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.

**Bachelors**


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

**Masters**


Test focuses on knowledge acquired while obtaining a Master’s degree in Social Work (MSW). There is no postgraduate supervision needed.

**Clinical**


Test focuses on knowledge acquired while obtaining a Master’s degree in Social Work (MSW). It is usually taken by those with postgraduate supervised experience.

**Advanced Generalist (forthcoming)**


Test focuses on knowledge acquired while obtaining a Master’s degree in Social Work (MSW). It is usually taken by those with postgraduate supervised nonclinical experience.
Dawn Apgar, PhD, LSW, ACSW, has helped thousands of social workers across the country pass the ASWB® examinations associated with all levels of licensure. In recent years, she has consulted in numerous states to assist with establishing licensure test preparation programs, including training the instructors.

Dr. Apgar has done research on licensure funded by the American Foundation for Research and Consumer Education in Social Work Regulation and is currently 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 ASWB® Masters Exam Guide
A Comprehensive Study Guide for Success

Dawn Apgar, PhD, LSW, ACSW
Contents

Preface xiii
Acknowledgments xv

Introduction
About the Examination 3
  10 Things That You Should Know About the ASWB Examinations 3
Test-Taking Strategies 7
  10 Essential Strategies for Study Success 8
  20 Tips You Need to Use to Answer Questions Correctly 12
  Assessing Examination Difficulties 22
Dealing With Test Anxiety 25
Examination Content 29
  Visual Learners 30
  Auditory Learners 31
  Kinesthetic or Hands-On Learners 31
Self-Assessment 33

Unit I: Human Development, Diversity, and Behavior in the Environment (28%)

1. Theories and Models 43
  Developmental Theories 43
  Systems Theory 43
  Family Theories 44
    Family Therapy Approaches 46
  Group Theories 49
    Key Concepts 51
  Psychodynamic Theories 52
    Psychoanalytic Theory 52
    Psychosexual Stages of Development 53
Contents

Individual Psychology 54
Self Psychology 55
Ego Psychology 55
Stages of Psychosocial Development 55
Object Relations Theory 57
Behavioral, Cognitive, and Learning Theories 59
  Behavioral Theory 59
  Cognitive Theory 61
  Learning Theory 63
Community Development Theories 64
Person-in-Environment 65
Addiction Theories and Concepts 65
Communication Theories 68
Defense Mechanisms 71
Normal and Abnormal Behavior 73
Indicators of Normal Physical Growth and Development 73
Adult Development 74
Effects of Life Crises 76
Impact of Stress, Trauma, and Violence 77
Emotional Development 80
Sexual Development 80
Aging Processes 82
Family Life Cycle 83
Family Dynamics and Functioning 84
Cognitive Development 85
Social Development 85
Child Development 86
Basic Human Needs 88
Adolescent Development 90
Human Genetics 90
Gender Roles 91
Impact of Environment on Individuals 92
Impact of Physical, Mental, and Cognitive Disabilities on Human Development 92
Interplay of Biological, Psychological, and Social Factors 93
Effects of Family Dynamics on Individuals 93
Dynamics of Grief and Loss 93
Impacts of Economic Change on Client Systems 94
Effects of Body Image on Self and Relationships 94
Cultural, Racial, and Ethnic Identity Development 96
Strengths Perspective 97

2. Abuse and Neglect 99
Abuse and Neglect Concepts 99
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators and Dynamics of Sexual Abuse</td>
<td>99</td>
</tr>
<tr>
<td>Indicators and Dynamics of Psychological Abuse and Neglect</td>
<td>100</td>
</tr>
<tr>
<td>Indicators of Physical Abuse and Neglect</td>
<td>101</td>
</tr>
<tr>
<td>Characteristics of Abuse Perpetrators</td>
<td>102</td>
</tr>
<tr>
<td>Indicators and Dynamics of Exploitation</td>
<td>103</td>
</tr>
<tr>
<td>3. Diversity, Social/Economic Justice, and Oppression</td>
<td>105</td>
</tr>
<tr>
<td>Influences of Culture, Race, and/or Ethnicity on Behaviors</td>
<td>105</td>
</tr>
<tr>
<td>and Attitudes</td>
<td></td>
</tr>
<tr>
<td>White American</td>
<td>105</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>106</td>
</tr>
<tr>
<td>Asian</td>
<td>106</td>
</tr>
<tr>
<td>African American</td>
<td>107</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>107</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>108</td>
</tr>
<tr>
<td>Influence of Sexual Orientation and/or Gender Identity on</td>
<td>108</td>
</tr>
<tr>
<td>Behavior and Attitudes</td>
<td></td>
</tr>
<tr>
<td>Influence of Disability on Behavior and Attitudes</td>
<td>109</td>
</tr>
<tr>
<td>Effects of Differences in Values</td>
<td>110</td>
</tr>
<tr>
<td>Impacts of Cultural Heritage on Self-Image</td>
<td>110</td>
</tr>
<tr>
<td>Impacts of Spirituality and/or Religious Beliefs on</td>
<td>112</td>
</tr>
<tr>
<td>Behavior and Attitudes</td>
<td></td>
</tr>
<tr>
<td>Effects of Discrimination</td>
<td>112</td>
</tr>
<tr>
<td>Systematic (Institutionalized) Discrimination</td>
<td>113</td>
</tr>
<tr>
<td>Professional Commitment to Promoting Justice</td>
<td>113</td>
</tr>
<tr>
<td>Impact of Social Institutions on Society</td>
<td>113</td>
</tr>
<tr>
<td>Family</td>
<td>114</td>
</tr>
<tr>
<td>Religion</td>
<td>114</td>
</tr>
<tr>
<td>Government</td>
<td>114</td>
</tr>
<tr>
<td>Education</td>
<td>114</td>
</tr>
<tr>
<td>Economics</td>
<td>114</td>
</tr>
<tr>
<td>Impact of Diversity on Styles of Communicating</td>
<td>115</td>
</tr>
<tr>
<td>Influence of Age on Behavior and Attitudes</td>
<td>116</td>
</tr>
</tbody>
</table>

**Unit II: Assessment and Intervention Planning (24%)**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Biopsychosocial History and Collateral Data</td>
<td>119</td>
</tr>
<tr>
<td>Psychopharmacology</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>119</td>
</tr>
<tr>
<td>Antimanic Agents (Mood Stabilizers)</td>
<td>120</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>120</td>
</tr>
<tr>
<td>Antianxiety Drugs</td>
<td>121</td>
</tr>
<tr>
<td>Stimulants</td>
<td>122</td>
</tr>
<tr>
<td>Components of a Biopsychosocial History</td>
<td>122</td>
</tr>
<tr>
<td>Components of a Sexual History</td>
<td>123</td>
</tr>
<tr>
<td>Common Prescription Medications</td>
<td>123</td>
</tr>
</tbody>
</table>
5. Use of Assessment Methods and Techniques
   - Use of Collateral Sources to Obtain Relevant Information 135
   - Methods to Evaluate Collateral Information 135
   - Process Used in Problem Identification 135
   - Methods of Involving Client's Communication Skills 136
   - Use of Observation 137
   - Methods of Involving Clients in Identifying Problems 137
   - Indicators of Client’s Strengths and Challenges 137
   - Use of Assessment/Diagnostic Instruments in Practice 139
     - Beck Depression Inventory 139
     - The Minnesota Multiphasic Personality Inventory 139
     - Myers–Briggs Type Indicator 139
     - Rorschach Inkblot Test 139
     - Stanford–Binet Intelligence Scale 139
     - Thematic Apperception Test 140
     - Wechsler Intelligence Scale 140
   - Methods to Organize Information 140
   - Current DSM® Diagnostic Framework and Criteria 141
   - Components and Function of the Mental Status Examination 155
   - Process of Social Work Assessment/Diagnosis 156
   - Methods Used in Assessing Ego Strength 157
   - Methods Used to Assess Community Strengths and Challenges 158
   - Methods Used in Risk Assessment 158
   - Indicators of Client Danger to Self or Others 159
   - Indicators of Motivation and Resistance 161
   - Methods to Identify Service Needs of Clients 162
   - Use of Interviewing Techniques 162
   - Process of Assessing the Client’s Needed Level of Care 163

6. Intervention Planning
   - Factors Used in Determining the Client’s Readiness/Ability to Participate in Services 165
   - Criteria Used in Selecting Intervention Modalities 166
   - Components of an Intervention or Service Plan 167
Contents

Human Development Considerations in the Creation of an Intervention Plan 167
Methods Used to Develop an Intervention Plan 168
Techniques Used to Establish Measurable Intervention or Service Plans 168
Methods Used to Involve Clients in Intervention Planning 169
Methods for Planning Interventions With Groups 170
Methods for Planning Interventions With Organizations and Communities 171
Cultural Considerations in the Creation of an Intervention Plan 172

Unit III: Direct and Indirect Practice (21%)

7. Direct (Micro) 177
   Client Advocacy 177
   Empowerment Process 178
   Methods Used in Working With Involuntary Clients 178
   Psychosocial Approach 179
   Components of the Problem-Solving Process 179
   Crisis Intervention Approach 180
   Task-Centered Practice 180
   Short-Term Interventions 181
   Methods Used to Provide Educational Services to Clients 181
   Methods of Conflict Resolution 182
   Use of Case Management 182
   Techniques Used to Evaluate a Client’s Progress 183
   Use of Contracting and Goal-Setting With Clients 183
      Change Strategies 184
   Use of Timing in Intervention 184
   Phases of Intervention 185
   Indicators of Client Readiness for Termination 186
   Techniques Used for Follow-Up in Social Work Practice 186
   Use of Active Listening Skills 186
   Techniques Used to Motivate Clients 187
   Techniques Used to Teach Skills to Clients 188
   Use and Effects of Out-of-Home Placement 188
   Methods Used to Develop Behavioral Objectives 189
   Client Self-Motivating Techniques 189
   Techniques of Role-Play 190
   Assertiveness Training 190
   Role-Modeling Techniques 191
   Limit Setting 191
   Methods Used to Develop Learning Objectives With Clients 192
   Models of Intervention With Families 192
   Couples Intervention/Treatment Approaches 193
## Interventions With Groups

193

### Techniques for Working With Individuals Within the Group Context

194

### Use of Expertise From Other Disciplines

195

### Approaches Used in Consultation

195

### Processes of Interdisciplinary Collaboration

196

### Methods Used to Coordinate Services Among Service Providers

197

### Multidisciplinary Team Approach

198

### Case Recording and Record-Keeping

198

### Methods Used to Facilitate Communication

199

### Verbal and Nonverbal Communication Techniques

199

### Techniques That Explore the Underlying Meaning of Communication

200

### Methods Used to Obtain/Provide Feedback

201

### Methods Used to Interpret and Communicate Policies and Procedures

202

### Methods Used to Clarify the Benefits and Limitations of Resources With Clients

203

### Use of Case Recording for Practice Evaluation or Supervision

203

### Use of Single-Subject Design in Practice

204

### Evaluation of Practice

204

### Interpreting and Applying Research Findings to Practice

205

### Process Used to Refer Clients for Services

206

### Use of Cognitive Behavioral Techniques

207

#### Steps in Cognitive Restructuring

208

### Culturally Competent Social Work Practice

208

### 8. Indirect (Macro)

211

#### Applying Concepts of Organizational Theories

211

##### Classical Organizational Theories

211

##### Neoclassical Theories

212

##### Modern Organizational Approaches

212

#### Impact of Social Welfare Legislation on Social Work Practice

212

### Methods Used to Establish Service Networks or Community Resources

217

### Techniques for Mobilizing Community Participation

217

### Techniques of Social Planning Methods

218

### Techniques of Social Policy Analysis

219

### Techniques to Influence Social Policy

219

### Techniques of Working With Large Groups

220

### Use of Networking

221

### Approaches to Culturally Competent Practice With Organizations and Communities

222
Advocacy With Communities and Organizations 222
Impact of Agency Policy and Function on Service Delivery 223

Unit IV: Professional Relationships, Values, and Ethics (27%)

9. Professional Values and Ethical Issues 227
   - Professional Values and Ethics 227
   - Client Self-Determination 228
   - Intrinsic Worth and Value of the Individual 228
   - Client’s Right to Refuse Services 228
   - Ethical Issues Regarding Termination 228
   - Bioethical Issues 229
   - Identification and Resolution of Ethical Dilemmas 230
     - Essential Steps in Ethical Problem-Solving 230
   - Applying Ethics to Practice Situations 231
   - Responsibility to Seek Supervision 231
   - Use of Professional Development to Improve Practice 232
   - Professional Boundaries 233

10. Confidentiality 235
    - Legal and Ethical Issues Regarding Confidentiality, Including
      Electronic Communication 235
    - Use of Client Records 238
    - Ethical and Legal Issues Regarding Mandatory Reporting 238
    - Obtaining Informed Consent 238

11. Social Worker Roles and Responsibilities 241
    - Social Worker–Client Relationship Patterns 241
    - Concept of Empathy 241
    - Process of Engagement in Social Work Practice 242
    - Concept of a Helping Relationship 243
    - Principles of Relationship Building 243
    - Professional Objectivity in the Social
      Worker–Client Relationship 244
    - Concepts of Transference and Countertransference 244
    - Use of Social Worker–Client Relationship as an Intervention Tool 245
    - Social Worker–Client Relationships in Work With
      Communities and Organizations 246
    - Social Worker–Client Relationships in Work With
      Small Groups 247
    - Methods Used to Clarify Roles of the Social Worker 248
    - Social Worker’s Roles in the Problem-Solving Process 248
    - Client’s Roles in the Problem-Solving Process 249
    - Influence of the Social Worker’s Values on the Social
      Worker–Client Relationship 249
    - Dual Relationships 250
## CONTENTS

Influence of Cultural Diversity on the Social Worker–Client Relationship  251

**Practice Test**

170 Question Practice Test  253

Answers  293

*Index*  323
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.

This guide aims to assist helping you through this process in several important ways. It will:

1. Increase your knowledge of the Association of Social Work Boards (ASWB®) examination, including testing conditions and scoring
2. Provide valuable test-taking strategies that will assist in developing a good study plan and in analyzing question wording in order to select the correct answer
3. Summarize content areas that may be included on the examination as per the Knowledge, Skills, and Abilities (KSA) statements published by ASWB, which are used by test developers to formulate actual questions
4. Supply sample questions that can be used to simulate an actual examination experience
Although there are other test preparation materials produced, this guide provides all these essential elements in a single, manageable, easy-to-use guide.

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 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.

Best wishes as you study for the examination. 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.
About the Examination

Generally, when social workers are getting ready to take the 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 will be asked and the number of correct answers required to pass. Becoming familiar with the examination basics will assist in making you more comfortable with the examination conditions and structure, thereby reducing your anxiety about the unknown.

10 THINGS THAT YOU SHOULD KNOW ABOUT THE ASWB EXAMINATIONS

1. All of the ASWB examinations have the same format, meaning that each has the same number of questions that each test-taker is given the same amount of time to complete. There are 170 multiple-choice questions and you will have 4 hours from the time that you start answering the questions. You can take a brief restroom break or stand to stretch, but the clock does not stop and these activities will be included in your 4-hour limit, so you want to be judicious with your time.

2. Although you will be answering a total of 170 questions, 20 of these questions are non-scored items that are being piloted for possible inclusion as scored questions on future ASWB examinations. Thus, only 150 questions will determine whether you pass or not. However, you will never know which 20 are pilot items because they are mixed in with scored items, so you will need to try to select the right answers on all 170 questions.
3. You **do not want to leave any questions blank**; answer all 170 questions in the 4 hours.

4. The examination is **computerized**, but requires no specialized computer knowledge. There is a brief computer tutorial that will assist you when you first sit down and look at the screen, and spending time getting to feel comfortable with the device at that time is a good idea, since it will not count toward your 4-hour time limit.

5. You will be taking your examination at a **testing center with others who are being tested in different disciplines** and may be taking shorter or longer examinations, so do not be concerned if they finish before or after you.

6. Testing center activities are **closely monitored**, and you will need to leave all of your belongings, including your watch, in a provided locker. You can ask for earplugs, scrap paper, or a pencil, but will not be able to bring anything into the room with you. The room may be hot or cold, so you should dress in comfortable layers. All testing accommodations related to documented disabilities must be approved by your state licensing board and arranged in advance with ASWB. **Some states allow for extra time or foreign language dictionaries as accommodations for those who do not have English as a first language.**

7. You will leave the testing center with an unofficial copy of your examination results. It will tell you how many questions you were asked and how many you got correct in each of the four areas or domains. You will never know which specific answers were correct and incorrect. You will also not find out the correct answers for those that you answered incorrectly. **The exam is pass/fail**, and a passing score can be used for certification or licensure in any state.

8. Although the KSAs are in four content areas and you may structure your studying to learn all the related material in a given domain before moving on to the next, **the questions on the examination are in random order** and skip across topics. There is not a separate section of questions labeled Human Development, Diversity, and Behavior in the Environment, or so on. You may have a human behavior question followed by one on ethics, so you really need to clear your head between questions and avoid trying to relate them to one another in any way. Each question stands alone as a way to assess knowledge related to a distinct KSA.

9. Social workers always want to know how many questions of the 150 scored items they will 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 asked to answer harder questions that have been randomly selected from the
test bank will need to answer fewer questions correctly than those who were lucky enough to have easier questions randomly assigned. 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 that you have to get correct generally varies from 93 to 106 of the 150 scored items.** You will find out how many needed to be answered correctly only after you are finished with your examination and it is immediately scored electronically. When you examine your unofficial test results, which are provided in a printout prior to leaving the testing center, you will be able to gauge the difficulty of your examination. If you needed to get closer to 93 correct, you had a harder combination of questions, and if you needed to get 106 or above correct, you had an easier combination.

10. **If you do not pass the examination, you will not have the same questions repeated on any of your examinations in the future.** Other questions in the four areas will be selected from the test bank. As the four domains are so broad, you may find that the topics of the questions may be quite different than those on a previous examination. To be adequately prepared, it is best to go back and study all the KSAs listed for a content area and not just those that may have caused you problems. If you do not pass, you will have to wait 90 days before taking the examination again.

If you have questions about the examination or scoring, such as the process for sending your passing exam score to another state in which you want to be licensed, visit the ASWB website at www.aswb.org for additional information and necessary forms. The *ASWB Examination Candidate Handbook*, which is free and located on this website, provides additional information about registering for the examination that may be useful.
Test-Taking Strategies

Social workers studying for the ASWB® examinations always want to know techniques that will assist them in studying wisely and answering questions correctly. Remember that there are no replacements for good old-fashioned work, and test-taking strategies are not enough on their own to eliminate all of the incorrect answers. Usually, applying test-taking strategies can help you dismiss two of four possible multiple-choice responses and it is your knowledge of the content area that will be needed to select the correct answer from the two that are remaining. Thus, you will need to make sure that you are well versed in the examination content in order to pass the examination.

However, there are two types of strategies that may assist. The first concerns things to remember when developing your study plan. These are important pieces of information that may help when you are trying to decide what to learn and how to learn it. The second includes those strategies that can assist you when actually answering the questions. These “tips” are important to remember after you have learned all the needed content and are tasked with applying it in the proper way to select the correct answer.

As both of these strategy types are keys to success on the examinations, they are outlined here.
10 ESSENTIAL STRATEGIES FOR STUDY SUCCESS

**Tip 1**

This is an examination to assess knowledge of social work content, so you will need to make sure that you can describe an overview of the key concepts and terms related to each of the KSAs. You will know if you are ready to take the examinations when you are able to briefly explain these areas 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 you need to make sure that the bulk of your studying is aimed at filling in knowledge gaps or refreshing information already learned.

**Tip 2**

You will never be “ready” to take the ASWB examination. Not unlike other standardized examinations, such as the Scholastic Aptitude Test (SAT) or Graduate Record Examination (GRE), you cannot judge readiness as knowing everything about the content areas. The ASWB® examinations are not designed for test takers to “know it all” in order 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 a date even when they do not feel ready. For the ASWB examination, you will need to select a date in the next few weeks or months, perhaps dictated by job opportunities or promotions predicated on being licensed. You will walk into the examination without feeling totally ready, but this is typical of others who have passed.

**Tip 3**

You need to limit your study materials to this guide or other key resources that summarize material. This is *not* the time to go back and read your textbooks! There are so many topics that you are asked to know about under each KSA that you cannot and are not expected to know everything related to the topic. This guide is geared to provide important information on these areas “under one roof.” It will be hard enough to read through all this material. You should only use outside materials if something in this guide is unclear or you feel that you need more than the information included, perhaps because you never learned this area in the first place. In these instances, you can use free resources on the Internet or any other documents that have no more than a paragraph summarizing key points. Remember, you do not need to read
a book on Freud to understand his work and its importance in explaining human development.

**Tip 4**

Although individuals like to study from sample questions, this is *not* advisable. There are many reasons why using this technique will hurt you on the examinations, but here are just a few:

1. Although it makes individuals feel better when they get an answer correct on a sample test, getting an answer correct is not a valid indicator of really knowing the content in the KSA for which the question was developed. Studying from the KSAs and the topics within them will ensure that you are able to answer any question, not just the one that is in a sample test.

2. Your answers to sample questions inappropriately influence your decisions on the actual examinations when asked about similar topics. For example, you may see an answer that is similar to one that was correct or incorrect in a practice test and you will be more apt or less apt to select it based upon this prior experience. However, the question in the “real” examination will not be exactly the same as the one on the practice test, and you must evaluate all four answers independently without any undue bias that may be caused by your practice question experience.

3. The sample questions that you study are not going to be on your examination and probably are not even written by those who developed items for your test. Thus, the idea that many social workers have of wanting to “get into the head” of the individuals writing the exam or understand their logic is not valid—though it might make them good clinicians in real life!

**Tip 5**

If you have access to sample questions, such as those in the last section of this guide, you should use them to create a “mock” examination. Most people have trouble resisting the urge to look at the answer key to see if they were correct immediately after selecting a response. However, a far better way to use these questions is to pretend that they are an actual examination.

1. *After* you are done studying the content and think you are ready to take the ASWB examination, select a 4-hour period where you can create a quiet environment without interruptions.
2. Answer the questions as you would on the actual examination—using the strategies and having to pick one answer—even if you are not completely sure that it is correct.

3. If you do not take unnecessary breaks, you will see that you can easily get through 170 questions in the 4 hours allotted. This experience should relieve some of your anxiety about the timed nature of the examination.

4. See which answers that you got correct and incorrect. The “mock” examination is not to be used to determine whether you are ready to take the actual test—even if getting 93 to 106 puts you in the range of having the knowledge to pass the actual examination. Instead, it gives you some idea of the length of the examination and how long you will need to focus, while giving you the confidence that you can get most of the answers correct within the time period allotted.

Tip 6

It probably has been a long time since you had to sit for a 4-hour examination—if ever! Our lives are hectic, and we rarely get a chance to really focus on a single task or have the luxury of thinking about a single topic in a way that allows us to really understand it. Thus, many people find it helpful to study in 4-hour blocks of time rather than for a few minutes here and there. This may be difficult, but it will be beneficial because it will get you prepared to not lose your concentration or focus during such a long period. Remember, runners do not start with marathons, they need to build their strength and endurance over time before they can tackle 26.2 miles. Your preparation is similar: You do not want the first time that you have to sit and engage in critical thinking to be your actual examination.

Tip 7

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. For example, when the Health Insurance Portability and Accountability Act (HIPAA) of 1996 was passed, there were several years before questions related to this law were asked. Although the DSM-5 was published in 2013, ASWB announced that it would not be included on examinations until July 2015. This lag is good and bad. The good news is that you do not have 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 a particular
specialty area, some of the content or answers may appear to be dated. This is often the case in the area of psychopharmacology, because new medications are being approved and used rapidly. Remember the time lapse in your studying, and do not rely on breaking news or even practices in your own agency as information sources.

**Tip 8**

As you think about what is important to learn or remember when you are reviewing this guide, you should recognize that social workers who have attended social work programs at different schools, as well as courses within a program taught by various instructors, have passed the examinations. Thus, although there is always information to add to a KSA related to experience or depth of knowledge, there are “core” elements included in any overview or lecture on the topic, regardless of school or professor. These elements are the ones that have to be learned and remembered because they are the basis of the knowledge being tested. In addition, there are also “core” or essential areas that contain information that is seen as critical to competent practice. Can you imagine a social worker leaving an undergraduate or graduate program without reviewing the signs of child abuse and neglect and his or her duty as a mandatory reporter? Of course not! This is a “core” topic that often is the basis of examination questions. The list of these areas is not fixed, but includes confidentiality, assessment of danger to self and others, cultural competence, and so on. You should ask yourself when studying, “Is this something that every social worker needs to know, regardless of setting or specialization?” If so, it may be essential to include it in your review of a topic because it is likely to be included on the examination.

**Tip 9**

When studying, it is not necessary to memorize the content because you will not have to recall a term or definition from memory. The ASWB examinations are not tests geared to test your memory. Instead, they require you to be able to pick the one of several answers that most directly relates to the topic or is the best based on your knowledge of the content area. Thus, it is much more important that you understand each of the KSAs and are not focused on memorizing fancy terms or facts. If you stumble when asked a question about something that you are saying about a KSA, or cannot go off script when discussing these areas, you may be just memorizing the material instead of really understanding it.
Dealing With Test Anxiety

Perhaps one of the biggest issues that social workers have 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 social workers to assist with anxiety during this stressful time in their professional development.

It is important to acknowledge that anxiety can be useful during this process because it helps you prioritize studying and preparing above other demands placed upon you in everyday life. There are no magic ways to instill the necessary knowledge in your brain besides good old-fashioned studying. Anxiety can be a motivator to keep going over the material even when there are more interesting things you could be doing!

Remember, everyone who is studying for the examinations is feeling the same way. This stress is typical, and you are not alone in feeling anxious.

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 prepared the way that you set out to do. A study plan will help you break the material into smaller manageable segments and avoid last minute cramming.

2. **Don’t Forget the Basics**
   You need to make sure that you don’t neglect your biological, emotional, and social needs leading up to and on the day of the examination. Get plenty of rest, build in relaxation time to your study plan, and eat well to give you energy during this exhausting process.
3. **Familiarize Yourself With the Test Environment**
   Before the day of the examination, drive to the testing center so you know how to get there. Arrive early so you are not rushed. Take your time reviewing the tutorial on the computer before you start the examination.

4. **Use Relaxation Techniques**
   Breathe and give yourself permission to relax during the examination. You may need to shut your eyes and stretch your neck or stand up several times during the 4-hour exam to help you to refocus.

5. **Put the Examination Into Perspective**
   Rarely do people get the score that they want the first time taking any standardized test. Taking the SATs or GREs more than once is the rule rather than the exception. Social workers often attach too much meaning to whether or not they pass the examination the first or second time. They walk into the testing center feeling 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. Remember that you will be able to retake the examination if you do not pass—this is not your only chance. Not passing is not in any way reflective of your ability to practice social work. You will eventually pass, whether it is this time or another, so don’t let the test define you. 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 are occurring and how you can use this information as feedback for making improvements. You did not get a social work degree without some disappointments and challenges. Studying for and passing the examination will also not be easy, but you will be successful if you keep focused and learn from challenges encountered.

7. **Reward Yourself**
   You don’t have to wait until you pass in order 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 so you can enjoy a movie when you get home. Improving your attitude about the test-taking experience can actually help you study more and improve your performance on the examination.

8. **Acknowledge and Address the Anxiety**
   Ignoring the anxiety that accompanies this process will not help. It is impossible to completely eliminate it through any of the techniques mentioned. However, you do need to assess whether it is
Theories and Models

DEVELOPMENTAL THEORIES

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. You need to understand these systems and use them as conceptual tools.

Often, the name of the theory will not be used in a question, but understanding it will be essential to selecting the correct answer.

Study the theories broadly to understand their general theme or focus, and deeply enough to know the meaning of terms originating from them that may be mentioned in exam questions.

SYSTEMS THEORY

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, meso, 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**

- **closed system**: uses up its energy and dies
- **differentiation**: becoming specialized in structure and function
- **entropy**: closed, disorganized, stagnant; using up available energy
- **equifinality**: arriving at the same end from different beginnings
- **homeostasis**: steady state
- **input**: obtaining resources from the environment that are necessary to attain the goals of the system
- **negative entropy**: exchange of energy and resources between systems that promote growth and transformation
- **open system**: a system with cross-boundary exchange
- **output**: a product of the system that exports to the environment
- **subsystem**: a major component of a system made up of two or more interdependent components that interact in order to attain their own purpose(s) and the purpose(s) of the system in which they are embedded
- **suprasystem**: an entity that is served by a number of component systems organized in interacting relationships
- **throughput**: energy that is integrated into the system so it can be used by the system to accomplish its goals

**FAMILY THEORIES**

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 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 personal 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 goals 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 a 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 by the family system are mutually influenced by and are mutually dependent upon one another. What happens to one family member, or 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 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.

**Family Therapy Approaches**

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:**

- 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

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” and 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 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 symptomatic behavior so a client realizes he or she can control 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 autonomous, 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, but 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 by 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 system, 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 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.

Sibling position is a factor in determining personality. Where a client is in birth order has an influence on how he or she 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.

GROUP THEORIES

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 his or her 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:

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
- Interdependence: dependent on one another for achievement of common goals
- Member stability: frequent change in membership results in less cohesiveness

Contraindications for group: client who is in crisis; suicidal; compulsively needy for attention; actively psychotic; and/or paranoid

**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—creates excessive optimism 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
6. Self-censorship—doubts and deviations from the perceived group consensus are not expressed
7. Illusion of unanimity—the majority view and judgments are assumed to be unanimous
8. 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
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.

PSYCHODYNAMIC THEORIES

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.

Psychoanalytic Theory

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 its 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 of his or her behaviors, he or she 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**

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 \textit{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.

In psychoanalytic psychotherapy, the primary technique used is analysis (of dreams, resistances, transferences, and free associations).

\textbf{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 the \textbf{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 \textit{compensation} to refer to the attempt to shed normal feelings of inferiority.

However, some people suffer from an exaggerated sense of \textit{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**

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**: validates the child’s sense of a perfect self
- **Idealization**: child borrows strength from others and identifies with someone more capable
- **Twinship/Twinning**: child needs an alter ego for a sense of 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:

- How a client behaves in relation to the situation he or she finds himself or herself in
- Reality testing: a client’s perception of the 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.

**Stages of Psychosocial Development**

Like Freud and others, Erik Erikson maintained that personality develops in a predetermined order. However, instead of focusing on sexual development, 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 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 around him or her 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.** 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.

**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.

**Object Relations Theory**

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.

<table>
<thead>
<tr>
<th>Age</th>
<th>Phase</th>
<th>Subphase</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1 month</td>
<td>Normal</td>
<td>autism</td>
<td>First few weeks of life. The infant is detached and self-absorbed. Spends most of his or her time sleeping. Mahler later abandoned this phase, based on new findings from her infant research.</td>
</tr>
<tr>
<td>1–5 months</td>
<td>Normal</td>
<td>symbiotic</td>
<td>The child is now aware of his or her 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.</td>
</tr>
<tr>
<td>Age</td>
<td>Phase</td>
<td>Subphase</td>
<td>Characteristics</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------</td>
<td>---------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5–9 months</td>
<td>Separation/Individuation</td>
<td>Differentiation/Hatching</td>
<td>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.</td>
</tr>
<tr>
<td>9–15 months</td>
<td>Practicing</td>
<td></td>
<td>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. The child experiences himself or herself as one with his or her mother.</td>
</tr>
<tr>
<td>15–24 months</td>
<td>Rapprochement</td>
<td></td>
<td>The infant once again becomes close to the mother. The child realizes that his or her physical mobility demonstrates psychic separateness from his or her mother. The toddler may become tentative, wanting the mother to be in sight so that, through eye contact and action, he or she can explore his or her 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.</td>
</tr>
<tr>
<td>24–38 months</td>
<td>Object Constancy</td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
BEHAVIORAL, COGNITIVE, AND LEARNING THEORIES

Behavioral Theory

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 operant.

1. Respondent: involuntary behavior (anxiety, sexual response) that is automatically elicited by certain behavior. A stimulus elicits a response.

2. Operant: voluntary behavior (walking, talking) that is controlled by its consequences in the environment.

Best known applications of behavior modification are sexual dysfunction, 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 will 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 that 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).

Specific Behavioral Terms:

1. **Aversion therapy**: Any treatment aimed at reducing the attractiveness of a stimulus or a behavior by repeated pairing of it with an aversive stimulus. An example of this is treating alcoholism with Antabuse.

2. **Biofeedback**: Behavior training program that teaches a person how to control certain functions such as heart rate, blood pressure, temperature, and muscular tension. Biofeedback is often used for ADHD and panic/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 (the 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 by argument, persuasion, and rational reevaluation and by teaching a client to counter self-defeating thinking with new, nondistressing self-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. *Anxiety-producing stimulus is paired with relaxation-producing response* so that eventually an anxiety-producing stimulus produces a relaxation response. At each step a client’s reaction of fear or dread is overcome 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.

### Cognitive Theory

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.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| 1. Sensorimotor  | 0–2 years | a. Retains image of objects  
b. Develops primitive logic in manipulating objects  
c. Begins intentional actions  
d. Play is imitative  
e. Signals meaning—infant invests meaning in event (i.e., babysitter arriving means mother is leaving)  
f. Symbol meaning (language) begins in last part of stage  |

(continued)
Stage | Age | Characteristics
--- | --- | ---
2. Preoperational | 2–7 years | a. Progress from concrete to abstract thinking  
b. Can comprehend past, present, future  
c. Night terrors  
d. Acquires words and symbols  
e. Magical thinking  
f. Thinking is not generalized  
g. Thinking is concrete, irreversible, egocentric  
h. Cannot see another point of view  
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.

3. Concrete Operations | 7–11 years | a. Beginnings of abstract thought  
b. Plays games with rules  
c. Cause and effect relationship understood  
d. Logical implications are understood  
e. Thinking is independent of experience  
f. Thinking is reversible  
g. Rules of logic are developed

4. Formal Operations | 11 through maturity | a. Higher level of abstraction  
b. Planning for future  
c. Thinks hypothetically  
d. Assumes adult roles and responsibilities

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.

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.

<table>
<thead>
<tr>
<th>Level</th>
<th>Age</th>
<th>Stage</th>
<th>Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconventional</td>
<td>Elementary school level (before age 9)</td>
<td>1</td>
<td>Child obeys an authority figure out of fear of punishment. Obedience/punishment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Child acts acceptably as it is in her or his best interests. Conforms to rules to receive rewards.</td>
</tr>
<tr>
<td>Conventional (follow stereotypic norms of morality)</td>
<td>Early adolescence</td>
<td>3</td>
<td>Person acts to gain approval from others. “Good boy/good girl” orientation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Obeys laws and fulfills obligations and duties to maintain social system. Rules are rules. Avoids censure and guilt.</td>
</tr>
<tr>
<td>Postconventional (this level is not reached by most adults)</td>
<td>Adult</td>
<td>5</td>
<td>Genuine interest in welfare of others; concerned with individual rights and being morally right.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>Guided by individual principles based on broad, universal ethical principles. Concern for larger universal issues of morality.</td>
</tr>
</tbody>
</table>

**Learning Theory**

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 in behavior and the stimuli in the external environment are the locus 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 locus 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 his or her full potential, and the locus 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.

COMMUNITY DEVELOPMENT THEORIES

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.

Similarly, 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.
Coercive: power from control of punishment

Reward: power from control of rewards

Expert: power from superior ability or knowledge

Referent: power from having charisma or identification with others who have power

Legitimate: power from having legitimate authority

Informational: power from having information

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.

PERSON-IN ENVIRONMENT

The person-in-environment 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 person-in-environment (PIE) classification system was developed as an alternative to the commonly used disease and moral models (i.e., Diagnostic and Statistical Manual of Mental Disorders (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.

ADDITION THEORIES AND CONCEPTS

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 for 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 or 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.

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 feeling 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 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 no 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
Substance Use Disorder in DSM-5 combines the DSM-IV categories of Substance Abuse and Substance Dependence into a single disorder measured on a continuum from mild to severe. Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is addressed as a separate use disorder (Alcohol Use Disorder, Stimulant Use Disorder, etc.).
Mild Substance Use Disorder in DSM-5 requires two to three symptoms from a list of 11. Drug craving is added to the list, and problems with law enforcement is eliminated because of cultural considerations that make the criteria difficult to apply.

Non-Substance-Related Disorders
Gambling Disorder is the sole condition in a new category on behavioral addictions. Its inclusion here reflects research findings that Gambling Disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.

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 a substance abuse problem, and committing oneself to making changes
2. Rehabilitation/habilitation: focus is on remaining substance-free by 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 use, 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 B₁) deficiency resulting from the chronic consumption of alcohol. A person with Korsakoff’s syndrome has memory problems. Treatment is administration of thiamine.

**Treatment Approaches**

1. *Medication-assisted treatment interventions* assist with interfering with the symptoms associated with use. For example, methadone, a synthetic narcotic, can be legally prescribed. A client uses it to detox 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, or 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,” (a 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* (AA, NA) provide mutual support and encouragement while becoming abstinent or in remaining abstinent. Twelve-step groups are utilized throughout all phases of treatment. After completing formal treatment, the recovering person can continue attendance indefinitely as a means of maintaining sobriety.

**COMMUNICATION THEORIES**

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.
The NASW Code of Ethics states that a social worker should only solicit information essential for providing services (minimum necessary to achieve purpose).

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 persons 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 or sermonizing by a client and elicit feelings of resentment, guilt, or obligation. In reaction to feeling judged, a client may oppose a social worker’s pressure to change.

2. Offering advice or solutions prematurely, before thorough exploration of the problem, may cause resistance because a client is not ready to solve the problem.

3. Using logical arguments, lecturing, or arguing to convince a client to take another viewpoint may result in a power struggle with a client. A better way of helping a client is to assist him or her in exploring options in order to make an informed decision.

4. Judging, criticizing, and blaming are detrimental to a client, as well as to the therapeutic relationship. A client could respond by becoming defensive or, worse yet, internalizing the negative reflections about himself or herself.

5. Talking to a client in professional jargon and defining a client in terms of his or her diagnosis may result in a client viewing himself or herself in the same way (as “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 his or her situation.

7. Ill-timed or frequent interruptions disrupt the interview process and can annoy clients. Interruptions should be purposive, 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, he or she 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 (1) reduce the importance of conflicting beliefs, (2) acquire new beliefs that change the balance, or (3) remove the conflicting attitude or behavior. This theory is relevant when making decisions or solving problems.

Congruence: matching of awareness, experience, and communication (essential for the vitality of a relationship)

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: 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
DEFENSE MECHANISMS

To manage internal conflicts, people use defense mechanisms. Defense mechanisms are behaviors that protect people from anxiety. Defense mechanisms are automatic, involuntary, 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 disguised as a disturbance of body 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 organization in which a person attributes exaggerated negative qualities to self or another. It is the split of primitive idealization.

7. **Dissociation**—a process that enables a person to split mental functions in a manner that allows him or her to express forbidden or unconscious impulses without taking responsibility for the action, either because he or she is unable to remember the disowned behavior, or because it is not experienced as his or her own (i.e., pathologically 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 a person patterns himself or herself after a significant other. Plays a major role in personality development, especially superego development.

11. Identification With the Aggressor—mastering anxiety by identifying with a powerful aggressor (such as an abusing parent) to 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 psychic representation of a person (or parts of a person) is/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 a 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 is 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—unconsciously perceiving others’ behavior as a reflection of one’s own identity.

19. Rationalization—third line of defense; not unconscious. Giving believable explanation for irrational behavior; motivated by unacceptable unconscious wishes or by defenses used to cope with such wishes.

20. Reaction Formation—person adopts affects, ideas, attitudes, or behaviors that are opposites of those he or she harbors consciously or unconsciously (i.e., excessive moral zeal masking strong, but repressed asocial impulses or being excessively sweet to mask unconscious anger).

21. Regression—partial or symbolic return to more infantile patterns of reacting or thinking. Can be in service to ego (i.e., as dependency during illness).