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This is a sample of our table of contents for the clinical level study guide. In an effort to protect our intellectual property, a significant amount of detail has been omitted from this sample. The sole purpose of this document is to provide you with general information about how our book is organized.

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ANNA FREUD

Anna Freud was a child psychoanalyst and theorist who identified defense mechanisms. She worked directly with children. Anna clarified and extended her father’s work. She agreed with her father that adult neuroses develop in response to an overly punitive superego and expanded her father’s work on ego defense mechanisms (her father’s focus had been primarily on repression). Anna Freud believed the psychotherapist’s role is to help the patient to make alterations in the superego so that it is not unreasonably restrictive. This is an easier task with children and adolescents because the superego is still in development. Anna worked with parents to alter their expectations of their children, in addition to how the parents relate to them. She also worked to affect change in the way the various parts of the child’s personality (i.e. id, ego and superego) relate to each other. She believed that observations by the psychoanalyst and information obtained from the child’s significant others could substitute for data obtained through free association, which was the basis of adult psychoanalysis.

Ego Defense Mechanisms are unconscious strategies used by the ego to minimize distress caused by the conflicting demands of the id and superego. A mature ego typically meets these conflicting demands through a process of acknowledging the demands and developing a way of meeting these challenges as much as possible. An immature ego is more apt to resort to the frequent use of defense mechanisms, which involves self-deception and deception to others. Defense mechanisms identified by Anna Freud are listed below.

- **Compensation** is the seeking of success in one area of life as a substitute for success in another area of life that has been limited because of personal or environmental barriers.

- **Conversion** is the transformation of anxiety into a physical dysfunction, such as paralysis or blindness, which does not have a physiological basis.

- **Denial** is a refusal to acknowledge an aspect of reality, including one’s experience, because to do so would result in overwhelming anxiety.

- **Displacement** is a shifting of negative feelings one has about a person or situation onto a different person or situation.

- **Identification** is a mechanism by which anxiety is handled through identifying with the person or thing producing the anxiety, such as “identifying with a kidnapper.”

- **Isolation of Affect** is a mechanism by which painful feelings are separated from the incident that triggered them initially.
Intellectualization is a mechanism by which reasoning is used to block difficult feelings. It involves removing one's emotions from a stressful event.

Projection is a mechanism by which one’s own negative characteristics are denied and instead seen as being characteristics of someone else.

Rationalization is a mechanism by which a person substitutes a more socially acceptable, logical reason for an action rather than identifying the real motivation.

Reaction Formation is adopting a behavior that is the antithesis of the instinctual urge (e.g. acting as if one has deep sympathies for an oppressed group when the individual actually has significant prejudices against that group).

Regression is reverting to more primitive modes of coping associated with earlier and safer developmental periods.

Repression is the unconscious pushing of anxiety-producing thoughts and issues out of the conscious and into the unconscious. (Sigmund Freud is accurately credited with identifying this defense mechanism, although Anna Freud also addressed this mechanism frequently in her work.)

Sublimation is a mechanism by which intolerable drives or desires are diverted into activities that are acceptable.

Substitution is a mechanism by which a person replaces an unacceptable goal with an acceptable one.

Undoing is a mechanism by which an individual engages in a repetitious ritual in an attempt to reverse an unacceptable action previously taken.

Other defense mechanisms not identified by Anna Freud, but of importance include:

Acting Out is a defense mechanism that allows an individual to deal with emotional conflict or stress (internal or external) by exhibiting observable behavior rather than by merely feeling or reflecting. Defensive acting out differs from antisocial behavior in that defensive acting out is directly related to stress and emotional conflict.

Affiliation is a mechanism utilized when an individual shares with others his or her emotional conflict or stress for the purpose of eliciting support or help rather than for the purpose of trying to place the responsibility on someone else.

Aim inhibition is a mechanism that is utilized when an individual places a limit on his or her instinctual demands and accepts a modified fulfillment of goals or desires. An example of this would be an individual who has a desire to become a medical doctor, but who realizes that he or she does not have the financial resources or intellectual ability to realize that goal. Subsequently, that individual becomes a pharmacist instead.
Altruism is a mechanism that is seen when an individual deals with his or her emotional conflict or stress by selflessly dedicating his or her life to meeting the needs of others, thereby receiving vicarious gratification.

Anticipation is a mechanism that is utilized when an individual deals with anxiety by “practicing” his or her emotional reactions to an anticipated future event and by considering the responses or solutions that he or she may utilize to deal with that event.

Autistic Fantasy (sometimes only called Fantasy) is a mechanism by which an individual daydreams excessively as a substitute for real action.

Avoidance is a defense mechanism that is reflected in an individual’s refusal to participate in activities or encounter situations or objects that represent unconscious, aggressive or sexual impulses and the possible punishment for those impulses. According to dynamic theorists, avoidance is considered a major defense mechanism utilized by individuals who experience phobias.

Deflection refers to a group member who redirects attention away from himself or herself and on to another group member.

Devaluation is a mechanism whereby an individual deals with his or her emotional conflict or stress by attributing negative qualities to him or herself or to others.

Dissociation is a mechanism of compartmentalization, or separating of activities or thoughts from the main portion of one’s consciousness. This is often seen in the behavior of individuals who live “two lives,” separating one from the other.

Fixation is the interruption of normal personality development at a stage short of mature independence.

Help-Rejecting Complaining is a mechanism whereby an individual deals with his or her emotional conflict or stress by asking for help and then rejecting the help that is given. Often the requests for help are disguised feelings of hostility, which are then expressed by refusing to accept the suggestions and advice of others.

Humor is a mechanism by which an individual deals with his or her own emotional conflict or stress by pointing out amusing aspects of the stress.

Idealization refers to the process of over-estimating the desirable qualities and under-estimating the limitations of something that is important to the individual.

Identification is seen in both the unconscious and conscious modeling of another person’s behavior or style, but often in a less intense or complete manner than would be seen in pathological identification.

Incorporation is one of the earliest mechanisms used in the developmental process
whereby a child, through the process of observation, assimilates into his or her own ego and superego the values, attitudes, and preferences of the parents.

**Introjection** is the mechanism of *unconsciously* incorporating ideas, attributes, or mental images into one’s own personality.

**Isolation** is a mechanism whereby an individual is able to split off emotional components from a thought or experience, such as a flight attendant who remains calm during a crisis but then exhibits an emotional reaction after the crisis is over. This mechanism is commonly used by individuals who are diagnosed with Obsessive-Compulsive disorder.

**Omnipotence** is described as an individual dealing with his or her own emotional stress by feeling or acting in a superior manner.

**Passive Aggression** is a mechanism by which an individual expresses aggression toward another person in an indirect and unassertive manner, which, in turn, gives the agitator the opportunity to avoid the emotional stress related to dealing with the other person’s reaction.

**Projective Identification** is a mechanism that, like projection, falsely attributes to another person one’s own unacceptable impulses, thoughts or feelings. However, the individual consciously recognizes the attributes that are projected and considers them as justifiable reactions to the individual to whom they are projected. The main difference between projection, identified by Anna Freud, and projective identification is that the former belongs to intrapsychic dynamics, while the latter describes a very primitive form of relating. In terms of feelings experienced by the projector there is notable difference between the two phenomena. During projective identification, the projector feels at one with the other person. This is not the case in projection. Also, for the receiver, projective identification is far more disturbing and more difficult to deal with than projection.

**Resistance** is a defense mechanism that prevents the bringing of repressed (unconscious) feelings or information to conscious awareness, thus sparing the anxiety that would arise from those memories or insights.

**Restitution** is a mechanism of relieving stress or guilt by doing something to make up for what one considers a behavior error committed against another individual.

**Self-Assertion** is a healthy mechanism by which an individual deals with his or her emotional conflict or stress by expressing feelings and thoughts directly and in a non-coercive or non-manipulative manner.

**Somatization** is a mechanism whereby an individual experiences physical symptoms of the body’s sympathetic and parasympathetic system as the result of emotional conflict or stress.

**Splitting** is a mechanism whereby, in order to relate to significant others, an individual may “split” the significant other into two parts, good and bad, in an effort to cope with
the painful feelings associated with that person.

**Suppression** is viewed as the conscious and intentional exclusion of data from consciousness. This defense mechanism may be seen in an individual who refuses to think about something that is temporarily interfering with his or her current functioning.

**Symbolization** is a way of handling emotional conflicts by turning those conflicts into symbols, which can be viewed as displacements of deeper desires. An example of this would be interpreting a specific dream as a symbol of a deeper feeling or desire.

This is a SMALL section of Chapter 2

CHAPTER II

ASSESSMENT, DIAGNOSIS (including psychopharmacology) AND INTERVENTION PLANNING

Assessment is a critical element in the treatment of a client. Assessment refers to the process of arriving at tentative conclusions about the nature of the client’s situation, including problems and resources. This process provides the basis for treatment planning. Assessment should be an ongoing process. Mary Richmond was one of the first practitioners in casework to concentrate on assessment and diagnosis. Assessment should focus on many different aspects of the client’s internal and external experience, including the following:

**Internal**

- Biophysical functioning
- Use and abuse of alcohol and drugs
- Cognitive and perceptual functioning
- Emotional functioning
- Mental disorders
- Behavioral functioning
- Motivation
- Degree of acculturation
- Language fluency
- Problem solving skills

**External**

- Health and safety factors
- Social support systems
- Environmental needs of adults and children
- Cultural norms
- Educational support and needs
- Precipitating events that brought the client to seek social work services
INTAKE

The assessment process generally begins with the intake interview, where pertinent information is gathered. Then, the intake interview a more extensive social history is written, which leads to a statement of client strengths and problem areas (or to a diagnosis) and then a treatment plan. The components of this process are suggested in the following section.

CLIENT INTERVIEWING AND OBSERVATION

Gathering data via interviewing

In some settings social workers conduct intake interviews over the telephone, which may limit the amount and type of information that can be obtained. Social workers who can have face-to-face interviews with the client are able to make observations while they gather data. The client’s self-report should focus on the following areas:

- **Problem areas** should be identified from the client’s point of view. The client should be encouraged to express him or herself regarding the presenting problem, as well as other problems that are of concern to the client. Sometimes social workers are hesitant to ask questions for fear that they may upset the client. However, the most pertinent information is often obtained when the client is most upset. A social worker should never deliberately try to evoke an upset emotional state in a client. The social worker should also be cautious when dealing with a client who is psychiatrically unstable, as knowledge and skill are needed to handle this type of client reaction.

- **Strengths** of the client and the client’s support system need to be identified. The client may be able to readily identify strengths or may need direction from the social worker to assess the client’s strengths.

- **The support system** of the client is one of the most important aspects of the treatment process and needs to be thoroughly explored. If a client has at least one significant individual in his or her life, his or her ability to be resilient is greatly enhanced. Support systems include biological family members, friends, religious affiliations, caretakers, pets, helping professionals, etc. All of these supports are important factors in the treatment plan.

- **The attitude** of the client also needs to be assessed. If the client has a positive attitude about his or her current situation and has the ability to see things as being able to get better, he or she will have a greater chance of being able to deal with the problems. If the client has a negative, defeatist, or persecutory attitude about his or her situation, the prognosis is generally not as good.

- **Client motivation** should also be explored. The social worker can ask the client directly about his or her level of motivation or can assess the level of motivation based on the client’s answers to questions that are asked.
Use of resources, both personal and environmental, is important to the client’s situation. The social worker should determine if the client has used community resources in the past and his or her attitude toward seeking and accepting help. An assessment should be made of the client’s personal resources, such as problem solving skills, faith or spirituality, cultural values, cognitive abilities, and dependence on his or her support system.

Danger to self or others should be explored in the initial interview. If the social worker senses any indication that the client is planning to harm him or herself or another person, the social worker should take immediate action.

Gathering data via observation

The social worker should observe the client over time and in multiple situations. It is very difficult to make an accurate assessment of a client and his or her situation based on one interview, which is why the assessment process is ongoing. Observation based data gathering includes evaluating the following areas:

Appearance of the client is an important factor for the social worker to consider. The worker should note any condition relevant to understanding the client, such as body weight, physical disabilities, apparent healthiness, facial affect, grooming, etc.

Health concerns can be identified through observation in addition to information obtained through medical records. The impact of life stressors on the client can often be seen in the physical and emotional health of the client. Self care, cognitive abilities, emotional functioning, and social skills can be observed. Drug use may also be considered a possibility when certain physical, behavioral, and cognitive elements are observed.

Life skills are indicative of client functioning and may be deemed as strengths or limitations in the client’s situation. Depending on the age and ability of the client, factors to be observed may include the client’s mobility, money management, cleanliness, personal hygiene, communication skills, organizational skills, social skills, problem-solving skills, self care, and work skills.

Referral for additional evaluations

It may be necessary to obtain additional information through formal psychological testing, psychiatric evaluation, vocational testing, or medical evaluations. In this case, the intake social worker may need to refer the client to another mental health professional, medical doctor, or agency. The social worker should explain to the client why this type of referral is necessary and facilitate the referral process. The social worker should then follow up with the individual with whom the client was referred and use that information to complete the intake process.
ASSESSMENT METHODS

ASSESSMENT OF PROBLEM AREAS AND STRENGTHS

The biopsychosocial model of assessment considers three elements of the client’s situation: (a) the biological component, or how the body’s functioning may be contributing to the client’s current problems; (b) the psychological component, or the emotions, the thinking processes, and the behaviors of the client and (c) the social component, or the role of environment, culture, socioeconomic status, poverty, and spirituality in the individual’s health. After gathering the previous information, the social worker then identifies the client’s current level of functioning, strengths and weaknesses, mental health status (including previous problem areas), and the client’s needs.

The traditional medical model of assessment focuses on the client’s pathology or what is “wrong” with the client. Most standardized assessment instruments are concerned with the problem areas and inadequacies of clients. In the process of gathering data and formulating a diagnosis, social workers have traditionally identified problem areas, but often without enough of consideration of the clients’ strengths, resiliency, and positive life factors.

The strengths perspective of assessment is based on the notion that client strengths are essential ingredients in the healing process and that incorporating the strengths of the client will aid in empowering the client to reach the desired goals. Focusing on what is wrong with the client often reinforces the powerlessness of the client in his or her current situation.

The strengths perspective of assessment provides the following benefits for the client and his or her social environment:

- empowers clients to solve their own problems
- examines possible alternatives
- teaches competencies
- creates more equity between the client and social worker
- builds self-confidence
- helps clients to see that problems are influenced by multiple factors, are interactive, and are ever-changing

SOCIAL HISTORY

The following is an outline for a social study to be used by social workers. The study should focus on the strengths of the client, as well as the problem areas, and should include information gathered from multiple sources.

Gathering data via interviewing and observation
Interviewing and observation are important techniques to use when writing the social history documentation. The details of these types of data gathered are listed above under the heading of Intake. The topics include problem areas, client strengths, support system, attitude of the client, client motivation, client’s use of resources, danger to self and others, appearance, health, and life skills.

**Identification of presenting problem**

Information gathered initially should focus on why the client (sometimes called the “identified patient”) was referred to the agency or setting. The social worker should find out the reason for referral from the viewpoint of the agency, the client, and the family. Although there will likely be several problem areas to consider, there will be one problem that will be considered the referral problem, which is the primary reason for seeking help. That is the problem area that needs to be addressed first. The client, agency, and family members may have differing opinions about the presenting problem, but all perspectives should be stated in the social study record.

**Family history**

The taking of a family history can provide social workers with valuable information about the client’s past and can identify potential predictors of the client’s future prognosis. Information can be gathered by asking open-ended questions (e.g. “Tell me about your family,”) or direct questions (e.g. “Were you abused as a child?”). A client’s response to an open-ended question gives the client a chance to identify what may be most important to him about his family, rather than the social worker deciding what is most important. A client’s response to a direct question can provide specific information that the social worker wants to know. Social workers should always be attuned to cultural factors as they ask questions and interpret client responses. Social workers should look for patterns of behavior in families (e.g. problems with the law, poor decision-making, abuse, etc.) as possible predictors of how the client may function. The position that the client holds in the family constellation and his or her relationship with family members may also be important information needed to complete the social history.

**Sexual history**

Social workers may be uncomfortable taking a sexual history of a client, but the data gathered may provide information that is vital to the treatment plan. The taking of a sexual history may depend on the client’s age and reason for treatment. A social worker should prepare a client that he will be asking several different kinds of questions and may then embed sexually-related questions among other general questions. The social worker should not ask questions of a personal sexual nature until well into the assessment process. The client should be made as comfortable as possible, and the questions can be open-ended or specific. If a client is receiving social work services for a sexual offense, or if a history of sexual abuse or sexual perpetration is noted in the client’s referral information, it is vital to take a sexual history. Sex offenders may be reluctant or unwilling to admit to sexual behavior and may become angry when confronted. When working with a child who has been sexually abused, the social worker may want to use
strategies such as engaging the child in a play situation (perhaps with puppets or objects that represent the child and others) or having the child draw pictures and describe what he has drawn. Social workers can also ask parents about their child’s sexual knowledge, including whether the parent suspects that the child has been molested.

**Records**

Records pertinent to the client and his or her situation, both current and past, are vital to the social history as they provide information that may not be readily attainable through the interview process. Relevant records to be obtained, with client permission, include school, medical, abuse and neglect, substance abuse treatment (psychiatric and medical), and criminal records. All record requests and evaluations should be in compliance with HIPPA regulations.

**Assessment instruments**

Any tests or assessments that have been given to the client are necessary pieces of information for the formulation of a diagnosis and treatment plan for the client. In general, social workers are not trained nor licensed to administer or interpret psychological tests and are only allowed to use evaluation tools for which they are qualified to administer and interpret. As part of the assessment procedure, the social worker can, with client permission, gather school test results, vocational testing, achievement tests, psychiatric evaluations, and psychological tests.

**Collateral contacts**

Collateral information refers to data that is gathered from individuals who know or have had contact with the client, rather than from the client. Collateral contacts provide valuable information and often differing points of view with regard to the client and his or her situation. Social workers may interview relatives, neighbors, caregivers, school personnel, and co-workers. The social worker should inform the client that these collateral contacts will be made and should use caution and sensitivity in dealing with the client’s feelings about these contacts.

**Suicide Risk**

Suicide risk requires a timely assessment. When someone is having suicidal thoughts, it is important to take the necessary steps to prevent harm. A “no harm” contract is sometimes created for those who are having suicidal ideation, but some research suggests that this is ineffective. If a client has a specific plan, it is important to have the client admitted to the hospital. If the client refuses to voluntarily admit him or herself into the hospital, it may be necessary to contact emergency services and a family member or friend to assist with the process. Drastic changes in mood may also indicate a problem in a client who has a history of suicide or is coming out of major depression.

**Standardized Testing**

Social workers are usually neither trained nor licensed to administer many standardized
tests related to mental health, but the results of such tests can be helpful in arriving at an accurate diagnosis. As such, social workers seek information from allied professionals, such as psychologists and medical doctors. Most tests are focused on identifying dysfunction and problem areas and can be utilized in making an accurate diagnosis.

Standardized tests include such commonly-used instruments as:

- Psychiatric evaluations
- Intelligence (IQ) tests
- Personality tests such as the MMPI
- Depression inventories such as the Beck Depression Inventory
- Adult and children’s ADHD tests
- Behavioral checklists
- Personality inventories
- Alcohol use inventories

Social workers cannot administer some tests; however, they should be trained in understanding the results and using the information to make an accurate diagnosis of the client’s situation. Internet tests are available for client’s to self-diagnose; social workers should be cautious about utilizing diagnostic information obtained from such sources.

**Mental Status Examination**

The mental status examination is a part of a psychiatric clinical assessment. The purpose of the examination is to obtain evidence of symptoms and signs of mental disorders, including danger to self and others, that are present at the time of the interview. Furthermore, information on the patient's insight, judgment, and capacity for abstract reasoning is considered in developing the treatment strategy and the choice of an appropriate treatment setting. The mental status exam can be used in outpatient and inpatient settings. Mental status exams consist of an informal inquiry, using a combination of open and closed questions, supplemented by structured tests to assess cognition. The domains examined are: appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight, and judgment.

**Specific Domains**

- **Appearance:** Physical appearance includes a client’s age, height, weight, and overall grooming.
- **Attitude:** Attitude refers to the client’s interaction with the mental health professional. The client’s attitude may be described as cooperative, uncooperative, hostile, guarded, or suspicious.
- **Behavior:** Behavior includes general observations about the client’s level of activity, specific abnormal movements, eye contact, and gait. Examples of abnormal movements or tremor include tics, catatonia, repetitive purposeless movements.
(head banging, rocking), odd mannerisms, restlessness, psychomotor agitation, or retardation.

**Mood and Affect:** Mood is described by the client in his or her own words; it is an internal emotional state. Types of mood states include neutral, euthymic (normal mood), depressed or dysphoric, euphoric, angry, anxious, indifferent (apathetic), or anhedonic (inability to experience pleasure).

Affect is the emotion conveyed by the client’s nonverbal behavior. The affect is evaluated by appropriateness, intensity, range, reactivity, and mobility. Types of affect: include full range, restricted, blunted, flat, labile, congruent, incongruent, exaggerated, or dramatic. Affect is subject to cultural influences.

**Speech:** Speech is assessed by listening to the client. The focus is on the production of speech rather than the content of speech (which is related to thought). Examples of speech include loudness, rhythm, pitch, articulation, quantity, rate, and spontaneity. This category also includes the client’s ability to name objects, produce specific words in a set time, and repeat short sentences. Abnormalities of speech may include stuttering, mutism, echolalia (repetition of another person’s words), palilalia (repetition of the individual’s own words), and neologisms (made-up words that have specific meaning to the individual).

**Thought process:** Thought process refers to the quantity, rate and form (logical or coherent) of thought. It cannot be directly observed, only inferred from the client’s speech. Rate can be described as “flight of ideas” (i.e. thoughts are rapid and pressured). Poverty of thought is a term used to describe a reduction in the quantity of thought. Perseveration is noted if the client keeps returning to the same limited set of ideas.

A formal thought disorder may be exhibited by thought blocking (where the client’s thoughts seem to be interrupted without apparent cause; frequently mid-sentence), loose associations (thoughts appear unconnected unbeknownst to the speaker), tangential thinking (replying in an oblique or irrelevant way), derailment, and circumstantial (where the client includes a great deal of irrelevant details and makes frequent diversions).

**Thought content:** A description of thought content would describe a client’s delusions, obsessions, phobias, over-valued ideas, and pre-occupation. Thought content abnormalities are measured through open-ended, conversational types of questions with the client. Delusions (false ideas or beliefs which are not held by the client’s educational, cultural and social background) are abnormalities of thought content. The content of delusions can be paranoid, grandiose, erotomanic, jealousy, or delusions of reference (a comment or action that is interpreted to have special meaning to the client). Thought withdrawal is a belief that one’s thoughts are being withdrawn from one’s mind. Thought insertion is a belief that others are putting thoughts into one’s mind. Thought broadcasting is a belief that one’s thoughts are broadcasted or heard by others.
1. What is the best treatment for children who are diagnosed with Autistic Disorder?

A. Behavior modification  
B. Specialized diet that includes natural supplements  
C. Medication  
D. There is no single treatment that has been accepted as the best treatment for children with autism

The correct answer is “D” — There is no single treatment that has been accepted as the best treatment for children with autism. Every child is an individual and responds differently to treatment strategies. Behavior modification (answer “A”), specialized diet that includes natural supplements (answer “B”), and medication (answer “C”) are all appropriate options for treatment, but no one treatment has been accepted as the “best” treatment given the disorder's complexities and the lack of conclusive evidence regarding its cause.

2. A client has been seeing a social worker in private practice and is benefiting from the treatment. The client recently lost her job and, therefore, her medical insurance. She wants to continue treatment but cannot afford to do so. In an effort to help her, the social worker has discussed options. Which of the following is the BEST option?

A. In lieu of payment, the social worker will continue to see the client if she will help him edit a book he is writing  
B. In lieu of payment, the social worker will continue to see the client if she promises that she will not tell anyone  
C. The social worker will continue to see the client at no cost until she obtains medical insurance  
D. The social worker will refer the client to a mental health agency where she can receive low-cost social work services

The answer is “D” — The social worker will refer the client to a mental health agency where she can receive low-cost social work services. Continuing to see the social worker if the client helps him edit a book he is writing (answer “A”) is not correct because this would be an ethical violation. Continuing to see the social worker if the client promises that she will not tell anyone (answer “B”) is not correct because this is a threat and an exploitation of a client. Continuing to see the social worker at no cost until the client obtains medical insurance (answer “C”) is not the best answer because social workers have a right to be paid for their services and it may be a long time before the client’s financial situation changes.
3. A social worker in a mental health agency has received a referral to provide services for a client who is court-ordered to receive social work treatment for criminal activity that led to his probation. The client does not want to participate in the treatment process and has told the social worker that he does not intend to keep his appointments. What should the social worker do?

A. She should respect the client's right to self determination and inform the probation officer that the client does not wish to participate in treatment  
B. She should inform the client that since he is court ordered, he has no option but to participate in the treatment  
C. She should provide the client with information about what services she can offer and let him know the extent of his right to refuse services  
D. She should encourage the client to try at least one session with her and then decide what he would like to do

The correct answer is “C” – She should provide the client with information about what services she can offer and let him know the extent of his right to refuse services. This is the procedure recommended by the NASW Code of Ethics. The social worker would need to consult with the probation officer to determine what the client’s rights of refusal are since he is court ordered, and provide that information to the client. Respecting the client's right to self-determination and informing the probation officer that the client does not wish to participate in treatment (answer “A”) is not correct because the client does have court-ordered restrictions regarding his participation in treatment. Informing the client that since he is court-ordered he has no option but to participate in the treatment (answer “B”) is not correct because there may be conditions that allow him to have options. Encouraging the client to try at least one session with her and then decide what he would like to do (answer “D”) is not correct because this is coercive and the decision should rest with the client.

4. A school social worker has been seeing a Caucasian high school student who has joined a gang of Hispanic youth and has participated in criminal activity with them. The student is dating Hispanic girls and hangs spends time with Hispanic friends. He has told his social worker that he secretly despises Hispanics but that he is friendly with them because he is lonely. The student is MOST LIKELY using which defense mechanism?

A. Denial  
B. Reaction Formation  
C. Projection  
D. Sublimation

The correct answer is “B” – Reaction Formation. Reaction formation is a defense mechanism that is the antithesis of the instinctual urge (e.g. acting as if one has deep sympathies for a certain group when the individual actually has significant prejudices against that group).

5. When a therapist uses an empathic response, she is attempting to
A. Build a relationship with the client  
B. Provide accurate listening  
C. Develop confidence  
D. Be sympathetic

The correct answer is “A” - Build a relationship with the client. Research indicates that therapist empathy is a critical factor in the quality of the therapeutic relationship. Providing accurate listening (answer “B”) is not the best answer as providing accurate listening is only a part of building a relationship with the client. Developing confidence (answer “C”) is not correct because developing confidence is a function of the client, not the therapist. Being sympathetic (answer “D”) is not correct because being sympathetic means feeling sorry for the client, which is not an empathic response.

6. A family comes to see a social worker in a child welfare agency to discuss family problems. The father discusses how he was sexually abused by his father. The following is the most likely situation in this family

A. Sexual abuse in this family  
B. Depression in the children  
C. Depression in the father  
D. A passive mother

The correct answer is “A” - Sexual abuse in this family. Men who have been sexually abused by a father are significantly more likely to sexually abuse their own offspring. The question makes no reference to depression (answers “B” and “C”) in any of the family members or to the functioning of the mother (answer “D”), which makes those three answers incorrect.