formal operational thought is attained), which only a few fully achieve. Each level of morality contains two stages, which provide the basis for moral development in various contexts. The age of the children is not provided, but they are at the preconventional level based on their actions. At the conventional level, morality is tied to personal and societal relationships. At the postconventional level, morality is defined in terms of more abstract principles and values. People now believe that some laws are unjust and should be changed or eliminated.

## **Question Assesses**

### Human Development, Diversity, and Behavior in the Environment

**156. B.** The client focuses on the past during the assessment process, causing the social worker to feel frustrated and annoyed. The social worker's feelings are the most significant problem described in the question. Importantly, the client may be speaking about the past as part of his current grieving process. When grieving, clients often speak about past events and memories so reminding him to speak about the present is not appropriate. Speaking about his wife's death may not be as important to him as speaking about her life. The social worker should not facilitate discussions to learn more about the wife as it will not help address the problem. The social worker should self-acknowledge that important information about the

client's behavior is not being considered. Understanding the importance of this information will help the social worker alleviate frustration and be more attentive to how past recollections can assist with present coping. Respecting the self-determination of clients is critical to service delivery.

### **Question Assesses**

#### Professional Values and Ethics

**157. B.**Analyses on cost-effectiveness examine both the costs and outcomes of one or more interventions. These analyses compare costs to gained units of a defined outcome, like a life year gained or a death prevented in healthcare. Analyses on cost-effectiveness can be useful in choosing between different interventions with the same outcome. For example, a decision maker might find it useful to determine how much one intervention costs compared to another. Such analyses focus on cost-benefit as opposed to identifying target populations. Funding needed is also not the MOST important aim. Some costly services may produce outcomes associated with significant savings.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

**158. A.**This question requires recall knowledge about structural family therapy. A vital technique in this treatment approach is the process of enactment that occurs when social workers invite family members to interact directly with each other. Such interactions bring problematic behavioral sequences into treatment by showing them to social workers in a demonstrative manner. This process redirects communication between the social worker and family so that communications and resulting changes in behaviors occur among family members instead of between the family and social worker. Enactment uses the relationship between family members as

an agent of change while it simultaneously and directly facilitates change within the relationship.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 159. A.** Single subject designs can be useful for evaluating the effectiveness of treatment, but the MOST significant limitation is external validity or generalizability. Single subject designs are very helpful when evaluating the effectiveness of services but generalizing results to other clients is challenging. The best way to enhance generalizability is through replication. This question requires recall of knowledge about research principles. Internal validity relates to confidence in cause and effect. Single subject designs can be quite rigorous. Instrumentation is a threat to internal validity when different surveys or measures are used to assess the same construct, which is a threat to internal validity not necessarily associated with single subject research.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 160. B.** The question has a qualifying word, NEXT, indicating that the order of the response choices is critical. The social worker makes the agency supervisor aware of the situation but will need to take additional action. Social workers should inform clients if unauthorized access to information occurs. Social workers should be aware of the ethical standards so should not need to discuss the situation with a social work supervisor. Seeking legal consultation is a good idea but does not precede notifying clients, which is required according to professional ethical standards.

### **Question Assesses**

## Professional Values and Ethics

**161.** **B.**The social worker's statement occurs during the initial meeting which is pivotal in establishing the therapeutic alliance with the client. The statement by the social worker does not directly speak to motivation or having a better life quality. The correct response choice stresses the connection between the client and social worker which happens during engagement.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

**162.** **B.**The supervisor should not be researching the client's past criminal history without the client's consent as the information is not needed in this situation to prevent harm to self or others. The social worker is asking for the supervisor's help in locating resources. There is no justification in the question for the supervisor to research the client's past criminal activities. While supervisors may have access to the same information as those working directly with clients, there is no indication in the question that the social worker is even aware of this information.

### **Question Assesses**

#### Professional Values and Ethics

**163.** **B.**Social workers' primary obligation is to protect clients and avoid self-disclosure that has the potential to undermine clients' progress. They should always ask the question, "Whose needs are being met by the disclosure?" when considering self-disclosure. Social workers' disclosure of personal information to clients is sometimes self-serving and is evidence of impairment, incompetence, or unethical conduct. Some forms of self-disclosure are benign and may be therapeutically useful as they help clients connect with social

workers and view them as humans; other forms of self-disclosure are exploitative, self-serving, and harmful to clients. The issue is not necessarily the amount of information disclosed but the type of information. Disclosure about intimate marital or relationship histories and struggles is always inappropriate regardless of the amount of information revealed. Indicators of boundary violations can be treating some clients differently than others. However, social workers may be inappropriately disclosing to all clients so there will be no difference in treatment between clients even though the behavior is unethical.

### **Question Assesses**

#### Professional Values and Ethics

- 164. B.**Moral injury is harm that results when acts are perpetrated, witnessed, or not prevented that transgress the deeply held convictions or moral beliefs of others. Those who cause moral injury often experience distress and yearn for repair. Moral repair focuses to restore trust and hope in relationships. While the social worker was not the perpetrator, she failed to act. The MOST effective intervention would be for the social worker to address the feeling of remorse. In-depth supervision does not directly address the issue. Also, reparations by the agency is a distractor as it does not focus on the social worker who must address these feelings in order to effectively work with the client. A real or imagined apology by the social worker to the client for the act of omission will be most effective.

### **Question Assesses**

#### Professional Values and Ethics

- 165. C.**Abrupt discontinuation of opioid use during pregnancy can result in premature labor, fetal distress, and miscarriage. Medical withdrawal from opioids should be conducted under the supervision of physicians experienced in perinatal

addiction so referral to such physicians must occur FIRST. Pregnant women who stop using opioids abruptly are at greater risk of relapse and overdose death. There is also an increased risk of harm to the fetus. Medication-assisted treatment is typically recommended instead of withdrawal or abstinence but referring to a medication assisted provider occurs after attending to medical concerns and monitoring so it is not the initial action by a social worker.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 166. C.** In mental health settings, a standard clinical assessment, called a mental status exam, is often used to assess mental functioning. Mental status exams are especially important for clients who are manifesting extreme symptoms of disorientation or unusual behavior. It is helpful to examine client behavior systematically in the areas of appearance, general behavior, mood, flow of thought, content of thought, orientation, language, memory, attention and concentration, abstract reasoning, and insight and judgment. Additionally, social workers should note clients' dominant cultural identities and how they influence the domains being assessed. Simply identifying a client's cultural identity is not enough and consistency across all cultural groups is not appropriate as it is a "cookie cutter" or "one size fits all" approach.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 167. C.** Ego strength is often used to describe clients' abilities to maintain their identity and sense of self despite pain, distress, and conflict. Good defense and coping mechanisms are important components of ego strength. Clients with well-developed ego strength tend to share a number of essential

characteristics including their abilities to deal with challenges, high levels of emotional intelligence, and successful regulation of their emotions, even in difficult situations. Clients with low ego strength struggle to cope in the face of problems and try to avoid reality through wishful thinking and fantasies.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 168.** **A.**Brief psychotic disorder is the sudden onset of psychotic behavior that lasts less than 1 month followed by complete remission with possible future relapses. It is differentiated from schizopreniform disorder and schizophrenia by the duration of the psychosis. Schizophreniform disorder is characterized by symptoms identical to those of schizophrenia but that last  $\geq 1$  month but <6 months. Schizophrenia is characterized by psychosis (loss of contact with reality), hallucinations (false perceptions), delusions (false beliefs), disorganized speech and behavior, flattened affect (restricted range of emotions), cognitive deficits (impaired reasoning and problem solving), and occupational and social dysfunction. One or more episodes of symptoms must last  $\geq 6$  months before the diagnosis is made.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 169.** **A.**Social workers should rely on legal and ethical documents to guide them when problems, such as ethical breaches occur. Social workers should disclose confidentiality breaches to clients involved, but clients are not experts in these matters so conversations with them will not be most “helpful.” Supervisors may not be social workers and may have limited knowledge about ethical standards or what to do when breaches occur so consulting them will not be the best course of action. Additionally, supervisors may handle situations differently,

which is not advised when ethical violations related to confidentiality occur.

### **Question Assesses**

#### Professional Values and Ethics

**170. B.** Indirect power blocks refer to internalized oppression. Groups with histories of mistreatment often absorb the negative messaging of the abuse they receive. They develop stories about their limited options and ability to achieve and then pass those ideas down across generations. Direct power blocks are the structures that stop people from achieving goals such as better employment, advanced education, or safe housing. Magical thinking is the belief that one's ideas, thoughts, actions, words, or use of symbols can influence external events in the world. The community members' negative views about their abilities are consistent with the definition of indirect power blocks.

### **Question Assesses**

#### Human Development, Diversity, and Behavior in the Environment

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# Evaluation of Results

Content Area	Question Numbers	Number of Questions	Number Correct	Percentag Correct
Human Development, Diversity, and Behavior in the Environment (24%)	2, 4, 5, 9, 10, 11, 18, 20, 25, 35, 40, 41, 53, 58, 60, 61, 62, 63, 64, 75, 77, 81, 93, 96, 103, 109, 112, 113, 123, 124, 128, 130, 133, 134, 147, 149, 150, 151, 155, 165, 170	41	___/41	___%
Assessment, Diagnosis, and Intervention Planning (30%)	3, 6, 8, 13, 19, 21, 22, 24, 28, 29, 30, 31, 36, 37, 38, 39, 52, 54, 59, 68, 69, 73, 76, 78, 87, 89, 92, 95, 100, 102, 107, 108, 111, 115, 121, 122, 125, 126, 129, 136, 140, 141, 142, 143, 144, 146, 154, 159, 166, 167, 168	51	___/51	___%
Psychotherapy, Clinical Interventions, and Case Management (27%)	1, 14, 15, 16, 17, 23, 26, 27, 32, 34, 42, 43, 47, 49, 50, 51, 55, 56, 72, 74, 82, 83, 84, 85, 86, 88, 90, 91, 97, 99, 101, 114, 116, 117, 118, 119, 120, 127, 131, 137, 139, 152, 153, 157, 158, 161	46	___/46	___%
Professional Values and Ethics (19%)	7, 12, 33, 44, 45, 46, 48, 57, 65, 66, 67, 70, 71, 79, 80, 94, 98, 104, 105, 106, 110, 132, 135, 138, 145, 148, 156, 160, 162, 163, 164, 169	32	___/32	___%
Overall Clinical Examination Knowledge	-----	170	___/170	___%

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# **Study Notes**

# **Practice Test**

## **170-Question Practice Test**

This practice test contains 170 questions but remember that your score on the actual examination will be based on 150 questions because 20 items are being piloted. As you won't know which items will be scored and determine whether or not you pass, you will need to complete all 170 questions. Thus, this test has 170 questions so that you can gauge the length of time that it takes you to complete an equivalent number of questions. The questions in each domain or area are in random order on this practice test, as they are on the actual examination, and there is a similar distribution of questions from each section as will appear on your actual examination.

Human Development, Diversity, and Behavior in the Environment

41 Questions

Assessment, Diagnosis, and Treatment Planning

51 Questions

Psychotherapy, Clinical Interventions, and Case Management

46 Questions

Professional Values and Ethics

32 Questions

The best way to use this practice test is as a mock examination, which means:

- a. Take it AFTER you have completed your studying—do not memo answers to these questions.

- b. Do not apply the answers to these questions to the actual examination or you may miss subtle differences in each question that can distinguish the correct from the incorrect response choices.
- c. Take it in its entirety during a 4-hour block of time to show yourself that you can finish in the allotted time period for the examination.
- d. Do not look up the correct answers until you are completely finished with the entire practice test, and do not worry if you get questions incorrect. Remember, this examination is not one in which you can expect to get all of the answers correct. **The number of questions that you will need to answer correctly generally varies from 90 to 107 correct of the 150 scored items.**

- 1.** Grounding techniques used with clients who are experiencing flashbacks of past traumatic events primarily aim to:

  - A. Connect clients with the present so that they do not have additional negative effects associated with reliving their past traumatic experiences
  - B. Assist clients to understand the triggers for their flashbacks so that they can be reduced or avoided in the future
  - C. Teach clients coping skills to reduce the emotional, physical, social, and other impacts of trauma on personal well-being
- 2.** A client tells a social worker that she has been communicating with her recently deceased son. The client states that she has an altar in her home at which she leaves daily food offerings. She is hopeful that her son will return to the home sometime in the future to visit her. In this situation, the **MOST** important action for the social worker to:

  - A. Determine if the client is at risk for self-harm
  - B. Assess the client for psychotic symptoms
  - C. Understand the mourning rituals of the client's culture
- 3.** Given her family history, a client who has recently married undergoes genetic testing to learn if she is a carrier of a specific disease. Upon learning that she is a carrier, the client becomes very upset that the news will impact a future decision to have children. The client is

nervous about telling her husband as he is not aware of the testing. In this situation, the social worker should **FIRST**:

- A. Arrange a joint session with the husband to support the client when she tells him
- B. Work with the client to minimize the anxiety and depression that she is experiencing
- C. Help the client understand the likelihood of her children having the disease

**4.** A client reports feeling very frustrated by his wife's behavior. She becomes upset when he is quiet at the dinner table, but constantly criticizes him when he speaks. What **BEST** describes what the client is experiencing?

- A. A paradoxical directive
- B. A double bind
- C. A negative feedback loop

**5.** What should be the focus when a social worker is treating clients who have experienced complex childhood trauma?

- A. Removal of and protection from other sources of trauma
- B. Recognition that recovery is possible and can occur quickly
- C. Acknowledgement that what was lost can all be recovered

**6.** A social worker who provides counseling to clients in a job training program is charged with evaluating the program's effectiveness. The social worker finds that 80% of clients get jobs and keep them for a year after graduation. Which of the following is the focus of the social worker's assessment?

- A. Outcome
- B. Impact
- C. Output

**7.** A client who was briefly admitted to the hospital after a panic attack is being discharged with a prescription for a benzodiazepine. Which of the following medications has been recommended?

- A.** Prolixin
- B.** Prozac
- C.** Ativan

- 8.** What is the **MOST** significant difference between bipolar I and bipolar II disorders?
- A.** Bipolar II never includes psychosis which is always present in bipolar I
  - B.** Depression is more severe in bipolar I as compared with bipolar II
  - C.** Bipolar I must include at least one manic episode while bipolar II includes only hypomania
- 9.** A school social worker is asked by a funder to conduct an evaluation of a youth services program. The evaluation is based on personal interviews with middle school children who are participating in the program. What permissions will be needed for the social worker to ethically conduct the evaluation?
- A.** Consent from the children's guardians
  - B.** Assent from the children and consent from their guardians
  - C.** Consent from the children
- 10.** Due to an agency closure, a social worker has referred a client to a new provider. With the client's consent, all relevant treatment information has been transferred. The social worker and client have also had several joint meetings with the new provider to discuss ongoing client needs. Several weeks later, the social worker learns that the client has had no contact with the new provider despite numerous outreach attempts. The social worker feels strongly that ongoing treatment is needed. The social worker should:
- A.** Seek consultation to determine if steps in the referral process inhibited continuity of treatment
  - B.** Send a termination letter with the discharge plan and contact information of the new provider
  - C.** Meet with the client to determine issues that have prevented following through

- 11.** When social workers receive clinical supervision from those who are not employed in their agencies, which of the following is **MOST** important for social workers to obtain?
- A. Contractual agreements with supervisors and agencies
  - B. Authorization by agency directors allowing social workers to receive outside clinical supervision
  - C. Consent from clients that information will be discussed with non-agency employees
- 12.** When clients have co-occurring mental health and substance use disorders, what is the appropriateness of taking psychotropic medications?
- A. Psychotropic medications should not be taken when there are co-occurring disorders
  - B. Psychotropic medications can only be prescribed if clients understand the side effects
  - C. Psychotropic medications are part of accepted treatment protocols in some instances
- 13.** Who has the ultimate responsibility for selecting models of social work supervision?
- A. Administrators
  - B. Supervisees
  - C. Supervisors
- 14.** A social worker is making a level of care determination for an older adult client who will be moving from home into a residential setting. Which of the following client abilities will be **MOST** helpful for the social worker to assess?
- A. Adaptation to life changes
  - B. Management of medical problems
  - C. Perform activities of daily living
- 15.** During an assessment, a social worker learns that a couple spends little time apart despite having problems that have caused them to seek treatment. The wife feels lonely when her husband travels for

work as she has few friends outside the marriage. The husband states that he is “smothered,” but gets jealous easily, causing him to contact his wife frequently throughout the day. The husband reports that he is often unhappy as his wife seems miserable, while the wife states that she is frustrated as she is just trying to find ways to make her husband more content. In order to **BEST** address the problem, which of the following actions should be the focus of treatment?

- A. Assisting the wife to develop a stronger sense of self-worth in the marriage
  - B. Helping the husband and wife to better understand each other's feelings
  - C. Differentiating roles and boundaries for the husband and wife in the relationship
- 16.** A social worker has additional information on a client situation that the social worker would like to add to the record as this information helps clarify discussions that took place with the client during the last session. In this situation, the social worker should:
- A. Ask a supervisor about agency protocol related to management of client records
  - B. Add the material to the previous case note to clarify material presented in the last session
  - C. Record the information as a new, separate record entry with a reason for the addition
- 17.** A client is referred to a social worker as she has been repeatedly hospitalized due to medication noncompliance. During the assessment, the client admits to frequently missing doses of her prescribed medication. This behavior has resulted in numerous inpatient stays, which she complains are both costly and adversely impacting her quality of life. Which of the following is the **BEST** question for the social worker to ask?
- A. “Why haven't you been able to take your medication as prescribed?”
  - B. “Can you think of any advantage of having to stay in the hospital?”

C. "What are some of the reasons for skipping your medication?"

**18.** When is family therapy **BEST** introduced in the treatment of clients with substance use disorders?

- A. Concurrently with clients' acknowledgements that substance use problems exist
- B. Immediately after clients complete detoxification
- C. Once clients are stable in their new patterns of behavior

**19.** During a session, a client discloses to a social worker that she was sexually abused by her father when she was an adolescent. The client has never confronted her father and does not want the social worker to disclose the information. There is no legal duty to report the abuse since the client is no longer a minor. The father poses no current threat to children given a significant decline in his functioning. In order to handle the situation ethically, the social worker should:

- A. Respect the client's wishes by keeping the disclosure confidential
- B. Seek supervision to determine whether to keep the information confidential
- C. Report the suspected abuse to the child welfare agency

**20.** Which of the following is the **MOST** important reason for seeking feedback from a client during the beginning phase of treatment?

- A. Ensuring an understanding of the client's problem
- B. Focusing the treatment on a client's feelings and thoughts
- C. Emphasizing that treatment is a mutual and reciprocal process

**21.** Which of the following describes the structured inequality of entire categories of people who have different access to social rewards because of their status, power, and wealth?

- A. Social stratification
- B. Discrimination
- C. Institutional malfeasance

- 22.** Which of the following documentation practices of supervisory sessions is **MOST** appropriate in social work?
- A. Supervisory records should solely be maintained by supervisors as they are legally responsible for the delivery of services by supervisees
  - B. No records should be kept by either supervisees or supervisors in order to maintain client confidentiality
  - C. Supervisees and supervisors should maintain separate records of each session with both parties being able to access the other's notes as needed
- 23.** A newly hired social worker in an agency setting learns that he will simultaneously be supervised by more than one person. In order to minimize conflicts in this situation, the social worker should:
- A. Develop a memorandum of understanding with the supervisors
  - B. Meet with the supervisors simultaneously at all times
  - C. Review the professional code of ethics with the supervisors
- 24.** The primary goal of court-ordered competency restoration is for clients to:
- A. Identify ways to provide restitution for actions which have harmed others
  - B. Develop or regain ability to participate in legal proceedings
  - C. Serve legal sentences that have been imposed but not served due to mental impairment
- 25.** Which of the following is a condition often cited by courts when deciding whether information is considered privileged?
- A. Harm caused by keeping information confidential outweighs the benefits
  - B. Written records documenting services have been kept secured
  - C. Parties involved in the communication assumed that it was confidential
- 26.** A client tells a social worker that she is having problems with her teenage daughter's behavior. The daughter has begun to violate

strict rules set in the home. The client, who is frustrated with this disobedience, states that she often does not speak to her child for days as punishment. The client does not understand why the girl questions the rules and does not behave as expected. Based on this description, which style of parenting is the client **MOST** likely using?

- A. Authoritarian
  - B. Authoritative
  - C. Uninvolved
- 27.** A couple seeks assistance from a social worker as they are having problems in their marriage. While they have been happily married for about 10 years, the wife complains that issues have arisen in the last year as her husband frequently telephones his mother after the couple argues. The wife states that she now feels uncomfortable when with her mother-in-law and is worried that her mother-in-law has a negative opinion of her based on her husband's conversations. The husband insists that he has tried to work out issues directly with his wife but needs his mother's opinion to successfully resolve his feelings. Which of the following **BEST** describes this family dynamic?
- A. Role reversal
  - B. Triangulation
  - C. Entropy
- 28.** Which of the following is **BEST** characterized as a delusion of reference?
- A. Insisting assertions are correct despite contradictory evidence
  - B. Believing neutral stimuli or communications have personal meaning or messages
  - C. Attributing personal failure to external factors that cannot be controlled
- 29.** According to client-centered therapy, what is essential for a climate conducive to growth and therapeutic change?
- A. Cultural competence

- B. Positive unconditional regard
- C. Client expertise

- 30.** A mandated client questions the confidentiality of specific documentation that is generated as part of treatment. The social worker should:
- A. Suggest the client speak to legal counsel to determine whether material is privileged
  - B. Review the court order with the client to determine what documents have to be released
  - C. Explain that client consent will be obtained prior to releasing any records to the court
- 31.** Which of following is considered best practice in treating pregnant women who are addicted to heroin?
- A. Continued use of heroin under medical supervision
  - B. Discontinuation of all opioids immediately
  - C. Enrollment in a methadone maintenance program
- 32.** A social worker employed at a nursing home notices that a client with Alzheimer's disease experiences heightened delirium during the evening hours with improvement during the day. Which of the following terms **BEST** describes this client's change in mental state?
- A. Folie à deux
  - B. Sundowning
  - C. Neurodegeneration
- 33.** A social worker is assisting a client to cope with depression after a stroke. The client reports having difficulty meeting his basic needs and suggests having his daughter come to the next session to discuss his current problems as she lives nearby and is supportive. In this situation, the social worker should:
- A. Determine whether other family members or friends should be included in the meeting
  - B. Explain that including her in sessions is not allowed due to

confidentiality standards

- C. Ensure there is an agreement about the meeting purpose and what information will be shared

**34.** A hospital social worker being supervised by a professional of a different discipline is having difficulty with a social work practice issue. The social worker should:

- A. Seek supervision or consultation from another social worker
- B. Consult professional resources to identify possible solutions
- C. Determine how the issue would be handled in the supervisor's discipline

**35.** Which of the following is the primary aim of performance monitoring in social work agencies?

- A. Identifying key aspects of program operations
- B. Determining whether program objectives are being achieved
- C. Justifying the need for service delivery to meet target problems

**36.** A social worker is counseling a client who suffers from depression and has recently been hospitalized for a suicide attempt. During a therapy session, the social worker notices that the client appears significantly more cheerful than she has in past weeks. The client reports that she feels better generally without citing any specific reasons for her improved affect. In this situation, the social worker should **FIRST**:

- A. Praise the client for the progress that she has made since her hospital discharge
- B. Conduct a suicide risk assessment of the client
- C. Ask about changes that have taken place in the client's life in the last week

**37.** A client who was recently promoted speaks to a social worker about how he believes that his boss does not like him and is critical of his work despite never verbally stating any dissatisfaction. The client, who has lost a previous job due to company downsizing, is nervous that he might be fired if rumors of financial troubles in the business

prove accurate. After accurately reflecting the client's nervousness, the social worker should **NEXT**:

- A. Listen as the client describes further feelings about his relationship with his boss
- B. Suggest that the client's feelings may result from his prior job loss
- C. Help the client examine behavioral cues by his boss that support or dispel his claims

**38.** A social worker charged with giving a case presentation provides background and demographic information on the client, the reason for the presentation, and the interventions delivered. Which of the following would **MOST** appropriately describe this case presentation?

- A. Inappropriate as a case presentation should never contain demographic information
- B. Incomplete because it did not include the nature of the problem
- C. Acceptable as a basis for collaborative discussion with other treating professionals

**39.** According to a public health model, which of the following is the desired outcome of screening for those found to be at-risk of a medical or behavioral health condition?

- A. Further diagnostic testing
- B. Referral to treatment
- C. Targeted education

**40.** The primary goal of attending behavior by social workers is to:

- A. Determine the scope and severity of client problems
- B. Assist clients to identify alternatives which result in change
- C. Encourage clients to speak openly about their concerns

**41.** Which of the following is the **MOST** critical factor in the selection of an appropriate intervention?

- A. Presenting problem

- B. Past service history
- C. Agency setting

**42.** A social worker meeting with a 10-year-old boy and his mother notices what appear to be bite marks on the boy's legs. The social worker suspects that the marks resulted from physical abuse in the home. The mother asks if the social worker will be reporting the incident to the authorities. The social worker should **FIRST**:

- A. Document the nature of the injuries
- B. Ask to meet with the child alone
- C. Inform the mother and child that reporting is required

**43.** A social worker receives a referral from a high school guidance counselor for a student who has received a full scholarship to college but decided not to attend due to family responsibilities at home. Both school officials and the social worker feel that the student is making a mistake as it is unlikely that she will be able to attend college without the current scholarship opportunity. In order to effectively work with the student, the social worker should:

- A. Understand the extent of the family responsibilities that prevent her attendance
- B. Determine the short- and long-term career goals of the student
- C. Acknowledge the differences in values that may exist between the student and school personnel

**44.** Which action would be **MOST** appropriate when using a medical model to treat gender dysphoria?

- A. Providing medication and surgical interventions as needed
- B. Exploring mind–body connections associated with gender nonconformity
- C. Screening for physical conditions that may accompany the disorder

**45.** Which of the following is an assessment to detect an alcohol or substance use problem?

- A. AUDIT

- B. SCOFF**
- C. MDS**

- 46.** Which of the following is the primary distinction between defense and coping mechanisms?
- A. Defense mechanisms are discrete reactions to traumatic stressors while coping mechanisms are continuous unconscious actions taken to deal with everyday life events**
  - B. Defense mechanisms are maladaptive methods of addressing threatening events while coping mechanisms are based on healthy decisions aimed toward self-preservation**
  - C. Defense mechanisms are unconscious while coping mechanisms involve deliberate cognitive and emotional modifications**
- 47.** In an initial meeting with a man who has been mandated to receive counseling due to severely beating his young son, a social worker explains the terms outlined in the court order and what can be expected in treatment. The social worker ends by asking the client, "What do you think about what we have talked about so far?" The purpose of the social worker's question is to:
- A. Assess the presence of denial with regard to the incident in question**
  - B. Identify whether the client is aware of the legal mandates placed upon him**
  - C. Convey to the client that treatment is a mutual and reciprocal process**
- 48.** Which approach is a social worker using when viewing marital problems as stemming from different understandings and expectations that spouses have of their marriages?
- A. Psychodynamic**
  - B. Symbolic interactionism**
  - C. Functionalism**
- 49.** In an initial meeting with a man who is seeking assistance after several arrests, a social worker determines that his reasoning is

significantly impaired as he admits to using drugs before the meeting. The social worker wants to obtain the man's consent to find out more about his arrests and begin providing services aimed at assisting him to meet his basic needs. However, the social worker questions his ability to understand what she is asking and understand the information provided on the agency's consent form. The social worker should:

- A. Waive the informed consent procedures since the man is in need of services immediately
- B. Employ verbal informed consent procedures in lieu of written forms given his impairment
- C. Arrange to meet the man at a later time when informed consent can be obtained

**50.** During an assessment, a client reveals a long history of substance abuse, but states that she has not used drugs in the last 15 years. She reports that she was sexually abused as both an adult and child, engaging in prostitution for many years. The client states that she has a strained relationship with her three children who she did not raise. Recent health problems have resulted in loss of ambulation, requiring her to use a wheelchair when leaving the house. The client reports that she has become isolated and unable to meet her friends due to issues with transportation. Not seeing her friends has resulted in her feeling worthless. The client feels that meeting with her friends as she did in the past would help decrease her feelings of insignificance. Which of the following would be the **MOST** important step in establishing a measurable target for this objective?

- A. Finding out the frequency of contact with her friends in her premorbid functioning
- B. Determining the impact of the poor relationships with her children on her current feelings
- C. Assessing the magnitude of her hopelessness and depression

**51.** A social worker is treating a client with bipolar I disorder. When the client is in a depressive state, she feels out of control and that

something terrible will happen. Which specifier should be added to this client's diagnosis to further clarify her symptoms?

- A. With melancholic features
- B. With anxious distress
- C. With rapid cycling

**52.** Which of the following does not alleviate emotional distress due to caregiving?

- A. Transition of the person requiring care into a nursing home
- B. Improvement in activities of daily living of the person requiring care
- C. Recovery from illness that impeded functioning of the person requiring care

**53.** According to the *DSM*, which specifier can be used with obsessive-compulsive and related disorders?

- A. With dissociative symptoms
- B. With poor insight
- C. With anxiety

**54.** According to the *DSM*, which is not a specifier used for autism spectrum disorder?

- A. Associated with psychosocial stressors
- B. With or without accompanying language impairment
- C. With or without accompanying intellectual impairment

**55.** A client who is sexually attracted to other men tells a social worker that he is very distressed over his homosexuality. He has low self-esteem and appears distraught. The client feels that he will not be accepted by others. In assisting the client to formulate treatment goals, the social worker should:

- A. Role model discussions with family and friends about his sexuality
- B. Identify those in his life who the client feels will not accept him
- C. Explore the client's past relationship with family and friends to

better understand his concerns

**56.** A social worker receives a counseling referral for a student who is getting a social work degree at a local university. The social worker teaches a course in the program but has not had the student in class. In order to handle the situation ethically, the social worker should:

- A.** Speak with the program director to determine if it is likely that the student will need to take a course with the social worker
- B.** Meet with the student to assess whether the problems that the student is experiencing pose a conflict of interest for the social worker
- C.** Inform the student that services cannot be provided given the potential for a conflict of interest

**57.** Which is a negative symptom of schizophrenia?

- A.** Hallucinations
- B.** Delusions
- C.** Difficulty beginning and sustaining activities

**58.** When a social worker is meeting with a court-ordered client for the first session, the client appears apprehensive about discussing mandated services. Which of the following is **MOST** likely the cause of the client's behavior?

- A.** Fear of having information shared with those in the criminal justice system
- B.** Unwillingness to change the behavior which caused the current problems
- C.** Feelings about not being given a choice about service provision

**59.** When doing narrative therapy, how should a social worker view a client problem?

- A.** As part of a larger system so that a client does not internalize responsibility
- B.** Enmeshed with a client's sense of self which necessitates the need for change

C. Separate or external from a client so that it can be deconstructed and controlled

**60.** A social worker who is treating a client with binge eating disorder asks the client to engage in self-monitoring by writing down what is eaten and any triggers of excessive food intake. Which practice method is **MOST** likely being used by the social worker?

- A. Task-centered treatment
- B. Cognitive behavioral therapy
- C. Narrative therapy

**61.** Which of the following is the **BEST** definition of hegemony within society?

- A. Universal rejection of practices that do not value all people as equal
- B. Power of one group to lead and dominate other groups
- C. Discrimination based on gender norms that promote masculine identities

**62.** Which statement is accurate about those diagnosed with borderline personality disorder?

- A. They are less likely than those without the disorder to be childhood neglect or abuse victims
- B. They usually show little improvement in social functioning over time even when treated
- C. They often do not meet the criteria for the disorder if assessed a decade after the first diagnosis

**63.** A social worker is concerned about a client's alcohol use and wants to use a brief four-question screening instrument to assess for problem drinking and possible alcohol problems. First, the social worker asks the client whether she has ever wanted to cut down on her drinking. The social worker then questions whether the client ever felt bad or guilty about her drinking. Lastly, the social worker inquires about whether the client has ever had a drink first thing in the morning (an "eye opener") to steady her nerves or get rid of a

hangover. In order to complete the assessment, which of the following should be the focus of the social worker's last question?

- A. Legal involvement resulting from the client's drinking
- B. Whether criticism about her drinking has made the client annoyed
- C. If medical problems that have recently been diagnosed related to the client's drinking

**64.** If a social worker is ordered to release information without a client's consent and such disclosure would cause harm to a client, the social worker's **MOST** appropriate action is to:

- A. Request that the court withdraw the order
- B. Minimize releasing harmful information by redacting sensitive material
- C. Ask that the records be maintained under seal

**65.** Which statement **BEST** supports the need for professional development of social workers?

- A. Staying well-informed of social work issues and trends makes social workers more competitive in the job market
- B. New research provides social workers with information that can impact the use of interventions in practice
- C. Many licensing boards require social workers to take continuing education courses to obtain or maintain professional credentials

**66.** What is the **MOST** significant contributor to cultural convergence?

- A. Education
- B. Globalization
- C. Marriage

**67.** When completing intake paperwork, a client identifies as "Latinx." What meaning can the social worker assign to the use of this term by the client?

- A. The client identifies with a demographic age cohort of people who were born in the mid-1960s

- B. The client values gender identities that are not strictly binary
- C. The client is of Latin American descent but is not Spanish speaking

- 68.** A social worker is terminating with an adolescent who has shown marked improvement in her anxiety. She received counseling for several months to address school absenteeism, which resulted from her excessive nervousness. During the termination process, the social worker learns that the client will be going to a new school due to redistricting. In this situation, the social worker should:
- A. Conduct an assessment to determine whether termination is still appropriate
  - B. Acknowledge progress that the client has made during treatment
  - C. Contact student services at the new school to see if follow-up services are available
- 69.** How should a social worker store psychotherapy notes to afford a client the greatest confidentiality protection?
- A. In a separate section of the client's file
  - B. Separate from the rest of the client's clinical record
  - C. According to agency policy
- 70.** A social worker believes that the client who abruptly stopped smoking cannabis after heavy, prolonged daily use may meet the criteria for a diagnosis of cannabis withdrawal. The social worker notices that the client is anxious and restless immediately after quitting. Which of the following signs must also be present for the diagnosis to be made?
- A. Depressed mood
  - B. Increased appetite or weight gain
  - C. Hallucinations
- 71.** A social worker receives a referral for a child with a neurodevelopmental disorder who is having trouble in school. The social worker's goal is to identify appropriate learning opportunities within the school setting that can help address areas of delay. In

which of the following areas will in-depth knowledge be needed by the social worker to effectively work with this child?

- A. Child growth
- B. School policy
- C. Past academic performance

**72.** When there is a distant relationship between family members, which type of line is used to connect these individuals in a genogram?

- A. Dotted
- B. Shaded
- C. Jagged

**73.** A client who has a stable, well-paying job tells a social worker that she plans to quit in the coming weeks. The client states that she is miserable, but she is not able to specify what she does not like about her current employment. The social worker feels that the client is making a poor decision which could have serious ramifications for her financial well-being. In order to handle this situation appropriately, the social worker should **FIRST**:

- A. Acknowledge the client's right to make her own decisions about her life
- B. Assess whether there have been changes in the client's life that have resulted in this decision
- C. Review with the client the risks and benefits of leaving her job

**74.** A client with brain damage due to Korsakoff syndrome often tells stories based on false memories of events which never occurred. Which of the following **BEST** describes this disorder?

- A. Reaction formation
- B. False memory syndrome
- C. Confabulation

**75.** Which type of law initially established social workers' duty to disclose confidential information without client consent to protect third parties from harm?

- A. Case
- B. Constitutional
- C. Regulatory

**76.** When a social worker experiences a value conflict with a client, the social worker should:

- A. Refer the client to another social worker
- B. Respect the client's right to self-determination
- C. Acknowledge the impact of this conflict on the problem-solving process

**77.** A woman seeks the help of a social worker because her son who has schizophrenia will not take medication. She is distraught as his mental illness is causing significant problems in the functioning of the family. Which of the following factors should the social worker emphasize as the factor is the **MOST** prevalent reason why clients with this diagnosis often do not take medications?

- A. Side effects
- B. Anosognosia
- C. Denial

**78.** Which of the following is the **BEST** definition of intersectionality?

- A. Conflicting values that are rooted in differences in beliefs that undermine pluralism
- B. Negative impacts in social, emotional, and other life domains due to discrimination
- C. Interdependent forms of privilege resulting from different social locations and power relations

**79.** A social worker receives a referral for a young woman who was recently arrested after assaulting someone on the street. At intake, she reported being surprised that she got into a fight but admits that she was drinking at the time of the incident. In describing her childhood, she uses a flat affect when mentioning severe physical and sexual abuse at the hands of her mother's boyfriend between ages 4 and 15. The client states that her abuse does not affect her

life now, but she is unable to answer specific questions about the abuse due to being unable to remember much about the time period. Which of the following responses to trauma is the client **MOST** likely experiencing?

- A. Excessive guilt
- B. Intrusive thoughts and memories
- C. Dissociation

**80.** Which behavior would be atypical for a client with a diagnosis of schizoid personality disorder?

- A. Avoiding sexual relationships
- B. Engaging in angry outbursts when criticized
- C. Declining invitations to social events

**81.** Which situation would warrant family-centered social work practice over individual counseling?

- A. Boundaries within the family structure are continually being violated
- B. Violence is being perpetrated by one family member against another
- C. Stabilization is needed for a family member in crisis due to substance abuse and/or psychosis

**82.** A social worker receives a referral for a client who has been diagnosed with both obsessive-compulsive disorder and tic disorder. The client reports regularly taking the medication prescribed by his psychiatrist, but still not being able to control his urges. He would like help to reduce his obsessive thoughts and compulsions that accompany them. In order to best assist the client, which of the following therapeutic models should the social worker employ?

- A. Solution-focused
- B. Psychoanalytic
- C. Behavioral

**83.** A social worker is conducting an assessment with a client who has

been living with a chronic disease for many years. The client has been able to manage the symptoms of her illness successfully with no reported negative impact on her daily life. She has just learned that she will need to begin a complicated medication regimen in the coming weeks to slow the illness's progression. The client is very worried about ensuring that the drug administration does not adversely affect her current routine. Which of the following will

**BEST** meet the client's needs?

- A. Case management
- B. Psychoeducation
- C. Psychotherapy

**84.** A social worker is hired by an agency to provide consultation aimed at reducing high client dropout rates. According to the funder, a greater proportion of this agency's clients leave services when compared with clients of similar providers. Which of the following is the source of the social worker's authority when making recommendations?

- A. Agency employment
- B. Professional expertise
- C. Organizational structure

**85.** A mother seeks treatment with a social worker due to her 9-year-old daughter's behavior. The child has refused to go to school due to unwillingness to be separated from her mother and is falling behind in her schoolwork. The situation has caused stress within the family and the woman reports that she will likely be fired due to being preoccupied with her daughter's problems while at work. The mother feels hopeless and frustrated. The social worker's **MOST** appropriate intervention is to:

- A. Suggest that the woman explain the reasons for her recent behavior to her employer
- B. Acknowledge that hopelessness and frustration are common in these situations
- C. Teach the woman ways to cope while addressing the causes of her daughter's behavior

- 86.** Which of the following findings on social development is the **BEST** justification for mainstreaming children with unique learning needs?
- A. Peer relationships depend on inhibiting impulses and understanding cause–effect relationships
  - B. Peer acceptance is affected by family support, parental interactions, and sibling relationships
  - C. Peer friendships are protective factors from psychological problems and promote self-image
- 87.** A client who has been chronically depressed is prescribed a selective serotonin reuptake inhibitor by his psychiatrist. He feels much more hopeful with many of his unhappy thoughts dissipating. The client reports that his relationship with his wife has improved, but he has recently been experiencing erectile dysfunction which has made sexual intercourse difficult. Which of the following is **MOST** likely the cause of this dysfunction?
- A. Relationship problems that were masked by his depression
  - B. A side effect of his antidepressant medication
  - C. Biological changes that are typical as men age
- 88.** A social worker is observing to determine if the frequency of a high-rate behavior has declined due to operant conditioning. Which of the following is the **MOST** significant concern about using this approach?
- A. Observation is a very costly method of data collection
  - B. The client is in the presence of the social worker for part of the day
  - C. Some behaviors do not lend themselves to observational study
- 89.** A social worker is meeting with a third-grade boy who is struggling in school. Despite his poor grades, his parents seem disinterested in assisting him with his schoolwork. He is frustrated by his academic performance, but he does not know how to do better. Which psychosocial problem is the boy **MOST** likely to experience if this situation is not addressed?
- A. Mistrust

- B.** Guilt
- C.** Inferiority

- 90.** Which of the following consent procedures **BEST** informs clients of the nature and expectations of the social worker/client relationship?
- A.** Discussing written policies throughout the problem-solving process
  - B.** Asking clients to sign written consent forms prior to initial meetings
  - C.** Ensuring that written policies are updated regularly and signed by clients
- 91.** In object relations theory, which of the following occurs when two contradictory thoughts or feelings cannot be tolerated simultaneously, causing only one to be recognized at a time?
- A.** Isolation
  - B.** Resistance
  - C.** Splitting
- 92.** Which role does a family member assume when aiming to draw attention away from addiction in a family unit?
- A.** Enabler
  - B.** Mascot
  - C.** Scapegoat
- 93.** For which disorder do children with disruptive mood dysregulation disorder (DMDD) often meet the diagnostic criteria?
- A.** Oppositional defiant disorder
  - B.** Bipolar disorder
  - C.** Autism spectrum disorder
- 94.** A school social worker learns that the academic needs of a new student can be adequately met in either the regular classroom with additional supports or a separate resource room for students who require special assistance. The parents would like their child to

remain with his friends in the classroom, but the guidance counselor feels strongly that the student would be better served in a resource room for at least part of the day. In this situation, the social worker should:

- A. Meet with the child to determine whether there is a preference about the settings offered
- B. Suggest ways to maintain friendships while the child receives instruction in a resource room
- C. Advocate for the child to receive any supports needed in the regular classroom

**95.** After completing an assessment, a social worker diagnoses a client with binge eating disorder. Which of the following will be **MOST** effective in treating the client for this condition?

- A. Psychoanalysis
- B. Task-centered treatment
- C. Cognitive behavioral therapy

**96.** A social worker in a hospital emergency department meets with an elderly client who demonstrates significant memory and cognitive loss. In order to differentiate whether these impairments are due to major neurocognitive disorder or delirium, which of the following should the social worker assess?

- A. Symptom progression from first onset
- B. Severity of memory loss
- C. Impact on all areas of adaptive functioning

**97.** When completing a functional behavioral assessment, a social worker should **FIRST**:

- A. Determine why an intervention is needed
- B. Identify antecedents which are hypothesized to cause the behavior
- C. Define a problem behavior in measurable terms

**98.** Which of the following factors often threatens social workers having shared power with clients?

- A. Social workers view issues more objectively than clients
- B. Most services are delivered in agency-based settings
- C. Clients may need immediate assistance from social workers to address their problems

**99.** A client is having trouble achieving a treatment goal, so the social worker breaks it down into small successive steps and rewards the client after achieving each one. Which behavioral technique is the social worker utilizing with this client?

- A. Biofeedback
- B. Modeling
- C. Shaping

**100.** During the first meeting, a client whose spouse has recently died tells the social worker that she is just now accepting the reality of the death. Understanding the mourning process, the social worker can expect the client to:

- A. Move sequentially through the stages of grief towards acceptance
- B. Need more time before talking about the loss
- C. Require the support of others to enhance her capacity for healing

**101.** A social worker recently terminated with a client who made substantial progress in managing her anxiety. The former client has been asked by her church to facilitate a peer support group for others who have experienced similar problems. The former client is nervous about this request and asks the social worker to be a co-facilitator. The social worker feels that the former client would benefit from this peer interaction. In this situation, the social worker should:

- A. Assist with helping prepare for, but not co-facilitate, the group
- B. Help co-facilitate for several sessions until the former client feels more comfortable
- C. Encourage participation while declining the request to co-facilitate

**102.** A school social worker who is facilitating a group for adolescents notices that one member who recently immigrated with her family from Japan interacts very little during most of the sessions. In order to meet this client's needs, the social worker should:

- A. Suggest that meeting individually may be more appropriate to facilitate expression of feelings
- B. Determine class participation to see if this behavior occurs in other settings
- C. Create ongoing varied opportunities for interaction by all group members

**103.** During an initial session, a client appears reluctant to speak and states, "I am not sure if this is going to work out." In this situation, the **BEST** course of action for the social worker is to:

- A. Clarify what can be expected, including the roles of the social worker and client
- B. Inform the client that treatment will be focused in achieving desired outcomes
- C. Ask about other situations in which the client has felt this way

**104.** A young man who has a criminal history for violent acts later becomes an acclaimed boxer. Which of the following defense mechanisms is the client **MOST** likely exhibiting?

- A. Introjection
- B. Sublimation
- C. Undoing

**105.** Which of the following is the **BEST** definition of conversion?

- A. Therapeutic process aimed at turning negative thoughts directed at others into positive ones
- B. Defense mechanism in which a repressed urge is expressed by disturbance of a body function
- C. Strategy used in family therapy to get consensus among those with divergent viewpoints

**106.** A social worker is serving an elderly woman who has recently experienced declining health due to aging and loss due to the deaths of several close friends. She has missed several appointments due to illness and states that she is not participating in many of her prior community activities as she is too tired to do so. In order to determine if the client is in crisis, the social worker should:

- A. Review her most recent physical evaluation to determine the severity of her health problems
- B. Conduct an interview with her to gather subjective data on recent life events and changes
- C. Obtain information from collaterals to get a better understanding of her current functioning

**107.** To be diagnosed with cyclothymic disorder, how long does an adult need to experience mood cycling?

- A. 2 years
- B. 6 months
- C. 12 months

**108.** Which of the following types of events are **MOST** significantly associated with emotional or psychological trauma?

- A. Events that occur in adulthood
- B. Events that happen unexpectedly without warning
- C. Events that can be prevented

**109.** A family seeks counseling as their adolescent daughter recently ran away from home. During the first session, the daughter states her parents do not care about her well-being and are overly concerned with meeting their job demands. She feels that all interactions with them are contentious and end in arguments. The mother admits to feeling overwhelmed by daily life and disconnected from both her husband and her daughter at times. The father feels that the root of the problem is that the daughter has been given too much control in the household. Using a structural family therapy approach, the social worker should:

- A. Assess whether the current state of the mother requires immediate attention due to a risk of self-harm
- B. Instruct the daughter to discuss with her parents a current concern that she has that she feels they are not addressing
- C. Determine when each family member's concerns began in an attempt to determine the etiology of the problem

**110.** When social workers engage in peer supervision, which of the following is the primary method for learning?

- A. Modeling
- B. Positive reinforcement
- C. Formative feedback

**111.** A social worker is developing a contract with a client who has been mandated for treatment. Which of the following actions by the social worker would be **MOST** helpful in promoting client's self-determination?

- A. Explaining directives contained in the court order to the client
- B. Advocating for clinically appropriate modifications to mandates
- C. Eliciting input from the client about the methods of intervention to be used

**112.** At the conclusion of the sixth session, a client states that her attorney would like to speak to the social worker. When the social worker asks about the nature of the request, the client states that she does not know the reason and the social worker will need to contact the attorney to find out. The social worker should **FIRST**:

- A. Contact the attorney with assurance that all legal matters will be discussed with the client in future sessions
- B. Decline the request until the social worker's role is clarified and client expectations are understood
- C. Arrange a time for the client to be present during the social worker–attorney conversation to ensure transparency about what is disclosed

**113.** During the first session, a client blames the recent termination

from his job for many of his other problems. He reports that his girlfriend ended their relationship as she was angry that he was fired. He also had to move in with a relative as he could no longer afford his rent. He reports feeling like a failure and does not know "how things got so bad." The **BEST** response by the social worker is to:

- A. Identify which problem is the top priority so it can be targeted for immediate assistance
- B. Assure him that many people lose their jobs and experience similar feelings
- C. Explore the reasons for his termination in order to get at the root cause of the problem

**114.** A social worker, who is counseling a couple, learns that the husband has recently been diagnosed with a rare medical condition that is being treated with medication. The wife reports that this medication causes dramatic mood changes, which she has witnessed. Due to a lack of knowledge about this medical condition and the medication prescribed, the social worker contacts a physician for consultation. Which of the following concepts is the basis of the social worker's action?

- A. Interdisciplinary collaboration
- B. Coordinated service delivery
- C. Standard of care

**115.** Which of the following statements is accurate about the blending and braiding of resources in human service programs?

- A. Federal categorical limitations make blending and braiding of resources difficult to administer
- B. Braiding of resources is seen as advantageous by administrators due to ease of implementation
- C. Blending and braiding of resources allows collective reporting on how monies are spent overall

**116.** A client reports that she is very upset by her 17-year-old daughter's behavior. She has not been completing her homework and is showing up late for her classes. The client reports that she

recently took away her daughter's cell phone until her behavior changes. Which of the following behavioral techniques is the client using with her daughter?

- A. Negative reinforcement
- B. Positive punishment
- C. Negative punishment

**117.** When an agency receives a single disbursement for services provided by two or more providers during a single episode of care or over a specific time period, which payment methodology is being employed?

- A. Capitation
- B. Fee-for-service
- C. Bundled payment

**118.** A client who is planning on ending her marriage comes from a culture in which divorce is strictly prohibited. The client has a poor self-image due to years of feeling a duty to stay married despite being unhappy. In order to be most effective, the social worker should:

- A. Use universalization when speaking with the client about her situation
- B. Help the client identify the steps needed for her to achieve her goal
- C. Explore why the client wants to end her marriage now

**119.** A social worker whose client engages in heavy alcohol consumption notices that he has confusion, problems with muscle coordination, drowsiness, and memory loss which persist even when he has not been drinking. Which of the following **BEST** treats these symptoms which are associated with his alcoholism?

- A. Thiamine injections
- B. Cognitive rehabilitation
- C. Physical therapy

**120.** A social worker is providing counseling to a client who is having

trouble in her workplace. The client feels isolated as she does not have any meaningful collegial relationships in her job. The client, who is lesbian, feels that her support system is limited to her partner with whom she has been living for the past 2 years. At the end of a session, the client gives the social worker a hug while thanking her for understanding the situation. The social worker, who has a policy not to have physical contact with her clients, hesitates, which causes the client to accuse the social worker of being homophobic. In this situation, the social worker should:

- A. Ask the client why the action is being viewed as homophobic
- B. Explain the reasons for the rule about not touching clients
- C. Provide assurance that the response was not meant to be homophobic

**121.** A social worker is reviewing referral information for a new client which identifies him as xenophobic. Which of the following tasks should be the focus of the social worker's initial interaction to help the client address this fear?

- A. Exploring the benefits of his interaction with those who are younger
- B. Managing the anxiety which results from his physical contact with others
- C. Understanding his aversion to those from other countries and their cultures

**122.** Which category of *DSM* disorders includes gambling disorder?

- A. Obsessive-compulsive and related disorders
- B. Disruptive, impulse-control, and conduct disorders
- C. Substance-related and addictive disorders

**123.** In the provision of mental health counseling, the primary purpose of social workers' case notes is to:

- A. Serve as documentation so supervisors can evaluate worker performance and skill
- B. Provide evidence of service receipt for reimbursement by third-party insurers

C. Ensure continuity of care as well as a means by which to evaluate client progress

**124.** The goal of a client with terminal cancer is to receive hospice services at home. Her health has deteriorated rapidly, but the social worker is having difficulty finding an appropriate provider due to the complexity of the client's medical condition and her current living situation. In order to meet the needs of the client, which social work value is **MOST** critical when intervening?

- A. Dignity and worth of the person
- B. Competence
- C. Social justice

**125.** A social worker at an outpatient treatment program observes a court-mandated client who is being treated for alcohol use disorder become outraged during a group session when leniency for those arrested for addiction-related offenses is discussed. The client states that severe punishment, as opposed to treatment options, must be required. This behavior surprises the social worker as the client has repeatedly expressed his appreciation for being offered treatment in lieu of imprisonment. Based on this behavior, which of the following defense mechanisms is the client **MOST** likely exhibiting?

- A. Projection
- B. Displacement
- C. Reaction formation

**126.** When evaluating the effectiveness of treatment, which technique statistically controls, on a post hoc basis, for differences between nonequivalent groups on outcomes of interest?

- A. Random sampling
- B. Case-mix adjustment
- C. Descriptive analyses

**127.** A social worker is working with a client who is attending an adult medical day program. Staff report that her hygiene has

deteriorated and she is increasingly disoriented. She has a visiting nurse coming to her home to administer her medications on the evenings when her adult son, with whom she lives, works outside the home. After a stroke several months ago, she began getting home-delivered meals. The client requires constant supervision while in the day program and the social worker is concerned about her current safety. Which collateral source will be **MOST** helpful in making this assessment?

- A. The client's adult son
- B. The client herself
- C. The agency staff who are providing direct and ancillary services

**128.** Which of the statements describes why fee splitting is considered unethical in social work practice?

- A. Fee splitting represents a conflict of interest which can adversely impact client care
- B. Fee splitting creates prohibited dual relationships which are boundary violations
- C. Fee splitting occurs without client consent which is mandatory for all treatment decisions

**129.** A mother and her adult son with developmental disabilities meet with a social worker for assistance in helping the young man move into his own apartment. While both the mother and son would like this move to occur, they have concerns as he will need support to meet his daily living needs, as well as attend to ongoing medical issues. The social worker recommends an interdisciplinary team approach to service planning. The **FIRST** step in this process should be to:

- A. Complete a biopsychosocial history to inform planning
- B. Develop a timeline for the problem-solving process to help structure decision making
- C. Identify areas of anticipated support to identify skills needed of team members

**130.** A former client contacts a social worker and requests a copy of

her record. The social worker asks about the reason for the request, but no explanation is provided. While the social worker is not worried about the client seeing the information in the record, the social worker is concerned about the client sharing the documents with others as the record contains sensitive information about the client's history. The social worker should:

- A. Send a copy of the entire record to the client
- B. Meet with the client to determine if the client will explain the reason for the request
- C. Ask the client to put the request in writing prior to making a decision

**131.** Which approach focuses on well-being and happiness through cultivation of meaningful experiences?

- A. Psychoanalysis
- B. Positive psychology
- C. Psychoeducation

**132.** Which statement **BEST** describes a difference between values and ethics?

- A. Values are unwritten personal belief systems while ethics are written rules or regulations that guide professional behavior
- B. Values are principles which guide behavior while ethics dictate whether this behavior is appropriate based on a moral code of conduct
- C. Values are individual standards of conduct which are stable over time while ethics vary based on cultural changes and advances

**133.** Which cognitive developmental stage is characterized by magical thinking?

- A. Concrete operations
- B. Preoperational
- C. Formal operations

**134.** Which criterion must be present for a social worker to diagnose a child with gender dysphoria?

- A.** Dislike of one's sexual anatomy
- B.** Desire to be the other gender or belief that one is the other gender
- C.** Preference for clothing and playmates of the other gender

**135.** Which of the following statements accurately describes the appropriateness of including assessment and service provision descriptions in client discharge plans?

- A.** Reasons for admission should not be incorporated, but descriptions of treatment must be contained in client discharge plans
- B.** Both reasons for admission and services provided must be included in client discharge plans
- C.** Client discharge plans should include reasons for admission, but not descriptions of treatment provided

**136.** Which nonverbal technique used in social work practice primarily aims to gain rapport at the unconscious level?

- A.** Clarifying
- B.** Mirroring
- C.** Reframing

**137.** A counseling agency charges the same amount to all clients enrolled in its group treatment program. Given a recent bequest, the board of directors proposes providing a standard subsidy to all group therapy clients to reduce their fees by a set amount. A social worker in the agency advocates for these subsidies to be proportional, with clients having the lowest incomes receiving the highest subsidies. The social worker argues that some clients can afford to pay the actual cost while those who have lower incomes cannot and should receive the subsidies. Which of the following is the basis of the social worker's recommendation for resource allocation?

- A.** Equity
- B.** Equality
- C.** Fidelity

**138.** A hospital social worker is meeting with a 54-year-old man who was admitted after police found him walking in the middle of the highway intoxicated. An assessment reveals that the client has tried unsuccessfully to reduce his drinking for many years, most recently after his wife left him. His marital problems stemmed from being fired from work due to excessive absenteeism related to his alcohol use. The client admits to spending most of his time drinking or thinking about drinking and often drinks more than he intends. According to the *DSM*, which of the following is the **BEST** diagnosis for this client?

- A. Alcohol intoxication
- B. Alcohol dependence
- C. Alcohol use disorder, severe

**139.** A social worker is interested in determining the impact of culture and race on self-image using an ethnographic approach. Which of the following would be the **BEST** method for this inquiry?

- A. Participant observation
- B. Experimental design
- C. Self-administered questionnaires

**140.** Which of the following social work core values supports unconditional positive regard?

- A. Importance of human relationships
- B. Self-determination
- C. Dignity and worth of the person

**141.** Which of the following is a defining characteristic of dyspareunia?

- A. Pain that occurs during sexual intercourse
- B. Short-term memory loss due to brain damage
- C. Urinary incontinence associated with age-related muscular changes

**142.** At which age does object permanence typically develop?

- A. 18 months

- B. 8 months
- C. 3 years

**143.** A social worker is providing counseling to a couple who are experiencing communication problems in their marriage. During a session, the wife becomes angry as she states that she never gets to speak or express her opinions. The social worker comments that the wife has done almost all the talking during the weekly sessions to date. Which of the following interviewing techniques is the social worker employing?

- A. Confrontation
- B. Interpretation
- C. Clarification

**144.** A client tells a social worker that he needs help managing his anxiety as it is interfering with both his professional and personal lives. He states that he has had problems with anxiety throughout his life, but his anxiety has become worse lately. The client reports feeling overwhelmed and wanting to change but does not know where to start. The social worker should **FIRST**:

- A. Determine what informal or formal treatments have been tried in the past
- B. Provide cognitive behavioral therapy to replace unhelpful, anxiety-producing thoughts
- C. Identify any risk for self-harm due to the report of being overwhelmed

**145.** A social worker has been working with an 8-year-old girl for over a year. The client's mother, who is going through a divorce, states that she is going to ask if the social worker can be appointed to supervise visits with the father. The need for supervised visitation has already been determined by the court. The mother feels strongly that the social worker is the best choice given the presence of a strong relationship with the child. The social worker should:

- A. Inform the mother that this additional role is not permitted
- B. Determine the child's feelings about the mother's request since

the child is the client

- C. Request to meet with the father to determine if he is comfortable with the arrangement

**146.** When engaging in reflective listening, a social worker should:

- A. Anticipate what should be said next to move clients through the therapeutic process
- B. Reconstruct what clients are thinking and feeling through verbal and nonverbal methods
- C. Help clients understand social work responsibilities in the problem-solving process

**147.** The primary goal of interdisciplinary service collaboration is to:

- A. Address the holistic needs of clients across life domains
- B. Develop innovative strategies for addressing social problems
- C. Increase the effectiveness of assistance provided to clients

**148.** A 22-year-old woman meets with a social worker due to her excessive fear of heights. During the assessment, the client states that she avoided climbing trees and other activities which raised her above the ground when she was a child. Recently, she has been unable to fly in planes and drive over bridges, causing the client to be restricted in her travels. The client is upset as she spends a great deal of time worrying about whether she will need to cross a bridge, causing her to sweat, breath heavily, and feel anxious throughout the day. During a recent visit with her physician, she was prescribed medication for this condition. Which medication was **MOST** likely recommended for the client?

- A. Ativan
- B. Risperdal
- C. Tegretol

**149.** A social worker formats client records into distinct sections representing all relevant information, issues to be addressed, and activities that need to be undertaken, respectively. Which model of recording is this social worker **MOST** likely using?

- A.** SOAP
- B.** DAP
- C.** APIE

**150.** A social worker is approached by a group therapy client who is concerned about the confidentiality of information that he would like to share during the next session. The social worker should:

- A.** Inform the client that information disclosed during meetings will be kept private unless it involves danger to himself or others
- B.** Ask the client about the nature of the disclosure so that appropriate guidance can be given as to whether it should be shared
- C.** Inform the client that confidentiality cannot be guaranteed as group members are not legally prohibited from disclosing information that is learned

**151.** A client has been approved for six sessions with a social worker by his insurance company. In formulating treatment goals, the client articulates changes which the social worker does not feel are achievable in the time frame approved. The social worker should:

- A.** Inform the client that more feasible goals must be developed
- B.** Advocate for the insurance company to authorize additional sessions
- C.** Respect the client's right to self-determination by working toward the client's desired changes

**152.** A social worker is working in a cultural community in which bartering is the accepted practice for obtaining goods and services. For the social worker to accept goods from clients for the provision of services, which of the following criterion must be met?

- A.** Clients must demonstrate that these arrangements will not be detrimental.
- B.** Bartering must be essential for the provision of services.
- C.** Social workers must initiate the request for bartering arrangements.

**153.** According to family systems theory, in which types of relationships does blame for the dynamics rest with specific individuals?

- A. Parent-child
- B. Abusive
- C. Adulterous

**154.** A social worker who is seeing a client for the first time asks the client how she would like to be addressed. Which of the following is demonstrated by the social worker's action?

- A. Cultural sensitivity
- B. Professional boundaries
- C. Practitioner objectivity

**155.** A social worker proposes a pilot program for youth with substance use problems to determine whether an intervention which has been highly effective with adults has similar results with children. The social worker wants to examine whether outcomes can be generalized to younger age groups before offering the service to all minors in the agency. Which of the following concerns does the pilot program hope to address?

- A. Internal validity
- B. Reliability
- C. External validity

**156.** Which of the following is classified as an anxiety disorder in the *DSM*?

- A. Obsessive-compulsive disorder
- B. Acute stress disorder
- C. Separation anxiety disorder

**157.** A social worker is counseling a middle-aged client who regrets spending most of his time during his adult life building a business. He blames this decision for preventing him from getting married and having children. The client would like to spend more time focused on hobbies that he abandoned due to his work schedule but does not know how to make this change. With which stage of

psychosocial development does the client appear to be struggling?

- A. Generativity versus stagnation
- B. Industry versus inferiority
- C. Initiative versus guilt

**158.** After determining that an ethical dilemma exists, a social worker should **NEXT**:

- A. Seek supervision to determine which agency policies impact on the situation
- B. Prioritize the ethical values which must be used to choose correct courses of action
- C. Weigh the issues in light of key social work values and principles

**159.** Which of the following is the evidence-based treatment for alcohol withdrawal?

- A. Psychopharmacology
- B. Self-help group participation
- C. Cognitive behavioral therapy

**160.** Which of the following **BEST** defines the concept of privilege when referring to client privacy?

- A. Legal rule that protects communications from compelled disclosure in court proceedings
- B. Mandate to obtain written consent from clients when information is to be disclosed
- C. Requirement to keep treatment information of minors confidential even from their parents

**161.** A primary purpose of a forensic interview with a child who has been a victim of child abuse or neglect is to:

- A. Identify emotional and psychological strengths to be used in successfully coping with abuse and trauma
- B. Determine the occurrence of abuse or trauma based on information that can be used for prosecution of perpetrators

C. Assess whether abuse or trauma has led to the perpetration of violent acts against others

**162.** Which of the following is not considered a deficiency need?

- A. Self-actualization
- B. Safety
- C. Esteem

**163.** Which of the following actions by a social worker is considered unethical according to the professional code of ethics?

- A. Charging rates which are significantly higher than those of other colleagues for the same services based on professional experience and training
- B. Soliciting private fees for providing services which are available through the social worker's employer or agency
- C. Terminating services to clients who are not paying overdue balances after financial contractual arrangements have been made clear

**164.** A social worker at an inpatient psychiatric unit is reviewing an intake assessment completed on a 21-year-old college student who was admitted the previous day due to bizarre behaviors. He was brought to the emergency department by the police who responded to student concerns about him yelling in an agitated voice, even though there was no one nearby. When asked about his actions, the client stated that he was being monitored by a deadly chip implanted in his brain by evil aliens. When contacted, his parents reported that they began to worry about him 8 months ago due to the presence of some unusual behaviors, but their concerns grew in the last 2 months when he stopped attending classes altogether. The social worker sees that the client was examined by the psychiatrist upon intake and medication was prescribed. Due to these symptoms, which medication is the client **MOST** likely going to be prescribed?

- A. Lithium
- B. Prozac
- C. Clozaril

- 165.** A woman comes to see a social worker as she does not want to cause conflict in her marriage, but she is very unhappy. She has a preschool child and would like to return to working outside her home. The client reports that she misses working in the company that she left shortly before giving birth. She states that her husband's family comes from a culture which strictly forbids such employment. Which of the following is **MOST** likely the basis of this problem?
- A. Role conflict
  - B. Cultural bias
  - C. Social injustice
- 166.** Which of the following is **MOST** commonly the cause of "doorknob disclosures"?
- A. Premature closure of inquiry by social workers when doing biopsychosocial assessments
  - B. Fear and embarrassment by clients about information provided
  - C. Perceived power imbalance by clients within therapeutic relationships
- 167.** A mother comes with her 4-year-old daughter to a social worker as her husband is receiving hospice and she is worried about the child's reaction to his death in the coming weeks. The mother has many questions about the child's ability to comprehend what will happen. Based on developmental theories, which of the following **BEST** describes how the client will likely view death?
- A. A comforting experience which should not be feared
  - B. A temporary state which can be reversed at any time
  - C. A permanent condition which is caused by accidents and factors that cannot be controlled
- 168.** According to the professional code of ethics, social workers who need to report suspected abuse should:
- A. Inform clients about the need to report and potential actions which may result before any disclosures are made

- B. Seek supervision to determine that agency policies about informing clients are appropriately followed
- C. Refrain from telling clients about the need to report and reasons for reporting in order to protect the integrity of abuse investigations

**169.** A social worker employed in an agency setting receives a referral for a former girlfriend who he has not seen in 20 years. The client is Spanish speaking and the social worker is the only staff linguistically competent to provide clinical services in Spanish. In order to act ethically in this situation, the social worker should:

- A. Speak to his supervisor to disclose the prior relationship before meeting with the client
- B. Inform agency personnel that he cannot provide services to the client
- C. Schedule an intake given the time that has passed since the prior relationship

**170.** For which diagnoses is brief cognitive behavior therapy **MOST** appropriate?

- A. Substance use disorders
- B. Dissociative disorders
- C. Adjustment disorders

# Practice Test Answers

**1. A.** A flashback is an indicator of trauma that is characterized as reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times specific physical states increase vulnerability to reexperiencing a trauma (e.g., fatigue, high stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma. During flashbacks, clients need to focus on what is happening in the here and now, which is accomplished using grounding techniques. Social workers should be prepared to help the client get regrounded so that the client can distinguish between what is happening now versus what had happened in the past.

There are lots of grounding techniques, but the best are those that use the five senses (sound, touch, smell, taste, and sight) as they bring attention to the present moment; for example, turning on loud music (sound), feeling something cold or comforting (touch), sniffing a strong pleasant fragrance (smell), and so on. Social workers should also offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It is often helpful for a client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places the client at higher risk for retraumatization and requires use of coping strategies, including seeking support.

While all of the response choices are helpful for survivors of trauma, the aim of grounding techniques is immediate assistance to get clients back to the “here and now.” The incorrect response choices involve “talk” or psychotherapy by understanding or teaching. Incorrect response choices also do not address that clients are “experiencing flashbacks of past traumatic events,” but instead deal with the impacts of or responses to trauma more broadly. Only the correct answer deals with orienting the client to the present, which is necessary when flashbacks occur.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**2. C.** Each culture has its own traditions, rituals, and ways of expressing grief and mourning. The effects of culture, race, and ethnicity on behaviors, attitudes, and identity should be considered. Almost every religion or culture has its own traditions involving mourning. Grief is the thoughts and feelings associated with loss, while mourning is the outward behaviors that represent a person’s grief. Every culture has its own traditions regarding mourning, and it is important for people to realize that everyone mourns differently and that there is no right way to mourn. While social workers cannot be expected to know the mourning ceremonies and traditions of each client’s culture, understanding some basics about how different cultures may prepare for and respond to death is important. Though difficult to ask, there are crucial questions that need to be part of conversations between social workers and clients. For example:

- What are the cultural rituals for coping with dying, the deceased person’s body, the final arrangements for the body, and honoring the death?
- What are the family’s beliefs about what happens after death?
- What does the client consider to be the roles of each family member in handling the death?
- Are certain types of death less acceptable (e.g., suicide) or are certain types of death especially hard to handle for that culture (e.g., the death of a child—in countries with high infant mortality, there may be different attitudes about the loss of children)?

*Clients should be viewed as a source of knowledge about their special/cultural needs and norms—but social workers sometimes are at a loss about what to ask under such trying circumstances. While there*

are many similarities across cultures, such as wearing black as a sign of mourning, there are always exceptions. The mix of cultural/religious attitudes and behaviors surrounding death and dying can become very complex indeed. And when a death occurs, some clients break with tradition entirely, often creating chaos within families.

The question contains a qualifying word—**MOST**. The client's behavior may be psychotic, placing her at risk for self-harm. It also may be typical given the client's cultural practices and religious beliefs. In order to best understand these actions, the social worker should ask the client about her mourning rituals.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 3. C.** Human genetics is the study of inheritance as it occurs in humans. Genetic testing can confirm or rule out suspected genetic conditions or help determine clients' chances of developing or passing on genetic disorders. This process can be very stressful for clients, and it is important that social workers have knowledge about the benefits, as well as the limitations and risks, of genetic testing. Social workers can help clients weigh the pros and cons of the test and discuss the social and emotional aspects of testing.

Every person carries two copies of most genes (one copy from the mother and one from the father). A carrier is a person who has a change in one copy of a gene. The carrier does not have the genetic disease related to the abnormal gene. A carrier can pass this abnormal gene to a child. Carrier identification is a type of genetic testing that can determine whether clients who have a family history of a specific disease, or who are in a group that has a greater chance of having a disease, are likely to pass that disease to their children. Information from this type of testing can guide a couple's decision about having children.

For many genetic disorders, carrier testing can help determine how likely it is that a child will have the disease:

- If both parents carry the abnormal gene, there is a one-in-four (25%) chance that their child will have the disease and a two-in-four (50%) chance that their child will be a carrier of the disease (but will not have

There is also a one-in-four (25%) chance that the child will not get abnormal gene and so will not have the disease nor be a carrier.

- If only one parent carries the abnormal gene, the child has a one-in (50%) chance of being a carrier but almost no chance of having disease.

The question asks about an appropriate role for a social worker when a client has FIRST learned information through genetic testing. The client is a woman who was recently married. It would not be appropriate to meet with the husband initially as there is no indication, in the scenario, that the client wants a joint session to occur, and the couple is not the client. While the client is anxious and upset, her feelings may result from not understanding that her children will not automatically contract the disease. The client needs information about the potential likelihood that her children would be carriers or have the disease. This information may alleviate some of her fears. Knowing whether the husband is also a carrier is critical information which may not yet be known and/or is not provided in the scenario. Anxiety and depression are the symptoms, not the root of the problem, which is a lack of understanding. Providing education is a critical social work task when clients are deciding to have genetic testing and interpreting its results.

### ***Question Assesses***

Human Development, Diversity, and Behavior in the Environment

- 4. B.** Therapy requires recognizing a client as part of a family system. Additionally, it focuses on studying the role that a client has in a family dynamic. Sometimes client problems arise due to dysfunctional communication within the family. Disturbed communication in families resulted in enormous pressure being felt by one or more members of that family system.

A double bind is a dilemma in communication in which an individual (or group) receives two or more conflicting messages, with one message negating the other; this is a situation in which successfully responding to one message means failing with the other and vice versa, so that the person will automatically be put in the wrong regardless of response. And the person can neither comment on the conflict, nor resolve it, nor opt out of the situation. Contradictory messages result in the “victim” feeling powerless and trapped in a “damned if you do and damned if you don’t” double bind.

A paradoxical directive involves prescribing the very symptom the client wants to resolve. It is often equated with reverse psychology. The underlying principle is that a client engages in a behavior for a reason, which is typically to meet a need (rebellion, attention, a cry for help, and so on). In prescribing the symptom, a social worker helps a client understand this need and determine how much control (if any) the client has over the symptom. By choosing to manifest the symptom, a client may recognize that the client can create it, and therefore has the power to stop or change it.

A negative feedback loop is information that flows back into the family system to minimize deviation and continue functioning within prescribed limits. It helps to maintain homeostasis or keep things stable or the same over time.

This is a recall question which relies on social workers understanding communication patterns within families so that they can assist in addressing them when they interfere with effective functioning. Often roles within family units can be identified through assessing both verbal and nonverbal communication. Much of social work intervention focuses on helping clients with enhancing their expressive and receptive communication skills.

### ***Question Assesses***

#### ***Psychotherapy, Clinical Interventions, and Case Management***

- 5. A.** When a client has experienced multiple, severe forms of trauma, the psychological results are often multiple and severe as well; this phenomenon is sometimes referred to as complex posttraumatic disturbance. Complex trauma can be defined as a combination of early and late-onset, multiple, and sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature. In most cases, such trauma includes exposure to repetitive childhood sexual, physical, and/or psychological abuse, often (although not always) in the context of concomitant emotional neglect and harmful social environments. Complex trauma has a dramatic impact on development and resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—this often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood.

The impact of complex trauma includes anxiety and depression; dissociation; relational, identity, and affect regulation disturbance;

cognitive distortions; somatization; “externalizing” behaviors such as self-mutilation and violence; sexual disturbance; substance abuse; eating disorders; susceptibility to revictimization; and traumatic bereavement associated with loss of family members and other significant attachment figures.

Clients who have experienced complex trauma may be diagnosed with a range of disorders, and consequently treated with multiple medications and therapies that are ultimately ineffective because they fail to address the underlying problem and do not reflect a trauma-informed approach to assessment and treatment. It is essential that social workers perform comprehensive assessments that capture the broad range of reactions. Thorough assessments should also carefully date and track the various traumatic events so they can be linked with developmental derailments. Treatment approaches that are limited to a single modality (e.g., exposure therapy, cognitive therapy, or psychiatric medication) may be less helpful—especially if the intervention is not adapted to the specific psychological and cultural needs of a client.

Treatment should focus on:

- *Removal of and protection from the source of the trauma and/or abuse*
- *Acknowledgement that recovery from the trauma is not trivial and require significant time and effort*
- Acknowledgment of the trauma as real, important, and undeserved
- Acknowledgment that the trauma came from something that was stronger than clients and therefore could not be avoided
- Acknowledgment of the “complex” nature of trauma (trauma may have led to decisions that brought on additional, undeserved trauma)
- *Mourning for what has been lost and cannot be recovered*
- Placement in a supportive environment where clients can discover they are not alone and can receive validation for their successes and support through their struggles

While recovery from complex trauma is possible, it will require significant time and effort. Additionally, not all that has been lost can be recovered. Thus, the correct answer is the only accurate one about treating clients with complex grief.

### **Question Assesses**

## Assessment, Diagnosis, and Treatment Planning

- 6. A.** When evaluating agency programs, it is necessary to understand different types of assessment and the terms used to describe them. Outputs, outcomes, and impacts are often used interchangeably, but are not the same.

Outputs are what are produced by programs. For instance, a training program provides graduates. A homeless shelter creates filled beds. Outputs are usually described with numbers. For instance, “96% of available beds were filled” or “the training program graduated 96 individuals.” Outputs are measurable and readily determined. It is tempting to stop with outputs because they are easy to produce as they reflect the number of people served or meals distributed.

Outcomes are the effects programs produce on the people served or issues addressed. For instance, the result of a training program might be the number of graduates who get a job and keep it for a particular period. An outcome is a change that occurred because of a program. It is measurable and time limited, although it may take a while to determine its full effect. Measuring outcomes requires a bigger commitment of time and resources.

Impacts are the long-term or indirect effects of outcomes. Impacts are hard to measure since they may or may not happen. They are what is hoped that efforts will accomplish. For instance, graduating from a training program may eventually lead to a better quality of life for the individual.

This is a recall question about evaluation methods. Social workers are required to know terms, as well as key concepts, related to each of the KSAs. This scenario requires the ability to distinguish between an output, outcome, and impact.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 7. C.** Benzodiazepines are psychotropic medications that help relieve nervousness, tension, and other symptoms by slowing the central nervous system. Benzodiazepines are a type of *antianxiety drug*. While anxiety is a normal response to stressful situations, some clients have unusually high levels of anxiety that can interfere with everyday life. For them,

benzodiazepines can help bring their feelings under control. The medicine can also relieve troubling symptoms of anxiety, such as pounding heartbeat, breathing problems, irritability, nausea, and faintness. They are also sometimes prescribed for other conditions, such as muscle spasms, epilepsy and other seizure disorders, phobias, panic disorder, withdrawal from alcohol, and sleeping problems. The family of antianxiety drugs known as benzodiazepines includes alprazolam (xanax), chlordiazepoxide (librium), diazepam (valium), and lorazepam (ativan). These medicines take effect fairly quickly, starting to work within an hour after they are taken. Benzodiazepines are available only with a prescription and are available in tablet, capsule, liquid, or injectable forms.

Prolixin is an *antipsychotic medication* used to treat hallucinations and delusions.

Prozac is an *antidepressant medication* used to treat depression.

This is a recall question about benzodiazepines (commonly called “tranquilizers”), which are useful for treating anxiety. They are highly addictive, and their use is normally limited to a short-term, as-needed basis. They need to be carefully controlled by prescribing physicians.

The examination requires social workers to be aware of the four major types of psychotropic medications—antipsychotics, antidepressants, mood stabilizers, and antianxiety drugs—and be able to identify some common medications in each of these types. While it is possible to have no medication questions on the examination as other KSAs under assessment, diagnosis, and treatment planning are tested instead, it is important to have some knowledge about psychotropic drugs. For example, knowing which types of medications are commonly prescribed for various diagnoses can be helpful.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 8. C.** There are two major forms of bipolar disorder—bipolar I and bipolar II (also known as bipolar 1 and 2)—which are separate diagnoses with significant differences between them. To be diagnosed with bipolar I, a client must have had at least one manic episode. The manic episode may be preceded by or followed by hypomanic or major depressive episodes. Mania symptoms cause significant impairment in life and may require hospitalization or trigger a break from reality (psychosis). To be diagnosed

with bipolar II disorder, a client must have had at least one major depressive episode lasting at least 2 weeks and at least one hypomanic episode lasting at least 4 days, but never had a manic episode. Major depressive episodes or the unpredictable changes in mood and behavior can cause distress or difficulty in areas of your life.

The most important distinction between bipolar I and II is that a client with bipolar I has manic episodes while a client with bipolar II has hypomanic episodes. The main difference between mania and hypomania is a matter of severity. In the hypomania of bipolar II, a client has a sustained mood that is elevated (heightened), expansive (grand, superior), or irritable. This mood must be noticeably different from normal mood when not depressed. In mania, that mood is extremely abnormal, and is also combined with increased activity or energy that is also abnormal. Examples of hypomania may include being exceptionally cheerful, needing only 3 hours of sleep instead of the usual 7, spending more money than can be afforded, and/or speaking far more rapidly than usual. Hypomanic behavior is *noticeably different* from a client's own mood, but not outside the range of possible behavior in general. Manic episodes may include being out-of-control happy even during serious events, which is atypical behavior for anyone.

Someone with bipolar I disorder may also have hypomanic episodes, but someone with bipolar II cannot ever have had a manic episode. If a manic episode occurs in someone with bipolar II, the diagnosis will be changed. However, the depressive episodes of bipolar II disorder are often longer lasting and may be even more severe than in bipolar I disorder. Therefore, bipolar II disorder is not simply a "milder" overall form of bipolar I disorder.

*At least one of the following conditions must exist in mania, but can't be present in hypomania:*

- Mania may include psychotic symptoms—delusions or hallucinations. Hypomania does not have psychotic symptoms. (However, a client with bipolar II may experience hallucinations or delusions during depressive episodes without the diagnosis changing to bipolar I.)
- While hypomania may interfere to a degree with daily functioning, in mania day-to-day life is significantly impaired.
- The manic person was hospitalized because of the severe symptoms.

In this question, only one response choice is an accurate statement, and it is the primary difference between the disorders. Depressive episodes of bipolar II disorder are often longer lasting and may be even more severe than in bipolar I disorder. A client with bipolar II may experience hallucinations or delusions during depressive episodes without the diagnosis changing to bipolar I. Thus, all responses except the correct answer are incorrect.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 9. B.** Competently conducting evaluations of practice requires skill and knowledge. There are also many ethical considerations. Social workers engaged in evaluation should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

*When evaluation or research participants are incapable of giving informed consent (including due to being below the age of consent), social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from those legally authorized to act on their behalf.*

This is a recall question which relies on social workers being fully informed of ethical standards of evaluation and research. The correct answer is that which is required for "the social worker to ethically conduct the evaluation." When questions concern ethical behavior, the professional ethical standards should be remembered. Written consent is necessary, but not sufficient, as the assent of the children is also needed. Assent is a willingness to participate even though a child is not legally able to provide authorization. Children are not able to provide written consent as consent indicates authority to make legal decisions, which those under the age of majority are not able to do unless emancipated.

### **Question Assesses**

## Professional Values and Ethics

- 10. C.** Social workers should handle issues surrounding the discharge and termination of services very carefully. Clients whose services are discharged or terminated unethically may not receive needed supports.

Once services are provided, social workers have legal and ethical responsibilities to continue these services or properly refer clients to alternative providers. While social workers do not have to work with all those in need or requesting services, services cannot terminate abruptly once therapeutic relationships have been established. Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary. When it is necessary to terminate services, social workers should provide clients with names, addresses, and telephone numbers of multiple appropriate referrals, if available. *When feasible, they should follow up with clients who have been terminated. If clients do not visit the referrals, clients should be contacted about the risks involved with the lack of follow.*

Clients who will be terminated should be given as much advance notice as possible. When clients announce their decision to terminate prematurely, social workers should explain the risks involved and provide suggestions for alternative care. All decisions and actions related to termination of services should be documented in letters and clients should be provided with clear written instructions to follow and telephone numbers to use in the event of an emergency. Clients should be asked to sign a copy of the documents, affirming that they received the instructions and that the instructions were explained to them.

In instances involving court-ordered clients, social workers should seek legal consultation and court approval before terminating services.

The correct answer involves direct action by the social worker to assist with the referral and discharge process. Seeking consultation to review what has already occurred may be helpful for professional development after the situation has been resolved, but it will not directly help reengage the client. Additionally, sending a letter is very passive and there is no reason to believe that the client is not aware of the discharge

plan and contact information of the new provider. This action should have been taken earlier in the referral process and will not be helpful now. Meeting with the client to discuss issues that may have impacted following through is an active response to address the situation. Central to this contact can be an assessment of why the benefits of continuing treatment have not compelled the client to make contact.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 11. C.** Social workers should be aware of models of supervision and consultation, including those provided via contract. In situations in which an agency may not have a clinical supervisor who meets the qualifications of a supervisor, a social work supervisee may contract for supervision services outside the agency. Supervisees should contact the regulatory board in their jurisdictions in advance of contracting to confirm if such a practice is permitted and confirm the documentation required from the supervisor. The time frame required for the supervision period should also be verified.

While it is important for agency staff and supervisors to agree with the terms of the arrangement, there is not a need for contracts. Additionally, having authorization from agency directors is important but the MOST critical is having the consent of the clients. Clients need to understand that their information is being shared with individuals outside of the agency.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

- 12. C.** Clients with mental health disorders are more likely than clients without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, clients may receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate training or screening by service providers, an overlap of symptoms, or that other health issues need to be addressed first. In any case, the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead

to a higher likelihood of experiencing housing instability, incarceration, medical illnesses, suicide, or even early death.

Clients with co-occurring disorders are best served through integrated treatment. With integrated treatment, social workers can address mental, and substance use disorders at the same time, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve treatment outcomes and the quality of life for those who need these services.

*Prescribed medications play a key role in the treatment of many co-occurring disorders.* They can reduce symptoms and prevent relapses of a psychiatric disorder. Medications can also help clients minimize cravings and maintain abstinence from addictive substances.

Clients should make an informed choice about taking medications and understand the potential benefits and costs associated with medication use. In addition, they should take the medication as prescribed.

Taking medication is not substance abuse. Clients in recovery for a substance use disorder may think it is wrong to take any medications. However, a medication that manages clients' moods is very different from a drug that alters clients' moods.

As co-occurring disorders are so prevalent, social workers should be versed in their treatment. While not all clients with psychiatric comorbidities need or receive psychotropic medications, the treatment of mental health symptoms with medications can be effective in reducing the severity of the symptomatology. Much research has been done in this area. Further, it might reduce the elevated risk of suicide attributed to each of the comorbid disorders and to their combined effect. Reducing risk of suicide is an important aim of treatment.

Psychotropic medications should only be prescribed after clients understand their side effects, but informed consent is not unique to only those with co-occurring mental health and substance use disorders—which makes it an incorrect response choice.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**13. C.** There are many models of supervision described in the literature, ranging from traditional, authoritarian models to more collaborative models. Different models of supervision place emphasis, in varying degrees, on the client, the supervisor, the supervisee, or the context in which the supervision takes place. Ideally, the supervisor and the supervisee use a collaborative process when a supervision model is selected; however, *it is ultimately the responsibility of supervisors to select the model that works best for the professional development of supervisees.*

Supervision encompasses several interrelated functions and responsibilities. Each of these interrelated functions contributes to a larger responsibility or outcome that ensures clients are protected and that clients receive competent and ethical services. As a result, supervision services received by the client are evaluated and adjusted, as needed, to increase benefits. It is supervisors' responsibilities to ensure that supervisees provide competent, appropriate, and ethical services.

Social workers should be knowledgeable about supervision models. This question requires social workers to remember that supervisors are responsible for the quality of services delivered by supervisees and their ultimate benefit to clients. Ruling out administrators leaves supervisees and supervisors as possible correct response choices. As the question asks about "ultimate responsibility," supervisors are distinguished from the supervisees as they have authority in supervisory relationships. While administrators have influence on service delivery, they are not direct parties in supervisory relationships and their directives should never be honored over those of supervisors.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

**14. C.** Many programs use the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as eligibility criteria to determine eligibility and/or level of care. Whether or not clients are capable of performing these activities on their own or if they rely on family caregivers to perform the ADLs can serve as a comparative measure of their independence. Assessments can help with determining assistance needed.

Measuring a client's ability to perform the ADLs and IADLs is important not just in determining the level of assistance required, but as a metric for a variety of services and programs related to caring for older adults and for those with disabilities.

Many state-funded, non-Medicaid programs use an inability to perform two or three ADLs as one of the eligibility criteria for participation in their assistance programs.

Medicaid often requires older adults to be qualified for nursing home care, and nursing home care qualification can be determined by how much assistance one requires with ADLs. Long-term care insurance often uses an inability to perform the ADLs as a trigger for paying out on a policy. Social Security Disability Insurance (SSDI) also considers ADLs as a qualification factor.

ADLs are activities in which clients engage on a day-to-day basis. These are everyday *personal care* activities that are fundamental to caring for oneself and maintaining independence.

There are many variations on the definition of the ADLs, but most organizations agree there are five basic categories.

- Personal hygiene—bathing, grooming, and oral care
- Dressing—the ability to make appropriate clothing decisions and physically dress oneself
- Eating—the ability to feed oneself though not necessarily to prepare food
- Maintaining continence—both the mental and physical ability to use a restroom
- Transferring—moving oneself from seated to standing and getting in and out of bed

IADLs are activities related to *independent living*. The instrumental activities are more subtle than ADLs. They can help determine with greater detail the level of assistance required. The IADLs include:

- Basic communication skills—such as using a regular phone, mobile phone, email, or the Internet
- Transportation—either by driving oneself, arranging rides, or the ability to use public transportation
- Meal preparation—meal planning, preparation, storage, and the ability to eat outside the home

- Safely use kitchen equipment
- Shopping—the ability to make appropriate food and clothing purchase decisions
- Housework—doing laundry, cleaning dishes, and maintaining a hygienic place of residence
- Managing medications—taking accurate dosages at the appropriate time, managing refills, and avoiding conflicts
- Managing personal finances—operating within a budget, writing checks, paying bills, and avoiding scams

The question contains a qualifying word—MOST. While it may be useful to assess all areas listed, level of care is primarily determined by the amount of help that the client needs to complete necessary personal assistance and independent living tasks.

Adapting to life changes may be important to the client's ability to adjust to a new home but will not directly relate to "making a determination of the needed level of care." Managing medical problems may also need to be addressed. However, such assistance can be done by care management in any setting.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 15. C.** Clients engaged in enmeshed interpersonal relationships are nearly always the last to know. Often social workers work with adult children who are recovering from the pain and confusion caused by enmeshed relationships with parents.

There are many signs of enmeshed relationships including:

- Neglecting other relationships because of an obsession or concern about one relationship
- Happiness contingent upon a relationship
- Self-esteem contingent upon a relationship
- Excessive anxiety, fear, or a compulsion to fix the problem whenever there is a disagreement in a relationship
- Feeling of loneliness that overwhelms when not with the other person

- often creating irrational desires to reconnect
- Symbiotic emotional connections which result in an individual becoming angry, upset, or depressed when another person is angry, upset or depressed
- Strong desire to fix another person's situation and change the person's state of mind

When relationships are enmeshed, they are no longer able to grow. Social workers should work to establish healthy boundaries and respect for autonomous choices. This process can be painful for clients.

The feelings and behaviors of the couple are indicative of enmeshment. Once the cause of the problem is identified, the question can be simplified to picking out the treatment focus when working with enmeshed relationships. The wife is not the client as the couple sought treatment, so focusing on the wife's self-worth will not address the problem. Understanding each other's feelings will not help each person develop boundaries and differentiate from one another, which is the root of the issue.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 16. C.** Case notes may be subject to a range of legislative processes and requirements during and following the conclusion of professional relationships. The nature of these requirements may differ greatly according to the jurisdiction or nature/context of practice. Social workers should use care to make sure that case notes are impartial, accurate, and complete. Information may need to be added to client records to ensure that they are not misleading and are comprehensive. Care should be always taken to avoid errors or omissions. If a change must be made to correct an error or omission, the change should be recorded as a new and separate case note. In addition to outlining the error or omission as part of new case notes, it is advisable to provide explanations for earlier absences or inaccuracies.

An existing case note should never be amended or changed in light of additional information obtained at a later date. This should always constitute a new case note.

Careful and diligent documentation enhances the quality of services provided to clients. Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided. In addition, social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future. Comprehensive records are necessary to assess clients' circumstances, as well as plan and deliver services.

Social workers should know the professional protocol for adding or making changes to client records, so asking for supervisory input is not needed. Material should never be added to existing case notes as they need to accurately reflect documentation of "the facts" that were known at the times of these entries.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 17. C.** Interviewing skills are essential to ensuring that clients feel understood, problems are assessed, and effective treatment is delivered. A comprehensive social work interview includes conducting a multiple biopsychosocial–spiritual–cultural assessment in order to better understand the presenting problem. Questions asked and techniques used may promote or inhibit information gathering and other aspects of the problem-solving process. Skills and questioning techniques used include active listening, empathy, rapport building, open- and closed-ended inquiries, silence, and so on.

When interviewing clients, social workers should avoid "Why" questions in order to prevent clients from feeling as though they need to defend their choices and actions. Although it may be necessary to learn the reasoning behind clients' choices and actions, the wording used may impact responses. For example, if a social worker needs to know why a client is missing doses of medication, instead of asking "Why haven't you been able to take your medication as prescribed?" it is better to ask, "What are some of the reasons for skipping your medication?" The difference may be subtle, but it can affect the way a client perceives the question. With the "Why" method, a client may be defensive, whereas the "What" method allows a client to reflect on action without feeling judged.

The correct answer is the BEST question for the social worker to ask as part of the assessment. The use of the qualifying word, which is capitalized, indicates that other response choices may be appropriate, but are not as essential to identifying causes for the presenting problem, the primary aim of assessment. The social worker should find out the reasons for the medication noncompliance. There is no indication that the client is not taking the medication to become hospitalized.

The correct “What” question is preferred to the inaccurate “Why” question to avoid having the client feel judged. The “Why” response choice also implies that the client’s actions are in direct violation of the doctor’s orders as she has not been able to take her medication “as prescribed.” Pointing out that she has done something other than what the doctor stated can cause defensiveness or shame.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 18. C.** Family therapy is based on the idea that a family is a system of different parts. A change in any part of the system will trigger changes in all the other parts, so when one member of a family is affected by a substance use disorder, everyone is affected. As a result, family dynamics can change in unhealthy ways. Some family members may take on too much responsibility, other family members may act out, and some may just shut down. Often a family remains stuck in unhealthy patterns even after the family member with the behavioral health disorder moves into recovery. Even in the best circumstances, families can find it hard to adjust to the person in their midst who is recovering, who is behaving differently than before, and who needs support. *Family therapy can help the family as a whole recover and heal.*

*Family therapy is typically introduced after the individual in treatment for addiction has made progress in recovery.* This could be a few months after treatment starts, or a year or more later. Timing is important because people new to recovery have a lot to do. They are working to remain stable in their new patterns of behavior and ways of thinking. They are just beginning to face the many changes they must make to stay mentally healthy, as well as remain clean or sober. They are learning such things as how to deal with urges to fall into old patterns, how to resist triggers and cravings, and how to avoid temptations to rationalize and make excuses. For them to explore family issues at the same time can be too much. It can potentially contribute to relapse.

*Family therapy tends to be most helpful once the person in treatment is fully committed to the recovery process and is ready to make more changes.*

Social workers should understand family roles in addiction and codependency. Addiction is a “family affair”; therapy with the entire family involves understanding the roles that members assume which are dysfunctional and support the addictive behavior. However, it is important that clients have made progress in their recovery before taking on additional stress, which comes with understanding family roles in families impacted by addiction. Clients’ acknowledgement of their addictions and family dysfunction, as well as detoxification—if needed—would come prior to the onset of family therapy. Clients may not yet be stable in their new patterns of behavior.

This question contains a qualifying word—BEST. There may be reasons for engaging in family therapy earlier or later in the recovery process, but it is most beneficial after individual progress has been made by clients.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 19. A.** Ethical and legal issues regarding mandatory reporting are very clear when victims are minors. There is both a legal and ethical obligation to report all child abuse to protective services. However, when the victim is a client who is now an adult, the required action becomes less clear. Laws vary by jurisdiction, and it is important for social workers to be aware of their legal duties.

Social workers face ethical dilemmas in these situations as they may want perpetrators to be accountable for their actions. However, if clients disclose such abuse in strict confidence and do not want the abuse reported, there is a need to respect their privacy. This abuse does not meet any of the exceptions for disclosure such as due to consent by clients, clear and immediate danger, and other requirements by law (such as duty to warn).

In these instances, social workers should provide clients with information and other support so they can consider their options more fully. For instance, they may not be familiar with what happens during abuse investigations, fearing that reports may lead to immediate

notoriety and broad publication. Legal and procedural protections afforded to survivors of sex-related crimes may also not be known.

However, even with such information and support, adult clients may resist wanting their abuse reported. Thus, social workers should respect their right to self-determination and should avoid imposing their own beliefs on clients.

As professional ethical standards do not explicitly address the situation in the scenario, it is necessary to consider the ethical principles of beneficence (doing good), nonmaleficence (avoiding doing harm), justice, and respect. While reporting the abuse may help protect other minors from being abused, it may be experienced as harm by the client as she is not emotionally ready to confront her father about the abuse. Reporting the abuse also may have a negative impact on the social worker/client relationship as the client may feel betrayed by the disclosure. From a justice perspective, reporting the abuse may be a method of bringing the alleged perpetrator to justice, but justice could entail prioritizing the client's emotional well-being. Finally, respect involves honoring the client's rights to privacy and self-determination.

The scenario stated that there was no legal duty for social workers, in this jurisdiction, to report past abuse as the survivor is no longer a minor. If it were required, the correct response may have been different. The scenario also indicates that the father is not a danger to other children given his physical and/or mental status.

While supervision is always useful, the social worker should not be "passing the buck" and relying on the supervisor to make the decision. The social worker should be knowledgeable about the laws and issues regarding mandatory reporting.

### **Question Assesses**

#### Professional Values and Ethics

- 20. C.** In using feedback during the beginning phase of the problem-solving process, a social worker encourages clients to comment about service purpose, social worker-client roles, ethical factors, or any other aspect of the introductory sessions. An important part of communicating effectively involves checking whether clients have understood the messages being conveyed. Seeking feedback serves this function. Seeking feedback early in the problem-solving process is part of the

informed consent process. Clients are forced to identify areas that are unclear, share thoughts that have occurred to them, or express disagreements. The use of feedback sends the message that treatment is a mutual and reciprocal process and that social workers are interested in what clients have to say. It sets the expectation that clients will continue to be active participants throughout the helping process.

The question contains a qualifying word—MOST. The question specifically asks about “the beginning phase of treatment.” During the beginning phase, social workers introduce and identify themselves and seek introductions from clients. Following the exchange of introductions, social workers describe the initial purposes for meetings, identify professional roles that social workers might undertake, orient clients to the process, and identify relevant policy and ethical factors that might apply. Two of the response choices do not directly relate to this initial orientation and educating clients about the reciprocal nature of the work, as well as engaging them by showing interest. Ensuring an understanding of the client’s problem is done during assessment and focusing the treatment on a client’s feelings and thoughts is part of intervention. Both actions involve feedback but not during “the beginning phase of treatment.”

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 21. A.** Social stratification refers to a system by which a society ranks categories of people in a hierarchy. By examining policies, procedures, regulations, and laws—as well as practices—it is perfectly clear that some groups have greater status, power, and wealth than other groups. Social stratification is based on four major principles:
1. Social stratification is a trait of society, not simply a reflection of differences.
  2. Social stratification persists over generations.
  3. Social stratification is universal but takes different forms across societies.
  4. Social stratification involves both inequality and beliefs, as inequality in a society’s philosophy.

This question requires social workers to understand the effects that policies, procedures, regulations, and laws have on practice, including perpetuating social stratification.

Racial inequality results from institutional discrimination in which policies and procedures do not treat all racial groups equally. While people of color often do not have the same opportunities, the question is broader, seeking the term which relates to differences in social status. These differences can also result from other attributes, such as gender.

Institutional malfeasance refers to wrongdoing by an organization or corporation.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 22. C.** Supervision is an essential and integral part of training and continuing education required for the skillful development of professional social workers. The knowledge base of the social work profession has expanded and the population it serves has become more complex. Supervision protects clients, supports practitioners, and ensures that professional standards and quality services are delivered by competent social workers. It is important to the profession to have assurance that all social workers are equipped with the necessary skills to deliver competent and ethical social work services. Equally important to the profession is the responsibility to protect clients.

Documentation is an important legal tool that verifies that services, including supervision, occurred. Supervisors should assist supervisees in learning how to properly document client services performed, regularly review their documentation, and hold them to high standards. When appropriate, supervisors should train the supervisees to document for reimbursement and claim submissions.

*Each supervisory session should be documented separately by supervisors and supervisees.* Documentation for supervised sessions should be available to both parties and provided to supervisees within a reasonable time after each session. Social work regulatory boards may request some form of supervision documentation when supervisees apply for licensure. Records should be safeguarded and kept confidential.

The question contains a qualifying word—MOST. Supervisors are responsible for the actions of supervisees, but records should not only be kept by them. Failure to keep any documentation of supervision sessions is ill-advised as information used to make critical treatment decisions will not be recorded. These records should be transparent and consistent with both supervisor and supervisee having agreed upon knowledge about and documentation of the sessions.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 23. A.** Social workers employed in agency settings may find that they are required to have multiple supervisors. In circumstances in which a social worker is being supervised simultaneously by more than one person, it is best practice to have a contractual agreement or memorandum of understanding delineating the role of each supervisor, including parameters of the relationships, information sharing, priorities, and how conflicts will be resolved.

Only the correct answer results in an agreement delineating the role of each supervisor. Meeting with all supervisors simultaneously is not realistic or needed if all parties agree about their respective roles and responsibilities. When a social worker answers to more than one supervisor, the likelihood of conflict is enhanced; therefore, guidelines which outline the agreed upon flow of information and how conflicts should be resolved are essential.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 24. B.** Social workers who do forensic work wrestle with professional ethical issues that emerge in determining client mental fitness to face prosecution. The process of evaluating whether clients are competent to stand trial involves two major areas. First, clients should understand the legal proceedings against them, what they have been charged with, what the roles of the different court personnel are, the difference between pleading guilty and not guilty, and what accepting a plea bargain means. The second factor is the clients' ability to assist in their own defense or their ability to work with their attorneys and take an active part in their own defense.

If a client's mental status is in question, the social worker tells the defense attorney, who then brings the issue to the judge. Alternately, the state's attorney or the judge could raise the issue. The judge then issues a court order mandating a formal evaluation of client competency to stand trial.

A formal evaluation may be done by a psychiatrist working alone or a team of mental health professionals, including a psychiatrist, psychologist, and/or forensic social worker.

After the formal evaluation of competence to stand trial, the next phase is often "restoration," in which a client is sent to a particular setting, most often a hospital, to be "restored to competence." A client is usually in the hospital for 60 to 90 days for the initial restoration, undergoing a full evaluation by psychologists, psychiatrists, and social workers and attending classes to learn about the court process to face charges as a competent defendant.

Competency restoration is a psychoeducational intervention in which clients who have been found incapable of proceeding in legal trials due to any combination of limited understanding, communication deficits, or impaired ability to conform their behaviors to the demands of the courtroom are rendered capable. It is generally a part of a multifaceted treatment strategy that may include anger management skills, relaxation training, and cognitive behavioral therapy (CBT) as adjunct interventions to education regarding general legal processes and specific aspects of the defendant's case. At the conclusion, clients should be able to discuss aspects of their cases with their attorneys, differentially weigh the risks and possible benefits of the different pleadings, strategize consideration of testimonials and evidence, testify, and conduct themselves in a manner suitable to the courtroom. Clients should understand the roles of the court officers, the responsibilities and limitations of judges and juries, and that their attorneys have their best interests in mind.

Competency restoration processes occur before sentencing or restitution decisions. Social workers evaluate and deliver services focused on developing or regaining clients' abilities to participate in legal proceedings.

### **Question Assesses**

Professional Values and Ethics

**25. C.** The right of privileged communication—which assumes that a professional cannot disclose confidential information without the client's consent—originated in British common law. The attorney-client privilege was the first professional relationship to gain the right of privileged communication. Over time, other groups of professionals have sought this right.

Social workers should understand the distinction between confidentiality and privileged communication. Confidentiality refers to the professional norm that information offered by or pertaining to clients will not be shared with third parties. Privilege refers to the disclosure of confidential information in court or during other legal proceedings.

Courts commonly cite the following four conditions that must be met for information to be considered privileged:

- The harm caused by disclosure of the confidential information outweighs the benefits of disclosure during legal proceedings.
- *The parties involved in the conversation assumed that it was confidential.*
- Confidentiality is an important element in the relationship.
- The broader community recognizes the importance of this relationship.

A significant court decision for social workers concerning privileged communications was the landmark case of *Jaffe v. Redmond* (1996) in which the U.S. Supreme Court ruled that the clients of clinical social workers have the right to privileged communication in federal courts. Many states, though not all, now extend the right of privileged communication to clinical social workers' clients.

Just because service information is kept in a secured location does not mean that this information is considered privileged by the courts. Additionally, when the harm caused by keeping information confidential outweighs the benefits, the courts are less, not more, likely to uphold privilege.

### **Question Assesses**

#### Professional Values and Ethics

**26. A.** There are four major parenting styles which reflect the skills and capabilities of clients.

Permissive parenting, sometimes referred to as indulgent parenting, has very few demands placed on children. Permissive parents rarely discipline their children because they have relatively low expectations of maturity and self-control. They are often nontraditional and lenient, not requiring mature behavior, allowing considerable self-regulation, and avoiding confrontation. Permissive parents are generally nurturing and communicative with their children, often taking on the status of a friend more than that of a parent.

Authoritative parenting establishes rules and guidelines that children are expected to follow. However, this parenting style is democratic. Authoritative parents are responsive to their children and willing to listen to questions. When children fail to meet the expectations, these parents are nurturing and forgiving rather than punishing. These parents monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible and self-regulated as well as cooperative.

In authoritarian parenting, children are expected to follow the strict rules established by the parents. Failure to follow such rules usually results in punishment. Authoritarian parents do not explain the reasoning behind these rules. If asked to explain, the parent might simply reply, "Because I said so." These parents have high demands but are not responsive to their children. These parents are obedience- and status-oriented and expect their orders to be obeyed without explanation.

An uninvolved parenting style is characterized by few demands, low responsiveness, and little communication. While these parents fulfill the child's basic needs, they are generally detached from their child's life. In extreme cases, these parents may even reject or neglect the needs of their children.

This is a recall question on parenting styles. Social workers should be knowledgeable about the impact that parenting styles have on child development outcomes. Authoritarian parenting styles generally lead to children who are obedient and proficient, but they rank lower in happiness, social competence, and self-esteem. Authoritative parenting styles tend to result in children who are happy, capable, and successful. Permissive parenting often results in children who rank low in happiness and self-regulation. These children are more likely to experience problems with authority and tend to perform poorly in school.

Uninvolved parenting styles rank lowest across all life domains. These children tend to lack self-control, have low self-esteem, and are less competent than their peers.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 27. B.** Dysfunctional family dynamics are traits or behaviors that characterize unhealthy interactions between members. In dysfunctional families, members tend to communicate poorly and not listen to each other. Triangulation is a family therapy concept discussed most famously by multigenerational family systems theorist Murray Bowen. Bowen described dyads as being inherently unstable under stress, much like a two-legged stool. When in balance, the dyad is capable of functioning well and meeting the needs of both people in it. However, when thrown out of balance by conflict, stress, or transitions, the dyad will often pull in a third person, or “leg” of the stool, to help them stabilize the relationship.

According to Bowen, some triangulation is normal and even healthy in the course of family interactions. Because dyads are inherently unstable, the involvement of a third party can assist a two-person relationship in overcoming impasses, meeting needs, and coping through stressful times. This kind of triangulation occurs because both people in a dyad are looking for healthy and effective mediation. When the triangulated person gives input, it is accepted into the dyad and processed together in a way that moves the original dyad forward in their relationship. Healthy triangulation can also occur in the context of parents (or other family caregivers) who come together to meet the needs of a third member, such as a child.

Triangulation can become unhealthy in families when it causes undue stress on the third party and/or when it prevents, rather than invites, resolution of the dyad’s conflict. In the scenario, the triangulation is being sought by only one of the spouses. Furthermore, the input provided is not being brought back into the marriage for joint processing by both spouses. It is being withheld by the husband for his own individual purposes. The husband’s conversations with his mother are essentially taking the place of the emotional process that needs to be occurring within the marriage itself in order to return the marriage to healthy functioning.

Role reversal is a situation in which two people have chosen or been forced to exchange their duties and responsibilities, so that each is now doing what the other used to do. This scenario is not a role reversal as the mother has taken on being an emotional confidant, a function usually assumed by a spouse. However, the wife has not taken on the mother's duties or responsibilities.

Entropy, based in systems theory, is characteristic of randomness and disintegration within a structure.

This is a recall question related to family systems. Even when the names of theories are not mentioned, social workers are often asked about their key terms and concepts. When proper names are listed as response choices, it is useful to look at them first, before reading the question. Often a response choice will look correct after reading the question simply due to the words used. However, the one that looks the best is often not correct.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 28. B.** Delusions are false beliefs which clients hold with a strong amount of conviction. These beliefs are not typical of their culture or religion, and clients adhere to the erroneous beliefs despite evidence and proof which totally contradict them. Delusions of **reference** are perceptions that stimuli in the environment are directed toward clients themselves and referencing them specifically even though they are not. It is the belief that simple coincidences are relevant and specific to clients even though they are not connected to them in any way; for example, clients thinking people they do not know are talking about them or thinking that newscasters are speaking directly to them.

Clients with delusions of reference may think that things written in newspapers or stated in newscasts, passages found in a book, or the words in a song are about them directly. Thus, neutral events are believed to have special and personal meaning; for example, clients might believe billboards or celebrities are sending messages meant specifically for them.

These ideas and connections are delusions as they are thought to be true, though they are not. This can be a sign of mental illness such as schizophrenia spectrum and other psychotic disorders.

The question requires knowledge about basic terminology associated with psychopathology or the study of mental illness or the manifestation of behaviors that may be indicative of mental illness or psychological impairment. There are also common delusions such as delusions of grandeur, control, guilt, persecution, jealousy, or paranoia. Social workers should be aware of the presence of delusional thoughts by clients and the diagnostic methods/tools that can be used to identify them.

The qualifying word—BEST—indicates that more than one listed response choice may apply, but the most suitable definition is the one that illustrates the key attributes of this delusional type. Thus, the correct response choice is the one which indicates that neutral events are believed to have special and personal meaning.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 29. B.** Client-centered therapy, also known as person-centered therapy, is a nondirective form of talk therapy that was developed by humanist psychologist Carl Rogers during the 1940s and 1950s. Client-centered therapy operates according to three basic principles that reflect the attitude of the therapist to the client:

1. The social worker is congruent with the client.
2. The social worker provides the client with unconditional positive regard.
3. The social worker shows empathetic understanding to the client.

Congruence is also called genuineness. Congruence is the most important attribute in counseling, according to Rogers. This means that, unlike psychodynamic practitioners who generally maintains a “blank screen” and reveals little of their own personality in therapy, the Rogerian is keen to allow clients to experience the social workers as they really are. Social workers do not have a façade (like psychoanalysis); that is, social workers’ internal and external experiences are one in the same. In short, social workers are authentic.

The next Rogerian core condition is unconditional positive regard. Rogers believed that it is important that clients are valued as themselves so they can grow and fulfill their potential. A social worker

should have a deep and genuine caring for a client. A social worker may not approve of some of a client's actions, but a social worker does approve of a client. In short, a social worker needs an attitude of "I'll accept you as you are." The person-centered social worker is thus careful to always maintain a positive attitude to a client, even when disgusted by a client's actions.

Empathy is the ability to understand what a client is feeling by having the ability to understand sensitively and accurately a client's experience and feelings in the here-and-now.

While cultural competence is essential for working with diverse client groups, it is not specifically related to client-centered therapy, which is the focus of the question. The same is true for client self-determination and expertise. All clients are experts about their own lives so there would not be a distinction of client expertise in this treatment type.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 30. B.** Social workers should be knowledgeable about legal documents related to confidentiality of client information. Confidentiality of mandated clients is particularly tricky as documents may be subject to release without client consent.

Social workers have a duty to claim privilege on behalf of their clients when asked to release any information without client permission. Privilege is a right owned by clients to prevent their confidential information from being used in legal proceedings. The *NASW Code of Ethics* requires social workers to wait until *ordered by the court before disclosing information* in legal proceedings, absent client consent or an imminent threat of harm. A subpoena is a mandate to provide evidence or testimony—but is not a final ruling or order by a court on the legal requirement to provide information or admissibility of the evidence. A subpoena is not a court order. Most subpoenas are issued by attorneys.

*The NASW Code of Ethics provides that when a court-ordered disclosure could cause harm to the client, the social worker should request that the court withdraw or limit the order or keep the records under seal.* It is not clear how a social worker can meaningfully implement this provision. The social worker could refuse to obey a court's order as a matter of conscience, but this should be done only if

the social worker is prepared to be found in contempt of court and face time in jail, a fine, or both. The need to be aware of court or legal mandates is the cost of doing business in a profession where clients can be involved in legal disputes or matters.

Clients who are mandated to receive services may also be referred to as involuntary or court-ordered clients. All of these terms indicate that clients did not voluntarily choose or consent to receipt of services. There is legal authorization to mandate the receipt of treatment. Thus, there may also be a similar mandate to get access to documentation related to the receipt of services. The extent of what will need to be disclosed can vary and social workers are advised to be aware of these limits before the onset of treatment and review them with clients in their initial meetings.

The social worker has a responsibility to understand the extent to which documentation is privileged, so there is no need to have the client see a lawyer. Promising the client that consent will be obtained before releasing information can be misleading as the client is mandated which means that there is a court order.

The court order and any relevant legal documents should be obtained by the social worker and consulted whenever there are questions related to the service provision and/or reporting. These documents should be reviewed with clients. Social workers have legal mandates to comply with court orders once they are appointed to be providers of services and agree to the terms. If there is concern about mandates in court orders, social workers should try to get them changed or be removed as treating professionals by the appointing courts.

### **Question Assesses**

#### Professional Values and Ethics

- 31. C.** When addiction and substance abuse occur during pregnancy, it can have effects not only on the pregnant mother, but also on the unborn child. Opioid use in pregnancy is associated with an increased risk of adverse outcomes. *The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone.* Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. After birth, special considerations

are needed for women who are opioid-dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists.

The rationale for opioid-assisted therapy during pregnancy is to prevent complications of illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to a client of associating with a drug culture. Methadone maintenance, as prescribed and dispensed on a daily basis by a registered substance abuse treatment program, is part of a comprehensive package of prenatal care, chemical dependency counseling, family therapy, nutritional education, and other medical and psychosocial services as indicated for pregnant women with opioid dependence.

This is a recall question which assesses social workers' awareness of the effects of addiction and appropriate treatment protocols. Medically supervised withdrawal from opioids in opioid-dependent women is not recommended during pregnancy because the withdrawal is associated with high relapse rates. During pregnancy, chronic untreated heroin use is associated with an increased risk of fetal growth restriction, fetal death, preterm labor, and other adverse outcomes. Additionally, lifestyle issues associated with illicit drug use put the pregnant woman at risk of engaging in activities, such as prostitution, theft, and violence, to support herself or her addiction.

Methadone is an opioid used to treat pain and as maintenance therapy or to help with tapering in clients with opioid dependence. Thus, discontinuation of all opioids is an incorrect response choice. Best practice is medication-assisted treatment for all clients, including pregnant women.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 32. B.** Older adulthood is a time of continued growth. Clients in the later stages of life contribute significantly to their families, communities, and society. At the same time, clients face multiple biopsychosocial-spiritual-cultural challenges as they age: changes in health and physical

abilities; difficulty in accessing comprehensive, affordable, and high-quality health and behavioral health care; decreased economic security; increased vulnerability to abuse and exploitation; and loss of meaningful social roles and opportunities to remain engaged in society. Social workers should understand the needs of older adults and issues that may be facing them.

Sundowning is a term used to refer to behavioral changes that often occur in the late afternoon or evening in people with Alzheimer's disease and similar conditions. The behavioral changes may take the form of aggression, agitation, delusions, hallucinations, paranoia, increased disorientation, or wandering and pacing about. Sundowning is not a disease, but a group of symptoms that occur at a specific time of the day that may affect people with dementia. The exact cause of this behavior is unknown. Factors that may aggravate late-day confusion include fatigue, low lighting, increased shadows, disruption of the body's "internal clock," and/or difficulty separating reality from dreams. Reducing sundowning can be assisted by maintaining a predictable routine for bedtime, waking, meals and activities, and limiting daytime napping.

When sundowning occurs in a nursing home, it may be related to the flurry of activity during staff shift changes or the lack of structured activities in the late afternoon and evening. Staff arriving and leaving may cue clients with Alzheimer's to want to go home or to check on their children—or other behaviors that were appropriate in the late afternoon in their past. It may help to occupy their time with another activity during that period.

Folie à deux, or shared psychosis, is when symptoms of a delusional belief and hallucinations are transmitted from one individual to another.

Neurodegeneration is an umbrella term for the progressive loss of structure or function of neurons. Many neurodegenerative diseases including amyotrophic lateral sclerosis, Parkinson's, Alzheimer's, and Huntington's occur as a result of neurodegenerative processes. Such diseases are incurable.

This is a recall question which relies on social workers being able to recognize and understand terms associated with neuro generative diseases, such as Alzheimer's. Such diseases cause changes in client behavior. One of the response choices, folie à deux, is used to describe shared psychosis, which is not associated with neuro generative

disease. While the client's behavior may be caused by neurodegeneration, the BEST description of the change throughout the day is sundowning.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 33. C.** There is tremendous importance placed on social relationships, which consist of interactions between clients and their family and friends. Thus, social workers often rely on the use of collaterals to obtain relevant information to assist clients. Often ethical standards are silent on what obligations, if any, social workers owe to clients' family members, friends, and other collaterals who may be brought into the helping process. Thus, social workers should adhere to broad professional values when interacting with collaterals. In the absence of ethical standards, it is helpful for social workers to have agency policies and contracts that fill these gaps. For instance, before meeting with collaterals, there should be an agreement regarding the meeting's purpose, what information will be shared, and how that information may be used. Although contracts have traditionally been used with clients, they can also be used with collaterals to clarify expectations, to preempt conflicts, and to provide clients, collaterals, and social workers with legal safeguards. Service contracts with collaterals could include, but not be limited to, explaining the roles of social workers, their primary commitments to clients, any commitments to collaterals, the roles of collaterals, the nature of collateral involvement, benefits and risks to collaterals, and/or confidentiality issues.

The scenario relates to the client's request to have his daughter come to the next session. Using other family members or friends as collaterals may be helpful but does not address the suggestion at hand. Confidentiality is a client right, so a social worker can share information with others when requested by the client. Discussing client information with collaterals is appropriate if the social worker ensures that the sharing is done at the client's wishes and there is a clear understanding about what will be discussed. The correct answer ensures that there is a mutual understanding about key ethical issues which may arise when using the daughter as a collateral informant.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**34. A.** With the increasing focus on interdisciplinary practice in recent years, social workers may be supervised by a professional of a different discipline. Although this may be appropriate within the team or unit context, social workers should seek supervision or consultation from another social worker with regard to specific social work practices and issues. Similarly, a social worker providing supervision to a member of another discipline should refer that supervisee to a member of the supervisee's own profession for practice-specific supervision or consultation.

Professional resources may be helpful but should have already been consulted. The social work profession has a unique set of values and practice standards, so it is essential that the social worker seek supervision or consultation from another social worker. The hospital supervisor should be aware that such supervision is being sought and involved clients should be informed of the need for "outside" supervision or consultation if applicable. Determining how the supervisor's discipline would resolve the issue does not help with social work practice concerns.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

**35. B.** Performance monitoring is used to provide information on (a) key aspects of *how* programs are operating; (b) whether, and to what extent, program objectives are being attained (e.g., numbers of clients served compared to target goals, reductions in target behaviors); and (c) identification of failures to produce program outputs, for use in managing or redesigning program operations. Performance indicators can also be developed to monitor service quality by collecting data on the satisfaction of those served and report on program efficiency, effectiveness, and productivity by assessing the relationship between the resources used (program inputs) and the outcome indicators.

If conducted frequently enough and in a timely way, performance monitoring can provide social workers with regular feedback that will allow them to identify problems, take timely action, and subsequently assess whether their actions have led to the improvements sought.

Performance monitoring involves identification and collection of specific data on program outputs, outcomes, and accomplishments. Although

they may measure subjective factors such as client satisfaction, data is often numeric, consisting of frequency counts, statistical averages, ratios, or percentages.

Justification of the need for a service is not the aim of performance monitoring. Performance monitoring occurs during implementation of services while identification of needs happens before they are designed or planned. Needs assessments are conducted to determine the scope and severity of problems. Performance monitoring should not be approached as a perfunctory task to justify ongoing operations or delivery, or it will not lead to quality evaluations of what is working and what is not. Additionally, identifying key aspects of program operations is not linked to performance. Performance monitoring needs to involve an assessment of how agencies are doing regarding operations or outcomes.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 36. B.** Clients who suffer from severe depression may be at risk of suicide. Although suicide cannot be predicted or prevented with certainty, knowing the warning signs can help recognize when clients are at risk. The most effective way to try to prevent suicide is to recognize the warning signs, respond immediately, and treat underlying causes of suicide such as depression.

Some warning signs of suicide include the following behaviors:

- Talking about suicide or death
- Feeling hopeless, helpless, or worthless and saying things like, “It would be better if I wasn’t here” or “I want out”
- Exhibiting deep sadness, loss of interest in pleasurable activities, trouble sleeping and eating
- *Having abrupt change of mood, from extreme sadness to happiness or calm*
- Engaging in risk-taking behavior such as driving too fast and recklessly
- Calling or visiting people to say goodbye
- Putting affairs in order such as making changes to a will

Along with these behaviors, clients who are depressed have a higher risk of attempting suicide if they have ever previously made attempts, have chronic or terminal illnesses, are separated or divorced, are underemployed or unemployed, or have family histories of suicide.

The question contains a qualifying word—FIRST. There may be more than one appropriate response choice, but the order in which they are to occur is critical. Improvement in depressive symptoms can be an indication of upcoming suicide attempts. Clients who have put plans in place to end their lives often appear to be calmer or happier. The knowledge that they will be ending their lives soon appears to bring with it peace or happiness for clients plagued by depression.

Asking about changes which have recently taken place in the client's life is too vague and does not contain the questions needed to do a proper suicide risk assessment. Praise will not assist the social worker in understanding the client's current mental status. The need for a suicide risk assessment is most immediate when warning signs are present, such as those described in the scenario.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 37. B.** There are many methods that social workers use to facilitate communication. For example, within the teaching of dialectical behavior therapy (DBT), conscious validation is often called upon to help clients improve interpersonal effectiveness and mindfulness skills. DBT has six levels of validation, with each “level” offering a different tactic for validating a client.

#### *Six Levels of Validation*

1. *Mindful engagement*—listening as a way of showing presence and communicating understanding by way of nodding, making eye contact, and asking appropriate questions. (“I hear you! What’d you do after she said that?”)
2. *Accurate reflection*—repeating to ensure that the message is being accurately. (“I just heard you say that your boss really likes you, but I think you’re doing a good job.”)
3. *Reading cues*—using nonverbal and other cues to determine current mood. The social worker may need some guesswork and should seek confirmation from the client.

from a client if misunderstood (“You look unhappy. Is something you?”)

4. *Historical perspective*—drawing on knowledge of a client’s prior experience to lend perspective to current feelings (“Maybe you don’t trust your girlfriend because your previous girlfriend cheated on you?”)
5. *Assuring reasonableness*—letting a client know that thoughts, feelings, and behaviors are normal and quite reasonable. This provides reassurance, comfort, and healthy perspective (“I see your frustration. Most people can be annoyed.”)
6. *Respectful honesty*—providing feedback that lets a client know that the social worker respects the client enough to “keep it real.” This level of validation is best delivered with an accompaniment of *radical acceptance/geniality* along with a nonjudgmental stance—considering that everyone has strengths and limitations (“I understand why you said that, but I think you could have had a better result if you used a softer tone.”)

The correct answer is the one that demonstrates “a higher level of validation.” In the scenario, the social worker has already reflected the client’s nervousness (Level 2). Suggesting that the client’s feelings may result from his prior job loss—information that was deliberately provided in the scenario—draws on knowledge of the client’s prior experience to lend perspective to his current feelings (Level 4).

Listening to him is the first level of validation—*prior to reflection*. Helping the client examine behavioral cues may be helpful but is not a validation tool aimed at acknowledging and accepting his feelings.

While this question does not mention DBT, social workers are often called upon to apply practice modalities and techniques to scenarios on the examination. Social workers should never answer based on their own opinions of what they think is best. Correct answers are grounded in social work theories, models, and perspectives that were learned in graduate coursework.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 38. B.** Preparing a case presentation can be a daunting task for a social worker. While there is no standard format, there are key sections which

should be included. Sections include:

- Demographics: Age, gender, ethnicity, living situation, social involvement, and so on
- Background: Relevant history
- Presenting Problem/Key Findings: Details of the presenting problem current situation—signs and symptoms of illness, environmental factors that impinge on the situation, and actual or potential resources
- Formulation: Understanding of why things are as they are—including one or more theoretical perspectives and any uncertainty or ambivalence about the situation
- Interventions and Plans: What has been done and what plans exist to address the situation
- Reason for Presentation: Explanation of why this situation is being discussed—unique challenges? unusual problems?
- More detailed case presentations may include additional sections including legal/ethical, crisis/safety, diversity, and so on.

The supervisor is used in this question to determine if all the necessary elements of a case presentation were included. The goal of supervision is to ensure that clients receive the most effective and efficient services possible. Thus, the supervisor will appear in many questions throughout the examination to provide quality assurance, ensuring that a social worker is meeting acceptable standards.

The case presentation described only contains some of the required elements. Even a brief case presentation should contain information on the presenting problem. The presenting problem was not mentioned, making the case presentation incomplete.

### ***Question Assesses***

**Psychotherapy, Clinical Interventions, and Case Management**

- 39. A.** Social workers should be well versed in techniques and instruments used to assess client problems. Screening is the first step. Screening is a universal process, meaning that an entire population group is screened for an illness or disease. Screening is different from assessment. Screening is brief, time limited, and intended to simply identify clients at risk. In contrast, assessment is a deeper, more

thorough process that may take several sessions. Assessment interviews are conducted by specialists. Social workers need to be aware of screening models used in public health which identify people in large populations who need further assessment. It would be unlikely that clients would receive referrals to treatment directly after being screened as further information about the scope and severity of the problem would be needed. While education is usually provided during screening processes, the desired outcome for those at-risk is further diagnostic testing.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**40. C.** Attending is a term frequently used to describe the process of nonverbally communicating to clients that social workers are open, nonjudgmental, accepting of them as people, and interested in what they say. The purpose of attending is to encourage clients to express themselves as fully and freely as possible. During the beginning of the problem-solving process, especially, nonverbal presentation is equally important to verbal communication as clients are usually doing most of the talking.

Many of the guidelines available may be useful, but they tend to reflect nonverbal characteristics of majority-member, middle- and upper-class adults. Good attending behavior is usually described as follows.

- Eye Contact: Looking at clients is one way of showing interest. However, social workers can make clients feel uncomfortable if they stare at them too intensely. The best way of showing that social workers are listening is by looking at clients naturally.
- Posture: This is a natural response of interest. It is best to lean slightly toward clients in a relaxed manner. Relaxation is important, since social workers want to shift focus from themselves, so they are better able to listen to clients.
- Gesture: Social workers communicate a great deal with body movement. If hands are flailed, arms are crossed, or chest/shoulders are hunched, then messages, whether intentional or unintentional, will be communicated.
- Facial Expressions: Facial expressions, such as smiling, eyebrow raising, and frowning, indicate responsiveness.

Social workers should be aware of verbal and nonverbal communication techniques. This question requires recall of the name of a nonverbal technique. Determining the scope and severity of client problems is an assessing task. Identifying alternatives which will result in change is a planning or intervening action. Attending behavior is heavily used in engaging, though it continues throughout the problem-solving process.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 41. A.** Effective interventions depend on using the most appropriate theory and practice strategies for a given problem or situation. *Different theories/interventions are best suited for different problems.* Evidence-based practices (EBPs) are treatments that have been proven effective (to some degree) through outcome evaluations. EBPs are interventions that have strong scientific proof that they produce positive outcomes for certain types of disorders. *Clearly defining problems will help rationalize the implementation of EBPs and help inform the selection process.*

Other interventions—sometimes labeled promising practices—may also produce good outcomes, but research has not been conducted at a level to say that there is strong evidence for those practices. As such, EBPs are treatments that are likely to be effective in changing target behaviors if implemented with integrity.

The selection of an EBP depends on client problems, the outcomes desired, and treatment preferences. For example, both antidepressant medications and psychotherapy interventions are effective in the treatment of depression in older adults. The choice of one of these interventions over the other may vary with respect to the nature and severity of depression, the presence of other health conditions or medications, tolerability of side effects or required effort, and the preferences and personal values of older adults regarding these treatment characteristics.

The question contains a qualifying word—**MOST**—that indicates that all response choices may be considered, but the correct answer is the factor which should drive this decision. Treatment modalities differ depending upon presenting problems. Social workers should not limit available options to clients based on past history and/or setting. EBPs which have demonstrated that they are effective for problems at hand should be used. Social workers can advocate for additional resources or

refer clients to settings which provide the appropriate treatment if it is not available in the current setting. In addition, treatment decisions should not be based predominantly on what has been done in the past. Interventions can be very effective to address some problems and useless in helping others. Thus, matching EBPs/interventions to presenting problems is vital to ensuring that change will occur.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

**42. C.** Social workers should be familiar with standards regarding confidentiality, including the process for disclosing information because of mandatory reporting. Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply. Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client. Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. *Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information based on a legal requirement or client consent.*

The scenario calls for reporting the suspicions to the child protection agency (referred to as the authorities in this question). The social worker does not need to prove that the abuse is occurring or identify the perpetrator so meeting with the child alone is not warranted. The child protection agency is responsible for doing the investigation. There should be no delays for documentation, though documentation will be necessary at some point in the process.

### **Question Assesses**

## Professional Values and Ethics

**43. C.** A social worker's own values and beliefs can greatly influence the social worker–client relationship. Culture, race, and ethnicity are strongly linked to values. *Social workers should have self-awareness about their own attitudes, values, and beliefs and a willingness to acknowledge that they may be different than those served.* Differences in values and beliefs are very common when working with diverse populations. A social worker is responsible for bringing up and addressing issues of cultural difference with a client and is also ethically responsible for being culturally competent by obtaining the appropriate knowledge, skills, and experience.

Social workers should:

1. Move from being culturally unaware to aware of one's own heritage and the heritage of others
2. Value and celebrate differences of others rather than maintain an ethnocentric stance
3. Have an awareness of personal values and biases and how they influence relationships with clients
4. Demonstrate comfort with racial and cultural differences between themselves and clients
5. Have an awareness of personal and professional limitations
6. Acknowledge their own attitudes, beliefs, and feelings

The question acknowledges that “both school officials and the social worker feel that the student is making a mistake.” Thus, it is critical for the social worker to acknowledge the differences in values between the professionals involved and the student as she is choosing family responsibilities over pursuit of her education. This choice is based on the personal principles and tenets that are important to her.

The incorrect response choices may be useful, but the correct one is essential for the formation of a social worker–client relationship built on the core values of the profession, including the student’s right to self-determination. Despite the extent of the existing responsibilities and her

career goals, the student may value the needs of her family over furthering her own education.

### ***Question Assesses***

#### Professional Values and Ethics

- 44. A.** Many believe that gender dysphoria should be viewed and approached from the perspective of a medical model rather than that of a mental health model. Many anatomical inconsistencies can now be corrected surgically or chemically to align with the experienced true self. A medical diagnosis for individuals who are transgender, whose self-experienced gender does not match the gender assigned at birth and who require medical services to align the body with the experienced self, is considered more appropriate and consistent with research and best practices.

Those with the aforementioned diagnoses already are stigmatized by society due to myths and misunderstandings and victimized by intolerance and prejudice. The effects of this stigma are profound and long-standing, resulting in increased risks for negative health, mental health, educational, professional, and social outcomes. Continuing to include these diagnoses as aberrant contributes to sustained oppression of those who receive them.

Labeling individuals with gender dysphoria views these conditions as “abnormal” and is harmful. Considering medical diagnoses instead is more appropriate and addresses intolerance, discrimination, and oppression related to considering these diagnoses as psychological problems needing to be fixed. Gender-affirming care involves much more than medication and surgery but both are best practice when working with those with gender dysphoria.

### ***Question Assesses***

#### Human Development, Diversity, and Behavior in the Environment

- 45. A.** Despite the high prevalence of alcohol and substance use problems, many go without treatment—in part because their disorders go undiagnosed. Regular screenings enable earlier identification. Screenings should be provided to people of all ages, even the young and the elderly.

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization (WHO), the test correctly classifies 95% of people into either alcoholics or non-alcoholics. The AUDIT is particularly suitable for use in primary care settings and has been used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional.

The SCOFF Questionnaire is a five-question screening tool designed to clarify suspicion that an eating disorder might exist rather than to make a diagnosis. The questions can be delivered either verbally or in written form.

The Minimum Data Set (MDS) is a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status. It is commonly used in long-term care facilities and outpatient and home-based social service programs for older adults.

While most questions on the examination will not be this specific, there are always a few that require very specific knowledge. It is important not to get nervous when such questions arise as these select few can be missed and still get a passing score. In these instances, it is helpful to try to eliminate any incorrect response choices to increase the chances of selecting the correct answer.

### ***Question Assesses***

#### ***Assessment, Diagnosis, and Treatment Planning***

- 46. C.** Defense mechanisms are *unconscious* mechanisms which are activated in times of anxiety, stress, and distress without any choice or conscious intentionality. They are a necessary tool of protection and in moderate use contribute to successful adaptation. Defense mechanisms are a part of normal functioning, but they can be considered as pathological in some instances.

Coping, on the other hand, includes *conscious* strategies that enable clients to attain realistic goals by using available resources and past experiences while acting within society's rules of conduct. While defense mechanisms are unconscious processes whereas coping methods are conscious, in reality, sometimes clients exhibit rational coping simultaneously with unconscious defenses.

Coping mechanisms are often confused and interchanged with defense mechanisms due to their similarities. Both processes are activated in times of adversity. Defense mechanisms and coping strategies reduce arousal of negative emotions. Furthermore, both processes aim at achieving adaptation; only the means to the end differ. Defenses help the individual by distorting reality and coping strategies attempt to solve the problem, thus changing the reality. Coping behaviors involve conscious modification of cognitive and emotional appraisals, which eventually modify the reactions to the stressful event rather than distort the perception of the event. Clients have full control of coping strategies used. They can choose to stop certain coping styles and choose others.

Defense mechanisms, on the other hand, operate outside consciousness and awareness. Clients cannot intentionally choose to use other defense mechanisms.

Coping involves flexibility, and defenses are more rigid. The choice of coping mechanisms is perceived more as dependent on timing, situation, and personality factors. Different situations lead to different coping strategies. Defense mechanisms are more stable and habitual.

The idea regarding whether defense mechanisms produce adaptive and functional behaviors is still controversial. In the long term, defense mechanisms do contribute to the development of severe pathology, yet the fact that they seem to help individuals to cope in the short term should not be ignored or dismissed. Defenses are efficient mechanisms that help deal with threatening and, at times, traumatic stressors. Pathology probably does not originate from the actual use of defense mechanisms; it is caused by a continuous reliance on defenses, instead of actually attempting to solve the core problems that cause their necessity in the first place.

The incorrect response choices are not accurate. Coping mechanisms are not “unconscious actions.” Additionally, defense mechanisms can be adaptive and functional ways to deal with stress.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 47. C.** Feedback during engagement in the problem-solving process encourages clients to comment about treatment purpose, social worker/client roles, policy or ethical factors, and so on. An important part

of communicating effectively involves checking to see whether clients have understood social workers' messages. Seeking feedback serves this function. In addition, seeking feedback is essential for informed consent by inviting clients to identify areas that are unclear, share thoughts that have occurred to them, introduce new topics, or express disagreement. *By seeking feedback, social workers effectively send messages that treatment is a mutual and reciprocal process. Social workers convey that they are genuinely interested in what clients have to say and there is a desire to have them actively participate in the process.*

Social workers routinely seek feedback throughout the problem-solving process by asking, "How does that sound to you?" Other feedback can be elicited by inquiring, "What do you think about what we have talked about so far?" It is also good to find out about client questions or comments.

In this question, the social worker is "in an initial meeting with a man," indicating that engagement is occurring. During engagement, a social worker should begin to form a working alliance with a client. A client should feel respected and understand that a social worker can be a valuable resource toward making change but cannot solve a client's problems and is not there to tell the client what to do.

The social worker's question demonstrates to the client that his opinions about treatment matter despite the involuntary nature of the service. It aims to get the client talking about his feelings, which is the first step in forming a therapeutic relationship. While the client may reveal some resistance when answering, the question is not aimed to do so. It also does not seek to determine if denial is present or identify whether the client is aware of his legal mandates. These are assessment tasks which will occur later. Assessment follows engagement in the problem-solving process. In addition, a social worker should not make assumptions about the presence of resistance or denial just because a client is mandated into services.

Universal among involuntary clients is that other entities have the power to influence terms of their treatment, which may make them feel that they have less control in the process. Social workers can address this issue by eliciting their feedback, sending the message that their input is essential.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**48. B.** Symbolic interactionism sees clients as active in shaping their world, rather than as entities who are acted upon by society. With symbolic interactionism, reality is seen as social, developed interaction with others. Symbolic interactionists believe physical reality exists based upon clients' social definitions, and that social definitions develop in part or in relation to something "real." Thus, clients do not respond to this reality directly, but rather to the social understanding of reality; that is, they respond to this reality indirectly through a kind of filter which consists of clients' different perspectives. This perspective is based on three premises:

- Clients act toward things on the basis of the meanings they ascribe to those things.
- The meaning of such things is derived from, or arises out of, the social interaction that they have with others and society.
- These meanings are handled in, and modified through, an interpretive process used by clients in dealing with the things encountered.

Essentially, clients behave toward objects and others based on the personal meanings that they have already given these items. The second premise explains the meaning of such things is derived from, or arises out of, the social interaction that one has with other humans. Lastly, clients interact with each other by interpreting or defining each other's actions instead of merely reacting to each other's actions. Therefore, responses are not made directly to the actions of one another, but instead are based on the meaning which clients attach to such actions.

Thus, the interaction of intimate couples involves shared understandings of their situations. Spouses have different styles of communication, and social class affects the expectations that spouses have of their marriages and of each other. Marital problems stem from different understandings and expectations that spouses have of their marriage.

In functionalism, marriage performs several essential functions for society. It socializes children, it provides emotional and practical support for its members, it helps regulate sexual activity and sexual reproduction, and it provides its members with a social identity. Marital problems stem from sudden or far-reaching changes in the structure or

processes; these problems threaten the marital stability and weaken society.

Psychodynamic models focus on the dynamic relations between the conscious and unconscious mind and explore how these psychological forces might relate to early childhood experiences.

This is a recall question which requires knowledge of various theories, perspectives, and treatment approaches. When response choices consist of proper names in recall questions, it is often wise to look at them first and ruminate about the theories, perspectives, and treatment approaches before reading the questions. Getting the question correct requires some basic knowledge about each of the response choices to assist with selection or elimination.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 49. C.** Social workers' commitment to informed consent is based on clients' right to self-determination. The informed consent process is one of the clearest expressions of social workers' respect for clients' dignity and worth as individuals to make choices which are best suited to meet their needs.

A client should have the right to refuse or withdraw consent. Social workers should be prepared for the possibility that clients will exercise these rights. Social workers should inform clients of their rights and help clients make thoughtful and informed decisions based on all available facts and information about potential benefits and risks.

Social workers should be familiar with informed consent requirements concerning clients' right to consent, especially when working with those who are incarcerated, children, individuals with cognitive impairments, and so on.

While laws and regulations vary in interpretations and applications of informed consent standards, there are essential standards in all processes which are needed for their validity. First, coercion and undue influence must not have played a role in clients' decisions. As social workers often maintain control over approving benefits, admission into programs, and the termination of services, they should ensure that clients do not feel pressured to grant consent based upon this control.

Second, social workers should not present clients with general, broadly worded consent forms that may violate clients' right to be informed and may be considered invalid if challenged in a court of law. The use of broad or blank consent forms cannot possibly constitute informed consent. Social workers should include details that refer to specific activities, information to be released, or interventions. Typical elements include details of the nature and purpose of a service or disclosure of information; advantages and disadvantages of an intervention; substantial or possible risks to clients, if any; potential effects on clients' families, jobs, social activities, and other important aspects of their lives; alternatives to the proposed intervention or disclosure; and anticipated costs for clients. This information should be presented to clients in clear, understandable language. Consent forms should be dated and include a reasonable expiration date.

Third, clients must be mentally capable of providing legal consent. Clients with significant permanent cognitive deficits may be unable to comprehend the consent procedure. Social workers should assess clients' ability to reason and make informed choices, comprehend relevant facts and retain this information, appreciate current circumstances, and communicate wishes. *Some clients may be only temporarily unable to consent, such as individuals who are under the influence of alcohol or other drugs or are experiencing transient cognitive symptoms at the time consent is sought. Clients who are unable to consent at a given moment may be able to consent in the future if the incapacity is temporary.*

The use of drugs has interfered with the man's ability to give informed consent. It is not appropriate to waive consent procedures. Verbal consent procedures are also problematic as "the social worker questions his ability to understand what she is asking." Thus, he cannot give consent if he is unable to understand parameters of the information to be gathered or the services to be delivered (the nature and purpose of the service; the advantages and disadvantages of an intervention; substantial or possible risks; anticipated costs; and so on).

His impairment may be temporary as he admits to using drugs which interfered with his reasoning prior to the meeting. Arranging to meet him at a later time may result in him being in a mental state in which he can make informed choices and comprehend relevant facts, which are necessary elements for informed consent.

### **Question Assesses**

## Professional Values and Ethics

- 50. A.** Developing goals, objectives, and interventions is critical to alleviating client problems. The document that contains the problem statement, goals, objectives, and methods is the intervention, treatment, or service plan (contract). It is a road map that outlines the journey from problems that are identified through assessment to life when those issues have been successfully addressed.

The first step in any helping process is to identify the solvable problem and why a client is seeking help now. Once the problem is identified, goals and objectives can be specified that will help toward a solution. *Goals are long-term, general, and often the opposite of the problem.* The most basic goal should be for a client to be able to function at the level of functioning before the current problem started. This baseline is referred to as premorbid functioning.

The specific steps taken to achieve the goal are called objectives. *Objectives are short term and specify who does the action, for how long, and how often to achieve the desired outcome (who will do what by when).* Because the goals and objectives derive from the assessment, the frequency of the desired outcome should not be made up out of thin air. Using the frequency before the problem starts and working backwards is helpful. Being realistic and precise in targets will assist in achieving success. Considering premorbid functioning ensures that goals and objectives are not set too high.

*Strategies are the means by which treatment goals are achieved.* Each objective can have more than one intervention. Interventions are typically specific to varying theoretical approaches.

The identified objective was to meet friends, which is not happening now. If she met friends weekly in the past, prior to her feelings of worthlessness, the objective would be to engage in that behavior again. Thus, it is critical to understand the frequency of the behavior so a measurable target can be established.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 51. B.** In addition to the typical diagnosis of bipolar I disorder, further information about the mood can be denoted with a “specifier.” A *specifier*

*is an extension to the diagnosis that further clarifies the course, severity, or special features of the disorder or illness.* One specifier is “with anxious distress.” The “with anxious distress” specifier means that during periods of mania, hypomania, or depression, clients also have anxiety symptoms. The symptoms include feeling tense, feeling especially restless, problems concentrating due to worry, fear that something terrible will happen, and feeling a loss of control. The intensity ranges from mild to severe, depending on how many symptoms are present.

The difference between this specifier and having an anxiety disorder, such as generalized anxiety disorder or panic disorder, is that these symptoms are only present during mood episodes related to bipolar disorder. When a client’s mood is normal, the anxiety will be gone.

Having bipolar disorder with anxious distress means clients have bipolar disorder, plus anxiety that interferes with life, but do not meet the diagnostic criteria of an anxiety disorder.

*High levels of anxiety have been associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment nonresponse. As a result, it is clinically useful to specify accurately the presence and severity levels of anxious distress for treatment planning and monitoring of response to treatment.*

In order to add the specifier “with anxious distress,” at least two of these symptoms should be present:

- Feeling tense or keyed up
- Unusual restlessness
- Worry that makes it difficult to concentrate
- Fear that something terrible may happen
- Feeling that clients might lose control

The symptoms have to be present most days of the current or most recent bipolar episode, regardless of whether the episode involved manic, hypomanic, or depressive symptoms.

The severity of the condition is determined by the number of symptoms present: two symptoms mean the condition is mild, three symptoms mean it is moderate, four to five symptoms mean it is moderate to

severe, and 4 to 5 symptoms with psychomotor agitation means it is severe.

Clients with bipolar disorder with anxious distress also can be diagnosed with other anxiety disorders. For example, if they get panic attacks, they can be diagnosed with panic disorder, and if they are acutely afraid of a specific object or situation (e.g., spiders or flying), then they could be diagnosed with specific phobia.

When two or more illnesses not related to each other are diagnosed in a single client, they are called “comorbid,” which simply means they occur together.

Anxiety disorders that frequently have been diagnosed together with bipolar disorder include:

- Panic disorder
- Generalized anxiety disorder
- Obsessive compulsive disorders
- Social anxiety disorder (social phobia)
- Agoraphobia
- Specific phobia

Other specifiers for bipolar disorder include:

- With rapid cycling
- With melancholic features
- With atypical features
- With mood-congruent psychotic features or with mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

This is a recall question about the use of specifiers with diagnosed mental disorders. Social workers should be familiar with the criteria associated with their use and know when they are to be appropriately added.

## **Question Assesses**

### Assessment, Diagnosis, and Treatment Planning

- 52. A.** Understanding the impact of caregiving includes understanding transitions into and out of caregiving.

There is much evidence on the health effects of caregiving. Providing assistance with basic activities of daily living (ADLs) has resulted in increased depression and psychological distress, impaired self-care, and poorer self-reported health.

Also studied are the effects of making the transition out of the caregiving role because individuals improve, enter institutions, or die. Improved functioning of care recipients is associated with reductions in caregiver distress. The death of the care recipient has been found to reduce caregiver depression, and caregivers are often able to return to normal levels of functioning within a year. However, the effects of a transition to a nursing home are less positive, with caregivers continuing to exhibit the same level of psychiatric morbidity after placement. While nursing home placements may reduce the strain associated with physical assistance, family members often still have responsibilities associated with caregiving, including the added financial burden of paying for out-of-home care and/or losing complete control over the delivery of services.

## **Question Assesses**

### Human Development, Diversity, and Behavior in the Environment

- 53. B.** There are several specifiers for obsessive-compulsive and related disorders. Specifiers are extensions to a diagnosis that further clarify its course, severity, or special features. The “with poor insight” specifier for obsessive-compulsive disorder (OCD) distinguishes between individuals with “good or fair insight,” “poor insight,” and “absent insight/delusional” OCD beliefs (i.e., complete conviction that OCD beliefs are true).

According to the *DSM*, one of the diagnostic criteria for OCD is that the person at some point in time has recognized that the obsessions or compulsions they experience are “excessive or unreasonable.” This acknowledgment of the irrational nature of the OCD symptoms has been coined “insight.” However, social workers who treat clients with OCD observe that they do not always seem to recognize or agree that

their obsessions and compulsions do not make sense. Insight into OCD symptoms exists on a continuum, with some clients completely acknowledging that their symptoms do not make sense, and others having a very strong belief in the validity of their obsessions and compulsions.

Although there is some disagreement, poor or absent insight into OCD symptoms is generally thought to predict a worse response to both psychological and medical treatments for OCD. Poor or absent insight may make it difficult for the client to get up the motivation to do the hard work that therapy requires or to stick with taking a medication daily, especially if there are initial side effects that are unpleasant. Clients with less insight may also be less likely to attend regular appointments or to contact social workers in the first place.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 54. A.** Autism spectrum disorder (ASD) is a neurodevelopmental disorder, characterized by severe and pervasive impairments in reciprocal social communication and social interaction (verbal and nonverbal), and by restricted, repetitive patterns of behavior, interests, and activities. There are specifiers that can be used to describe features such as “with or without intellectual impairment,” “with or without language impairment,” “associated with known medical or genetic condition or environmental factor,” “associated with another neurodevelopmental, mental, or behavioral disorder,” and “with catatonia.” The question is asking about which response choice is not a specifier. Understanding the nature of ASD may assist as intellectual impairment and language impairment can be, but do not have to be, comorbid. “Associated with psychosocial stressors” is not a specifier for ASD as those with this disorder find typical social interactions stressful.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 55. B.** Despite advances in human rights and acceptance, stigma, both internal and external, continues to be the greatest problem facing sexual and gender minorities. Internally, many people who are lesbian, gay, bisexual, transgender, queer, or intersex (LGBTQI) develop an internalized homophobia that can contribute to problems with self-

acceptance, anxiety, depression, difficulty forming intimate relationships, and being open about what sexual orientation or gender identity one actually has. Externally, stigma may be exhibited by the surrounding society and even from within the LGBTQI community. For example, some people who are gay or lesbian may have difficulty accepting those who are bisexual. People who are transgender also have historically been excluded from some gay organizations.

In addition, most people who are LGBTQI are not raised by people who identify as LGBTQI. Accordingly, they might not have the ability to seek support from parents or peers who may understand these struggles.

Lastly, those who are LGBTQI struggle with higher rates of anxiety, depression, and substance use disorders. Many have struggled with stigma and the self-acceptance process. Alarmingly, those who are LGBTQI have higher rates of suicide or suicidal behavior.

They are also at greater risk for discrimination, verbal abuse, physical assaults and violence, and so on. Though legal protections have been increasing, fear of potential discrimination contributes to not seeking needed help.

The scenario also asks about appropriate actions “in assisting the client to formulate treatment goals,” which is part of planning in the problem-solving process. Exploring familial relationships is an assessment task which would have happened prior to planning. Lastly, role modeling can be effective, but represents an intervention. For goal setting to occur, there should be an identification of the people whose acceptance is important to the client.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 56. C.** Many ethical standards speak to the professional boundaries that social workers should maintain with clients. Social workers should ensure that they do not engage in dual or multiple relationships that may impact on the treatment of clients. Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should avoid potential or real conflicts of interest. Dual relationships can be simultaneous or consecutive.

The social worker cannot commence a relationship with the student given the presence of a dual relationship. The student may not be able to be honest with the social worker if therapy were to begin, given a belief that what would be disclosed may impact standing in the social work program. Contrarily, the social worker may receive information that would otherwise not be known by a faculty member, calling into question the ability of the student to competently practice. Even though the social worker did not have the student in class, there is a conflict of interest as the social worker is a faculty member in the program. Meeting with the student to learn more about the problem is inappropriate given the presence of an existing relationship. Lastly, speaking to the program director also should not be done. Informing the student that services cannot be provided is the ethical action and helps the student learn about appropriate boundaries.

### **Question Assesses**

#### Professional Values and Ethics

- 57. C.** Schizophrenia is a brain disorder that affects how clients think, feel, and perceive. The hallmark symptom of schizophrenia is psychosis, such as experiencing auditory hallucinations (voices) and delusions (fixed false beliefs).

Clients with the disorder may hear voices or see things that are not there. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can be scary and upsetting to clients with the illness and make them withdrawn or extremely agitated. It can also be scary and upsetting to others around them.

Clients with schizophrenia may sometimes talk about strange or unusual ideas, which can make it difficult to carry on a conversation. They may sit for hours without moving or talking. Sometimes clients with schizophrenia seem perfectly fine until they talk about what they are really thinking.

The symptoms of schizophrenia fall into three broad categories: positive, negative, and cognitive symptoms.

Positive symptoms are psychotic behaviors not generally seen in healthy people. Clients with positive symptoms may “lose touch” with some aspects of reality. For some, these symptoms come and go. For

others, they stay stable over time. Sometimes they are severe, and at other times they are hardly noticeable. The severity of positive symptoms may depend on whether a client is receiving treatment.

Hallucinations are sensory experiences that occur in the absence of a stimulus. These can occur in any of the five senses (vision, hearing, smell, taste, or touch). “Voices” (auditory hallucinations) are the most common type of hallucination in schizophrenia. Many clients with the disorder hear voices. The voices can either be internal, seeming to come from within one’s own mind, or they can be external, in which case they can seem to be as real as another person speaking. Sometimes clients with schizophrenia talk to the voices that they hear. Clients with schizophrenia may hear voices for a long time before family and friends notice the problem.

Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects, and feeling things like invisible fingers touching their bodies when no one is nearby.

Delusions are strongly held false beliefs that are not consistent with a client’s culture. Delusions persist even when there is evidence that the beliefs are not true or logical. Clients with schizophrenia can have delusions that seem bizarre, such as believing that neighbors can control their behavior with magnetic waves. They may also believe that people on television are directing special messages to them, or that radio stations are broadcasting their thoughts aloud to others.

Thought disorders are unusual or dysfunctional ways of thinking. One form is called “disorganized thinking.” This is when a client has trouble organizing thoughts or connecting them logically. The client may talk in a garbled way that is hard to understand.

Movement disorders may appear as agitated body movements. A client with a movement disorder may repeat certain motions over and over. In the other extreme, a client may become catatonic. Catatonia is a state in which a client does not move and does not respond to others.

Negative symptoms are associated with disruptions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions.

These symptoms include the following:

- “Flat affect” (reduced expression of emotions via facial expression or v

tone)

- Diminished feelings of pleasure in everyday life
- *Difficulty beginning and sustaining activities*
- Reduced speaking

Clients with negative symptoms may need help with everyday tasks. They may neglect basic personal hygiene. This may make them seem lazy or unwilling to help themselves, but the problems are symptoms caused by schizophrenia.

For some, the cognitive symptoms of schizophrenia are subtle, but for others, they are more severe; clients may notice changes in their memory or other aspects of thinking. Similar to negative symptoms, cognitive symptoms may be difficult to recognize as part of the disorder. Often, they are detected only when specific tests are performed.

Cognitive symptoms include the following:

- Poor “executive functioning” (the ability to understand information and it to make decisions)
- Trouble focusing or paying attention
- Problems with “working memory” (the ability to use information immediately after learning it)

Poor cognition is related to worse employment and social outcomes and can be distressing to clients with schizophrenia.

This question is particularly tricky as all the response choices are, in fact, symptoms of schizophrenia. However, the correct answer is a *negative symptom*—not a positive one. It is necessary to know the difference between negative, positive, and cognitive symptoms of schizophrenia to answer correctly.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 58. C.** Engagement with mandated clients takes skill and patience. Most therapeutic models are based on the assumption that the process of therapy will be a voluntary endeavor in which both clients and social workers will engage in therapeutic relationships through mutual consent.

While clients often seek mental health services due to realizing they have a problem, many may also be referred involuntarily to mental health professionals for treatment. Mandated clients are individuals who are sent or brought by someone else for treatment, including courts, protective service agencies, employment assistance programs, schools, and so on. Clients mandated for therapy may indicate the insistence of others as their reasons for coming to therapy, present themselves as not needing help, or demonstrate little willingness to establish a relationship with social workers. The involuntary nature of the relationship could present hurdles early on in the therapeutic process, making it exasperating for both social workers and their involuntary clients. *Clients mandated into therapy may view the process of therapy as being forced upon them, with social workers representing yet another part of the legal system.* On the other hand, social workers may anticipate certain attitudes in mandated clients and label them as resistant, unmotivated, uncooperative, involuntary, defiant, reluctant, difficult, or noncompliant.

The question contains a qualifying word—MOST. While the apprehension by the client to speak to the social worker in the scenario may be an indication of more than one of the response choices listed, it is likely related to the involuntary nature of the relationship. The client might be fearful about sharing information. However, it is unlikely that the client would be providing information in the first session that would be highly sensitive. The question also states that the client is apprehensive to discuss mandated services—not current problems. The discussion of mandated services would not likely be personal in nature.

The first session focuses on engagement and the formation of a therapeutic alliance. It is likely that the client will be upset about being told to see the social worker, regardless of a willingness to make changes. The assumption that legally mandated clients will not contemplate change and voluntary clients are open to modifying behavior is not supported by research. Those who are court-ordered into treatment often have made decisions that changes are needed. However, they need to learn to trust social workers who they did not choose to see. Acknowledging clients' lack of choice during the first meeting can often be common ground upon which to build relationships in the future.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

**59. C.** Narrative therapy is a method of therapy that separates a client from a problem and encourages clients to rely on their own skill sets to minimize problems that exist in their everyday lives. Throughout life, personal experiences are transformed into personal stories that are given meaning and help shape a client's identity; narrative therapy utilizes the power of clients' personal stories to discover their life purpose.

Narrative therapy was created as a nonpathologizing, empowering, and collaborative form of therapy that recognizes that clients possess natural competencies, skills, and expertise that can help guide change in their lives. *Clients are viewed as separate from their problems, and in this way, social workers can help externalize sensitive issues.* This objectification dissipates resistance and defenses and allows a client to address this issue in a more productive manner. *By externalizing problems, clients see that problems can be separated from their identities or sense of self (ego) and therefore can be removed or changed. It can be very empowering for clients to see themselves as separate from, and having control over, "problems."*

Rather than transforming a client, narrative therapy aims to transform the effects of a problem. The objective is to get some distance from the issue; in this way, it is possible to see how a particular concern is serving a client, rather than harming the client. For example, posttraumatic stress might help protect a client from the difficult emotions associated with a particular event, although it also contributes a host of new troubling symptoms, such as anxiety. This process of externalization can help a client develop greater self-compassion, which, in turn, can help the client feel more capable of change. Social workers using narrative therapy help clients view their problems within the context of social, political, and cultural storylines that influence the way they view themselves and their personal stories.

Social workers who use narrative therapy believe that simply telling one's story of a problem is a form of action toward change. *They help to objectify problems, frame them within a larger sociocultural context, and make room for other stories.* Together, a social worker and client identify and build upon "alternative" or "preferred" storylines that exist beyond the problem story; these provide contrast to the problem, reflect a client's true nature, and offer opportunities to rewrite the story. In this way, clients move from what is known (problem stories) to what is yet unknown. By exploring the impact of a problem, it is possible to identify

what is truly important and valuable to a client in a broader context beyond the problem.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 60. B.** Self-monitoring is a key feature of cognitive behavioral therapy (CBT) for feeding and eating disorders. It provides a detailed measure of eating problems and the circumstances under which they occur. It indexes the progress of treatment and helps guide the focus of each therapy session. Food diaries are self-monitoring tools.

One of the reasons self-monitoring is so helpful is that it can be very difficult to recall thoughts, feelings, or behaviors after some time has passed. In the moment, self-monitoring makes it possible to get an accurate picture of what is really going on with eating behavior. This can be an important tool when clients are working to change behaviors or problems.

CBT focuses on the relationship between thoughts, feelings, and behaviors. Social workers assist clients in identifying patterns of irrational and self-destructive thoughts and behaviors that influence emotions.

Task-centered practice is a short-term treatment where clients establish specific, measurable goals. Social workers and clients collaborate together and create specific strategies and steps to begin reaching those goals.

Narrative therapy externalizes a person's problem by examining the story of the person's life. In the story, the client is not defined by the problem, and the problem exists as a separate entity. Instead of focusing on a client's depression, in this social work practice model, a client would be encouraged to fight against the depression by looking at the skills and abilities that may have previously been taken for granted.

The question contains a qualifying word—MOST. While self-monitoring may be used in various social work practice models, it is a common cognitive behavioral technique with Socratic questioning, homework, behavioral experiments, systematic desensitization, and so on. CBT is also effectively used with feeding and eating disorders, which may be an additional clue as to the correct answer.

## **Question Assesses**

### Psychotherapy, Clinical Interventions, and Case Management

- 61. B.** Hegemony refers to the leadership, dominance, or great influence that one entity or group of people has over others. Historically, this term often referred to a country that exerted power over other countries indirectly rather than through military force. Modern uses often refer to a group in a society having power over others within that society. For example, the wealthy class might be said to have hegemony over the poor because of its ability to use its money to influence many aspects of society and government. Wealthy individuals can contribute the most money to the campaigns of certain political candidates, political parties, or causes. To ensure reelection or continued contributions, government officials who use those funds might then pass laws or create policies that favor those who contributed to the campaigns. People who do not have the money to contribute, however, are unable to influence the government in the same way.

This word is derived from the Greek verb *hegeisthai*, which translates as “to lead.” Early leaders who were able to exert control and influence over a group of people might be referred to as hegemonic. A hegemon had to have the support from at least one dominant class of people to keep the population as a whole from rebelling against the leadership. A single country might also be considered to be hegemonic if it has enough power to influence the way that other countries behave.

The question contains a qualifying word—BEST. While all the response choices relate to diversity among groups and/or its impact on values, only the correct answer speaks to the power to “lead” or dominate, which is the essence of hegemony. Social workers should be familiar with key concepts and terms related to social work practice, including those related to morals and beliefs that are consistent with and antithetical to the profession.

## **Question Assesses**

### Human Development, Diversity, and Behavior in the Environment

- 62. C.** Borderline personality disorder (BPD) is characterized by emotional instability, distress, and neurosis. Clients with this disorder tend to experience difficulty in forming stable relationships. A paranoid fear of being abandoned haunts these clients, and this fear frequently becomes

a self-fulfilling prophecy. Angry outbursts are common. Clients with BPD tend to view people in black and white, idealizing someone one day and devaluing that person the next.

Clients with BPD have an increased incidence of childhood neglect and abuse. Many clients who have been diagnosed with BPD are told that their chronic disorder is not treatable. However, BPD can have a good prognosis if properly treated. Specialized psychotherapy can significantly improve the lives of individuals with this debilitating disorder.

Major research has been conducted on the prognosis of clients with BPD. A major finding was that the remission rate went from about 30% to 50% by the second-year follow-up, and up to about 80% by the 10th year. Thus, remission of symptoms is more frequent than what researchers and clinicians previously believed.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 63. B.** Several hundred screening instruments are available today to aid social workers and others in identifying clients with alcohol problems. One instrument in particular, the CAGE assessment, is useful in a variety of settings and with a range of target populations. CAGE is an acronym for its four questions; the instrument is a widely used screening test for problem drinking and potential alcohol problems. Instrument administration takes <1 minute and is often used in primary care or other general settings as a quick screening tool rather than as an in-depth interview for those who have alcoholism. The CAGE instrument does not have a specific intended population, and it is meant to find those who drink excessively and need treatment. The CAGE questionnaire is reliable and valid; however, it is not valid for diagnosis of other substance use disorders, although somewhat modified versions of the CAGE questionnaire have been frequently implemented for such a purpose.

The CAGE is designed as a self-report questionnaire. Because talking about drinking behavior can be uncomfortable or stigmatized, client responses may be subject to social desirability bias. The honesty and accuracy of responses may improve if clients trust social workers doing the interviews. Responses also may be more honest when the form is completed online, on a computer, or in other anonymous formats.

The CAGE assessment can identify alcohol problems over the lifetime. Two positive responses to the questions are considered a positive test and indicate further assessment is warranted.

- C: Have you ever felt you should *cut down* on your drinking?
- A: Have people *annoyed* you by criticizing your drinking?
- G: Have you ever felt bad or *guilty* about your drinking?
- E: *Eye opener*: Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Addiction—or compulsive alcohol or drug use despite harmful consequences—is characterized by an inability to stop using alcohol or drugs; failure to meet work, social, or family obligations; and sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs—including many prescription drugs, even if taken as instructed. Thus, physical dependence in and of itself does not constitute addiction, but it often accompanies addiction.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 64. A.** Resisting disclosure of privileged information is required to protect the confidentiality of clients. Social workers should employ varying methods to protect the confidentiality of clients during legal proceedings to the extent permitted by law. *When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.*

Social workers can use several additional strategies to protect clients' confidentiality during legal proceedings. If social workers believe court orders are unwarranted or without merit, they can arrange for lawyers to file motions asking the court to rule that the requests are inappropriate. In addition, social workers may request that judges review clinical notes and records in chambers to protect confidentiality and then rule on whether the information should be revealed in open court and made a

matter of public record. Judges may issue a protective order explicitly limiting the disclosure of specific privileged information to certain portions of social workers' clinical notes or certain aspects of interpersonal communications.

Social workers are instinctively inclined to protect clients' confidentiality. Clients' legal right to privileged communication strengthens social workers' ability to protect clients. To fulfill their ethical duty, social workers should be familiar with the concept of privileged communication, practical steps they can take to protect clients, and exceptions to clients' right to privileged information.

Redacting information is not recommended when a social worker receives a court order which mandates release of information which can be harmful without client consent. This action is probably prohibited by law as the court has requested the information in its entirety. In addition, if a social worker is successful in getting the court to withdraw an order, it would be better to not submit any documentation even if the most sensitive parts have been redacted. Lastly, while asking for the records to be maintained under seal is an option, it is not the MOST appropriate one as it does not provide the greatest protection afforded by having the court withdraw the order, if deemed appropriate by a judge.

### ***Question Assesses***

#### Professional Values and Ethics

- 65. B.** Professional development ensures that social workers continue to strengthen their skills and learn throughout their career. The most effective professional development engages social workers to focus on meeting the needs of their clients. Social workers learn new skills and competencies to ensure clients receive the most effective and efficient services possible.

Professional development refers to many types of educational experiences. Social workers participate in professional development to learn and apply new knowledge and skills that will improve service delivery.

Effective professional development enables social workers to develop the knowledge and skills they need to address complex client problems. To be effective, professional development requires thoughtful planning followed by careful implementation with feedback to ensure it responds

to social workers' needs. Social workers who participate in professional development then should put their new knowledge and skills to work. Professional development is not effective unless it causes social workers to learn new theory and techniques aimed at helping clients reach their goals.

This question contains a qualifying word—BEST. While the incorrect response choices may be reasons that social workers engage in professional development, the correct answer focuses on its benefits for improved practice. Correct answers on the examination are always ones that focus on the delivery of effective services and place client needs above agency policy, regulatory requirements, and employment considerations.

### **Question Assesses**

#### Professional Values and Ethics

- 66. B.** Interaction of people, organizations, and governments is the process of globalization. The process is determined by trade between the nations, investments in their businesses, and data gathered through information technology and has some effects on the cultural, environmental, political, and economic development of the countries. Globalization can have both negative and positive effects on quality of life.

Cultural convergence means bringing together different cultural groups, which results in these cultures becoming more alike in terms of technology, sports, language, and even politics.

Globalization and culture are interdependent. Globalization lies at the heart of modern culture; culture practices lie at the heart of globalization. Their relationship is reciprocal.

History shows that contact between different cultures leads to trade of products between them or globalization. Travelers and merchants from one culture to another culture bring products with them which allow people to know about the other culture and its products. Technology has made nations know about other nations and even adopt their customs if they like them.

Globalization is resulting in greater homogeneity around the globe, but it is also said that globalization is demolishing local cultures and

traditions. Thus, there are positive and negative impacts of globalization.

The question contains a qualifying word—MOST. Though some of the incorrect response choices can lead to cultural convergence, globalization is the greatest or most significant contributor. Globalization causes the greatest interaction between people, which results in cultural convergence. Social workers should be familiar with how human behavior changes as a result of the interactions of those from different societies and parts of the world.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 67. B.** Gender identity is an individual sense of femaleness or maleness or neither or both. It is also, to some degree, a social construction that traditionally has categorized certain behaviors into primarily binary, male and female, roles. Gender identity conflicts can stem from gender identity not matching an individual's biological sex, gender identity being neither completely male nor female, or biological sex not being uniquely male or female. The use of Latinx began more than a decade ago and is the gender-neutral alternative to Latino or Latina. The use of Latinx is gaining popularity as part of an effort to move beyond gender binary and be inclusive of the intersecting identities of Latin American descendants.

Latinx makes room for people who are trans, queer, agender, nonbinary, gender nonconforming, or gender fluid. In Spanish, the masculinized version of words is considered gender neutral, but that does not work for some who think it is inappropriate to assign masculinity as gender neutral. The use of "x" is a way of rejecting the gendering of words and recognition that language changes in order to accommodate the times in which it is used.

Though people may not identify as Latinx for various reasons, it is important to respect others who do and who want to be referred to as such. Latinx is a way to be more inclusive of identities that go beyond gender norms that are rapidly shifting and being redefined in today's culture. It is seen by some as vital to expressing who they are and being able to explain it to others.

This question requires knowledge of a specific term related to gender identity. There are always several questions on every version of the

examination which include very unique and specific knowledge. While this term may be unfamiliar, it is possible to use reasoning to get to the correct answer with some familiarity that most nouns (not all) are assigned a gender—masculine or feminine—in the Spanish language. The endings of words often indicate whether they are masculine or feminine. As “Latinx” does not end in the traditional “a” or “o” for this word, it may be possible to reason that the substitution concerns the assignment of gender.

When a question asks about a term that is unknown, it is best to use any information or reasoning available and select the response choice which appears logical (even if it is just a guess). Failing the exam will not occur just because there are a handful of unfamiliar terms or concepts.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 68. A.** Termination is an important part of the problem-solving process as there is a beginning, middle, and end to all clinical relationships. Most social work focuses on engaging clients in services, followed by helping them obtain stability. Too often, references to the inevitable end of client–social worker relationships are absent during all steps in the treatment process. Yet, clinical relationships have an end point. Some have clearly defined time limits, while others use assessment of clinical outcomes to determine when clients are ready for discharge. Even long-term programs serving chronic populations such as those with mental illness, persons with developmental disabilities, or persons with chronic medical conditions still experience staff turnover requiring termination issues to be broached.

The final stages of treatment with clients can be met with a range of emotion from jubilation to deep sorrow. Nevertheless, if work has been done during the initial and maintenance phases of treatment, transition and termination discussion should not be a surprise and should actually be expected.

During termination, greater independence should be encouraged. As it is important that clients not feel cast aside or abandoned, in-depth conversation about clients’ reactions to the end of their clinical relationships should take place in order to let them voice their fears. In

addition, progress should be reviewed and appropriate actions if problems reappear should be identified.

In the scenario, the social worker is in the last step in the problem-solving process, termination. However, new information about the client's situation has been revealed. This information appears to be directly related to the problem which originally brought her into treatment. While her anxiety has improved in recent months, a change in her environment, such as going to a new school, may serve as a stressor. Thus, termination may be premature as the client could require additional support. *Assessment is an ongoing activity which can take place during any step in the problem-solving process.* Thus, the social worker should determine whether termination is still appropriate through a thorough assessment.

Acknowledging progress made during treatment and identifying needed follow-up services are standard activities which occur during termination. However, they are incorrect response choices as they do not consider the new information about the client's situation.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

- 69. B.** The Health Insurance Portability and Accessibility Act of 1996 Medical Privacy Regulations (known as the HIPAA Privacy Rule) has important implications for the confidentiality of psychotherapy notes. The HIPAA Privacy Rule recognizes the unique characteristics of "psychotherapy notes" and defines them as notes that are:

- Recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session; and
- Separated from the rest of the individual's medical or clinical record.

Thus, any additional privacy protection that may be available to clients' psychotherapy notes depends on whether the notes are maintained separately from the rest of the clinical file. This has been interpreted to mean in a separate file (paper or electronic), rather than a subsection of a file. The underlying rationale is that the notes are intended primarily for use by social workers. Access to the notes should be limited to primary clinicians.

Under the Privacy Rule, the definition of “psychotherapy notes” does not include session start and stop times, modalities and frequency of treatment, medication monitoring, clinical tests, or summaries of diagnosis, prognosis, treatment plan, or progress.

If a social work practice decides to maintain separate psychotherapy notes, all the previously listed excluded material would be maintained in the primary client file or “medical record,” while the psychotherapy notes would be kept elsewhere. Thus, the primary client chart would include, as applicable:

- Medication prescription and monitoring
- Counseling sessions’ start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests
- Any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date
- Intake information
- Billing information
- Formal evaluations
- Notes of collateral contacts
- Records obtained from other providers

The previous information would be considered the “medical record” for HIPAA purposes and subject to disclosure with a general consent or authorization to release information. Under the Privacy Rule, for separately maintained psychotherapy notes to be released, the client should sign a separate authorization form. This means clients will be more aware as to when such a specific request has been made, and clinicians can provide clients an opportunity to consider whether or not they wish to sign a separate authorization for release of psychotherapy notes. Thus, if a clinician receives a request for “all records” or the “complete medical record,” along with a signed authorization, this is not sufficient to release separately maintained psychotherapy notes. A separate signed authorization, specific to the psychotherapy notes, is required. This provides additional protection from routine disclosure of the notes to third parties, such as insurers.

This is a recall question which relies on social workers understanding confidentiality standards concerning psychotherapy notes. Storing them in a section of a client's file does not afford them "the greatest confidentiality protections" under HIPAA. Agency policy will also not provide additional protections if separate files are not maintained for psychotherapy notes.

### **Question Assesses**

#### Professional Values and Ethics

- 70. A.** Cannabis-related disorders are a group of mental health conditions that stem from the use of THC-containing marijuana or hashish. The American Psychiatric Association (APA) classifies these conditions as specific examples of a more comprehensive category of problems called substance-related disorders.

The *DSM* contains definitions for four cannabis-related disorders: cannabis intoxication, cannabis use disorder, cannabis withdrawal, and other cannabis-induced disorders.

People affected by cannabis intoxication have typically smoked or ingested marijuana or hashish within roughly 2 hours of the onset of their symptoms. Specific symptoms that indicate the presence of intoxication include a significant spike in the normal heart rate, mouth dryness, appetite elevation, and unusual fluid accumulation in the eyelids (a condition known as conjunctival injection). In addition to at least two of these cannabis-related alterations, all diagnosed clients must experience substantial psychological or behavioral impairments as a result of marijuana or hashish use. They must also lack other conditions that provide a more reasonable basis for their mental/physical state.

Some people who withdraw from cannabis meet the mental health criteria for substance withdrawal. Cannabis use disorder is the continued use of cannabis despite significant negative impact on a client's life and health. Social workers can also use cannabis withdrawal to identify these people if they meet the following criteria.

- Cessation of cannabis use that has been heavy and prolonged (usually daily or almost daily use over a period of at least a few months)
- *Three or more of the following signs and symptoms* develop w approximately 1 week after cessation of heavy, prolonged use:

- Irritability, anger, or aggression
  - *Nervousness or anxiety*
  - Sleep difficulty (insomnia, disturbing dreams)
  - Decreased appetite or weight loss
  - *Restlessness*
  - *Depressed mood*
  - At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, headache
- The signs or symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Cannabis is known for its ability to produce symptoms in some users that strongly resemble the symptoms of certain diagnosable mental conditions. Other cannabis-induced disorders provide social workers with the freedom to specify exactly which issues they uncover in their cannabis-using clients.

This is a recall question which relies on social workers knowing the signs of substance withdrawal and whether the withdrawal meets the diagnostic criteria for a mental health concern because they significantly degrade participation in a functional routine or trigger a troublesome state of mind.

Withdrawal of cannabis often produces decreased appetite or weight loss—not hunger. Hallucinations are not a sign of withdrawal but may be an indication of other cannabis-induced disorder when associated with use. Depressed mood is the only withdrawal symptom listed that appears in the *DSM* as one of three or more that must be present within a week of stopping cannabis to be diagnosed with cannabis withdrawal.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**71.**

**A.** The neurodevelopmental disorders are a group of conditions with onset often before the child enters grade school and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. Diagnosing them involves understanding strong knowledge of child development and its milestones.

The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence. The neurodevelopmental disorders frequently co-occur, with individuals with autism spectrum disorder often having intellectual developmental disorder, and many children with attention-deficit/hyperactivity disorder also having a specific learning disorder. For some disorders, the clinical presentation includes symptoms of excess as well as deficits and delays in achieving expected milestones.

The correct answer must be one that is needed “to effectively work with this child.” The child has a neurodevelopmental disorder characterized by deficits in typical functioning. As the social worker is charged with developing learning opportunities to address these delays, it is essential that these activities be developmentally appropriate and targeted at areas needing growth.

There is a need to pick out the most salient or relevant answer. School policy may be useful when developing an intervention plan, but policy does not directly speak to the child’s area of need or delay. Past academic performance will not be needed to effectively work with the child as the performance is likely poor, hence the reason for the current referral.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 72. A.** A genogram is structurally similar to a family tree but serves a very different purpose. A genogram includes information about relationships and interactions between family members, while a family tree only depicts lineage. Genograms use a combination of special rules and symbols to depict a lot of information about families as succinctly as possible. Some rules and practices have been standardized and should be followed so future readers can understand the documentation. Other

rules and symbols used in genograms differ depending on the source or setting.

Emotional relationships are depicted with a line directly connecting two people on a genogram. Typically, dotted or dashed lines indicate distance which can be due to a variety of factors such as separation, mental illness, abuse, or infidelity. Social workers need to be familiar with genograms and other assessment measures used in social work practice.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 73. A.** Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may only limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. Limitation should not be made when social workers feel that clients are simply making poor choices or the actions could have negative ramifications for their well-being, but these consequences are not serious, foreseeable, and imminent.

The question contains a qualifying word—FIRST. There may be more than one appropriate action by the social worker, but each must be done after recognition that this decision is ultimately to be made by the client. Despite the social worker's belief that the decision is a poor one, the client should not be judged and instead should be supported throughout the process.

The decision by the client to leave her employment does not meet the threshold of causing serious, foreseeable, and imminent harm. The social worker may assess whether changes in the client's life have influenced this decision and help the client to understand the consequences of her decision. However, these actions should occur after the right of the client to make such a choice is acknowledged.

### **Question Assesses**

Professional Values and Ethics

- 74. C.** The effects of substance abuse and/or dependence can be

detrimental to client functioning. Wernicke's encephalopathy and Korsakoff syndrome are different conditions that often occur together. Both are due to brain damage caused by a lack of vitamin B<sub>1</sub>. Korsakoff syndrome is most commonly caused by alcohol misuse but can also be associated with certain other conditions. Korsakoff syndrome is often, but not always, preceded by an episode of Wernicke's encephalopathy, which is an acute brain reaction to severe lack of thiamine. Wernicke's encephalopathy is a medical emergency that causes confusion, staggering and stumbling, lack of coordination, and abnormal involuntary eye movements. Symptoms of Korsakoff syndrome include inability to form new memories, loss of memory, making up stories (confabulation), and seeing or hearing things that are not really there (hallucinations).

Confabulation is defined as the spontaneous production of false memories: either memories for events which never occurred, or memories of actual events which are displaced in space or time. These memories may be elaborate and detailed. The exact causes of confabulation are unknown, but basal forebrain damage may lead to memory impairments, while frontal damage may lead to problems in self-awareness. Thus, a client may have a memory deficit, but be unaware of this deficit.

Confabulators are not lying. They are not deliberately trying to mislead. In fact, clients are generally quite unaware that their memories are inaccurate, and they may argue strenuously that they have been telling the truth.

The correct answer must be the name of a disorder which is characterized by telling stories based on false memories due to brain damage. Reaction formation is a defense mechanism in which emotions and impulses which are anxiety-producing or perceived to be unacceptable are mastered by exaggeration of the directly opposing tendency. Confabulation should not be confused with false memory syndrome, the phenomenon whereby otherwise typical clients suddenly "remember" repressed incidents of childhood abuse or other trauma. Confabulation is a clinical syndrome resulting from injury to the brain, whereas false memory syndrome is not.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 75. A.** Many ethical issues in social work—although certainly not all—

require some legal knowledge. In addition, the *NASW Code of Ethics* requires social workers to consult laws that are relevant to ethical decisions. In the United States, three branches of government create laws: legislative, executive, and judicial.

Statutory law is enacted by Congress (federal) and legislatures (state). Statutes govern social workers' obligation to report suspected abuse and neglect of children, elders, and other vulnerable people; minors' right to consent to mental health counseling and to drug and alcohol abuse treatment; protection of school social workers' confidential records; and federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) laws.

Regulatory law is promulgated by federal and state government agencies, such as the U.S. Department of Health and Human Services and state human service, child welfare, and mental health agencies. Under our system of law, federal and state agencies have the authority to establish enforceable regulations. Public agencies must follow strict procedures when they create regulations (e.g., providing public notice and opportunity for public comment about drafts of regulations). Once enacted, federal and state regulations have the force of law.

Case law is created in the context of litigation and judicial rulings. For example, a judge may need to interpret the meaning or application of existing law, resolve conflicts between laws, or fill gaps in existing laws. Such rulings by appellate courts become legal precedent or case law.

Constitutional law is dictated by the Constitution and includes numerous provisions that pertain to social work practice. Examples concern Fourth Amendment guidelines concerning citizens' right to privacy and protections against improper search and seizure (important in residential treatment programs) and Eighth Amendment protections against cruel and unusual punishment (important in juvenile and adult correctional facilities).

This question requires social workers to be familiar with a landmark California court case related to duty to warn. Current guidelines concerning social workers' duty to disclose confidential information without client consent to protect third parties from harm were initially established by *Tarasoff v. Board of Regents of the University of California*. In 1976, the California Supreme Court ruled that mental health clinicians have a duty to protect potential victims if their clients make threats or otherwise behaved as if they presented a "serious

danger of violence to another." In its ruling, the court determined that the need for mental health clinicians to protect the public was more important than protecting client confidentiality.

### **Question Assesses**

#### Professional Values and Ethics

- 76. C.** Social workers should be mindful of value differences which often arise with clients. Social workers' own values and beliefs can greatly influence social worker-client relationships. Culture, race, and ethnicity are strongly linked to values. *A social worker's self-awareness about personal attitudes, values, and beliefs and a willingness to acknowledge value differences are critical factors in working with clients.* A social worker is responsible for bringing up and addressing issues of cultural or other differences with clients.

Social workers should value and celebrate differences of others rather than ignoring or minimizing them. Social workers should have an awareness of personal values and biases and how they may influence relationships with clients. They should also understand their own personal and professional limitations, as well as acknowledge their own stereotypes and prejudices.

All the response choices are plausible, but the correct one is most appropriate and relevant in this situation. Even though a qualifying word is not used, it is necessary to select the best action when value conflicts with clients arise. Referring clients to other practitioners implies that such conflicts cannot be successfully managed. It is common for social workers to have different beliefs and attitudes than their clients. Clients should not be penalized by having to reengage with other providers simply because their views differ. It is the responsibility of social workers to acknowledge and manage these conflicts.

Social workers should always respect clients' rights to self-determination. Self-determination concerns clients' rights to make decisions and take actions in their lives. Respecting clients' rights to self-determination should always occur, not just when there is a value conflict. Value conflicts should be acknowledged and examined so that they do not interfere with the therapeutic alliance and helping process.

### **Question Assesses**

## Professional Values and Ethics

- 77. B.** The impacts of mental illness on family dynamics can be devastating. Impaired awareness of illness (anosognosia) is the MOST prevalent problem because it is the single largest reason individuals with schizophrenia and bipolar disorder do not take their medications. It is caused by damage to specific parts of the brain, especially the right hemisphere. It affects about half of individuals with schizophrenia and about 40% of individuals with bipolar disorder. Impaired awareness of illness is a relative, not an absolute, problem. Some may also fluctuate in their awareness, being more aware at times and less at others. When taking medications, awareness of illness can improve for some.

It is difficult to understand how a person who is ill would not know it. Impaired awareness of illness is very difficult for family members to comprehend. Psychiatric symptoms seem so obvious that it is hard to believe that those exhibiting them are not aware. The term comes from the Greek word for disease (nosos) and knowledge (gnosis). It literally means “to not know a disease.”

Social workers need to understand the complex nature of mental illness, especially on members of families. While side effects of antipsychotics for the treatment of schizophrenia can be both dangerous and annoying, a person would have to have taken medication to be bothered by its effects. Also, side effects associated with a particular medication can be overcome by using a different antipsychotic drug instead.

Anosognosia differs from denial. Often those with schizophrenia who refuse medication do not see themselves as ill as they do not recognize their symptoms (anosognosia); rather, they are using a strategy to minimize the signs of their illness as they do not want to address it (denial).

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 78. C.** Intersectionality is the intersecting systems of privilege and oppression. Privilege is when people do not have to face an institutionalized form of oppression, and oppression is when they do have to face it. Just because people have one form of privilege do not mean they have all forms.

People can be oppressed and privileged in many different ways, such as due to their genders, sexual orientations, races, and so on. While a straight, white cisgender man has privilege, he may have a lower socioeconomic status and be oppressed due to his economic status. He also may have a physical or mental disability which results in oppression. This is an example of intersectionality.

Race, gender, gender expression, sexual orientation, socioeconomic status, physical and mental ability, religion, language, age, physical attractiveness, occupation, and education are just some of the categories of intersectionality.

Social workers should be aware of privilege and oppression, which are shaped by racism, homophobia, ableism, and other institutionalized discrimination. This recall question requires knowledge that inequities are never the result of single, distinct factors. Rather, they are the outcome of intersections of different social locations, power relations, and experiences. While some of the incorrect response choices are true or contain important points, they are not the BEST (which is a qualifying word) definitions of intersectionality, which is the criteria used to select the correct answer.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 79. C.** Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive)—is common and happens because the person is engaged in an automatic activity and is not paying attention to the immediate environment. However, dissociation can also be an **impact** of trauma as it serves as a protective element whereby the victim incurs distortion of time, space, or identity.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). Diagnoses of dissociative disorders are closely associated with histories of severe childhood trauma.

There are many signs of dissociation including fixed or “glazed” eyes, sudden flattening of affect, long periods of silence, monotonous voice, stereotyped or repetitive movements, responses not congruent with situations, and/or excessive intellectualization.

Excessive guilt is another response to trauma. It attempts to make sense cognitively and gain control over a traumatic experience by assuming responsibility.

Intrusive thoughts and memories can also occur as a result of trauma. Experiencing, without warning or desire, thoughts and memories associated with the trauma can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence.

Depression can also result from guilty feelings associated with the trauma. Survivors often believe that others will not fully understand their experiences, leading to isolation and depression.

In the scenario, there are many responses to trauma—substance use, aggression (perhaps tied to underlying anger), and memory gaps. However, no indicators of guilt or depression, such as crying, self-blaming, and lethargy, are mentioned. In addition, the scenario does not describe the presence of intrusive thoughts, such as flashbacks. It is likely that the client would exhibit strong emotional or behavioral reactions to such memories. Instead, the client is unemotional, denying the impact of the abuse. This reaction is typical of dissociation.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 80. B.** Schizoid personality disorder is characterized by eccentricity; clients with this disorder often appear odd or peculiar. They tend to be distant, detached, and indifferent to social relationships. They generally are loners who prefer solitary activities and rarely express strong emotion. Many people with schizoid personality disorder are able to function fairly well, although they tend to choose jobs that allow them to work alone, such as night security officers, library workers, or lab workers.

Clients with schizoid personality disorder often are reclusive, organizing their lives to avoid contact with other people. Many never marry or may

continue to live with their parents as adults. Other common traits of people with this disorder include:

- No desire or enjoyment in close relationships, even with family members
- Choice of solitary jobs and activities
- Pleasure in few activities, including sex
- Difficulty relating to others
- Indifferent to praise or criticism
- Aloof with little emotion
- Daydreaming and/or creating vivid fantasies of complex inner lives

The question asks about atypical behaviors, meaning those that are not commonly associated with the disorder. The correct answer must list behavior that is unlikely given the defining characteristics of this disorder. Clients with schizoid personality disorder do not enjoy relationships and have no close friends. They desire solitude. Thus, clients would avoid sexual activities and social events.

As clients with schizoid personality disorder rarely express emotion, it would be unlikely that they would express anger when criticized.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

**81. A.** There are several contraindications to family-centered social work practice. These include, but are not limited to, when:

- There is an unstable member or members and the risk of stimulation. Intense affect in a session might lead to decompensation or other adverse effects.
- There is violence in the family (elder abuse, domestic violence, and child abuse).
- Family members are physically or emotionally destructive toward another.
- Essential members of the family cannot or refuse to be included.
- Detoxification of a family member or the stabilization of a family member with psychosis is the goal.

- There is not a commitment to address issues by all family members or member is being deceptive (e.g., one partner has not disclosed a plan to leave the relationship).

This question is focused on choosing appropriate treatment modalities for client problems. Family-centered social work practice recognizes that people do not exist in a vacuum, and it is important, at times, to look at families as a whole, not just their members.

Two of the response choices are contraindications of family therapy, making them incorrect. Only the correct answer illustrates a reason to treat a family as a whole.

Boundaries occur at every level of a system. They influence the flow of information into and within a system. Using family systems theory, social workers can assist with establishing healthy structures in situations where they do not exist or are continually violated.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 82. C.** The *DSM* has a cluster of disorders that involve obsessional thoughts and/or compulsive behaviors. These include obsessive-compulsive disorder (OCD), body dysmorphic disorder (BDD), hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking) disorder.

Motor tics are often comorbid in clients with OCD. Both OCD and tic disorders are best treated with medication and behavior modification. Matching interventions to client problems is paramount.

One behavioral technique, habit reversal training, is extremely effective in reducing tics. Habit reversal training has four main components: awareness training, development of a competing response, building motivation, and generalization of skills. Awareness training is used to bring greater attention to tics and other behaviors so that a client can gain better self-control. Awareness training usually involves describing in detail each time the behavior occurs and identifying the earliest warning that a tic or impulsive behavior is about to take place. These warning signs can be urges, sensations, or thoughts. Once a client has developed a good awareness of a tic or impulsive behavior, the next step is to develop a competing response that replaces the old tic or

impulsive behavior. Usually, the competing response is opposite to that of the tic or impulsive behavior and is something that can be carried out for longer than just a couple of minutes. Choosing a response that will be more or less unnoticeable by others is best. To keep the tics and impulsive behaviors from coming back, a client is encouraged to make a list of all the problems that were caused by the behavior. The last step is to encourage new skills in a range of different contexts, not just those that clients mastered to date.

The treatment of OCD has also been well established in the roots of behavior therapy. Exposing clients to the feared stimuli and blocking the conditioned response helps reduce both the onset and severity of symptoms.

Solution-focused brief therapy (SFBT) places focus on a client's present and future circumstances and goals rather than past experiences. In this goal-oriented therapy, the symptoms or issues bringing a client to therapy are typically not targeted.

Psychoanalytic psychotherapy is a form of clinical practice which is based on psychoanalytic theory and principles and focuses on increasing self-understanding and deepening insight into emotional issues and conflicts which underlie the presenting difficulties. Treatment includes exploring unconscious thoughts and feelings and understanding aspects of the relationship between a social worker and client, which may relate to underlying emotional conflicts, interpretation of defensive processes which obstruct emotional awareness, and consideration of issues related to sense of self.

Social workers should be aware of interventions which have empirically been found to be effective with client problems or diagnoses. This is a recall question, testing knowledge of therapeutic models. In order to answer correctly, familiarity with the approaches listed as response choices is needed. In the scenario, the client would like to reduce the compulsive behavior which results from his obsessive thoughts. Existential and psychodynamic psychotherapy are based on the belief that client problems are caused by conditions or conflicts in human life. OCD and tic disorder are neuropsychiatric, making these two approaches incorrect.

SFBT is based on the belief that problems do not happen all the time and studying the times when problems are less severe or absent can assist clients to see what life will be like when the goal is accomplished,

and the problem is gone. *It requires clients to take control of their situation and focuses on developing greater awareness and repeating the successful things they do when the problem is less severe.* OCD and tic disorders are pervasive, with behaviors seen as uncontrollable to clients. Behavior management, as opposed to insight-oriented or brief therapy, is much more effective.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 83. B.** Prevention includes a wide range of activities—known as “interventions”—aimed at reducing risks or threats. Primary, secondary, and tertiary prevention are three terms that describe the range of possibilities.

Primary prevention aims to prevent disease or injury before it ever occurs. This is done by preventing exposures to hazards that cause disease or injury, altering unhealthy or unsafe behaviors that can lead to disease or injury, and increasing resistance to disease or injury should exposure occur.

Secondary prevention aims to reduce the impact of a disease or injury that has already occurred. This is done by detecting and treating disease or injury as soon as possible to halt or slow its progress, encouraging personal strategies to prevent reinjury or recurrence, and implementing programs to return clients to their original health and function to prevent long-term problems.

Tertiary prevention aims to soften the impact of an ongoing illness or injury that has lasting effects. This is done by helping clients manage long-term, often-complex health problems and injuries (e.g., chronic diseases, permanent impairments) to improve as much as possible their ability to function, their quality of life, and their life expectancy.

The question contains a qualifying word—BEST. In the scenario, the client “is very worried about ensuring that the drug administration does not adversely affect her current routine.” Her concern is the presenting problem, and the social worker can assist the client to better understand what will be required by ensuring that she receives accurate and complete information about what is required. Psychoeducation is often used to help clients learn how to slow the progression of a disease or

limit its long-term impacts through diet, medication, or exercise. She needs a tertiary prevention intervention.

The client may be worrying unnecessarily. Thus, providing information is the most effective strategy for determining whether there will be any impact to her current daily routine.

There is nothing in the scenario that indicates that the client needs help navigating multiple service delivery systems, thereby making the provision of case management futile at this point. Psychotherapy aims to facilitate change and confront barriers that interfere with emotional and mental well-being. Support may be needed to assist the client while she understands changes in her medication regimen, but there is no indication that she needs psychotherapy due to her most pressing concern.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 84. B.** Social workers often serve as consultants for problems related to clients, services, organizations, and/or policies. Consultation is the utilization of an “expert” in a specific area to assist with developing a solution to the issue. Consultation is usually time limited, and the advice of consultants can be used or not used by those who have formal decision-making power. *Although consultants do not have formal authority within agencies, they have informal authority as “experts” based upon their expertise and skill.* Formal authority comes from one’s official position with agencies, with those at the top of organizational structures having more formal authority than those at the bottom.

As the social worker in the scenario is a consultant, the source of authority comes from professional expertise. This knowledge base evolves from both education and experience in the field. The incorrect response choices are not sources of authority based on the social worker’s role. The social worker is not an employee of the agency. A consultant has no official position within an organizational structure. Thus, consultants usually do not appear on organizational charts or are depicted with dotted lines to show that they are advisory and not within the hierarchical structures.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

- 85. C.** Separation anxiety is normal in very young children (those between 8 and 14 months old). When this fear occurs in a child over age 6 years, is excessive, and lasts longer than 4 weeks, the child may have separation anxiety disorder.

Separation anxiety disorder is a condition in which a child becomes fearful and nervous when away from home or separated from a parent or other caregiver. Some children also develop physical symptoms, such as headaches or stomachaches, at the thought of being separated. The fear of separation causes great distress to the child and may interfere with the child's normal activities, such as going to school or playing with other children.

Most mild cases of separation anxiety disorder do not need medical treatment. In more severe cases, or when the child refuses to go to school, treatment may be needed. The goals of treatment include reducing anxiety in the child and developing a sense of security in the child and the caregivers. Treatment options include psychotherapy to help the child tolerate being separated from the caregiver without the separation causing distress or interfering with function. A type of therapy called cognitive behavioral therapy works to reshape the child's thinking (cognition) so that the child's behavior becomes more appropriate. Family therapy also may help teach the family about the disorder and help family members better support the child during periods of anxiety. Antidepressant or other antianxiety medications may be used to treat severe cases of separation anxiety disorder.

There is no known way to prevent separation anxiety disorder, but recognizing and acting on symptoms when they appear can minimize distress and prevent problems associated with not going to school. In addition, reinforcing a child's independence and self-esteem through support and approval may help prevent future episodes of anxiety.

The root cause of the problems experienced by the mother is her daughter's separation anxiety. Thus, appropriate intervention should focus on assisting the child to return to normal developmental functioning. A child with separation anxiety needs to be able to tolerate normal separation from caregivers without distress or impairment of functioning. A child with concomitant school refusal should return to school as quickly as possible. As the mother is the client, intervention

should focus on helping her deal with the child's symptoms while seeking treatment for the daughter.

Suggesting that the woman tell her employer about her situation will not help to address the underlying problem. Job performance will continue to be impacted until the child's anxiety is managed. It is helpful for the woman not to feel isolated and understand that her emotional reaction is typical. However, this acknowledgment will also not address the problem.

The question uses a qualifying word—**MOST**—to highlight that some of the response choices may be helpful to the client, but the correct answer is the one focused on addressing the presenting problem.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 86. C.** Child development literature draws attention to the importance of peer relationships in social development, especially in adolescence, when peers may facilitate each other's antisocial behavior. It has often been assumed that peers are less important in early childhood when relationships with family members are more influential. However, research shows clearly that even infants spend time with peers, and that some 3- and 4-year-olds are already having trouble being accepted by their peers.

Most infants and toddlers meet peers on a regular basis, and some experience long-lasting relationships with peers that start at birth. By 6 months of age, infants can communicate with other infants by smiling, touching, and babbling. In the second year of life, they show both prosocial and aggressive behavior with peers, with some toddlers clearly being more aggressive than others.

Although many investigators have described early peer relations, relatively little attention has been paid to the emotional, cognitive, and behavioral skills that underlie the ability to interact harmoniously with peers. Early peer relations depend on the following skills that develop during the first 2 years of life: (a) managing joint attention, (b) regulating emotions, (c) inhibiting impulses, (d) imitating another's actions, (e) understanding cause-and-effect relationships, and (f) linguistic competence.

Peer acceptance is affected by relationships at home with parents and siblings, the parents' own relationships, and families' levels of social support. However, peer acceptance is most directly affected by children's own behavior. Studies show that highly aggressive children are not accepted by their peers, but this may depend on gender.

There are clear links between very early peer relations and those that occur later in childhood. Peer acceptance in early childhood is a predictor of later peer relations. Children who were without friends in kindergarten were still having difficulties dealing with peers at the age of 10.

Thus, peers play important roles in children's lives. In fact, experiences in the first 2 or 3 years of life have implications for children's acceptance by their classmates in nursery school and the later school years. Children who are competent with peers at an early age, and those who show prosocial behavior, are particularly likely to be accepted by their peers.

Mainstreaming means that schools put children with unique learning needs into classrooms with peers who do not have special needs. Students who are mainstreamed have higher self-esteem and develop better social skills. Their peers without disabilities also become more tolerant and accepting.

Understanding that the goal of mainstreaming is to increase peer interactions with nondisabled peers will assist with selecting the correct answer. Family support, parental interactions, and sibling relationships are also not directly related to greater exposure with nondisabled peers in school settings. The idea that interactions lead to peer friendships which have positive effects is the most salient reason for inclusion of those with unique learning needs into classrooms with other students who are classified as disabled.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 87. B.** Selective serotonin reuptake inhibitors and other second-generation antidepressants have become common therapeutic options for the management of depression. Although these medications are effective, they frequently cause sexual adverse effects that can impact clients' quality of life, thus ultimately leading to nonadherence in many cases.

Clients should be educated about these possible adverse effects. Assessments of sexual functioning before the medication (baseline) and during its administration (treatment) should occur to monitor for these effects. Management strategies include watchful waiting, dosage reduction, drug holidays, switching antidepressants, and use of add-on medications.

The question contains a qualifying word—**MOST**—that requires social workers to select the response choice which is likely the cause. When **MOST** is used as a qualifying word, other appropriate and possible response choices will be listed. It is necessary to consider all the information provided and pick the probable cause of the sexual dysfunction.

There is no indication of relationship problems between the client and his wife in the scenario. While sexual dysfunction can occur due to physical changes associated with age, his erectile dysfunction coincided with his taking of antidepressant medication. Antidepressants are known to cause sexual problems, so his issue is likely a side effect of his medication.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 88. B.** Observation is probably the most common and the simplest method of data collection. It does not require much technical knowledge. Although scientific controlled observation requires some technical skill, it is still often easier than other methods.

There are many advantages and disadvantages to observation. With other data collection methods like interviewing and surveying, information is provided by clients so there is no means to examine the accuracy of the data supplied. But in observation, social workers can directly check the accuracy by seeing it happening. Thus, data collected through observation is often more reliable than that collected through interviewing or surveying. Observation can also be useful in learning about phenomena that occur for persons who are not capable of giving verbal information about their behavior, feelings, and activities because they cannot speak, such as infants. Observation is indispensable in finding out information on infants who can neither understand questions by social workers nor express themselves verbally.

However, some occurrences may not be open to observation. Personal behaviors are usually done when others are not present. In addition, much can occur when observers are not present. One is also not sure that what is observed is the same as it appears to others. Two persons may judge the same phenomena differently. Lastly, observation is a time-intensive process, making it costly.

The question contains a qualifying word—**MOST**. While there is more than one concern, the correct answer is most significant about “using this approach.” Observations are costly, but the expense does not appear to be prohibitive as the social worker is doing the data collection. No additional costs are incurred.

Behavior frequency is being collected. As the behavior was modified using operant conditioning, there is likely a well-defined behavior which can be directly observed. There can be ethical issues in the choice of any therapeutic technique. However, there is no indication that unethical practices were used. There are many punishments which are not aversive, such as time out. Also, the question is asking about “this approach”—observation—not the behavioral strategy.

The scenario states that the behavior has a “high rate” or occurs frequently. It is likely that many behaviors will be occurring when the social worker is not present. The social worker will need to get information on what is happening when the client is alone or not with the social worker as the client may be acting differently in these situations. Self-monitoring or self-reports—not direct observation—can be helpful in these instances.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 89. C.** Erik Erikson maintained that personality develops in a predetermined order. He was interested in how children socialize and how this affects their sense of self. He saw personality as developing throughout the life course and looked at identity crises as the focal point for each stage of human development.

According to Erikson, there are eight stages of psychosocial development, with two possible outcomes. Successful completion of each stage results in a healthy personality and successful interactions with others. Failure to successfully complete a stage can result in a

reduced ability to complete further stages and, therefore, an unhealthier personality and sense of self. These stages, however, can be resolved successfully at a later time.

Industry versus inferiority occurs during childhood between the ages of 6 and 11 and is the fourth stage of psychosocial development. School and social interaction play an important role during this time of a child's life. Through social interactions, children begin to develop a sense of pride in their accomplishments and abilities. During the earlier stages, a child's interactions centered primarily on caregivers, family members, and others in their immediate household. As the school years begin, the realm of social influence increases dramatically. Friends and classmates play a role in how children progress through the industry versus inferiority stage.

At earlier stages of development, children were largely able to engage in activities for fun and to receive praise and attention. Once school begins, actual performance and skill are evaluated. Grades and feedback from educators encourage kids to pay more attention to the actual quality of their work.

During the industry versus inferiority stage, children become capable of performing increasingly complex tasks. As a result, they strive to master new skills. Children who are encouraged and commended by parents and teachers develop a feeling of competence and belief in their skills. Those who receive little or no encouragement from parents, teachers, or peers will doubt their ability to be successful.

According to Erikson, this stage is vital in developing self-confidence. During school and other social activities, children receive praise and attention for performing various tasks such as reading, writing, drawing, and solving problems. *Kids who do well in school are more likely to develop a sense of competence and confidence. They feel good about themselves and their ability to succeed.*

*Children who struggle with schoolwork may have a harder time developing these feelings of sureness. Instead, they may be left with feelings of inadequacy and inferiority.*

At this stage, it is important for both parents and teachers to offer support and encouragement. However, adults should be careful not to equate achievement with acceptance and love. Unconditional love and support from adults can help all children through this stage, but particularly those who may struggle with feelings of inferiority.

Children who are overpraised, on the other hand, might develop a sense of arrogance. Balance plays a major role at this point in development. Parents can help kids develop a sense of realistic competence by avoiding excessive praise and rewards, encouraging efforts, and helping kids develop a growth mindset. Even if children struggle in some areas of school, encouraging kids in areas in which they excel can help foster feelings of competence and achievement.

The question contains a qualifying word—**MOST**. In order to select the correct answer, it is necessary to recall Erikson's stages of psychosocial development. The incorrect response choices reflect problems associated with other psychosocial crises throughout the life course. Trust versus mistrust occurs in the first year of life and is the first stage. Initiative versus guilt begins at age 3 until age 6. In the scenario, the boy is in third grade, making him too old for this stage and appropriate for struggles associated with industry versus inferiority.

When age is included in a question, it is usually critical to selecting the correct answer. In addition, even though Erikson is not explicitly mentioned, the question asks about a “psychosocial problem.” Erikson is a well-known theorist in this area and all the response choices are associated with negative outcomes of his stages. Thus, his work should be used to distinguish the correct answer from the incorrect response choices. Often the names of theorists are not mentioned in questions. However, reasoning using their work is essential to successfully selecting the correct answers.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 90. A.** Informed consent is most often thought of in the context of the contracting stage with a client, which comes at the beginning of the professional relationship. *To be effective, informed consent should be seen as an ongoing process. Informed consent can be integrated into each session with a client, or at regular/periodic intervals throughout a professional relationship. As the goals of the relationship change, informed consent should be revisited.*

Informed consent is the process through which social workers discuss with clients the nature of the social worker/client relationship. Through informed consent, the social worker and client outline what the client can expect from the professional relationship, as well as what the social

worker expects from the client's participation. Informed consent often includes a discussion of basic protocols, such as how to make or cancel appointments or the best way to contact the social worker. The process should also involve outlining what work will be done with and for the client and what expectations there are for client involvement. Integral to the informed consent process is a discussion of client confidentiality.

*Using simple language, appropriate to the developmental and language needs of the client, the social worker needs to explain to the client that the social worker will generally keep information private, but there are specific instances when the social worker is required to breach client confidentiality.* The social worker should highlight that if the social worker suspects child maltreatment based on information received from the client, the social worker will need to breach client confidentiality to make a report of the suspicion to child protective services.

In some agencies or practice settings, informed consent involves the client signing a form that acknowledges receipt of certain information. Although a written tool is a good idea, it is important that there be additional methods for ensuring informed consent. In all instances, with or without written informed consent tools, the social worker and client should discuss, face-to-face, expectations for confidentiality and when confidentiality will be breached. The social worker should use language the client can understand. As with other forms of communication with clients, it is important to ensure that the client understands what is said with regard to informed consent.

The qualifying word—BEST—indicates that more than one listed response choice may be informative or useful, but the correct one is that which most effectively “informs clients of the nature and expectations of the social worker/client relationship.”

None of the incorrect response choices speak to exchanges between social workers and clients about consent policies. Clients should have the opportunity to ask questions and have policies explained in clear, concise ways which are easy to understand. The correct answer acknowledges that informed consent is an ongoing process and does not just occur at intake.

### **Question Assesses**

Professional Values and Ethics

**91.**

**C.** Object relations is a variation of psychoanalytic theory that diverges from Sigmund Freud's belief that humans are motivated by sexual and aggressive drives, suggesting instead that humans are primarily motivated by the need for contact with others—the need to form relationships. The aim of a clinical social worker using object relations theory is to help a client in therapy uncover early mental images that may contribute to any present difficulties in relationships with others and adjust them in ways that may improve interpersonal functioning. In the context of object relations theory, the term “objects” refers not to inanimate entities but to significant others with whom a client relates, usually a mother, father, or primary caregiver. In some cases, an object may also be used to refer to a part of a person, such as a mother’s breast, or to the mental representations of significant others.

Object relations theorists stress the importance of early family interactions, primarily the mother–infant relationship, in personality development. It is believed that infants form mental representations of themselves in relation to others and that these internal images significantly influence interpersonal relationships later in life. Since relationships are at the center of object relations theory, the client–social worker alliance is important to the success of therapy.

Internal objects are formed during infancy through repeated experiences with one’s caregiver. The images do not necessarily reflect reality but are subjectively constructed by an infant’s limited cognitive abilities. In healthy development, these mental representations evolve over time; in unhealthy development, they remain at an immature level. The internal images have enduring qualities and serve as templates for future relationships.

*Central to object relations theory is the notion of splitting, which can be described as the mental separation of objects into “good” and “bad” parts. This is a process of “psychic economy” whereby a complex situation is simplified by separation rather than resolution.*

Infants first experience splitting in their relationship with the primary caregiver: The caregiver is “good” when all the infant’s needs are satisfied and “bad” when they are not. Initially, these two aspects of the object (the caregiver) are separated in the mind of the infant, and a similar process occurs as the infant comes to perceive good and bad parts of the self. If the mother can satisfactorily meet the needs of the infant or—in the language of object relations—if the mother is “good

enough," then the child begins to merge both aspects of the mother, and by extension the self, into an integrated whole.

Isolation is a state of separation from others. Intimacy versus isolation is one of Erikson's psychosocial stages of development which occurs in early adulthood.

Resistance is an attempt to prevent action or refuse to accept something new. Clients often display resistance during the problem-solving process as they are not ready to change or are fearful about addressing long-standing issues in their lives.

This is a recall question which relies on social workers understanding object relations theory. Questions on the examination may focus on general underlying principles of theories, as well as key terms. It is not necessary to memorize terms, but being able to identify them when they are listed is essential. Often ones that look correct, just based on their wording, are not. For example, in this question, "isolation" may seem to fit as it implies separation. However, it is not the correct answer as "splitting" is the formal name of this process. Thus, social workers should know specific terms associated with all the major theories studied.

### ***Question Assesses***

Psychotherapy, Clinical Interventions, and Case Management

- 92. C.** When there is addiction in a family system, members typically adapt to the person with the substance use problem by taking on roles that help reduce stress, deal with uncertainty, and allow the family to function. There is a problem with taking on these roles. While they tend to reduce stress, they allow the member with the addiction to continue the behavior. The following are roles that family members often take on in these relationships.

The Enabler: The enabler is a family member who steps in and protects the person who is addicted from the consequences of the addicted behavior. The motivation for this may not be just to protect the person who is addicted, but to prevent embarrassment, reduce anxiety, avoid conflict, or maintain some control over a difficult situation. The enabler may try to clean up the messes caused by the person who is addicted and make excuses, thus minimizing the consequences of addiction.

**The Mascot:** The mascot attempts to use humor to escape from the pain of the problems caused by addiction. The mascot will often act out by “clowning around,” cracking jokes or making light of serious situations. While the mascot can certainly help lighten up a desperate situation, the real intent is to ease tension to keep the peace. Many comedians come from dysfunctional homes.

**The Scapegoat:** *The scapegoat is a family member who creates other problems and concerns to deflect attention away from the real issue.* This can be through misbehavior, bad grades, or their own substance abuse. Oftentimes, the scapegoat is very successful at distracting the family and others from the addiction.

**The Lost Child:** The lost child is a family member who appears to be ignoring the problem completely. There could be a fight, with yelling and screaming, and the lost child will be absent or secluded from the situation. The lost child is often perceived as the “good” child because much time is spent alone with books or involved in isolated activities. While the lost child will not be successful at drawing attention away from the family problem, the lost child is able to avoid stress personally.

**The Hero:** The hero is a family member who attempts to draw attention away from the person with the addiction by excelling, performing well, and generally being “too good to be true.” The hero has a hope that somehow the behavior will help the person who is addicted to stop using. Additionally, the hero’s performance-based behavior helps to block emotional pain and disappointment.

This is a recall question about “survival” roles in families with members who have addictions. Families are organized around roles, rules, rituals, boundaries, and hierarchies. Structure serves to promote their well-being and the happiness of their members. But addiction in families distorts their structure, and family members assume roles that naturally do not belong to them. Members abandon their identities and needs and become enmeshed in the lives of those who are addicted. Each of the roles listed as response choices aims to release stress related to addiction.

The hero, like the scapegoat, attempts to draw attention away from the problem, with the former role doing so by excelling and the latter one distracting through misbehavior. The hero is not a provided response choice, so the scapegoat is the correct answer.

### **Question Assesses**

## Human Development, Diversity, and Behavior in the Environment

**93. A.** Disruptive mood dysregulation disorder (DMDD) is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts. DMDD symptoms go beyond being “moody” child—children with DMDD experience severe impairment that requires clinical attention. DMDD is characterized by severe and recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation. These occur, on average, three or more times each week for 1 year or more.

A child with DMDD experiences:

- Irritable or angry mood most of the day, nearly every day
- Severe temper outbursts (verbal or behavioral) at an average of three or more times per week that are out of keeping with the situation and child’s developmental level
- Trouble functioning due to irritability in more than one place (e.g., at school, and with peers)

To be diagnosed with DMDD, a child must have these symptoms steadily for 12 or more months.

Between outbursts, children with DMDD display a persistently irritable or angry mood, most of the day and nearly every day, which is observable by parents, teachers, or peers. A diagnosis requires the previous symptoms to be present in at least two settings (at home, at school, or with peers) for 12 or more months, and symptoms must be severe in at least one of these settings. During this period, the child must not have gone 3 or more consecutive months without symptoms.

The onset of symptoms must be before age 10, and a DMDD diagnosis should not be made for the first time before age 6 or after age 18.

While the *DSM* does include two diagnoses with related symptoms to DMDD, oppositional defiant disorder and bipolar disorder, the symptoms described in DMDD are different than these two diagnoses.

Oppositional defiant disorder is an ongoing pattern of anger-guided disobedience and hostilely defiant behavior toward authority figures that goes beyond the bounds of normal childhood behavior. While the symptoms may overlap with the criteria for DMDD, the symptom threshold for DMDD is higher since the condition is considered more

severe. Thus, while most children who meet the criteria for DMDD will also meet the criteria for oppositional defiant disorder, the reverse is not the case. *To avoid any artificial comorbidity of the two disorders, it is recommended that children who meet the criteria for both should only be diagnosed with DMDD.*

Bipolar disorder also has similar symptoms. While a social worker may have been assigning a diagnosis of bipolar disorder to these severely irritable youth to ensure their access to treatment resources and services, these children's behaviors may not present in an *episodic* way as is the case with bipolar disorder. In an effort to address this issue, research was conducted comparing youth with severe nonepisodic symptoms to those with the classic presentations of bipolar disorder. Results of that extensive research showed that children diagnosed with bipolar disorder who experience constant, rather than episodic, irritability often are at risk for major depressive disorder or generalized anxiety disorder later in life, but not lifelong bipolar disorder. This finding pointed to the need for a new diagnosis for children suffering from constant, debilitating irritability. The hope is that by defining this condition more accurately, social workers will be able to improve diagnosis and care.

This is a recall question which relies on social workers understanding diagnoses in the *DSM*, as well as the justification for their creation. Social workers should be able to differentially diagnose, choosing one disorder over another based on the presence or severity of beliefs, attitudes, and/or behaviors.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 94. C.** Children with disabilities should be educated in the least restrictive environment (LRE) that is appropriate. The spirit of this requirement is to ensure that children are not unnecessarily removed from the regular classroom or isolated from other nondisabled children of their age. To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, should be educated with children who are not disabled. Thus, special classes, separate schooling, or other removal of children with disabilities from the regular educational environment can only occur when the nature or severity of the disability of a child is such that education in regular

classes with the use of supplementary aids and services cannot be achieved satisfactorily.

Every student with a disability should be given the opportunity to start out in a general education classroom; if that environment does not allow for success and a more restrictive environment is deemed appropriate, then good reason must be given as to why the LRE is not working. This decision should be a main topic of discussion in educational planning meetings. LRE decisions are made based on children's learning needs and vary from child to child. Schools should provide a full continuum of services ranging from regular classrooms with support to special classes and special school placements, as needed.

The scenario describes a situation where a school official has an opinion contrary to the student's legal right. The student's needs "can be adequately met in either the regular classroom with additional supports or a separate resource room for students who require special assistance." The right to be served in the LRE should be the guiding principle in making decisions about needed level of care.

The child's preferences do not take precedent over the legal right to obtain supports in the regular classroom, so meeting with the child is not needed to resolve the presenting conflict. The guidance counselor's feelings also do not negate the rights of the child, as the child's academic needs can be met in the regular classroom with additional supports. Suggesting ways to maintain friendships assumes that the child will be receiving instruction in a resource room. Social workers should advocate for client rights when they are threatened or violated by others. Being knowledgeable about laws which must be followed when assessing and deciding needed level of care is critical.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 95. C.** Binge eating disorder (BED) is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. A client with BED may eat too quickly, even when the client is not hungry. The client may have feelings of guilt, embarrassment, or disgust and may binge eat alone to hide the behavior. This disorder is associated with marked distress and occurs, on average, at least once a week over 3 months.

With this diagnosis and others, social workers should be able to understand the differential use of therapeutic techniques, including those which are evidence-based practices. Cognitive behavioral therapy (CBT)—alone or in combination with medication—is effective in reducing binge eating. It is unclear which medications provide the greatest benefit in terms of binge eating remission; however, they do facilitate short-term weight loss in clients who are overweight due to BED. In addition to reducing binge eating, CBT can improve related psychological comorbidities.

This is a recall question about different intervention techniques and their appropriate usage. The incorrect response choices contain legitimate social work treatments but are not best suited for the diagnosed problem.

Psychoanalysis is a form of psychotherapy to treat clients who have a range of mild to moderate chronic life problems. It is related to a specific body of theories about the relationships between conscious and unconscious mental processes. The purpose is to bring unconscious mental material and processes into full consciousness so that clients can gain more control over their lives.

Task-centered treatment involves working closely with clients to establish distinct and achievable goals based on an agreed-upon presenting problem(s). Clients and social workers collaborate on devising tasks to work on those target problems which are memorialized in contracts that contain the target problems, tasks to be implemented by both clients and social workers to address the target problems, and overall goals of the treatment. Task-centered treatment emphasizes client preferences by asking clients what they most want to work on to address their problems. This approach involves working briefly with clients, typically for 8 to 12 sessions over the course of a 6-month period.

### ***Question Assesses***

Assessment, Diagnosis, and Treatment Planning

- 96. A.** Major neurocognitive disorder (formerly called dementia) and delirium are prevalent mental disorders in those who are elderly. While major neurocognitive disorder is prevalent in the community, hospitals, and nursing homes, delirium is seen most often in acute care hospitals. It is

imperative that social workers be adept at recognizing, evaluating, and managing clients with these syndromes.

The differential diagnosis hinges on a careful clinical evaluation. The first step is to recognize which of the syndromes is present. Major neurocognitive disorder is defined by a chronic loss of intellectual or cognitive function of sufficient severity to interfere with social or occupational function. Delirium is an acute disturbance of consciousness marked by an attention deficit and a change in cognitive function. It is important to recognize that these syndromes are not mutually exclusive, as major neurocognitive disorder can coexist with delirium and other disorders, such as major depressive disorder.

When a client presents with new cognitive complaints, the first consideration is whether this condition represents major neurocognitive disorder or delirium. Generally, a major difference between delirium and major neurocognitive disorder is the rapidity of onset: progression of symptoms is usually acute in delirium, rather than insidious and slowly progressive as in major neurocognitive disorder. Additionally, delirium may cause disturbance in the level of consciousness, attention, and vital signs, whereas major neurocognitive disorder should not. The *DSM* defines delirium as a disturbance from baseline in attention, awareness, and cognition over a short period of time, with fluctuation in severity throughout the day. These changes must not be explained by another neurocognitive disorder, and there must be evidence that the condition is not explained by another condition such as infection or substance intoxication and withdrawal.

This is a recall question about the differences between delirium and major neurocognitive disorder. Social workers should be able to make differential diagnoses as many of the response choices related to the competency of assessment and diagnosis have similar symptoms. Picking among them will require knowing how disorders differ from one another.

A significant difference that is used to diagnose delirium is the rapid onset of symptoms. Major neurocognitive disorder causes a more gradual progression of impairment. Alertness and orientation also fluctuate and are variable throughout the day when a client has delirium. In major neurocognitive disorder, a client may have issues with alertness or orientation, but symptomology should be stable throughout the day. The severity of the memory loss and the impact of the

symptoms are not the best methods “to differentiate” between these diagnoses.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 97. C.** A functional behavior assessment is a comprehensive and individualized strategy to identify the purpose or function of a client’s problem behavior(s), develop and implement a plan to modify variables that maintain the problem behavior, and teach appropriate replacement behaviors using positive interventions. While there are a variety of techniques available to conduct a functional behavioral assessment, the first step in the process, regardless of technique, is to define the behavior in concrete terms.

Before a functional behavioral plan can be implemented, it is necessary to pinpoint the behavior causing problems and to define that behavior in concrete terms that are easy to communicate and simple to measure and record. Behavior should be in specific, observable, and measurable terms. Simply stating that a client is aggressive is too vague. Instead, for example, a social worker should specify that a client pokes, hits, and kicks other students with her feet or hands during lunch period.

It may be necessary to carefully and objectively observe client behavior in different settings and during different types of activities, and to conduct interviews with others in order to pinpoint the specific characteristics of a behavior. Once a problem behavior has been defined concretely, it is possible to devise a strategy for determining the functions of this behavior.

The question contains a qualifying word—FIRST. While there may be more than one appropriate action by a social worker listed, the correct answer is the initial step in conducting a functional behavioral assessment. Determining why intervention is needed occur during engagement with a client. Engagement occurs prior to assessment in the problem-solving process. However, the question is asking about the first action taken “when completing a functional behavioral assessment”—not ever with a client. When doing a functional behavioral assessment, a problem behavior is defined in measurable terms; data is collected and analyzed; a hypothesis is formulated; and an intervention plan is developed, implemented, and monitored, respectively. Thus, the first action taken by a social worker is to define a

problem behavior in measurable terms. Identifying antecedents may be important if an operant approach is being used, but this action would occur after the behavior has been defined and data has been collected.

### ***Question Assesses***

#### Assessment, Diagnosis, and Treatment Planning

- 98. B.** Shared power views clients as experts on their lives, cultures, dreams, experiences, and goals. This perspective mandates that social workers assume power only over the limited activities in which they are trained while clients retain power to direct the work. Often shifting views on expertise and interest in sharing power do not come easily. There is a strong socialization to value expertise. Thus, social workers' values and contributions are seen through the lens of expertise. Social workers are educated and socialized in professional programs to become respected members of a profession. They are often pushed to adopt "expert" roles. Additionally, some clients may want social workers to be experts on their lives and relationships—just as they want doctors to dictate their medical care. Adopting the "expert" role can obscure client ownership or participation in the work.

Most social work services are delivered in agency settings. These settings, which are traditionally operated with "top down" approaches, place service recipients at the bottom of hierarchies with little say in many decisions. Social workers should recognize that the only experts on experiences are those who have lived them. Social workers honor this wisdom by sharing power within therapeutic relationships. Systems that rely on expertise can be humiliating, insulting, or patronizing and inspire disillusionment in those served.

While objectivity is important in social work practice, it is not directly related to shared power which views clients as experts in their lives. Objectivity should not be used to justify beliefs that clients cannot solve their own problems. The need for immediate assistance also should not compromise the use of shared power. From the onset, social workers should encourage a helping process based on mutual responsibility. The delivery of services in agency contexts often threatens sharing power with clients as protocols and regulations needed to operate can require "rules" or protocols that do not respect the individual self-determination of clients.

### ***Question Assesses***

## Psychotherapy, Clinical Interventions, and Case Management

**99. C.** Behavior modification is the generic term given to any process derived from learning theory where the goal is to change client behavior. To understand behavior modification, it is necessary to understand the two main concepts that it is based on: classical and operant conditioning. Classical conditioning refers to the pairing of naturally occurring stimulus-response chains with other stimuli to produce a similar response. Operant conditioning is recognition that behaviors have antecedents and consequences—and are increased or decreased by reinforcement or punishment, respectively.

Biofeedback is the process of learning to voluntarily influence physiological processes by making changes in cognition. It provides a visible and experiential demonstration of the mind–body connection. Biofeedback is also a therapeutic tool to facilitate learning self-regulation of autonomic functions for improving health.

Modeling is learning by observing or imitating. There are different types of modeling techniques to assist learners.

Shaping refers to the reinforcement of behaviors that approximate or come close to desired new behaviors. The steps involved are often called successive approximations because they successively approximate or get closer and closer to desired behaviors. This technique works well for phobias and anxiety-related disorders as the process of shaping can involve the creation of a hierarchy ranging from the least feared situation to the most feared situation. Rewards to greater incremental exposure are provided as a means to confront fears.

The question requires recall knowledge about behavioral techniques. Shaping is used when it may be, or has been, difficult to achieve a goal or demonstrate a behavior. Shaping allows the goal or behavior to be achieved in steps, each reinforced positively. After a client achieves each successive step of the behavior or goal, a reward is received and the next one is presented until the desired end result is reached. If there is difficulty in a client reaching the steps, they should be broken down into smaller increments. While behaviors may be broken down when they are modeled, there is no mention of the social worker demonstrating them or the client observing or imitating the social worker in the scenario presented.

## **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 100.** **C.** The dynamics of loss, separation, and grief are different for all who experience them. However, the needs of those who are grieving are universal. Unlike “stages of grief,” these needs of mourning are not orderly or predictable. Clients will address each need when ready to do so, sometimes working on more than one need at a time. These needs include:

### *Accepting the reality of the death*

Whether the death was sudden or anticipated, acknowledging the full reality of the loss can take weeks, months, and even years.

### *Feeling the pain of the loss*

It is easier to avoid or deny the pain of grief than to confront it. Yet, it is only reconciled through feeling the pain associated with the loss.

### *Remembering the person who died*

Mourning involves allowing the pursuit of the relationship, instead of trying to take memories away.

### *Developing a new self-identity*

Part of self-identity comes from relationships with others. When someone dies, the self-identity of those involved in these relationships naturally changes.

### *Searching for meaning*

When someone dies, it is natural to question the meaning of life as death is a reminder of one’s lack of control.

### *Receiving ongoing support from others*

The quality and quantity of support obtained from others has a major influence on the capacity to heal. Drawing on the experiences and encouragement of others is not a weakness but a healthy human need.

This question requires knowledge about the dynamics of loss, separation, and grief. Even if the correct answer is not readily apparent, it can be identified by eliminating the incorrect response choices.

Individuals do not sequentially move through stages of grieving, making the response choice that mentions sequential progression incorrect. Often people think that they are helpful by removing pictures of those who have died or not speaking about them. They try to keep those grieving busy. However, it is important to keep memories alive while embracing the reality of the death by talking to others. Thus, not all clients will need more time before talking about their loss.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 101. C.** Social workers should ensure that they do not engage in dual or multiple relationships that may impact on the treatment of clients. *Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.*

Social workers should be alert to, and avoid, conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes clients' interests primary and protects clients' interests to the greatest extent possible. In some instances, protecting clients' interests may require termination of the professional relationship with proper referral of clients. Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to a client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.

The scenario suggests that a former client would like to enter into a new relationship with a social worker. While this new relationship is professional in nature, it still reflects the existence of a dual relationship. While perhaps not readily apparent, the former client may be harmed by this relationship with the social worker. For example, the client may need treatment again in the future. Being a co-facilitator with the social

worker would preclude the client from receiving services, thereby eliminating the availability of a clinical support for the former client if needed. In addition, the client may personalize or feel that examples provided by the social worker during group sessions relate to her own service provision. While the former client is not currently receiving services from the social worker, dual or multiple relationships can occur consecutively such as described in the scenario.

Co-facilitating, even for a short time, would be inappropriate. In addition, assisting the former client in preparing for the group is also problematic. The former client may experience anxiety during this process and confuse the social worker's support with a therapeutic alliance. It is best for the social worker to keep involvement to a minimum.

### **Question Assesses**

#### Professional Values and Ethics

- 102. C.** The function of silence, like its meaning, is culturally defined. There are vast differences in culture, race, and/or ethnicity with regard to its use. It has a “linkage” function in that it can bind people together as well as isolate. Being silent with others can indicate rapport, respect, and comfort as it acknowledges solidarity or that no conversation is needed. Silence can also have an “affecting” function, meaning that it has the power to affect others for both good and ill. Silence can be interpreted as indifference, causing negative feelings by others who observe it. Conversely, it can also be seen as a sign of respect, viewed positively.

Assumptions should not be made that those who are silent are not benefitting from others' participation or not actively engaged. For some, silence is seen as an opportunity given to others to speak or express their ideas. This dialogue by others mutually benefits those who do not verbalize. Silence also can indicate assent—there may be no need to verbally affirm what is said as remaining quiet is seen as having the same effect. Silence may be viewed as a way to retain harmony among the group.

Silence can be seen as a way to agree with others without vocalizing. This indirect form of communication is more common among some cultures, including those who are Asian. In addition, some cultures are more collectivist, placing the views of larger groups as more important than those of individual members. Thus, remaining silent is seen as a

sign of respect even when having an opposing view. Dissenting opinions are viewed as having possible negative repercussions for the work of the overall group, which is prioritized.

In the scenario, there is no indication of the race, culture, and/or ethnicity of other group members. However, the recent immigration of the youth may have been mentioned as an indication that her participation may be influenced by different cultural, racial, and/or ethnic norms. Some races, cultures, and/or ethnicities are more dominant and pervasive than others. This influences how people in both dominant and minority cultures interact; this, in turn, can impact on a group's interactions. It is the social worker's job as facilitator to encourage participation and challenge behavior which inhibits it. The facilitator is not responsible for what a member chooses to say or withhold in a group—clients should not be forced to participate. *What a social worker can and must do is create an environment in the group where clients can choose to contribute and where it is safe for them to do so.* Thus, a social worker should challenge and dilute any negative impacts of prejudice which may arise in the group due to differences in communication styles. Ensuring that any negative effects of social prejudice are not tolerated will create a "safe space" where group members can choose to express their opinions if they wish.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 103. A.** Engagement within the context of building and maintaining helping relationships is defined as a point at which clients view treatment as a meaningful and important process. It involves developing agreement with social workers on the goals and tasks of treatment. Engagement can also be described as the time when the therapeutic relationship or therapeutic alliance forms between social workers and clients. *The engagement process is sometimes described using words like cooperation, collaboration, participation, or buy in.* During the engagement process, clients' worldviews including their values, core beliefs, and ways of life are challenged to facilitate substantive change.

As clients realize the need to change, resistance can occur. Resistance to change can occur throughout the problem-solving process as it helps clients to protect the status quo. Closely related to resistance is ambivalence, which is a condition of both wanting and not wanting a particular change. Social workers should be alert to the forces of

ambivalence and, when necessary, assist clients in working through these blocks to decision making and action. Such work involves various interviewing and therapeutic techniques, but initially it is critical that clients feel that social workers are there to help and will not be judging or giving advice.

Material in quotation marks deserves particular attention and usually relates to the answer. The client's comment may result from apprehension about the ability to make change or fear of the therapeutic process. The client is in the beginning phase of treatment (engagement) where the goal is to build a strong helping relationship with the social worker. Informing the client does not assist with engagement and asking about other situations distracts from the situation at hand. The best way to deal with any resistance or apprehension is by educating the client about what will happen in the future.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 104. B.** Defense mechanisms are psychological mechanisms aimed at reducing anxiety. They were first discussed by Sigmund Freud as part of his psychoanalytic theory and further developed by his daughter, Anna Freud. Often unconscious, defense mechanisms are used to protect clients from psychological pain or anxiety. While such mechanisms may be helpful in the short term, alleviating suffering that might otherwise incapacitate, they can easily become a substitute for addressing the underlying cause and so lead to additional problems. The solution, therefore, is to address the underlying causes of the pain these mechanisms are used to defray.

Sublimation is a mature type of defense mechanism where socially unacceptable impulses or idealizations are unconsciously transformed into socially acceptable actions or behavior. It causes "id" impulses to be channeled into refined and civilized behavior. Alfred Adler called sublimation "the healthy defense mechanism" because it produced socially beneficial outcomes for humanity.

This is a recall question on the defense mechanisms. It is not necessary to memorize the definitions of the defense mechanisms, but their meanings should be familiar.

Often questions on defense mechanisms include scenarios which describe clients' behavior. Thus, social workers should be able to distinguish between the defense mechanisms based on client verbalizations and actions within situational contexts.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 105. B.** Defense mechanisms are psychological mechanisms aimed at reducing anxiety. They were first discussed by Sigmund Freud as part of his psychoanalytic theory and further developed by his daughter, Anna Freud. Often unconscious, defense mechanisms are used to protect clients from psychological pain or anxiety. While such mechanisms may be helpful in the short term, alleviating suffering that might otherwise incapacitate, they can easily become a substitute for addressing the underlying cause and so lead to additional problems. The solution, therefore, is to address the underlying causes of the pain these mechanisms are used to defray.

Conversion is a defense mechanism which occurs when cognitive tensions manifest themselves in physical symptoms. The symptom may be symbolic and dramatic and often acts as a communication about the situation. Extreme symptoms may include paralysis, blindness, deafness, becoming mute, or having a seizure. Lesser symptoms include tiredness, headaches, and twitches. For example, a client's arm becomes suddenly paralyzed after the client has been threatening to hit someone else.

Conversion is different from psychosomatic disorders where real health changes are seen (such as the appearance of ulcers). It also is more than malingering, where conscious exaggeration of reported symptoms is used to gain attention. With time, symptoms will go away, especially if clients' stress is reduced, such as by taking them away from the initial, anxiety-provoking situations.

This is a recall question on the defense mechanisms. It is not necessary to memorize the definitions of the defense mechanisms, but their names should be familiar. The correct answer could have been obtained simply by recognizing that conversion was a defense mechanism.

Often questions on defense mechanisms include scenarios which describe clients' behavior. Thus, social workers should be able to

distinguish between the defense mechanisms based on client verbalizations and actions within situational contexts.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 106. B.** Crises are defined as an acute disruption of psychological homeostasis in which a client's usual coping mechanisms fail and there exists evidence of distress and functional impairment. The *subjective reaction* to life experiences dictates clients' abilities to cope or function. The main cause of a crisis is a stressful, traumatic, or hazardous event, but two other conditions must be present—(a) a client's perception of the event causes considerable upset or disruption and (b) a client is unable to resolve the disruption by previously used coping skills. Thus, it is a client's subjective experience that signals whether a crisis exists as it is the way that these experiences are perceived by a client that cause a crisis. Clients can encounter life stressors (deaths, health issues, and so on), but it is only if these events are perceived as threats or beyond coping abilities that crises occur.

The question requires knowledge about the difference between subjective and objective data in assessment and treatment planning. While all the response choices may be helpful in gathering information relevant to a client's state, a crisis is a subjective experience. Many clients experience adversity and cope. Only the correct response choice involves speaking with the client directly to understand her feelings about recent events. Incorrect response choices involve reviewing or obtaining objective, not subjective, information related to her physical/neurological condition. Additionally, speaking to collaterals, whose views about the current happenings may be different, are less relevant than the client's.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 107. A.** Cyclothymic disorder is a rare mood disorder which describes clients who experience mood cycling over a 2-year period but have not met the diagnostic criteria for bipolar I, bipolar II, or depressive disorder. There is debate if cyclothymic disorder is a discrete disease process, a temperamental variation, or a premorbid syndrome for

bipolar I or II, as many clients with cyclothymic disorder will develop one of these conditions.

According to the *DSM*, there are six diagnostic criteria, with one specifier:

1. For at least a 2-year period, there have been episodes of hypomanic depressive experiences that do not meet the full *DSM* diagnostic criteria for hypomania or major depressive disorder.
2. The previous criteria had been present at least half the time during the period, with no more than 2 months of symptom remission.
3. There is no history of diagnoses for manic, hypomanic, or depressive episodes.
4. The symptoms in criterion A cannot be accounted for by a psychotic disorder such as schizophrenia, schizoaffective disorder, schizophreniform disorder, or delusional disorder.
5. The symptoms cannot be accounted for by substance use or a medical condition.
6. The symptoms cause distress or significant impairment in social or occupational functioning.

A specifier is “with anxious distress.”

The disorder can also be diagnosed in children or adolescents, but the observational period for symptoms is 1 year rather than 2 years. However, diagnosing in younger children should be considered with clinical skepticism, as they are prone to moodiness, emotional dysregulation, and overreacting to minor stressors as they do not yet have adult coping skills. It is a fallacy to project adult behavioral norms onto children and adolescents and pathologize age-appropriate and typical behaviors.

This question requires recall about the *DSM* and its disorders, specifically cyclothymic disorder. Social workers should be aware of diagnostic criteria, including those for bipolar and related disorders. The mention that the time frame is associated with the observational period for adults provides a clue that it is different for children. It may also be assumed that the observational period for adults would be longer than

that required for children. Such an inference may help to eliminate some of the response choices with shorter time frames.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 108. B.** Emotional and psychological trauma result from extraordinarily stressful events that destroy a sense of security, making a client feel helpless and vulnerable in a dangerous world. Traumatic experiences often involve a threat to life or safety, but any situation that leaves a client feeling overwhelmed and alone can be traumatic, even if it does not involve physical harm. It is not the objective facts that determine whether an event is traumatic, but a subjective emotional experience of the event. Several risk factors make clients susceptible to emotional and psychological trauma. Clients are more likely to be traumatized by a stressful experience if they are already under a heavy stress load or have recently suffered a series of losses.

Emotional and psychological trauma can be caused by one-time events or ongoing, relentless stress.

Not all potentially traumatic events lead to lasting emotional and psychological damage. Some clients rebound quickly from even the most tragic and shocking experiences. Others are devastated by experiences that, on the surface, appear to be less upsetting.

Clients are also more likely to be traumatized by a new situation if they have been traumatized before—especially if the earlier trauma occurred in childhood. Experiencing trauma in childhood can have a severe and long-lasting effect. Children who have been traumatized see the world as a frightening and dangerous place. When childhood trauma is not resolved, this fundamental sense of fear and helplessness carries over into adulthood, setting the stage for further trauma.

An event will most likely lead to emotional or psychological trauma if it happened unexpectedly; there was no preparation for it; there is a feeling of having been powerless to prevent it; it happened repeatedly; someone was intentionally cruel; and/or it happened in childhood.

The question contains a qualifying word—**MOST**. Emotional or psychological trauma may occur because of events in adulthood or those which were anticipated/preventable. However, events which

happen unexpectedly with no preparation or warning are those which are associated with the greatest negative impacts. Clients who feel that there is no way to prevent these traumatic circumstances are likely to feel ongoing danger or that they are vulnerable for repeated incidents in the future.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 109. B.** Structural family therapy (SFT) is similar to other types of family therapies that view the family unit as a system that lives and operates within larger systems, such as a culture, the community, and organizations. This system—ideally—grows and changes over time. But sometimes a family gets “stuck,” often resulting from behavioral or mental health issues of one of its family members.

Rather than focus on the individual’s pathology, however, SFT considers problems in the family’s structure—a dysfunction in the way the family interacts or operates. SFT does not maintain that the family’s interactions, or “transactions,” cause the pathology, but rather that the family’s transactions support or encourage the symptoms. Transactions are simply patterns of how family members routinely interact with each other. Through its transactions, a family establishes a set of rules for its daily functioning, and these rules form its “structure.” A social worker employing SFT should first assess a family’s interactions, figuring out a family’s hierarchy and alliances within a family. The social worker composes a map or flow chart describing the process that a family unconsciously follows.

Ultimately, the social worker’s goal is to change or modify the family map or structure—to get it “unstuck” from its harmful transactions that are supporting and amplifying certain issues or problems. They delineate proper “boundaries” between family members and their transactions or interactions. When boundaries are crossed, ignored, and distorted, the family’s structure becomes dysfunctional.

Social workers using SFT identify a wide range of dysfunctional communication and interaction patterns. Unlike more traditional approaches that prescribe a supportive, empathetic-listening approach to therapy, social workers using SFT get involved with a family’s transactions. In this unique role, and in the context of the therapeutic setting, a social worker will provoke the family members to interact and

speak about the problem or issue. The therapist asks questions, points out harmful transactions, and uncovers not only dysfunctional patterns, but positive behaviors or personal qualities that are ignored or overlooked by a family.

During interactions that take place in therapy, hidden conflicts become apparent, inappropriate or counterproductive transactional patterns are observed, and, finally, ways to help a family change or restructure interactions are made.

To assist with understanding the family system, social workers will ask for “live” displays of concerns called *enactments*. The family will be encouraged to engage in a difficult communication so that social workers can best identify the current problematic patterns and dynamics. SFT focuses on family interaction in the “here and now.” It is less concerned with how their interactional styles evolved.

While several response choices may appear appropriate, the correct answer is most closely associated with SFT. This approach focuses on the boundaries, communication patterns, and interactions between family members. Using this technique, a social worker takes a very active role to provoke conflict and point out maladaptive behavior.

While the mother’s current mental status may be a concern and requires assessment, it is not the correct answer as it does not most directly relate to a SFT approach. Understanding each family member’s concerns is also not directly related to SFT.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 110. C.** Peer supervision enables social workers to go beyond individual limitations and to expand on their knowledge, skills, and experiences. It involves groups of social workers with the same knowledge, skill levels, and statuses meeting regularly to discuss challenges in the profession, self-exploration, diversity and culture, new interventions and solutions, and ethical dilemmas or situations in the workplace. Peer supervision groups do not have defined leaders. As a result of peer supervision, social workers may feel validated, discuss difficult situations, self-explore, and learn different interventions and perspectives. Peer supervision counteracts burnout and social isolation as members are supported and feel group cohesion.

Members also learn to practice supervisory skills for when they become supervisors in the field. They can do this because they practice giving and receiving feedback as well as boundary management. Peer groups serve as trusting environments where social workers talk about their mistakes and feelings in the field.

The question asks about the primary or main way in which social workers “learn” in peer supervision. Modeling is demonstration of a skill or task which may occur in peer supervision but is not the primary method for learning. Positive reinforcement is a technique to increase behavior frequency by adding a desirable stimulus. For example, praising actions can be very rewarding, making it likely that social workers will do them again. While peer supervision can be supportive, it is not the primary method for learning within these venues.

Feedback, specifically formative feedback, which is characterized as nonevaluative and supportive, is regarded as crucial to improving knowledge and skill acquisition in peer supervision. Formative feedback represents information communicated to social workers by peers that is intended to modify thinking or behavior. Formative indicates that it is occurring while social workers are experiencing difficulties with client situations, not after treatment has ended. It is instructional rather than evaluative. Feedback from others who have had similar experiences is the main method through which social workers gain new knowledge and develop their skills in peer supervision.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 111. C.** Self-determination is a cornerstone of the social work profession. Self-determination is built on the values of autonomy and respect for the dignity and worth of all people. So, given the primacy of self-determination, it is necessary to examine how its mandate can be met when working with clients who are mandated to receive services.

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others (*NASW Code of Ethics—Self-Determination*).

Posing “a serious, foreseeable, and imminent risk to themselves or others” typically applies to situations of suicidal or homicidal ideation. Thus, the *NASW Code of Ethics* is giving priority to the principle of protecting life over the principle of respecting self-determination which can include initiating processes that may result in involuntary admission for psychiatric treatment as a last resort.

This ethical standard does not say social workers may ignore self-determination. It says they may limit self-determination. Implicit in this language is the notion of the “least intrusive” course of action. In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients’ right to refuse service (*NASW Code of Ethics—Informed Consent*).

This standard recognizes that, even though involuntary clients are being pressured into services, they still have certain rights. First, social workers need to inform clients about the services being offered. For instance, social workers should inform them about the purpose and goals of the services, models of intervention used, research about benefits and risks, and expectations as participants in services. Social workers should inform clients about the extent of their right to refuse services. Social workers should also help clarify the consequences if clients do not do what has been mandated.

Self-determination is not simply an either/or situation. Honoring self-determination as much as possible may be more difficult with some clients than with others. Although social workers should recognize that self-determination may be imperfect for involuntary clients, workers are able to enhance self-determination through various intervention strategies:

- Social workers can empower clients by helping them set goals objectives that they genuinely want to pursue—even if they did not initially choose to participate in services.
- Social workers may be able to offer clients a range of choices about what methods of intervention will be used (e.g., individual vs. family counseling).
- Social workers may be able to have clients pick their choice of practice modality (cognitive vs. narrative therapy).

In addition, social workers should engage clients by empathizing and acknowledging pressures placed on them, building trust, and validating

concerns, so clients are more willing to participate in services. In appropriate instances, social workers can advocate with authorities to honor client wishes and revise court orders or other mandates in attempts to promote self-determination.

In the scenario, the social worker is “developing a contract.” A contract is another name for an intervention or service plan and outlines goals, objectives, time frames for completion, and so on. It is done during the planning step of the problem-solving process, following engagement. While it is important for a mandated client to understand the contents of a court order related to treatment, such a review usually occurs prior to planning, such as part of the informed consent process at the onset of the therapeutic relationship. In addition, advocating for clinically appropriate mandates does not “promote self-determination,” which is the lens through which each response choice must be evaluated. Only the correct answer elicits client input into the methods to be used, which is central to client self-determination.

### ***Question Assesses***

#### Professional Values and Ethics

- 112.** **B.** Policies, procedures, regulations, and laws can have a profound impact on social work practice. Social workers who treat clients involved with the legal system should be aware of problems that can arise prior, during, and after the delivery of services. Many of these issues can be avoided by clarifying and defining the nature of a social worker’s role. For example, some clients may be uncertain about what to expect from psychotherapy or have unrealistic hopes. Ethically, a social worker is expected to work jointly with clients in the development of treatment plans. By discussing what can and cannot be provided, clients are offered realistic portrayals of what may be expected from therapy, which may assist in deciding whether to work with a particular social worker.

In this scenario, the client appears to be directing the social worker and her behavior suggests that she believes the social worker is obligated to contact the attorney. In fact, the social worker would have no such obligation and would be wise to decline the client’s request, to clarify the social worker’s role and to better understand the client’s expectations. If the social worker elects to contact the attorney prior to discussing the specifics and implications with the client, there is a risk that the client may interpret the social worker’s action as an implied agreement to

become involved in the legal matter. If the social worker and client ultimately determine that the client's expectations were inconsistent with the social worker's understanding of the social worker's role, there may be a need for a referral to another professional who is better suited to the client's needs.

The incorrect response choices focus on contacting the attorney or meeting with the attorney with the client present which is premature until the expectations are understood.

### **Question Assesses**

#### Professional Values and Ethics

- 113. B.** In order to facilitate change through the problem-solving process, a social worker should use various verbal and nonverbal communication techniques to assist clients to understand their behavior and feelings. In addition, critical to ensuring that clients are honest and forthcoming during this process, social workers should build trusting relationships with clients. These relationships develop through effective verbal and nonverbal communication. Social workers should be adept at using both forms of communication successfully, as well as understanding them, because verbal and nonverbal cues will be used by clients throughout the problem-solving process. Insight into their meaning will produce a higher degree of sensitivity to clients' experiences and a deeper understanding of their problems.

A social worker should also display genuineness to build trust. Genuineness is needed to establish a therapeutic relationship. It involves listening to and communicating with clients without distorting their messages and being clear and concrete in communications.

Another method is the use of positive regard, which is the ability to view a client as being worthy of being cared about and as someone who has strengths and achievement potential. It is built on respect and is usually communicated nonverbally.

Communication is also facilitated by listening, attending, suspending value judgments, and helping clients develop their own resources. A social worker should always be aware of culturally appropriate communication behaviors. It is also essential to be clear to establish *boundaries* with clients to facilitate a safe environment for change.

Material in quotation marks deserves particular attention and usually relates to the answer. The question also contains a qualifying word—BEST. The client–social worker interaction in the scenario is occurring in the first session. The first session focuses on engagement or building a therapeutic alliance. The correct response choice is the one which addresses the client’s belief that he is a failure and his comment about not understanding “how things got so bad.” The incorrect response choices may be actions that will be taken at some time during the problem-solving process, but do not make him feel that the social worker understands his situation. The question asks for the social worker’s response to his statements. Central to the formation of a therapeutic alliance is displaying empathy, which the social worker is doing in the correct answer.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 114. C.** Relying on the expertise of other professions when needed can reduce major liability risks for social workers and result in better outcomes for clients. For example, in situations which require medical or other expertise, social workers should look to obtain appropriate guidance from others or else clients may be harmed. If such consultation does not occur, social workers breach standards of care through acts of omission (not acting when they should have done so).

Under the common law doctrine of standard of care, courts usually seek to determine what a typical, reasonable, and prudent (careful) social worker with the same or similar education and training would have done under the same or similar conditions. In many instances, establishing the standard of care is easy. But in other instances, it is not easy to establish what constitutes ordinary, reasonable, and prudent practice. Well-educated, skilled, thoughtful, and careful social workers may disagree with colleagues about the best course of action in complex circumstances, perhaps because of their different schools of thought, training, and experience.

In the scenario, the social worker has “a lack of knowledge about this medical condition and the medication prescribed,” which is causing dramatic mood changes in the client. Thus, the social worker has an ethical responsibility to learn more through consultation with an appropriate medical professional. Failure to seek consultation may adversely affect the client.

The reason for the contact is for the social worker to learn more about the medical condition and medication. The social worker is not collaborating, which is defined as working with another to produce or create something. Joint or interdisciplinary work by both the social worker and physician is not occurring. There is also no indication that the physician is the treating medical professional of the husband, so the social worker's action is not an effort to enhance coordination of services.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 115. A.** Enhanced coordination of client services can be achieved through the use of alternative funding approaches. Blending or braiding funding across related programs and across multiple agencies is a basic way that state and local agencies can more effectively serve the holistic needs of clients, more efficiently target high-priority performance goals, and streamline administrative requirements. *Blending and braiding of fiscal resources aim to enhance service coordination to meet the holistic needs of clients.*

Some jurisdictions, particularly at the local level, have successfully used blended and braided funding, but federal categorical limitations make taking this concept to a larger scale difficult. The terms “blending” and “braiding” are used frequently, often together, and generally with little definition. However, they refer to two very different approaches to fiscal coordination.

Blending funding involves comingling the funds into one “pot” where social workers can draw down service dollars, personnel expenses can be paid, or other program needs can be met. When funding is blended, it goes into the “pot,” and when it is pulled back out to pay for an expense, there is no means for the fiscal manager to report which funding stream paid for exactly which expense. Blending funding is politically challenging. Some funding streams cannot be blended. Other funding streams will require the funder to allow an exception to how the reporting normally functions. Instead of usual reporting, funders can opt to accept reports on services and outcomes across the population being served, rather than exactly which children, youth, and families received services with their dollars. To blend funding, social workers need to work closely with funders and ensure that reporting requirements are met. Though it is challenging politically, once funders are on board,

blended funding is less challenging to implement than braided funding. There is significantly less workload, as the tracking and accountability happens across all of the funding streams. Rather than reporting to funders on their funding stream alone, reporting is done on how the collective funds are used. Blended funding can allow you to pay for services that may not be allowable with more categorical funding approaches. However, for many funders, the flexibility associated with blending makes it seem too “risky” as it often looks like supplanting, and they end up with less detailed information about how each of their dollars have been spent.

Braided funding involves multiple funding streams utilized to pay for all the services needed by a given population, with careful accounting of how every dollar from each funding stream is spent. The term “braiding” is used because multiple funding streams are initially separate, brought together to pay for more than any one funding stream can support, and then carefully pulled back apart to report to funders on how the money was spent. Braided funding is often the only option. Federal funding streams require careful tracking of staff time and expenses to ensure that a federal funding stream only pays for those things directly associated with the intent of the funding. Consequently, when multiple funding streams are paying for a single program or system, the system will need to be carefully designed to allow for sufficient reporting to ensure each funding stream is only paying for activities eligible under that funding stream. Braided funding requires significant effort to create the systems for tracking how funding is utilized.

The design of a braided funding system that can respond to the individualized needs of many types of clients will require social workers to decide which services will be paid for by which funding streams. Ideally, this decision happens after the needs of the individual or family being served is identified, so that the funding does not drive the services being provided. This type of braided model requires a clear understanding of the eligible populations and the eligible services, so that decisions on how to fund the services can be made post hoc, rather than prior to discussing service needs with the families. The design of a blended funding program is simpler than the design of a braided funding system. Programs typically have clearly defined services that are provided and sometimes have very defined populations who are eligible for services.

The correct answer is identified through the process of elimination, with each false assertion being excluded. Blending is often not preferred by

funders as they receive less detail about how monies are spent, while braiding is frequently not seen as possible due to the burden of the tracking associated with its implementation. Braiding requires detailed reporting to ensure each funding stream is only paying for eligible activities. Only the correct answer is accurate as both blending and braiding are difficult to administer due to federal categorical limitations.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 116. C.** Operant conditioning attempts to understand complex human behavior without studying the internal mental thoughts and motivations. B. F. Skinner based his theory of conditioning on the preexistent theory called “Law of Effect,” or the belief that responses that produce satisfying effects are more likely to occur again and responses that produce discomforting effects are less likely to occur again.

Punishment has as its objective to decrease the rate of certain undesired behavior from occurring again. Punishment can be further classified into two major parts—positive and negative.

Positive punishment focuses on decreasing the undesired behavior by presenting negative consequences once undesired behavior has been exhibited. When subjected to negative consequences, individuals are less likely to repeat the same behavior in the future.

Negative punishment focuses undesired behavior by removing favorite or desired items. When desired stimuli are removed, there is less chance of the behavior occurring again in the future.

Reinforcement aims to strengthen or increase behavior frequency.

Positive reinforcement increases the likelihood that behavior will occur again in the future by pairing it with desirable stimuli (reinforcers).

Negative reinforcement increases the probability that behavior will occur again in the future by removing negative stimuli.

This is a recall question which relies on social workers understanding various operant conditioning techniques. Negative punishment is when a desirable stimulus is removed following an undesirable behavior for the purpose of decreasing or eliminating the behavior. In the scenario, the client takes away her daughter’s cell phone (a desirable stimulus)

with the desire to decrease her homework incompleteness and tardiness (targeted behaviors).

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 117.** **C.** Reimbursement methodologies can have a dramatic impact on the delivery of services. Social workers should be aware of different payment policies and the implications of each.

Capitation is based on a payment per person, rather than a payment per service provided. There are several different types of capitation, ranging from relatively modest per-person per-month case management payments to assist with care coordination to per-person per-month payments covering all professional services (professional, facility, pharmaceutical, clinical laboratory, durable medical equipment, and so on). There may also be particular services that are “carved out” of such payments. These may be handled on either a fee-for-service basis or by delegation to a separate benefit management company. Capitation is often used as a means of controlling growth in the cost of care.

Fee-for-service is a payment model where services are unbundled and paid for separately. It gives an incentive to provide more treatments because payment is dependent on the quantity of care, rather than quality of care. Similarly, when clients are shielded from paying (cost-sharing) by health insurance coverage, they are incentivized to welcome any medical service that might do some good. Fee-for-service is the dominant physician payment method in the United States.

In a bundled payment methodology, a single, “bundled” payment covers services delivered by two or more providers during a single episode of care or over a specific period of time. For example, if a client has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon, and a third payment to the anesthesiologist, the payer will combine these payments for the specific episode of care (i.e., cardiac bypass surgery). In some cases, one entity (for instance, an accountable care organization) may receive the bundled payment and subsequently apportion the payment among participating providers. In other cases, the payer may pay participating providers independently, but adjust each payment according to negotiated, predefined rules in order to ensure that the total payments to all of the providers for all of the defined services do not exceed the

total bundled payment amount. This latter type of payment methodology is frequently referred to as “virtual” bundling. Bundled payment arrangements are a type of risk-contracting. If the cost of services is less than the bundled payment, participating providers retain the difference. But if the costs exceed the bundled payment, providers are not compensated for the difference.

This is a recall question which relies on social workers understanding the effects that policies, procedures, regulations, and laws have on practice. Reimbursement methodologies can dramatically impact the ways in which services are coordinated and delivered. The question focuses on a single payment for multiple services. Fee-for-service would be excluded as it represents a separate reimbursement for each service provided.

Capitation should not be confused with bundled payments. Capitation is an actuarially determined payment per client who may or may not use services. The distinction between capitation and bundled payment is that capitation pays the same amount regardless of what clients need clinically or receive. The calculation of the capitation amount derives from actuarial principles of insurance. The big risk in capitation is incidence risk. The question asks about “services provided,” making bundled payment the correct answer over capitation.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 118. A.** Cultural identity is often defined as the identity of a group, culture, or an individual, influenced by one's belonging to a group or culture. Certain ethnic and racial identities may also have privilege.

Cultural, racial, and ethnic identities are important, particularly for those who are members of minority groups. They may instill feelings of belonging to a particular group or groups and identification with that group (i.e., shared commitment and values). Cultural, racial, and ethnic identities are passed from one generation to the next through customs, traditions, language, religious practice, and cultural values. Cultural, racial, and ethnic identities are also influenced by the popular media, literature, and current events.

Self-esteem or image can be negatively impacted by cultural issues, especially when practices interfere with childhood development, such as

being subject to criticism or abuse; missing out on experiences that would foster a sense of confidence and purpose; and/or receiving little or no positive reinforcement for accomplishments. In adulthood, cultural beliefs may compound life changes by further stigmatizing losing a job or changing jobs, ending an intimate relationship, having legal or financial troubles, struggling with addiction or substance abuse, having children with emotional troubles, developing physical health concerns, and so on.

People with poor self-image may work with social workers on becoming more assertive, confident, and self-aware. Finding a sense of accomplishment is a huge boost to self-esteem, and therapy can help clients identify specific activities that boost confidence and competence. In addition, many social workers focus on helping people develop self-compassion so that they can develop more realistic, achievable goals for themselves and treat themselves with kindness and encouragement.

Universalization is a supportive intervention used by social workers to reassure and encourage clients. Universalization places client experiences in the context of other individuals who are experiencing the same or similar challenges, and it seeks to help clients grasp that their feelings and experiences are not uncommon given the circumstances. A social worker using this supportive intervention intends to “normalize” client experiences, emotions, and reactions to presenting challenges. By normalizing client experiences, social workers attempt to help avert the client’s natural feelings of shame due to feeling alone or judged.

The scenario requires the correct answer to be chosen as it is “most effective.” As the poor self-image of the client is presented as a problem, it is necessary to select a response which will help the client see that she is not alone or to blame for her situation. The incorrect response choices may be actions that the social worker will take, but they are not the most critical. The woman has not felt that she had any other choice than to stay married. She may have been skeptical and cautious about seeking help for fear of being mistreated or misunderstood. Thus, trust is an important element in establishing a therapeutic alliance. The client needs to know that the social worker can be trusted and is competent to help her. Only the correct answer helps build trust and rapport by helping her to see that the social worker accepts and understands her situation.

### **Question Assesses**

## Human Development, Diversity, and Behavior in the Environment

- 119. A.** Long-term alcohol dependence leads to a variety of moderate to severe health problems. The longer and heavier the consumption, the worse the physical results become. “Wet brain” is another way of describing a condition called Wernicke-Korsakoff syndrome. It is caused by a deficiency in vitamin B<sub>1</sub> (thiamine). If “wet brain” is allowed to progress too far, it will not be possible to recover from it.

Wernicke-Korsakoff syndrome is actually a combination of two separate conditions: Wernicke’s encephalopathy and Korsakoff psychosis. These two disorders combine to produce a variety of symptoms including confusion, changes to vision, loss of muscle coordination, difficulty swallowing, and speech problems. Hallucinations, loss of memory, confabulation (occurs as clients make up stories to compensate for their memory loss), inability to form new memories, inability to make sense when talking, and apathy are due to Korsakoff psychosis. It is possible for clients who are alcoholic to develop either Korsakoff psychosis or Wernicke’s encephalopathy independently.

It is usual for the effects of Wernicke’s encephalopathy to become noticeable first. These symptoms tend to come on suddenly. The first sign that something is wrong will be that a client appears confused. This can be hard to diagnose in a client who is habitually intoxicated. This confusion differs from drunken confusion because it lasts even when a client has not been drinking. Later, the symptoms of Korsakoff psychosis will also become noticeable. In the beginning, only the ability to form new memories will be damaged, so a client can still appear quite lucid.

Clients who are alcoholic have poor dietary habits; over a long time, this will lead to nutritional deficiencies. Lack of thiamine in the diet interferes with glucose metabolism, which can then lead to atrophy in the brain. Wernicke’s encephalopathy occurs due to damage to the thalamus and hypothalamus. Korsakoff psychosis occurs because of damage to those parts of the brain where memories are managed.

If wet brain syndrome has been allowed to progress too far, there may be little that can be done to reverse the effects. *Thiamine injections can improve things greatly and may restore a client back to full recovery.* Those who have developed the chronic form of wet brain will be far less

likely to recover. In some cases, the best that can be done is prevention of any further deterioration.

The only possible cure for wet brain syndrome is complete abstinence from alcohol. Most of those who do find their way into recovery will be able to regain all functioning that was lost due to Wernicke-Korsakoff syndrome. Other clients will have to deal with lingering effects of the damage, but they should be able to adapt and find a good life away from alcohol.

The question contains a qualifying word—BEST—that requires social workers to select the response choice which will optimally treat the root cause of the symptoms listed. While some of the incorrect response choices may be helpful to the client, only the correct answer addresses the reason for the wet brain symptoms. Cognitive rehabilitation and physical therapy address the manifestations of the vitamin B<sub>1</sub> (thiamine) deficiency, but not the underlying problem.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 120. B.** There are many ethical standards, including those on touching clients, which speak to professional boundary issues that social workers face in practice. Often the maintenance of appropriate boundaries can be challenging for social workers. Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client because of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact. The *NASW Code of Ethics* leaves the door open but cautions social workers that they bear responsibility for ensuring that no negative consequences ensue.

The language leaves open the possibility that, when used responsibly, touch might occasionally make clinical sense, perhaps by helping a client stay grounded or feel less isolated or overwhelmed.

However, social workers using touch within the context of a therapeutic alliance should always carefully consider clients' factors, such as presenting problems and symptoms, personal touch and sexual history, ability to differentiate types of touch, and clients' ability to assertively

identify and protect their boundaries, as well as the gender and cultural influences of both clients and social workers.

Social workers should have clear policies about touching, self-disclosure, and other boundary areas which are applied consistently to client situations. One of the most effective ways to establish clear professional boundaries is for a social worker's behavior to set the standard for meetings with clients. Appropriate dress and behavior should be displayed, and talk should not include social workers discussing their personal life.

The scenario describes a client's reaction to a hesitation by a social worker to a hug at the end of a session. There is no indication that physical touch has been discussed between the client and social worker in this or any prior interaction. The client may be accusing the social worker of being homophobic due to an exchange with someone else in the past. In the scenario, it is necessary for the social worker to explain the policy on physical touch, as well as other boundary issues. Educating clients about the *NASW Code of Ethics* is essential so they can better understand therapeutic or helping alliances and not confuse them with friendships or romantic relationships. None of the incorrect responses include this critical education.

It would not be appropriate to explore the client's belief about being rejected based on her sexual orientation when the session is ending. In addition, there is no indication that the client's statement is anything other than a misunderstanding about professional boundaries between the social worker and client. The client may not realize that the social worker has a policy which is applied to all clients.

Simply telling the client that the social worker is not homophobic does not provide an explanation for the hesitation. It also misses the opportunity to educate the client about the importance of maintaining professional boundaries and differentiating the therapeutic alliance from other personal relationships.

### **Question Assesses**

#### Professional Values and Ethics

- 121. C.** Xenophobia is a severe aversion to foreigners, strangers, their politics, and their cultures. Often, the term "xenophobia" is used interchangeably with racism, yet the two are actually different. While

racism defines prejudice based solely on ethnicity, ancestry, or race, xenophobia covers any kind of fear related to differences in culture, race, and/or ethnicity, as well as other ways of being different. Those with xenophobia do not understand or accept that their condition is based in fear, yet it is the perceived threat of losing one's own identity, culture, and imagined superiority or purity that is the cause.

If left untreated, xenophobia can have seriously detrimental effects. An individual who is xenophobic is liable to pass along highly generalized and ungrounded perceptions to children and family members. Some symptoms of a xenophobic person include:

- Feelings of fear or dread when exposed to people or cultural it perceived to be different
- Apparent hostility toward people or cultures perceived to be different
- Distrust aimed specifically toward cultures perceived to be different
- Rash generalizations and stereotypes aimed at a set of people based on superficial qualities

Like all phobias, there is no universally specific cause that leads to the development of xenophobia. It can be caused by unique experiences or can simply be the result of alienation from people and cultures different from one's own.

Like many phobias, treatment focuses on first targeting the initial inciting factor that caused the irrational and extreme fear. Therapy includes talking about why the fear was unfounded and addressing any traumatic experiences that caused the phobia, as well as identifying ways to deal with symptoms. Sometimes behavioral techniques are used to systematically and gradually confront the source of fear and learning to control the physical and mental reactions to it. By facing the phobia directly, it is possible to realize that fears are not grounded in real or imminent danger.

This is a recall question which relies on social workers understanding terminology related to cultural awareness and its barriers. Social workers should promote conditions that encourage respect for cultural, racial, and/or ethnic diversity and promote policies and practices that demonstrate respect for difference; support the expansion of relevant knowledge and resources; advocate for programs and institutions that demonstrate cultural, racial, and/or ethnic competence; and promote policies that safeguard the rights of all people.

If the definition of xenophobia is not known, it may be possible to narrow the choices through eliminating other response choices.

Ephebiphobia, also known as hebephobia, is the fear of young people or teenagers.

Mysophobia, also known as germophobia, is a common fear of general contamination which can lead to extreme anxiety about contact with others.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 122. C.** In the *DSM*, the chapter on substance-related and addictive disorders also includes gambling disorder as the sole condition in a category on behavioral addictions. Gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment. Recognition of these commonalities will help people with gambling disorder get the treatment and services they need, and others may better understand the challenges that individuals face in overcoming this disorder.

While gambling disorder is the only addictive disorder included in *DSM* as a diagnosable condition, internet gaming disorder is included in section III of the *DSM*. Disorders listed there require further research before their consideration as formal disorders. This condition is included to reflect the scientific literature that persistent and recurrent use of internet games, and a preoccupation with them, can result in clinically significant impairment or distress. Other repetitive behavior, such as that related to exercise, sex, or shopping, are not included because there is insufficient peer-reviewed evidence to establish the diagnostic criteria to identify these behaviors as mental disorders at this time.

This is a recall question which relies on social workers understanding that empirical evidence supports treating other addictions, such as gambling, like substance-related disorders since gambling behaviors activate reward systems similar to those activated when abusing drugs. In addition, gambling disorder produces behavioral symptoms that are comparable to those produced by substance use disorders. Knowing which other addictions are included in the *DSM* is essential when social workers are working with clients who are experiencing impairment due to excessive or repetitive behaviors.

## **Question Assesses**

### Assessment, Diagnosis, and Treatment Planning

- 123.** **C.** Central to required social work documentation are case notes. Case notes are an integral and important part of practice. Record-keeping practices have an impact on client outcomes such that poor case notes can result in poor decision making and adverse client outcomes. A *case note is a chronological record of interactions, observations, and actions relating to a particular client.*

The guiding principle for deciding what information should be included in case notes is whether it is relevant to the service or support being provided. Case notes can include, but are not limited to:

- Biopsychosocial, environmental, and systemic factors
- Considerations of culture, religion, and spirituality
- Risk and resilience present
- Facts, theories, or research underpinnings that impact on assessment and/or treatment
- Summaries or all discussions and interactions
- Persons/services involved in the provision of supports including ref information, telephone contacts, and email/written correspondence
- Attendance/nonattendance at scheduled sessions
- Discussions of legal and ethical responsibilities (client rights, responsibilities, and complaints processes; parameters of the service support being offered and agreed to; issues relating to informed consent, information sharing, confidentiality, and privacy; efforts to promote support client self-determination and autonomy)
- Details of reasons for and outcomes leading up to or following termination or interruption of a service or support

The question asks about the primary function. While case notes may have multiple functions, the correct answer is the one that highlights their usefulness in ensuring efficient and effective client care. Using case records for worker development and/or reimbursement is not the main reason that social workers keep case or progress notes. These notes are used mainly by social workers to help them recall what was done in prior meetings or sessions so that future work can pick up there.

It helps to ensure that time is not wasted talking about issues that were already resolved. Additionally, by reviewing case notes prior to sessions, social workers reduce the likelihood that important next steps in discussions take place and therapeutic gaps do not emerge. Case notes also help social workers look back to initial and other past sessions to see progress made. This progress should be regularly reviewed with clients.

### **Question Assesses**

#### Psychotherapy, Clinical Interventions, and Case Management

- 124. A.** The mission of the social work profession is rooted in a set of professional values. These core values—service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence—are the foundation of social work's unique purpose and perspective.

These core values reflect what is unique to the social work profession. Core values, and the principles that flow from them, should be balanced within the context and complexity of the human experience.

When providing service, social workers' primary goal is to help people in need and to address social problems. Social workers elevate service to others above self-interest. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Social workers value social justice, challenging social inequities on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice.

Social workers respect the inherent dignity and worth of the person, treating each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs.

Social workers recognize the central importance of human relationships, as relationships between and among people are an important vehicle

for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Integrity means that social workers behave in a trustworthy manner. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Social workers practice within their areas of competence and develop and enhance their professional expertise. Social workers continually strive to increase their professional knowledge and skills and to apply them in practice.

Social workers should uphold all social work values. However, this scenario contains a qualifying word—**MOST**. The problem of finding an appropriate provider presents a barrier to fulfilling the client's wish to die at home. Thus, the social worker should focus on developing creative solutions to promoting the client's need for self-determination.

Competence involves practicing within one's expertise and developing as a professional, which are not prevailing issues in this scenario. Integrity, being honest or trustworthy, is also not directly related to the situation presented.

### **Question Assesses**

#### Professional Values and Ethics

- 125. C.** Defense mechanisms are unconscious processes that protect clients from unacceptable or painful ideas or impulses.

Projection involves clients attributing their own thoughts, feelings, and motives to others. Thoughts most commonly projected onto another are the ones that would cause guilt. For instance, a client might hate someone, but the client's superego tells the client that such hatred is unacceptable. Thus, the client solves the problem by believing that the other person hates the client.

Displacement is the redirection of an impulse (usually aggression) onto a powerless substitute target. The target can be a person or an object that can serve as a symbolic substitute. A client who is frustrated by

superiors on the job may go home and kick the dog or yell at a family member.

Reaction formation is actually a mental process, transforming anxiety-producing thoughts into their opposites in consciousness. A client goes beyond denial and behaves in the opposite way to which the client thinks or feels. By using reaction formation, the id is satisfied while keeping the ego in ignorance of the true motives. In short, reaction formation means expressing the opposite of inner feelings in outward behavior.

The question contains a qualifying word—MOST. While the client may be using more than one of the defense mechanisms listed, it is likely the behavior constitutes reaction formation. The client is engaging in actions, outrage, and advocacy, which are counter to his inner beliefs of appreciation for his own mandated services.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 126. B.** Social workers should be familiar with various research techniques which are applied to practice. Case-mix adjustment is the process of statistically controlling for group differences when comparing nonequivalent groups on outcomes of interest. It is done on a post hoc basis, after the treatment groups have been formed and the performance measures collected. The groups may be treatment agencies, consumers, providers, programs, regions, or states/jurisdictions. Any time these groups are to be compared on performance indicators, case-mix adjustment should be considered.

For example, mental health authorities and providers in both the public and private sectors are increasingly interested in measuring outcomes of mental health care. Performance measurement is mandated by some public mental health systems and managed care organizations. By using comparative performance indicators, mental health systems can track the effects of changes within their systems and the effectiveness of routine care provision across sites. They can identify sites providing the highest quality care and sites that may need to improve the quality of care they provide.

However, populations of mental health consumers served by different behavioral health care agencies can be vastly different. Agencies

serving individuals with severe and comorbid impairment cannot equitably be compared using raw outcome scores to agencies serving individuals with less challenging mental health concerns. The outcomes that providers or agencies strive for, and for which they are held accountable, are only partly under their control; many individual and environmental variables affect outcomes independently of care. These critical case-mix variables are not evenly distributed across groups.

Case-mix adjustment attempts to identify the individual and environmental variables that influence outcomes, measure those variables, correct for their influence through post hoc statistical methods, and display the case-mix adjusted results in ways that allow for ease of interpretation and use.

Case-mix adjustment is a partial correction that cannot create perfectly equivalent groups or duplicate the rigor of experimental assignment. In a true experiment, the researcher assigns people randomly to different treatment groups, controls the administration of the treatment, and measures the outcome or dependent variable. Statistical laws tell us that, with enough people, the average characteristics will be equal in all groups; the only systematic variation is the treatment. So, if the results show that the groups are unequal on the dependent variable, one concludes that the treatment caused the difference. Case-mix adjustment is a post hoc effort to correct for differences among the groups served by the agencies since random selection does not take place.

Case-mix adjustment has an additional function in setting appropriate reimbursement rates in capitation contracts. Adequately and fairly compensating providers on the basis of how much service will be needed, as indicated by case-mix adjustment, removes the incentive for providers to attract only those who are relatively healthy and avoid those with more severe conditions that will require more services.

There may be situations where case-mix adjustment is unnecessary. This situation will occur when the case-mix adjusted results lead to the same conclusions as the unadjusted results regarding group level performance. It may also occur when the gain from doing case-mix adjustment is considered to be small relative to the costs, or when the potential case-mix indicators that are available in a limited dataset do not correlate with the outcome. In the latter case, it is important to recognize that any results to be compared among groups are unadjusted and therefore potentially misleading.

Random sampling assists with creating equivalent treatment and control groups prior to the delivery of interventions.

Descriptive statistics describe the basic features of data in a study. They provide simple summaries and form the basis of virtually every quantitative analysis of data.

This is a recall question which relies on social workers being able to apply research principles to practice. Social workers should be able to correctly interpret empirical findings. Understanding whether outcomes are related to differences in sample selection or client characteristics rather than interventions is critical as social workers may inappropriately conclude that services are effective or ineffective when they are not.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 127.** **A.** A valuable source for data is collateral contacts or informants—relatives, friends, teachers, physicians, and others who possess insight into clients' lives. Collateral sources are particularly important when, because of developmental capacity or functioning, clients' ability to generate information may be limited or distorted. For example, assessments of clients with memory or cognitive limitations will be enhanced with data that collaterals (family members and friends) can provide.

Social workers should exercise discretion when deciding that such information is needed and in obtaining it. Clients can assist in this effort by suggesting collateral contacts who may provide useful information. Social workers should weigh the validity of information obtained from collateral sources. It is important to consider the nature of their relationships with clients and the ways in which that might influence these contacts' perspectives. Family members may be emotionally involved in client difficulties, skewing their perceptions. Other service providers may have limited contact with clients, with narrow views of their situations. As with other sources of information, input from collateral contacts should be critically viewed and weighed against other information.

The question contains a qualifying word—**MOST**. While all the sources listed may provide some useful information, it is likely that the client's adult son will be able to provide the most detailed and accurate

information as he lives with her. The scenario states that the client is disoriented. Additionally, clients often overrate their functioning. Therefore, the client herself is not the best person to provide information on her safety. While she is getting visiting nurse services and home delivered meals, agency staff involvement in the home is limited to medication administration and delivery of meals. The social worker's concern about her safety does not focus on her day program as she is constantly supervised there. The client's functioning at the day program may also be different than at home. Staff in the home will not be able to comment on her ability to perform activities of daily living (ADLs) like bathing, toileting, and cooking.

Collateral contacts who live with clients—in this scenario, her adult son—are usually very good sources of information about clients' functioning as they have the opportunity to observe them for extended periods while performing all tasks which are required for safe, daily living.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 128. A.** Social workers should be familiar with ethical standards related to payment for services. There are many practices which are not ethical such as setting unreasonable fees, bartering in most instances, and soliciting extra fees from clients when services can be provided by agencies at no additional cost. In addition, an arrangement where social workers accept a percentage of other independent providers' fees for professional services that they have not directly provided is not ethical. Receiving money for referrals made to other professionals constitutes fee splitting and is strictly prohibited. Costs of social work services should be established at market value and paid per agreement or contract with clients for services actually received.

Fee splitting represents a conflict of interest which may adversely affect client care and well-being. For example, clients may not necessarily be referred to the most appropriate professionals, but instead those with whom referring social workers have fee splitting or commission payment type arrangements. Fee splitting does not necessarily result in a boundary violation but could do so. This practice can also occur with client consent but fee splitting still creates a conflict of interest which is ill advised.

This is a recall question which relies on social workers understanding the ethical issues regarding payment for services, and specifically the practice of fee splitting.

### ***Question Assesses***

#### Professional Values and Ethics

- 129.** **C.** An interdisciplinary team is a group of individuals from different disciplines, each with unique skills and perspectives, who work together toward a common purpose or goal. The benefits of this approach are well documented. Interdisciplinary teams are often seen as advantageous to clients because they do not have the burden of navigating multiple service systems and communicating to multiple providers who are involved in their care.

The question contains a qualifying word—FIRST. While more than one response choice may be helpful throughout the process, the order in which they are to occur is critical. A biopsychosocial history may not be needed or appropriate. The team will ultimately decide the assessments required and develop the plan. It is also premature to outline the timeline for moving as the specific goals and objectives which need to be accomplished before the move have not been set.

The initial action should be to identify the requisite skills needed. Without knowing what other disciplines need to be represented, social workers will be unable to understand their roles, as well as those of others, on interdisciplinary teams. Central to effective interdisciplinary team approaches is the seeking to establish common ground with other professionals, including commonalities in goals. Professionals should also acknowledge the differences within the field and across other disciplines.

### ***Question Assesses***

#### Psychotherapy, Clinical Interventions, and Case Management

- 130.** **A.** Social workers should respect clients' right to privacy or confidentiality. In addition, social workers may only disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client. Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling

professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others.

Social workers should also provide clients with reasonable access to records. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to a client should provide assistance in interpreting the records and consult with a client regarding the records. *Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to a client.* Both clients' requests and the rationale for withholding some or all the record should be documented in clients' files. When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

The scenario clearly states that "the social worker is not worried about the client seeing the information in the record." Thus, there is no compelling reason to limit the client's access to her record. The client's lack of explanation about what will be done with the information does not change the social worker's duty to send a copy of the entire record to the client.

It is inappropriate for the social worker to meet with the former client. Termination has already occurred, and the former client has the right to withhold the reason for the request. The client can decide whether to share all, some, or none of the information with others once the client receives and reviews the record. It is always good to have requests put in writing, but not required as the information is being sent to the client who ultimately is in control of the information requested.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 131. B.** Positive psychology is the scientific study of the strengths that enable individuals, families, and communities to thrive. The field is founded on the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play.

Positive psychology is a reaction against psychoanalysis and behavioral analysis, which focus on negative thinking and emphasize maladaptive behavior. It builds further on the humanistic movement, which encouraged an emphasis on happiness, well-being, and positivity, thus creating the foundation for what is now known as positive psychology.

Positive psychology is concerned with eudaimonia, “the good life,” or flourishing, living according to what holds the greatest value in life—the factors that contribute the most to a well-lived and fulfilling life. While not attempting a strict definition of the good life, positive psychologists agree that one must live a happy, engaged, and meaningful life in order to experience “the good life” or use signature strengths every day to produce authentic happiness and abundant gratification.

Psychoanalysis refers both to a theory of how the mind works and a treatment modality. It is based on the belief that people could be cured by making conscious their unconscious thoughts and motivations, thus gaining insight. The aim is to release repressed emotions and experiences (i.e., make the unconscious conscious).

Psychoeducation refers to the process of providing education and information to those seeking or receiving services and their family members.

This is a recall question which requires social workers to be familiar with a type of psychology which is rooted in the humanistic movement and has many similarities to the strengths perspective used by social workers. Positive psychology is a strengths-based approach to working with clients.

When the names of diagnoses, theories, or approaches are listed as response choices, it is often wise to think about each of the response choices listed *before* looking at the question. Getting the question correct relies on knowing about all the response choices. Whenever there is a gap in knowledge about one of the diagnoses, theories, or approaches listed, the likelihood of getting the question wrong increases. Knowledge should be used to try to narrow down the possibilities by eliminating incorrect response choices, leaving those that are candidates for selection.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**132. B.** Often values and ethics are terms that are used interchangeably. Though different, together they form the basis for making decisions. *Values are beliefs that a person holds about aspects of life and serve as guiding principles that influence behavior.* Every individual has a set of values through which the individual looks at all things and also at the world.

*Ethics refers to the guidelines for conduct or a system of moral principles.* For example, killing and rape are acts which violate a code of conduct which dictates what is wrong and what is right. When these ethics were not in place, no human behavior could be categorized as good or bad, which is what led to the development of these standards to guide human behavior in a society.

The question contains a qualifying word—BEST. While the incorrect response choices contain some true assertions about values and/or ethics, they do not contain the basic distinction that values are principles held by people to help guide behaviors while ethics are moral codes of conduct that decide what is wrong and what is right about these behaviors.

There is incomplete or inaccurate information contained in the incorrect response choices. For example, ethics can be unwritten and do not only apply to professional behavior. Values and ethical beliefs can also both change over time, though such changes often occur slowly.

### Question Assesses

#### Professional Values and Ethics

**133. B.** According to psychologist Jean Piaget, children progress through a series of four critical stages of cognitive development. Each stage is marked by shifts in how kids understand the world.

- Sensorimotor stage, from birth to age 2
- Preoperational stage, from age 2 to about age 7
- Concrete operational stage, from age 7 to age 11
- Formal operational stage, begins at age 11 and spans into adulthood

According to Piaget, children in the preoperational stage of cognitive growth (ages 2–7) use magical thinking until they learn the properties of physics and reality—a trial and error process that takes years. Little

children do indeed have a hard time drawing the distinction between what is real and what is not, and they sometimes get confused and think that what occurs in their heads is happening in the outside world. Children do not make these errors because they are delusional or confused about the rules of the physical world. The more likely reason that imagination and fact can blend together is that little kids have acute powers of perception—they are experts at seeing, hearing, feeling, thinking, and imagining—but they cannot reflect on those perceptions. In other words, they think a lot, but they do not yet think about thinking. When adults wake up from a scary dream, the primitive brain feels the emotion, but advanced reasoning puts it in context. Kids, on the other hand, operate more from the gut, with less contemplation or insight about what they have experienced.

Around the age of 4, kids turn a corner and become more aware of their own perceptions and more astute about distinguishing appearance and reality, even though it is a process that takes time to truly sink in. One theory for why this happens is that the right brain, which processes perceptions, and the left brain, which analyzes them, start to communicate better with each other, leading to a higher level of insight for kids in the later preschool years.

This is a recall question which relies on social workers understanding stages of cognitive development. Even when theorists are not explicitly stated in questions, correct answers require knowledge of their specific work. For example, being familiar with the work of Kohlberg on moral reasoning, Piaget on cognitive development, and Erikson on psychosocial development can assist with narrowing down response choices to identify the correct answers to questions in their respective areas of development.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 134. B.** For a client to be diagnosed with gender dysphoria, the client must exhibit a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by six (or more) of the following for at least 6 months:

- Repeatedly stated desire to be the other sex (*must be present*)

- In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
- Strong and persistent preferences for cross-gender roles in make-believe play or persistent fantasies of being the other gender
- A strong rejection of toys/games typically played by one's gender
- Intense desire to participate in the stereotypical games and pastime of the other gender
- Strong preference for playmates of the other gender
- A strong dislike of one's sexual anatomy
- A strong desire for the primary (e.g., penis, vagina) or secondary (menstruation) characteristics of the other gender

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other gender, frequently passing as the other gender, desire to live or be treated as the other gender, or the conviction of having the typical feelings and reactions of the other gender.

Gender dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender dysphoria is not concurrent with a physical intersex condition.

There is a specifier for gender dysphoria in the *DSM*—post-transition, that is, the client has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is undergoing) at least one medical procedure or treatment regimen, namely—hormone treatment or gender reassignment surgery—confirming the desired gender.

The question seeks the criterion that “must” be present. Dislike of one’s sexual anatomy and preference for clothing and playmates of the other gender are indicators of gender dysphoria, but do not have to be present. The only criterion that must be present is that the client must want to be the other gender or believe to be the other gender.

“Gender nonconforming” is a broader term that can include clients with gender dysphoria, but it can also describe those who feel that they are neither only male nor only female. “Transgender” is an umbrella term for clients whose gender identity and/or expression is different from cultural expectations based on the gender they were assigned at birth. Being

transgender does not imply any specific sexual orientation. Clients may be straight, gay, lesbian, bisexual, and so on.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 135. B.** Effective discharge planning and appropriate post-discharge care are key for client well-being. Discharge planning usually begins early in treatment or clients' inpatient stays. In general, discharge planning is conceptualized as having four steps: (a) assessment; (b) development of plans; (c) provision of service, including providing education and making service referrals; and (d) follow-up/evaluation.

Discharge summaries serve as the primary documents communicating clients' care plans. Often discharge summaries are the only communication with subsequent client care settings. High-quality discharge summaries are generally thought to be essential for promoting client safety when returning home or going to other settings.

While the format of discharge summaries varies across settings, there are some required components:

1. Reason for admission
2. Significant findings
3. Procedures and treatment provided
4. Discharge condition and prognosis
5. Client and family instructions (as appropriate)—including needed services by other providers

Discharge summaries also should be signed by medical or other treating professionals.

The question is seeking the response choice that "accurately describes the appropriateness" of including the material mentioned. Each response choice must be read carefully and evaluated individually. The correct answer is identified through the process of elimination, with response choices containing inaccuracies excluded.

### **Question Assesses**

## Assessment, Diagnosis, and Treatment Planning

- 136. B.** Mirroring is a technique used to gain rapport at the unconscious level. Mirroring, as the name suggests, means copying another person's gestures, tone of voice, or even catchphrases. Mirroring has numerous benefits provided social workers carry it out properly.

One reason that spiders are hated, but other mammals are not, is that mammals look much more like people than insects. Individuals are hard-wired to like and feel comfortable around other humans.

When mirroring, social workers try to convince the subconscious mind of clients that they are like them. If it works, clients feel comfortable without knowing why. In mirroring, social workers copy the gestures of clients consciously with the goal of making them feel comfortable, even if they did not feel that way initially. Mirroring requires copying their gestures, using the same tone, or talking about common interests in a manner that is slow enough to make it unnoticeable to their conscious mind. There are other features that can be mirrored using neurolinguistic programming such as blinking rate, facial expressions, or tension in the muscles of the person. Even repeating words can lead to successful mirroring. For instance, if clients say "yes" social workers say "yes," they say "no" social workers say "no," and so on. The key is to do it very moderately and occasionally, without making clients suspicious.

If social workers want to make sure that mirroring was successful and clients are feeling comfortable, they can assume a new gesture. If clients unconsciously copy, then mirroring has been successful.

There are other verbal communication techniques.

*Clarifying* uses questioning, paraphrasing, and restating to ensure full understanding of clients' ideas and thoughts, including formulation of the existing problem.

*Reframing* shows clients that there are different perspectives and ideas that can help to change negative thinking patterns and promote change.

Selecting the correct answer requires knowledge of the verbal and nonverbal communication techniques listed. The question is asking about a "nonverbal technique." Mirroring is the only technique that includes nonverbal communication. In addition, the sole function of mirroring is rapport building while the other techniques focus more on

gathering information, ensuring understanding of information provided, or challenging negative thinking.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 137. A.** Social workers should be aware of the effects policies, procedures, regulations, and laws have on practice. Many of these impacts concern choices made based on equality and equity. While there is a common misconception that equity and equality mean the same thing and that they can be used interchangeably, they cannot as there is an important distinction between them. The idea of equality is that everyone should receive the same treatment and opportunities, a notion that is fundamental to democracy and the belief that everyone should benefit from the fruits of a good society.

However, when a society is stratified into poles of advantage and disadvantage, with the inevitable consequences of privilege and exclusion, the notion of equal access is just an ideal and does not exist in reality. Fair access, then, may take on a different meaning than equal access and opportunity. Rather than fairness occurring from uniform distribution (equality), where there is an entitlement to the same amount, there may be a need to level the playing field. In other words, equity is concerned with fairness by remedying historic injustices that have prevented or diminished access in the first place.

Policies aimed at ensuring that everyone can have access to the same opportunities (equity) provide more resources to those who need them.

Fidelity is the quality of being loyal or faithful.

This is a recall question which relies on social workers understanding the values used in making decisions about policies, procedures, regulations, and laws. It requires knowing the definitions of each of the words listed as response choices.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 138. C.** The severity of an alcohol use disorder is based on the number of criteria met. The severity of the alcohol use disorder is defined as: mild (presence of 2–3 symptoms), moderate (presence of 4–5 symptoms),

or severe (presence of six or more symptoms). This is a recall question which relies on social workers understanding the severity of the impairment due to alcohol use disorder. In the scenario, the client has six or more signs, indicating severe impairment.

The following six criteria were explicitly described:

1. Drank more than intended
2. Wanted to cut down drinking, but could not
3. Spent a lot of time drinking
4. Had employment troubles due to drinking
5. Continued to drink even though it caused marital breakup
6. Engaged in risky behavior (walking in the street) when drinking

Alcohol intoxication is a harmful physical condition caused when more alcohol than the body can handle is ingested and can include alcohol poisoning. Alcohol dependence is the medical term used to describe use of alcohol that continues even when significant problems related to their use have developed. Alcohol dependence is not a current *DSM* diagnosis as the reliance on alcohol is included in alcohol use disorder.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 139. A.** Ethnography affords social workers a powerful and unique vehicle for obtaining an in-depth, contextualized understanding of clients' perspectives and experiences necessary for effective social work practice and advocacy. Unlike other forms of social inquiry such as surveys, interviews, and analysis of administrative databases, a hallmark of ethnographic research is sustained engagement in clients' lives. Participant observation is a qualitative method with roots in traditional ethnographic research, in which the objective is to help social workers learn the perspectives held by clients. As qualitative researchers, social workers presume that there will be multiple perspectives within any given community. They are interested both in knowing what those diverse perspectives are and in understanding the interplay among them. Qualitative researchers accomplish this through observing and participating, to varying degrees, in a community's daily

activities. Participant observation always takes place in community settings, in locations believed to have some relevance to the issues at hand. The method is distinctive because social workers approach participants in their own environment. Social workers who engage in participant observation try to learn what life is like for “insiders” while remaining, inevitably, as “outsiders.”

While in these community settings, social workers make careful, objective notes about what they see, recording all accounts and observations as field notes in a field notebook. Informal conversation and interaction with members of the study population are also important components of the method and should be recorded in the field notes, in as much detail as possible. Information and messages communicated through mass media such as radio or television may also be pertinent and thus desirable to document.

The question contains a qualifying word—BEST. The question asks for the method which is used with “an ethnographic approach.” Social workers need to know the meaning of “ethnographic,” including basic research methods which would be consistent with this inquiry. Participant observation approaches have historically been important components of ethnographic research.

The incorrect response choices are all research terms, but do not relate to ethnography in any way.

Experimental design is a blueprint that enables the testing of hypotheses by reaching valid conclusions about relationships between independent and dependent variables. It refers to the conceptual frameworks within which experiments are conducted.

Self-administered questionnaires are data collection instruments, either in paper or electronic form, which respondents complete on their own.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 140. C.** The mission of the profession is rooted in a set of social work core values. These core values, embraced by social workers throughout the profession’s history, are the foundation of social work’s unique purpose and perspective and include:

Service—providing help and resources to help others achieve their maximum potential

- Social justice—ensuring equal rights, protections, and opportunities for
- Dignity and worth of the person—believing everyone is valuable
- Importance of human relationships—understanding how interactions be used
- Integrity—being trustworthy
- Competence—providing services within skills and abilities

This constellation of core values reflects what is unique to the social work profession.

Unconditional positive regard is a term used by humanist psychologist Carl Rogers to describe a technique used in his nondirective, client-centered therapy. According to Rogers, unconditional positive regard involves showing complete support and acceptance of a client no matter what that person says or does. It is the ability to view a client as being worthy of being cared about and as someone who has strengths and achievement potential. It is built on respect and is usually communicated nonverbally.

Social workers accept and support clients, no matter what they say or do, placing no conditions on this acceptance. It means caring for clients as separate people, with permission to have their own feelings and experiences. Rogers firmly believed every person was born with the potential to develop in positive, loving ways. Through the provision of services, social workers become clients' next chance, maybe their last chance, to be welcomed, understood, and accepted. Acceptance creates the conditions needed for change.

This is a recall question which relies on social workers knowing both the core social work values and the meaning of unconditional positive regard. Self-determination is not a core social work value, so it should be eliminated as a possible correct response. The correct answer distinguishes itself from the other choices as the dignity and worth of an individual are directly related to the notion of unconditional acceptance and support. Social workers should accept and support clients, no matter what they say or do, placing no conditions on this acceptance. This goal can only be accomplished if there is true belief in the dignity and worth of all humans.

## **Question Assesses**

### Professional Values and Ethics

- 141.** **A.** Dyspareunia is sexual dysfunction characterized by pain that occurs during sexual intercourse. It is not a disease but rather a symptom of an underlying physical or psychological disorder. The pain, which can be mild or severe, may occur in the genitals, the pelvic region, or the lower back. The condition is much more common among women than among men. Treatment for dyspareunia is aimed at identifying and properly treating the underlying disorder.

There are many potential causes of dyspareunia including vaginismus (a condition characterized by involuntary spasms of the vaginal muscles), insufficient vaginal lubrication, scars from an episiotomy (an incision made to facilitate childbirth), thinning and dryness of the vaginal wall due to estrogen deficiencies accompanying menopause or breastfeeding, and inadequate foreplay. Conditions that may cause pain upon vaginal penetration include, but are not limited to, pelvic inflammatory disease, ovarian cysts, and endometriosis. Other causes include infections, such as sexually transmitted diseases, which may irritate the vaginal walls; bladder or other urinary tract disorders such as cystitis or urethritis; cancer in the sex organs or the pelvic region; arthritis (especially in the lower back); and allergic reaction to clothes, spermicides or latex in condoms, and diaphragms.

For men, dyspareunia can result from such disorders as irritation of the skin of the penis due to an allergic rash; sexually transmitted diseases, which may irritate the skin of the penis; physical abnormalities of the penis; and infections of the prostate gland or testes.

This is a recall question about sexual dysfunction. It is necessary to know both general key concepts and specific terms associated with all of the KSAs. Terms do not need to be recalled from memory, but there should be a general familiarity with them because of studying so that they can be matched to definitions. All the response choices, except the correct one, are not associated with sexual dysfunction. Thus, knowing that this is a term to describe a sexual issue would be sufficient to select the correct answer even if its exact meaning is unknown.

## **Question Assesses**

### Assessment, Diagnosis, and Treatment Planning

**142. B.** Object permanence is the understanding that objects continue to exist even when they cannot be observed (seen, heard, touched, smelled, or sensed in any way). Object permanence occurs during the first of Piaget's four stages, the sensorimotor stage. Piaget assumed that a child could only search for a hidden toy if she or he had a mental representation of it. Piaget found that infants searched for hidden toys when they were around 8 months old.

Object permanence typically starts to develop between 4 and 7 months of age and involves a baby's understanding that when things disappear, they are not gone forever. Before a baby understands this concept, things that leave his view are gone, completely gone. Developing object permanence is an important milestone. It is a precursor to symbolic understanding (which a baby needs to develop language, pretend play, and exploration) and helps children work through separation anxiety.

The question requires knowledge of cognitive development, including key milestones. Research suggests that development of object permanence may begin before 4 months and be in place earlier than Piaget originally hypothesized. However, 8 months is the best response choice as object permanence is clearly developed by 18 months and "typically" associated with infancy, rather than toddlerhood.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**143. A.** Techniques of interviewing should be tailored to the specifics of a client, not generic, "one size fits all" inquiries. The focus is on the uniqueness of a client and the client's unique situation.

The purpose of the social work interview can be informational, diagnostic, or therapeutic. The same interview may serve more than one purpose.

Communication during a social work interview is interactive and interrelational. A social worker's questions will result in specific responses by a client that, in turn, lead to other inquiries. The message is formulated by a client, encoded, transmitted, received, processed, and decoded. The importance of words and messages may be implicit (implied) or explicit (evident).

There are several techniques that a social worker may use during an interview to assist clients.

*Confrontation* occurs when social workers call attention to clients' feelings, attitudes, or behaviors, often when there is inconsistency in them. Confrontation can be very effective when there is a need to highlight feelings, attitudes, or behaviors which may be useful to the therapeutic process.

*Interpretation* occurs when social workers pull together patterns of behavior to get a new understanding of client situations or problems.

*Clarification* uses questioning, paraphrasing, and restating to ensure full understanding of clients' ideas and thoughts, including formulation of the existing problem.

This is a recall question that relies on social workers knowing techniques of interviewing. In the scenario, there is a lack of congruence between the wife's beliefs and actions. Congruence is the matching of awareness and experience with communication. It is essential that clients can express themselves and that this communication is reflective of clients' feelings. Congruence is essential for the vitality of a relationship and to facilitate true helping as part of the problem-solving process. In the scenario, confrontation of the wife's actions by the social worker may assist her in seeing that her perceptions are not supported by the observed interactions during the sessions.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 144. A.** The problem-solving model is based on the belief that an inability to cope with a problem is due to some lack of motivation, capacity, or opportunity to solve problems in an appropriate way. Clients' problem-solving capacities or resources are maladaptive or impaired. The goal of the problem-solving process is to enhance the client's mental, emotional, and action capacities for coping with problems and/or making accessible the opportunities and resources necessary to generate solutions to problems. A social worker engages in the problem-solving process via the following steps—engaging, assessing, planning, intervening, evaluating, and terminating.

The question contains a qualifying word—FIRST—that is capitalized to stress the importance of the order in which the actions should occur. When response choices represent actions that social workers would take throughout the helping process, using the problem-solving model (also called the planned change or helping process) can be extremely helpful in determining their order.

Providing therapy is an intervention. The correct answer, determining what has been done before to address the problem, takes place during engagement and assessment—both of which precede intervention. Anxiety disorders do not go away and require psychotherapy, medication, or both. It is likely that the client in the scenario has a treatment history that can be useful in learning about what has worked and not worked in the past. There is no indication of risk for self-harm as the client states that he wants to change and is relying on the social worker to help him start the process.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 145. A.** Professional objectivity in social worker-client relationships is critical. This objectivity can be compromised if there is a conflict of interest in relationships with clients. A conflict of interest is a situation where regard for one duty may lead to disregard of another. When faced with potential or actual conflicts of interest, it is important that social workers consider the perceptions of others (clients, colleagues, the community, employers, and so on). It is important, therefore, that social workers are proactive in avoiding conflicts of interest and discuss any actual conflicts of interests with supervisors or employers so that they can be resolved. Dual relationships should never be entered into knowingly even if social workers feel that they can manage the potential conflicts or feel that there are no significant issues.

While the mother in this scenario has considerable confidence in the child's social worker, there is an apparent conflict of interest for the social worker in supervising the child's visits with the father. The social worker will be expected to provide feedback to the court concerning the need for ongoing supervision of the dad's contact with his daughter. The objectivity in writing the report may be or could be perceived as being impaired by virtue of the preexisting treatment role with the child. Thus,

even if the child and father are comfortable with the social worker taking on this additional role, it is inadvisable for legal and ethical reasons.

### **Question Assesses**

#### Professional Values and Ethics

**146. B.** Reflective listening is a valuable method used to facilitate communication. Reflective listening is at times used interchangeably with active or empathic listening. This technique is a way of listening and responding to clients that improves mutual understanding and trust. Reflective listening is an essential skill and critical to the therapeutic process. Empathic listening builds trust and respect with clients by enabling them to share their emotions and reduce tensions. It encourages the surfacing of information and creates “safe” environments that are conducive to collaborative problem solving. When engaging in empathic listening, social workers should:

- Concentrate on not talking and pay attention while looking directly at clients
- Prepare their replies
- Ask for time to respond if needed
- Pay attention to how the person is behaving nonverbally (e.g., yelling, screaming and not making eye contact)
- Demonstrate listening by nodding or shaking head
- Paraphrase or translate what is said; reflect it back
- Recognize client feelings (“you seem to be frustrated,” “you sound angry,” “you seem to be upset”)
- Be attentive, interested, nonjudgmental, and noncritical
- Avoid interrupting, changing the subject, interrogating, teaching, and giving advice

Selecting the correct answer requires knowledge that reflective listening is a communication strategy involving two key steps: seeking to understand client ideas and then offering the ideas back to them to confirm they have been understood correctly. *Reflective listening attempts to reconstruct what clients are thinking and feeling and to relay this understanding back.* While used interchangeably at times with active listening, reflective listening is a more specific strategy than the

more general methods of active listening. It arose from Carl Rogers' school of client-centered therapy in counseling theory.

The incorrect response choices either do not reflect good listening skills (anticipating what should be said next) or are not related to listening at all (helping clients to understand social work roles).

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 147.** **A.** Interdisciplinary collaboration is a necessary yet challenging social work activity. When multiple agencies which work with clients act independently of each other, the result is that clients are subject to fragmented services, none of which address clients as whole individuals. A shared vision among collaborators facilitates strategies to achieve common goals. The biggest benefit of collaboration among agencies is the improved well-being of clients.

Collaboration among agencies is the key to preventing fragmentation. In addition to reducing the likelihood of clients falling through the cracks between disparate and unconnected agencies, collaboration fosters a more holistic view of clients. With effective collaboration, service providers recognize differing viewpoints through their contact with professionals with expertise in different areas. In addition to decreasing paperwork and minimizing fragmentation, this process could help to strengthen linkages and communication among various agencies providing different services to meet clients' varying needs.

While the benefits listed in the incorrect response choices may result from collaborations between service providers, the correct answer to any question on the examination is always the one which speaks to enhancing the well-being of clients. Interdisciplinary service collaborations can foster innovation and lead to enhanced effectiveness. However, they predominantly exist to bring together professionals from different professions or disciplines. The multifaceted training and experience of these providers helps to ensure that all client needs are addressed. The correct answer is the only one that references the needs of clients across life domains, which is the principal reason for taking an interdisciplinary approach.

### **Question Assesses**

## Psychotherapy, Clinical Interventions, and Case Management

**148.** **A.** A phobia is an anxiety disorder involving a persistent fear of an object, place, or situation disproportional to the threat or danger posed by the object of the fear. The person who has the phobia will go to great lengths to avoid the object of the fear and experience great distress if it is encountered. These irrational fears and reactions must result in interference with social and work life to meet the *DSM* criteria. There are five subtypes of specific phobia: animal (including the fear of snakes, spiders, rodents, and dogs), natural environment (including the fear of heights, storms, water, and the dark), blood-injection-injury (including the fear of blood, injury, needles, and medical procedures), situational (including the fear of enclosed spaces, flying, driving, tunnels, and bridges), and other. The anxiety must be “out of proportion” to the threat, considering the environment and situation. Social phobia, involving fear of social situations, is a separate disorder.

A client who has a specific phobia disorder experiences significant and persistent fear when in the presence of, or anticipating the presence of, the object of fear, which may be an object, place, or situation.

The *DSM* criteria for a specific phobia disorder are:

- There is a marked and out-of-proportion fear within an environmental context to the presence or anticipation of a specific object or situation.
- Exposure to the phobic stimulus provokes an immediate anxiety response which may take the form of a situationally bound or situationally predisposed panic attack.
- There is recognition that the fear is out of proportion.
- The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- The avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person’s normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

The *DSM* criteria state that the symptoms for all ages must have a duration of at least 6 months. The anxiety, panic attack, or phobic avoidance associated with the specific object or situation must not be better accounted for by another mental disorder.

Many different types of medications are used in the treatment of anxiety disorders, including traditional antianxiety drugs such as benzodiazepines. Because they work quickly—typically bringing relief within 30 minutes to an hour—they are very effective when taken during a panic attack or another overwhelming anxiety episode. However, they can be physically addictive and need to be closely monitored.

This question requires determining the correct diagnosis for the client in the scenario. Based on the information provided, it appears that the client has a specific phobia disorder, natural environment type. This diagnosis, which is an anxiety disorder, is best treated with antianxiety medications. Thus, the response choices must be reviewed, and the drugs should next be classified into one of four major types—antipsychotics, mood stabilizers, antidepressants, or antianxiety medications. Ativan is the only antianxiety drug listed, making it the correct response choice.

Risperdal is an antipsychotic medication which is used to control hallucinations and delusions. Tegretol is a mood stabilizer used for the treatment of bipolar disorder.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 149. B.** There are many formats for the recording of case notes. Case notes document activity and client progress. They help social workers identify effective and ineffective treatment strategies. In addition, if auditors, advocates, or supervisors look at files, they need to be able to get clear pictures of clients and learn what has been done, what is working, and what areas need attention. In addition, without good, clear case notes, it can be next to impossible for successful client transition to other professionals should it be needed.

Subjective, objective, assessment, plan (SOAP) is a format used predominantly in health care facilities. The subjective section includes clients' reported symptoms, and the objective section contains test and exam results. The assessment section includes conclusions and impressions based on the first two sections. The plan section explains the next steps, including the need for treatment, medication, and/or further testing.

Another format is referred to as DAP. This format is similar to SOAP except that both subjective and objective data are included in the same section. DAP is an acronym that stands for data, assessment, and plan. The data section includes contact information for clients, subjective and objective data, and observational notes. Subjective data is a summary of information given by clients and may include direct quotes. Objective data includes information often gleaned from direct observation or other sources, including body movements, facial expressions, test results, and so on. The assessment is a summary based on subjective and objective information collected. The last section is the treatment plan, including any referrals or interventions that have been completed or are recommended.

Another popular problem-based case recording format is assessed information, problem addressed, interventions provided, and evaluation (APIE). The first section includes documentation of assessed information with regard to clients' problems while the second is an explanation of problems that are to be addressed. These sections are followed by intervention descriptions and plans and evaluations of problems once interventions are complete, respectively.

The question contains a qualifying word—MOST. While the client may be using another model, the scenario only describes three distinct sections, making DAP the probable model. SOAP includes both the assessment and plan as separate sections, but it also separates the subjective information from the objective data. Therefore, there are four separate components of a case record. APIE contains information on evaluation findings, which are not mentioned in the social worker's notes in this question.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 150. C.** Confidentiality is a cornerstone of healthy therapeutic relationships and effective treatment and is based upon the ethical principles of autonomy and fidelity and, to a lesser degree, beneficence and nonmaleficence. Autonomy assumes clients have the right to decide to whom they will reveal information, and confidentiality is based upon respect for clients' ability to choose what they disclose. Fidelity refers to social workers' faithfulness and loyalty to keep promises to clients, including not revealing information clients disclose. Social workers are also honest about limits of confidentiality, so clients can make informed

decisions about self-disclosure. Beneficence and nonmaleficence have an important role in confidentiality. Clients benefit when information is kept confidential and trusting relationships can be achieved. The disclosure of private information without client consent can do harm to therapeutic relationships even when such disclosures are mandated by law.

Issues of confidentiality are often complex, especially when group therapy is provided. Group psychotherapy is a powerful and curative method of psychological treatment, but issues of confidentiality are magnified at least as many times as there are group members. Not only is information revealed to social workers, information is also revealed to other group members, and there is no guarantee that other group members will maintain confidentiality. However, group members expect complete confidentiality and do not fully understand how confidentiality in group settings differs from confidentiality in individual therapy.

Informed consent is the process whereby clients learn about confidentiality. When group treatment is being provided, education regarding confidentiality should begin prior to entering the group. Potential group members should be informed that social workers may have to breach confidentiality in certain circumstances, and those circumstances should be fully explained. They should also be informed that social workers can assure confidentiality on their part (within the constraints of the law) but cannot promise that other group members will maintain confidentiality. Another important issue to discuss is the probable lack of privileged communication. Privileged communication does not usually exist in group settings due to the third-party rule, which states that information revealed in front of a third party was not intended to be private and is not privileged. Therefore, group members may be called to testify against their peers regarding information obtained in group sessions.

Confidentiality should be discussed openly, thoroughly, and often among group members. Maintaining confidentiality should be the goal for group members, and consequences for participation for those who breach confidentiality should be openly discussed. A common phrase used in group therapy is, "What is said in group—stays in group." However, absolute confidentiality in groups is difficult and often unrealistic.

This is a recall question which relies on social workers understanding the ethical standards related to the provision of group versus individual

therapy. For clients to make informed choices about what they disclose, it is critical that they understand the confidentiality standards which apply. The social worker cannot assure the client in this scenario that information disclosed will be kept confidential as there are no legal mandates which prohibit group members from sharing it with others. The client is participating in group therapy, not individual treatment, so it is not appropriate for the social worker to ask about the nature of the information outside of the group process. The group is the helping agent and concerns should be shared with all members, not the social worker individually. The correct answer provides the client with accurate information about confidentiality in group treatment and lets him make the decision on his own about whether to share it during the next session.

### **Question Assesses**

#### **Psychotherapy, Clinical Interventions, and Case Management**

- 151. A.** Contracts in social work specify goals to be accomplished and tasks to be performed to achieve these aims. They also set time frames for interventions and deadlines for completion of goals. They are agreements between social workers and clients and essential for positive outcomes. It is essential that goals contained in contracts be feasible. Unachievable goals set clients up for failure, which can lead to continued disappointment, disillusionment, and defeat. Chosen goals should be able to be accomplished. In instances where clients may have unrealistic expectations, social workers should assist them in realizing what is realistic.

There are many reasons that desired goals need to be examined and revised to be realistically achievable. In the scenario, the client has a limited number of sessions which will be paid by insurance coverage. It is premature for the social worker to advocate for additional sessions as there is no new information which would cause the insurance company to alter its decision. It is unfair for the client to think that the changes desired will occur in the time frame allotted. The client may become increasingly discouraged when goals are not achieved, jeopardizing motivation to reach desired outcomes. Lastly, making progress toward the target problem should not be abandoned completely as it was identified and prioritized through the assessment process. Instead, the social worker should tactfully work with the client to temper expectations about the amount of change that is possible in the fixed time frame.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 152.** **B.** Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should avoid accepting goods or services from clients as payment for professional services. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

While bartering in social work is extremely rare, the *NASW Code of Ethics* provides specific guidance about the criteria which must be met for bartering to occur. While these standards are located in provisions about payment for services, they speak to the potential that such financial arrangements have for inappropriate professional boundaries between social workers and clients.

Social workers—not clients—must demonstrate that bartering relationships are not detrimental and clients—not social workers—must initiate the request for bartering arrangements.

### **Question Assesses**

#### Professional Values and Ethics

- 153.** **B.** Family systems theory views issues and problems within a circular fashion, using what is described as a systemic perspective; this means that the event and the problem exist within the context of the relationship, where each influences the other. Family systems theory aims to assess these patterns of interactions and look at why things may be happening instead of why they happened.

Family systems theory considers the nature of relationships to be bidirectional and moves away from seeking blame of one person for the

dynamic of the relationship. *The exception to this theory is within abusive relationships, where the responsibility and blame lay clearly with the perpetrator of the abuse.*

Within family systems theory, behaviors are believed to arise due to the interrelated nature and connectedness of various family members. For example, to seek understanding of children in distress, their behavior would be viewed through the lens of their family (parent-child) behaviors and family systems rather than looking at young persons in isolation. Adultery or infidelity, using a family systems approach, is seen as a “family affair” that should be understood and treated within the marital system rather than from an individual perspective. Social workers use marital therapy to understand the relational dynamics that led to and/or sustain affairs. They shy away from blame and focus on issues of intimacy, communication, expectations, agreements, and conflict management in the marriage.

This is a recall question about family dynamics and functioning. Social workers should understand family systems theory, as well as the dynamics of abuse. *Those abused should never be seen as contributing to or responsible for their abuse.* As the question asks about “blame for the dynamics” resting with specific individuals as opposed to resulting from the action of all parties, a belief contrary to a family systems approach, the correct answer must involve abuse of one person by another.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 154. A.** Cultural sensitivity refers to a set of skills used in social work practice that facilitates learning about and understanding clients whose cultural background may not be the same. Social workers should operate with the awareness that cultural differences exist between them and clients without assigning these differences a value. These differences are positive—not better or worse, right or wrong.

Being culturally sensitive does not mean being an expert in each culture’s values. It simply means a willingness to ask honest questions, seek understanding, and demonstrate empathy rather than judging. It also means that, when knowingly entering spaces in which there will be cultural differences at play, social workers should do a bit of homework beforehand and avoid jumping to conclusions.

The most important thing when being culturally sensitive is remembering to ground interactions in the understanding that clients' background, experiences, and values naturally vary from those of social workers. These differences should lead to understanding and empathy, rather than judgment.

This is a recall question which relies on social workers understanding the effect of culture, race, and ethnicity on behaviors, attitudes, and identity. The social worker is demonstrating respect and not assuming that the client would like to be called by a first name. Such action is an example of cultural sensitivity. Professional boundaries are the invisible structures which are imposed in therapeutic relationships. The question to the client is not indicative of a limit placed on the interactions between the client and social worker. Objectivity concerns examining issues truthfully and impartially. The social worker is not examining or viewing information—the social worker is simply asking a question.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 155. C.** Social workers should have basic research knowledge to evaluate the appropriateness of interventions and assist in decision making. The promotion of evidence-based research within social work is widespread. Evidence-based research gathers evidence that may be informative for clinical practice or clinical decision making. It also involves the process of gathering and synthesizing scientific evidence from various sources and translating it to be applied to practice.

The use of evidence-based practice places the well-being of clients at the forefront, desiring to discover and use the best practices available. The use of evidence-based practices (EBPs) requires social workers to only use services and techniques that were found effective by rigorous, scientific, empirical studies—that is, outcome research. Social workers should be willing and able to locate and use evidence-based interventions. In areas in which evidence-based interventions are not available, social workers should still use research to guide practice. Applying knowledge gleaned from research findings will assist social workers in providing services informed by scientific investigation and lead to new interventions that can be evaluated as EBPs.

When reading and interpreting experimental research findings, social workers should be able to identify independent variables (or those that

are believed to be causes) and dependent variables (which are the impacts or results). In many studies, the independent variable is the treatment provided and the dependent variable is the target behavior that is trying to be changed. The reliability and validity of research findings should also be assessed. Reliability is concerned with obtaining the same findings repeatedly when conditions are not altered. Validity focuses on accuracy. There are two types of validity—internal validity and external validity. Internal validity is the confidence that exists that the independent variable is the cause of the dependent variable and not extraneous factors. External validity is the extent to which the same results will be produced if the context or population is altered. It determines to what extent an intervention can be generalized.

This is a recall question which relies on social workers understanding key research terms and concepts. Such knowledge is essential to having a sufficient understanding of KSAs related to the use of measurable objectives, subjective and objective data, applying research to practice, and so on. In addition to being able to understand and explain the meaning of important research terminology, social workers should be versed in experimental and single-subject research designs.

### **Question Assesses**

#### Assessment, Diagnosis, and Treatment Planning

- 156. C.** Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Fear is more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors, and anxiety is more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors. *Panic attacks* are a type of fear response. Panic attacks are not limited to anxiety disorders, but rather can be seen in other mental disorders as well.

Obsessive-compulsive disorder (OCD) is in its own chapter with hoarding disorder, trichotillomania (hair-pulling), and so on. Acute stress disorder is grouped with trauma- and stressor-related disorders. Separation anxiety disorder is an anxiety disorder based on scientific evidence that links it with other disorders, such as selective mutism, specific phobia, social anxiety disorder, agoraphobia, and so on.

This is a recall question which relies on social workers knowing the *DSM* and its diagnoses. When studying for the examination, social workers do not need to memorize all the diagnostic criteria, but should know the defining or distinguishing feelings, thoughts, and behaviors associated with each disorder. Also, questions may ask about groupings of disorders—such as those which are neurodevelopmental, psychotic, depressive, and so on. Thus, being able to recall in which chapter particular disorders are listed can be helpful, such as is the case in this question.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 157. A.** Erikson's psychosocial theory of development considers the impact of various "crises" on personality development from childhood to adulthood. According to Erikson's theory, everyone must pass through a series of eight interrelated stages over the entire life cycle.

#### 1. Infancy

##### *Basic Trust Versus Mistrust*

During the first or second year of life, the major emphasis is on nurturing, especially in terms of visual contact and touch. A child will develop optimism, trust, confidence, and security if properly cared for and handled. If a child does not experience trust, the child may develop insecurity, worthlessness, and general mistrust of the world.

#### 2. Toddler/Early Childhood Years

##### *Autonomy Versus Shame and Doubt*

At this point, a child has an opportunity to build self-esteem and autonomy as the child learns new skills and right from wrong. The well-cared-for child has a good sense of self and pride rather than shame. Children tend to be vulnerable during this stage, sometimes feeling shame and low self-esteem during an inability to learn certain skills.

#### 3. Preschooler

##### *Initiative Versus Guilt*

During this period, a child experiences a desire to copy adults and take initiative in creating play situations. A child also begins to use that wonderful word for exploring the world—"Why?" If a child is frustrated over natural desires and goals, the child easily experiences guilt. The most significant relationship is with the basic family.

#### 4. School-Age Child

##### *Industry Versus Inferiority*

During this stage, a child is capable of learning, creating, and accomplishing numerous new skills and knowledge, thus developing a sense of industry. This is also a very social stage of development; if there are unresolved feelings of inadequacy and inferiority, there can be serious problems in terms of competence and self-esteem. As the world expands a bit, the most significant relationship is with the school and neighborhood. Parents are no longer the complete authorities they once were, although they are still important.

#### 5. Adolescence

##### *Identity Versus Role Confusion*

Adolescents must struggle to discover and find their own identity, while negotiating and struggling with social interactions and "fitting in," as well as develop a sense of morality and right from wrong. Some adolescents attempt to delay entrance to adulthood and withdraw from responsibilities. Those unsuccessful with this stage tend to experience role confusion and upheaval. Adolescents begin to develop a strong affiliation and devotion to ideals, causes, and friends.

#### 6. Young Adulthood

##### *Intimacy Versus Isolation*

At the young adult stage, people tend to seek companionship and love. Young adults seek deep intimacy and satisfying relationships, but if they are unsuccessful, isolation may occur. Significant relationships at this stage are with marital partners and friends.

#### 7. Middle Adulthood

##### *Generativity Versus Stagnation*

During this time, adults strive to create or nurture things that will outlast them, often by parenting children or contributing to positive changes

that benefit other people. Contributing to society and doing things to benefit future generations are important. Generativity refers to “making a mark” on the world through caring for others, as well as creating and accomplishing things that make the world a better place. Stagnation refers to the failure to find a way to contribute. Those who are successful during this phase will feel that they are contributing to the world by being active in their homes and communities. Others may feel disconnected or uninvolved. Some characteristics of stagnation include being self-centered, failing to get involved with others, not taking an interest in productivity, exerting no efforts to improve the self, and placing one’s concerns over above all else. It is at this point in life that some experience what is often referred to as a “midlife crisis” and feel regret. This might involve regretting missed opportunities such as going to school, pursuing a career, or having children. In some cases, this crisis is an opportunity to make adjustments that will lead to greater fulfillment.

## 8. Late Adulthood

### *Integrity Versus Despair—Wisdom*

The last stage involves much reflection. Some older adults look back with a feeling of *integrity*—that is, contentment and fulfillment—having led a meaningful life and made a valuable contribution to society. Others have a sense of despair during this stage, reflecting upon their experiences and failures. They may fear death as they struggle to find a purpose to their lives, wondering “What was the point of life? Was it worth it?”

This is a recall question which relies on social workers understanding the stages of psychosocial development. The scenario provides the age of the client, as well as his struggles—both of which can assist with distinguishing the correct answer from the incorrect ones.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 158. C.** An ethical dilemma is a predicament in which a social worker should decide between two viable solutions that seem to have similar ethical value. Sometimes two viable ethical solutions can conflict with each other. Social workers should be aware of any conflicts between personal and professional values and deal with them responsibly. In

instances where social workers' ethical obligations conflict with agency policies or relevant laws or regulations, they should make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in the *NASW Code of Ethics*.

In order to resolve this conflict, ethical problem solving is needed. There are six essential steps in ethical problem solving:

1. Identify ethical standards, as defined by the professional code (which are being compromised (always go to the code of ethics first) rely on a supervisor or coworkers)
2. Determine whether there is an ethical issue or dilemma
3. Weigh ethical issues in light of key social work values and principles defined by the code of ethics
4. Suggest modifications in light of the prioritized ethical values and principles that are central to the dilemma
5. Implement modifications in light of prioritized ethical values and principles
6. Monitor for new ethical issues or dilemmas

The question contains a qualifying word—NEXT. Its use indicates that the order in which the response choices should occur is critical. Knowledge of the sequential steps in the ethical problem-solving process is needed. The question states that there is already a realization that an ethical dilemma exists. Once the issue has been identified, social workers should next weigh ethical issues considering key social work values and principles.

Seeking supervision is a practical response choice which is incorrect as it does not represent a step in the ethical problem-solving model. Social workers often seek supervision when they are not sure of the correct course of action. The examination expects social workers to have knowledge about the proper actions to take based on best practices in the field. Social workers cannot choose a correct course of action based on prioritized ethical values until they have been weighed considering existing principles. Thus, this action will occur after the one specified in the correct answer.

### **Question Assesses**

## Professional Values and Ethics

- 159.** **A.** Alcohol withdrawal is a potentially life-threatening condition that can occur in clients who have been drinking heavily for weeks, months, or years and then either stop or significantly reduce their alcohol consumption. Alcohol Withdrawal symptoms can begin as early as 2 hours after the last drink, persist for weeks, and range from mild anxiety and shakiness to severe complications, such as seizures and delirium tremens (DTs). DTs are characterized by confusion, rapid heartbeat, and fever.

Because alcohol withdrawal symptoms can rapidly worsen, it is important for clients to seek medical attention even if symptoms are seemingly mild. Appropriate alcohol withdrawal treatments can reduce the risk of developing withdrawal seizures or DTs.

Prescription drugs of choice include benzodiazepines, such as diazepam (valium), chlordiazepoxide (librium), lorazepam (ativan), and so on. Such medications can help control the shakiness, anxiety, and confusion associated with alcohol withdrawal and reduce the risk of withdrawal seizures and DTs. In clients with mild to moderate symptoms, anticonvulsant drugs may be an effective alternative to benzodiazepines, because they are not sedating and have low potential for abuse.

*Because successful treatment of alcohol withdrawal does not address the underlying disease of addiction, it should be followed by treatment for alcohol abuse.* Relatively brief outpatient interventions can be effective, but more intensive therapy may be required. Services range from 12-step groups—such as Alcoholics Anonymous and Narcotics Anonymous—to residential treatment that offers a combination of cognitive behavioral and family therapy.

The question is asking about alcohol withdrawal—not the treatment of the underlying disorder. Alcohol withdrawal focuses on reducing the effects of the symptoms and medically monitoring them for serious health implications. Medications are used to help shakiness, anxiety, and confusion. Thus, psychopharmacology is the treatment of choice to address them. The incorrect response choices are effective treatments for the underlying disease and relapse prevention, which occur after withdrawal symptoms have been addressed.

### Question Assesses

## Assessment, Diagnosis, and Treatment Planning

- 160. A.** Privileged communication is a legal right, existing by statute or common law, which protects clients from having confidences revealed publicly from witnesses stand during legal proceedings. Certain professionals, including social workers, cannot legally be compelled to reveal confidential information they received from their clients. The privilege protects clients, and the right to exercise privilege belongs to clients, not to professionals.

There are four conditions that are generally accepted as being necessary for a communication to be considered privileged:

1. The communication must originate in the confidence that it will not disclosed.
2. The element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties.
3. The relationship must be one that in the opinion of the community ought to be fostered.
4. The injury to the relationship caused by disclosure must be greater than the benefit gained through disclosure for the correct disposal of litigation

The landmark Supreme Court decision on the protection of psychotherapist-client privilege is *Jaffee v. Redmond*, 518 U.S. 1 (1996). The case created the right for federal litigants and witnesses to keep their private psychotherapy records out of the courtroom, rejecting an approach that would have permitted federal judges to review and weigh the value of the potential evidence excluded under the privilege.

The *Jaffee* decision is notable in several respects. For social workers, it is a landmark ruling recognizing the professionalism and relevance of social workers providing psychotherapy in today's mental health treatment milieu. For trial lawyers and their clients, *Jaffee* presented a new rule of evidence, drawing a bright line around a certain type of evidence that is inaccessible for legal probing. For mental health clients, the case bolsters the wall of protection afforded to the intimacy of the therapeutic relationship. Although *Jaffee* is only directly applicable to cases filed in federal court, many states have had occasion to review the *Jaffee* decision as they decide similar matters under their jurisdiction.

The question contains a qualifying word—BEST. While all the response choices relate to client privacy, only the correct answer mentions privilege being a legal term which aims to keep communication from being disclosed in court proceedings.

Best practice for social workers is to get clients' written consent when releasing information, though verbal consent is acceptable in certain situations. Often treatment information of minors cannot be withheld from parents, though laws vary across states/jurisdictions given the ages of minors and types of treatment received. This response choice is also incorrect as it is not related to privilege but concerns instead another important privacy topic.

### **Question Assesses**

#### Professional Values and Ethics

- 161. B.** A forensic interview of a child is a developmentally sensitive and legally sound method of gathering factual information regarding allegations of abuse or exposure to violence. This interview is conducted by a competently trained, neutral professional, such as a social worker, utilizing research and practice.

A forensic interview is one component of a comprehensive child abuse investigation, which includes, but is not limited to, the following disciplines: law enforcement and child protection investigators, prosecutors, child protection attorneys, victim advocates, and medical and mental health practitioners. *Forensic interviewing is a first step in most child protective services investigations, one in which a professional interviews a child to find out if the child has been maltreated. In addition to yielding the information needed to decide whether abuse or neglect has occurred, this approach produces evidence that will stand up in court if the investigation leads to criminal prosecution.* Properly conducted forensic interviews are legally sound in part because they ensure the interviewer's objectivity, employ nonleading techniques, and emphasize careful documentation of the interview.

A fuller understanding of forensic interviewing and its role in child welfare can be gained by comparing it with social work interviewing, another type of interviewing commonly used by child welfare workers. The social work interview allows social workers to assess and identify a family's strengths and needs and develop a service plan with the family.

This broad, versatile approach incorporates the use of a variety of interviewing techniques. Social work interviewing is used at every step of child welfare, from intake through closure; it is used with individuals, groups, children, and adults.

Although it employs some of the same techniques as the social work interview, such as open-ended and forced-choice questions, the forensic interview is much more focused. Generally, it is used only during the assessment portion of an investigation and involves only the children who are the subject of the investigation. Forensic denotes the scientific methods and techniques used in the investigation of crime. Its use relates to the collection of evidence used for prosecution. This question requires social workers to be knowledgeable about legal terms and the distinction between forensic and social work interviewing.

### **Question Assesses**

#### Professional Values and Ethics

- 162. A.** Maslow's hierarchy of needs is a motivational theory comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. Maslow stated that people are motivated to achieve certain needs and that some needs take precedence over others. The most basic need is for physical survival, which will be the first thing that motivates behavior. This five-tier model can be divided into deficiency needs and growth needs. The first four levels are often referred to as deficiency needs and the top level is known as growth needs. Growth needs can never be satisfied completely. They consist of the need to know and understand. They are linked to self-actualization.

Deficiency needs are said to motivate people when they are unmet. Also, the need to fulfill such needs will become stronger the longer the duration they are denied. Lower-level deficit needs must be satisfied before progressing on to meet higher level growth needs. When a deficit need has been satisfied it will go away, and our activities become habitually directed toward meeting the next set of needs that we have yet to satisfy. These then become our salient needs. However, growth needs continue to be felt and may even become stronger once they have been engaged.

Often the names of theorists are not mentioned in questions. However, reasoning using their work is essential to successfully select the correct answers. Maslow's hierarchy of needs can be divided into basic (or

deficiency) needs (i.e., physiological, safety, social, and esteem) and growth needs (i.e., self-actualization). “Deficiency needs” arise due to deprivation, according to Maslow.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 163. B.** Social workers’ ethical responsibilities include those related to payment for services. When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients’ ability to pay. Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers’ relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client’s initiative and with the client’s informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client. Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

*Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers’ employer or agency.*

This is a recall question which requires social workers to select the unethical action “according to the professional code of ethics.” While the examination will never refer directly to the *NASW Code of Ethics* as

there are other professional organizations with ethical mandates, it is helpful to read the *NASW Code of Ethics* and remember its standards when choosing between response choices. Most questions on the examination will focus on the first section, which addresses social workers' ethical responsibilities to clients. The correct answer is always the one which most closely mirrors the standard which is explicitly stated in the *NASW Code of Ethics*.

### **Question Assesses**

#### Professional Values and Ethics

- 164.** **C.** According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, to meet the criteria for diagnosis of schizophrenia, a client must have experienced at least two of the following symptoms:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

At least one of the symptoms must be the presence of delusions, hallucinations, or disorganized speech.

Continuous signs of the disturbance must persist for at least 6 months, during which the client must experience at least 1 month of active symptoms (or less if successfully treated), with social or occupational deterioration problems occurring over a significant amount of time. These problems must not be attributable to another condition.

Treatments for schizophrenia are aimed at reducing or eliminating symptoms such as hallucinations, delusions, and jumbled speech. There is, however, no cure for schizophrenia. Most clients will require both medications and psychotherapy. Antipsychotics are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, paranoia, or disordered thought), principally in schizophrenia. However, their long-term use is associated with significant side effects such as involuntary movement disorders and metabolic syndrome.

This question requires determining the correct diagnosis for the client in the scenario. Based on the information provided, it appears that the client has schizophrenia. This diagnosis is listed in the *DSM* with schizophrenia spectrum and other disorders, such as delusional disorder, brief psychotic disorder, schizophreniform disorder, schizoaffective disorder, and so on. These disorders are generally treated with antipsychotic medications. Thus, the response choices must be reviewed, and the drugs must next be classified into one of four major types—antipsychotics, mood stabilizers, antidepressants, or antianxiety medications. Clozaril is the only antipsychotic drug listed, making it the correct response choice.

Prozac are antidepressant medications while lithium is a mood stabilizer used for the treatment of bipolar disorder.

### **Question Assesses**

Assessment, Diagnosis, and Treatment Planning

- 165. A.** From the structural perspective, roles are the culturally defined norms—rights, duties, expectations, and standards for behavior—associated with a given social position. In other words, social position is seen as influencing behaviors. In addition, statuses such as gender, ethnicity, sexual orientation, and social class also shape roles. For example, as a mother, a woman is expected to place the care of her child above all other concerns. However, this normative expectation varies across cultures, with some cultures expecting mothers to be paid workers as well. Many cultures believe that women with preschool-age children should not work outside of the home and that their children will suffer if they do.

The actual enactment of role behavior, however, may not correspond to the role expectations. Role competence, or success in carrying out a role, can vary depending on social contexts and resources. In countries with strong normative expectations for women to be full-time mothers, single mothers and low-income mothers often must violate these role expectations and have been criticized as less competent mothers as a result.

Indeed, there is pressure to conform successfully to roles. Sanctions are used as tools of enforcement. Punishments for not following the role of mother can range from informal sanctions, such as rebukes from family members to formal sanctions, such as divorce. Social workers

should be aware of social role theory and view problems as emerging from interactions between clients and their environments. Person-in-environment perspectives are sensitive to role conflicts experienced by clients.

Cultural bias involves a prejudice or highlighted distinction in viewpoint that suggests a preference of one culture over another. There are cultural differences in views between the client and her husband's family, but the problem does not stem from cultural bias. If cultural bias existed, intervention would focus on education of the client about diverse perspectives. The client recognizes the views of her husband's family and does not appear to see her views as superior. However, she is unhappy due to the conflict that exists between the fulfillment of the various roles.

Social injustice is an unfair practice that results in violation of human rights. Her problem is a personal one and not an indicator of social injustice.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

**166. B.** A doorknob disclosure is an uncomfortable, painful, or embarrassing revelation offered at the end of a session, usually by a client who is leaving. Social workers often see clients reveal their most painful conflicts during the last 30 seconds of sessions, just when they are ready to leave. Often, they already have their hands on the doorknobs. These revelations may be new issues or other aspects of problems already discussed.

The two main reasons for doorknob disclosures are (a) the need to gauge reactions because of fear, rejection, or judgment about the disclosed material; and (b) the need to prolong the helping relationship by extending the session or number of sessions due to fear of not being able to cope without support.

Doorknob disclosures are often a form of resistance. Bringing up important material or intense emotions at the end of sessions, rather than earlier, ensures that there will not be enough time to deal with these issues.

Social workers should be skilled in the principles of communication—encouraging clients to raise all issues early in the session and therapeutic process. Social workers should also help manage the time in sessions—giving clients ample notice of when sessions are drawing to an end, which is an inappropriate time to bring up new concerns or topics.

Immediate responses to doorknob disclosures need to be to reassure clients that they will get to discuss material at the next sessions (once ruling out that there is an immediate safety issue that requires immediate attention). If the disclosure comes from a fear of coping alone or ending the therapeutic relationship, time should be spent discussing this issue—rather than the disclosure itself.

The question contains a qualifying word—**MOST**. While clients may use doorknob disclosures for more than one purpose, revealing information in this manner clearly stems from fear. Clients want the safety of gauging social workers' reactions to the material and/or lack time to discuss revelations more fully. It can be comforting to clients to bring up painful or sensitive topics in this manner as they have the knowledge that they will not have to explore them in more depth until the next session, giving them time to feel content with even saying the information aloud.

### **Question Assesses**

Psychotherapy, Clinical Interventions, and Case Management

- 167. B.** Death is just one life event or crisis which impacts families. When deaths of family members occur, children go through a series of stages in trying to understand its meaning. For example, preschool children usually see death as reversible, temporary, and impersonal. Watching cartoon characters on television miraculously come alive again after having been crushed or blown apart tends to reinforce this notion. In order to identify when death is truly understood by children, it is necessary to outline the complex concepts associated with death, including:

- Irreversibility or finality, the understanding that the dead cannot come to life
- Universality or applicability, the understanding that all living things (only living things) die

- Personal mortality, the understanding that death applies to oneself
- Inevitability, the understanding that all living things must die eventually
- Cessation or nonfunctionality, the understanding that bodily and mental functions cease after death
- Causality, the understanding that death is ultimately caused by the breakdown of bodily functions
- Unpredictability, the understanding that the timing of (natural) death is not known in advance

Piaget's cognitive developmental stages indicate that these death concepts cannot really be understood by someone until age 7 years at the absolute earliest. Using Piaget's model, child understanding emerges as follows:

First stage—Preoperational (2–7 years)—Children think of death as a temporary or reversible state and tend to characterize death with respect to concrete behaviors such as being still or having closed eyes or departing.

Second stage—Concrete operational (7–11 years)—Children recognize that all living things must die, and that death is irreversible; however, they consider death to be caused by concrete elements originating from outside the body and do not recognize death as an intrinsic and natural part of the life cycle.

Final stage—Formal operational (11 years and older)—Children hold an adult view of death as an inevitable, universal final stage in the life cycle of all living things, characterized by the cessation of bodily functions.

Thus, children's understanding of death is truly linked to cognitive developmental maturation.

If the age of a client is mentioned in a scenario, it is usually relevant in selecting the correct response choice. The age is a useful hint of where a client is in the life course and what might be expected with regard to cognitive, emotional, and/or social development.

This scenario requires knowledge about the complex concepts associated with death as well as child development. Most questions, like this one, require an integration of several knowledge areas. Memorization is not needed when studying, but instead the ability to apply knowledge learned.

As the child is only 4 years old, each response choice must be evaluated based on the theoretical knowledge about cognition at this age. As the beginning of abstract thought does not occur until age 7, the child would see death as a temporary or reversible state, like being asleep. Additionally, children find death to be an emotionally charged issue, reacting with sadness, anxiety, and fear over separation—not a feeling of comfort.

### **Question Assesses**

Human Development, Diversity, and Behavior in the Environment

- 168.** **A.** Social workers should respect clients' right to privacy and confidentiality. Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client. Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others such as duty to warn, child abuse, and so on.

In these instances, social workers should inform clients, to the extent possible and when feasible, about the disclosure of confidential information and the potential consequences before the disclosure is made due to being legally required or client consent. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

The *NASW Code of Ethics* explicitly acknowledges social workers' ethical obligation to inform clients, to the extent possible, of the need to make mandatory reports due to suspected child maltreatment. This obligation should not result in delays in reporting. Additionally, informing clients does not mean that social workers should be deterred in any way from reporting based upon clients' reactions. Social workers should be honest with clients throughout the problem-solving process. Clients should be aware of social workers' obligations for mandatory reporting since it is to be discussed as soon as possible in social worker-client relationships and as needed throughout the course of these relationships.

## **Question Assesses**

### Professional Values and Ethics

- 169. B.** The *NASW Code of Ethics* explicitly acknowledges that social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for a social worker and individual to maintain appropriate professional boundaries. In addition, social workers should not engage in sexual activities or sexual contact with current or former clients or clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to a client (*NASW Code of Ethics —Sexual Relationships*).

In the scenario, the social worker is aware that the referral is for a woman with whom he had a prior intimate relationship. According to the *NASW Code of Ethics*, it is unethical to provide clinical services to this client. Since there should be no therapeutic relationship between them, meeting with the client to discuss her problem or scheduling an intake are both inappropriate. Informing a supervisor is advisable, but not a sufficient action to properly “act ethically in this situation.” The social worker should decline the referral even if he is the only Spanish-speaking clinician. Services may need to be located for the client at another agency if there is no one linguistically competent to counsel her at the existing one.

## **Question Assesses**

### Professional Values and Ethics

- 170. C.** Cognitive behavioral therapy (CBT) combines cognitive and behavioral therapies. The basic premise of CBT is that emotions are difficult to change directly, so CBT targets emotions by changing thoughts and behaviors that are contributing to the distressing emotions. CBT builds a set of skills that enables an individual to be aware of thoughts and emotions; identify how situations, thoughts, and behaviors influence emotions; and improve feelings by changing dysfunctional thoughts and behaviors. The process of CBT skill acquisition is collaborative. Skill acquisition and homework assignments are what set CBT apart from “talk therapies.” Brief CBT is

the compression of CBT material and the reduction of the average 12 to 20 sessions into 4 to 8 sessions. In brief CBT, the concentration is on specific treatments for a limited number of client problems. Specificity of the treatment is required because of the limited number of sessions and because a client is required to be diligent in using extra reading materials and homework to assist in therapeutic growth. Brief CBT can range in duration from client to client and provider to provider.

*Certain problems are more appropriate for brief therapy than others.* Problems amenable to brief CBT include, but are not limited to, adjustment, anxiety, and depressive disorders. Therapy also may be useful for problems that target specific symptoms (e.g., depressive thinking) or lifestyle changes (e.g., problem solving, relaxation), whether or not these issues are part of a formal psychiatric diagnosis. Brief CBT is particularly useful in a primary care setting for clients with anxiety and depression associated with a medical condition. Because these clients often face acute rather than chronic mental health issues and have many coping strategies already in place, brief CBT can be used to enhance adjustment. Issues that may be addressed in primary care include, but are not limited to, diet, exercise, medication compliance, mental health issues associated with a medical condition, and coping with a chronic illness or new diagnosis.

Central to selecting the correct response choice is recognizing that the intervention modality mentioned in the question is brief therapy. Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapy providers can effect important changes in client behavior within a relatively short period.

Substance use disorders are chronic, requiring long-term support. Brief therapy for substance abuse treatment can be a valuable, but limited, approach and it should not be considered a standard of care. Dissociative identity disorder (DID), formerly called multiple personality disorder, is a condition that characterized by the presence of at least two clear personality states, called alters, which may have different reactions, emotions, and body functioning. While there is no “cure” for DID, long-term treatment is very successful. Effective treatment includes talk therapy or psychotherapy, medications, hypnotherapy, and adjunctive therapies to help clients with DID improve their relationships with others, prevent crises, and experience uncomfortable feelings.

Because oftentimes the symptoms of dissociative disorders occur with other disorders, such as anxiety and depression, Dissociative disorders may be treated using the same drugs prescribed for those disorders.

***Question Assesses***

Assessment, Diagnosis, and Treatment Planning



# Overall Results of Clinical Test

Content Area	Question Numbers	Number of Questions	Number Correct	Percent Correct
Human Development, Diversity, and Behavior in the Environment (24%)	2, 3, 12, 15, 18, 21, 26, 31, 44, 46, 48, 52, 55, 61, 66, 67, 74, 78, 79, 86, 89, 92, 99, 100, 102, 104, 105, 108, 116, 118, 119, 125, 131, 133, 142, 153, 154, 157, 162, 165, 167	41	___/41	___%
Assessment, Diagnosis, and Treatment Planning (30%)	1, 5, 7, 8, 10, 14, 28, 32, 33, 36, 39, 41, 45, 51, 53, 54, 57, 62, 63, 70, 71, 72, 77, 80, 81, 82, 85, 87, 88, 93, 94, 95, 96, 97, 106, 107, 121, 122, 127, 134, 135, 138, 139, 141, 148, 151, 155, 156, 159, 164, 170	51	___/51	___%
Psychotherapy, Clinical Interventions, and Case Management (27%)	4, 6, 11, 13, 16, 17, 20, 22, 23, 27, 29, 34, 35, 37, 38, 40, 47, 50, 58, 59, 60, 68, 83, 84, 91, 98, 103, 109, 110, 113, 114, 115, 117, 123, 126, 129, 130, 136, 137, 143, 144, 146, 147, 149, 150, 166	46	___/46	___%
Professional Values and Ethics (19%)	9, 19, 24, 25, 30, 42, 43, 49, 56, 64, 65, 69, 73, 75, 76, 90, 101, 111, 112, 120, 124, 128, 132, 140, 145, 152, 158, 160, 161, 163, 168, 169	32	___/32	___%
Overall Clinical Examination Knowledge	—	170	___/170	___%