

STUDY GUIDE: Licensed Clinical Social Worker Exam

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I. Important People

- **Piaget:** Swiss psychology who created theory of cognitive development to explain the processes by which humans come to perceive, organize knowledge, solve problems and understand the world. According to this theory, human cognitive development is the product of a consistent, reliable pattern or plan of interaction with the environment, known as a scheme. Schemes are goal-oriented strategies that help the person achieve some intended result. These schemes are sensorimotor (occurring in infancy and early which, in which reflexes and motor responses are prevalent) and cognitive (based on experience and on mental images, reflecting the person's ability to develop the use of abstract reasoning and symbolism).
- **Erikson:** German psychologist who worked in human psychosocial development theory. Created 8 stages of life.
- **Karen Horney:** Disputed penis envy, calling it both inaccurate and demeaning to women. Instead, Horney proposed that men experience feelings of inferiority because they cannot give birth to children.
- **Masters & Johnson:** Created sensate focus exercises, which focuses on progressive exercises, begins with non-genital touching only, leads to genital touching. Goal is to receive pleasure without pressure to perform and/or achieve orgasm.
- **Jesse Taft and Virginia Robinson:** Started functional theory. They attributed to the School of SW in PA and influenced the work of Mead, Dewey & Rank. This model was presented in contrast to the diagnostic school of thought (which was primarily psychoanalytic).
- **Anna Freud:** Started ego psychology
- **Fritz Perls:** Founder of Gestalt theory
- **Mahler:** Founder of object-relations theory
- **Carl Rogers:** Founder of client - centered theory
- **Pincus & Minahan & Garvin:** Founders of systems theory
- **Ackerman:** "Father of family therapy." He primarily used a psychoanalytic approach, insight oriented
- **Satir & Whitaker:** Communications in family therapy. Mainly experiential (through experience), communication and humanistic, awareness of here and now leading to personal accountability, and increasing patterns of interaction. Satir focused on communication problems, double bind, faulty communication is caused by low self-esteem, and she was more of a practitioner than a theoretician. Whitaker mostly operated with unconscious and discussed the transference phenomena. Generally communication family therapist acknowledges that intrapsychic factors can provide a foundation for family problems, but they do not try to interpret these factors. Family therapist who founded the emphasis in communication patterns are often referred to as the "Palo Alto" group

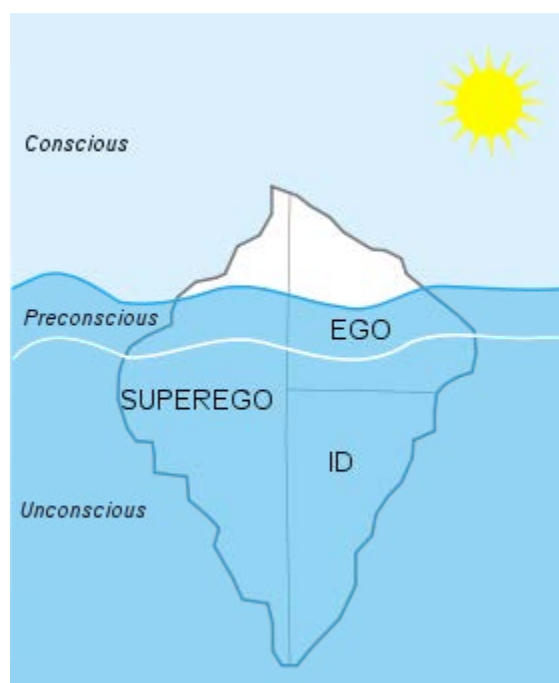
coming from CA. Strong emphasis on communication theory states that it is impossible to not communicate. Here emphasis is placed on behavior as communication and the communication inconsistencies that can occur.

- **Bowen:** Worked with extended family systems, where rational processes are applied to better understand relationships (current and intergenerational) and to maximize self-differentiation. Discussed triangulation and the dysfunction can come through several generations. Here the therapist is a coach. Remember, often used in this approach are genograms and ecomaps. Psychodynamic family therapy: resolution of problems should include intrapsychic exploration & resolution of unconscious object-relationships internalized from early parent-child relationships.
- **Minuchin:** Structural family therapy where behaviors are established through changes in transactional patterns, rather than through insight (action comes before insight). Treatment seeks to restructure family unit maladaptive transactional patterns. He believed if you “improve process” that you improve the family. Techniques often used in this model include: direct confrontation of family behaviors and prescribing the symptom. This model of family therapy is considered best for deriving specific outcomes.
- **Haley:** Strategic family therapy primarily utilizes communication theory, systems theory and behaviorism. Similar to structural, the emphasis is placed on action rather than insight. Here the therapist often joins the family and is active in forcing the family to respond differently to situations based on the presence of the therapist and making use of family symptoms to bring about change.
- **Liberman:** Focused on behavior family therapy & social learning theory. Treatment is focused on changing behavior patterns. Here the traditions of behavior modification remain where behavior is maintained by consequences.
- **Albert Bandura:** Focus on motivational needs, drives and impulses and cognitions toward action or change – are not enough. We are social creatures and therefore must take into account social environment - Social Learning theory.
- **Pavlov:** Classical model of conditions: relationship between a stimulus and a response is unlearned or prewired, emphasis on antecedents. (drooling dog)
- **Skinner:** Operant model of conditions: learning and reinforcement, emphasis on consequences. (Rat & treat lever)

2. Important Theories

- **Psychodynamic Theory:** (Little or no free will). The assumption that unconscious cause lies behind every mental process is known as: primary process thinking, secondary process thinking, psychic determinism, consensual validation. Psychodynamic theory is predicated on the assumption that there is an unconscious which informs one’s life. Psychic determinism – the idea that personality and behavior are determined more by psychological factors than by biological conditions or current life effects.
 - **ID** – The only component of personality that is around from birth. Entirely unconscious and includes instinctive & primitive behaviors. Source of all psychic energy, the primary component of personality. Strives for the immediate gratification of desires.
 - **Ego** – responsible for dealing with reality. Ensures that impulses can be expressed in a manner acceptable in the real world. Functions in the conscious, preconscious & unconscious mind. Based on the reality principle - strives to satisfy the id’s desires realistically & appropriately.
 - **Superego** – is our sense of right & wrong. Provides guidelines for making judgment. Emerges around age 5. Guilt is here.
 - Two parts of the superego-
 - **The ego ideal:** includes the rules & standards for good behaviors. These behaviors include those which are approved of by parental & other authority figures.
 - **The conscience:** includes info about things that are viewed as bad by parents and society. These behaviors are usually forbidden & lead to bad consequences.

- **Ego strength** – the ego’s ability to function, despite dueling forces.
- **Psychosocial development**
 - **Oral stage:** birth – 1 year. Most of the world is interacted with by the mouth. Issues can occur during weaning.
 - **Anal stage:** 1-3 years old. Primary focus is controlling the bladder & bowel movements. According to Freud, inappropriate parental responses can result in negative outcomes. If parents take an approach that is too lenient, Freud suggested that an anal-expulsive personality could develop in which the individual has a messy, wasteful or destructive personality. If parents are too strict or begin toilet training too early, Freud believed that an anal-retentive personality develops in which the individual is stringent, orderly, rigid and obsessive.
 - **Phallic Stage:** 3-6 years old. Child starts to discover the differences between male & females. Freud also believed that boys begin to view their fathers as a rival for the mother’s affections. The Oedipus complex describes these feelings of wanting to possess the mother and the desire to replace the father. However, the child also fears that he will be punished by the father for these feelings, a fear Freud termed castration anxiety. The term Electra complex has been used to describe a similar set of feelings experienced by young girls. Freud, however, believed that girls instead experience penis envy. Eventually, the child begins to identify with the same-sex parent as a means of vicariously possessing the other parent. For girls, however, Freud believed that penis envy was never fully resolved and that all women remain somewhat fixated on this stage.
 - **Latent period:** 6-12, the latent period is a time of exploration in which the sexual energy is still present, but it is directed into other areas such as intellectual pursuits and social interactions. This stage is important in the development of social and communication skills and self-confidence.
 - **Genital:** 12+ source of satisfaction: Genitals. Outcome – sexuality become focused in mature, genital love and adult satisfaction.
- **Primary process thinking:** is the language of the unconscious (e.g. slips of tongue, dreams, associations, jokes and child’s language and thought).



- **Ego Psychology (psychodynamic theory):**
 - Credited to the work of Ana Freud, Erikson and others

- Anna Freud's focus was on the healthy individual – not the sick one. From this perspective basic drives are influenced by the environment and critical periods.
- This model draws heavily from psychoanalysis and utilizes the effect of the conscious and unconscious
- Based on scientific determinism: individuals are products of the past, understanding the past explains the present (you are determined by your past)
- Ego psychology applied to practice: the individual adapts to the environmental context through:
 - Suggestion: the therapist plants a seed or idea
 - Abreaction – in therapeutic context, strong emotions are discussed in regard to the issue and catharsis (i.e., the release of tension in a protected setting) is achieved.
 - Manipulation – therapist directly or indirectly influences the client to a plan of action.
 - Clarification and interpretation: the therapist pinpoints significant themes, etc. Patterns and/or trends of thinking are highlighted. In interpretation you make inferences based on what the therapist hears and believes to be the situation.
- Psychosocially oriented concepts that built on Freudian theory but emphasize the individual's adult development and ability to solve problems & deal with social realities.
- **Gestalt therapies** – German for the word “whole.” Emphasize the current experiences of the client in the here and now. Patient learns to recognize their needs and how the drive to satisfy those needs may influence their behavior. Gestalt theory argues that behavior is more than the sum of its parts.
 - Founder is Fritz Perls: and the only real time is the present, individual must take responsibility for all aspects of his/her life.
 - Whole is greater and different from the sum of the parts.
 - Focus is on the here and now with immediate awareness of personal experiences
 - In gestalt therapy, unexpressed guilt is viewed as “unfinished business” and the client needs to re-address this (i.e., can use empty chair, psychodrama).
 - Techniques or games often used include:
 - Psychodrama
 - Skillful frustration
 - Dream work
 - empty chair
 - Rules of Gestalt theory include:
 - Directed awareness – speak in the present tense only, uses directed awareness
 - Use of “I” language – accept responsibility for self and own actions
 - Restricting and planning the use of questions. Avoiding “why” questions because they tend to refocus attention to others and away from the self.
- **Object relations Theory** (a human growth and development theory)
 - This is more of a psycho-social/human development approach introduced by Mahler and Associates.
 - According to Mahler, a child must separate and individuate so that he/she can move from being a part of the other/child unit to being a member of a family.
 - Separation occurs when a child differentiates or disengages from the mother.
 - The child often uses transitional objects such as a teddy bear to separate from the mother.
 - Individuation occurs when the child develops an inner representation of the mother, ability to test reality, a sense of time and an awareness of the existence of other individuals as separate and different from him/her. Rapprochement (have to know where it is, but doesn't have to have it with you anymore) is the last phase prior to the completion of individuation.
- **Client-Centered Theory** (a human relations theory)
 - Carl Rogers is noted as the founder
 - This model lack authoritative rigidity and dogma. Most of its premises were made ex post facto.

- It is based on relationship therapy and the functional school of social casework.
- Basic goal of therapy is to “release an already existing capacity for self-actualization in a potentially competent individual”
- On a person-environment continuum, this model is closest to the person
- Techniques used are often considered non-directive (passive, nonjudgmental listening), reflective (active listening); however, the therapist is seen as an active listener and reinterprets statements made by the client.
- **Developmental stages** – middle latency, late latency, early latency, the phallic stage: 3. early latency (ages 6-8) is a time when the child is cognitively able to separate fact from fantasy and is able to work logically and systematically on different tasks (Piaget). The child is yet unable to consider alternative ways of thinking or doing, thus she clings to what she “knows” something. I.e., something is black or white, all or nothing. The world is experienced and understood in terms of absolutes.
- **Reparative Therapy** – form of therapy that starts with the assumption that all people are born heterosexual and the purpose is to cure or convert homosexuals to heterosexuals.
- **Functional Theory:** (a problem solving focus with free will)
 - Two pioneers of this theory were Jesse Taft and Virginia Robinson. Attributed to the School of SW in PA and influenced the work of Mead, Dewey & Rank. This model was presented in contrast to the diagnostic school of thought (which was primarily psychoanalytic).
 - This model highlights the importance of agency function in the helping process.
 - Diagnosis is related to the use of services and is expected to change as client needs change.
 - Time phases in SW process are important (beginning, middle and end).
 - Agency function gives focus, content and legitimacy to services provided. It is the place where the interests of society and the individual join.
 - Clients are active in this model & are capable of individual choice.
- **Systems Theory:** This analysis is taken primarily from the work of Pincus & Minahan and Garvin
 - Value Based: Two primary values
 - Society has the obligation to ensure that people have access to resources and opportunity
 - When providing resources dignity and individuality should be obtained.
 - Assumptions:
 - General systems theory involves goal oriented planned change
 - The small group/individual is seen as an organic entity with boundaries, purposes and mechanisms for attaining change and maintaining stability. Whatever happens to one component of a system directly affects another.
 - Four systems are identified in which the social worker must be involved:
 - Change agent system: includes the change agent and others within the agency or employment organization
 - Client system: people who sanction or request services, the expected beneficiaries of the service and those who have a working agreement with the change agent.
 - Target system: people or things that need to be changed to accomplish goals.
 - Action system: change agent and individuals that help accomplish change
 - Worker use techniques of educating, advocacy, facilitation and intervention
 - Eight practice skill areas that workers need: assessing problems, collecting data, making initial contracts, negotiating contracts, forming action systems, maintaining and coordinating action systems, exercising influence and terminating the change effort.
 - Problems are not viewed as in the client; problems are viewed as in the system.
- **Ecological Systems Perspective**

- This is the study of relations between the organism and the environment. This constitutes transactional exchanges with each exchange affecting the other.
- This is considered a good model to use to address minority concerns since it addresses the person in his/her cultural environment.
- Must include the community in every part of the assessment.
- Adaption and the goodness of fit with the environment must be established
- Person environment relationship can either be positive or negative.
- Clients are seen as active and PRIMARY prevention strategies are stressed between clients, life transitions, interpersonal processes and environmental properties.
- This approach is often now taught in schools of social work as an alternative or addition to systems theory. It encouraged the PIE evaluation system than DSM IV.
- **Family Therapy / Family Systems**
 - Treatment is focused toward a family and or group and is the core of treatment.
 - Treatment is not dependent on all members attending the treatment session(s).
 - General system theory and communication theory forms the core of family therapy.
 - Dysfunction is seen as an interpersonal process, not based in within the individual.
 - Supports the principle when there is a system; everything functions together. Once one part of a system changes, the other parts will also change.
 - In the 1970's and 1980's, focus moved from differentiation within the family to more integration of the family.
 - From a system framework, family therapists are expected to be "somewhat" objective observers that help to interpret and reframe the situation.
 - Gender differences are not formally acknowledged or considered in treatment. "Family therapy from a systems perspective does not acknowledge the social definitions of role expectation placed by the society and cultural environment."
 - Family therapy is not best method of treatment if: key family members are unavailable, members are psychotic or suffer from mental illness not allowing change, and if family is so fragile that exploration could result in relationship termination.
 - Videotape and audiotaping is often used.
 - Some family therapist's practice prescribing the symptom, in this paradoxical view a therapeutic double bind is created and the client will generally rebel and stop the behavior.
 - In family therapy, the goal is homeostasis.
 - General Ways in Which Family Therapy is Applied to Practice:
 - Realize importance of relationship influences and family interaction patterns.
 - Help identify influential relationships at each life stage and how influences the future.
 - Use your power as a therapist to develop a positive relationship for change, helping to identify and anticipate problems based on past-established relationship patterns.
 - Structural family therapists are often very active in sessions with families & are likely to use individual as well as family sessions. The goals of therapy focus on reorganizing the family structure to reflect a parental hierarchy and to create clear and flexible boundaries between family members
 - Conjoint therapy: type of intervention in which a therapist or team of therapists treats a family by meeting with the members together for regular sessions; also, a type of intervention in which a husband and wife are treated as a unit and seen together by the marital therapist or therapy team.
- **Social Learning Theory**
 - Generally considered the work of Albert Bandura – focus on motivational needs, drives and impulses and cognitions toward action or change – are not enough. We are social creatures and therefore must take into account social environment.

- Learning takes place through observation and reinforcement in the social system. Therefore, from this perspective, opposites would never attract.
 - Reinforcement is key to continuing behavior. Feedback is important with self-evaluative comments. Intermittent reinforcement is the most powerful way to maintain a behavior.
- How Social Learning Theory is applied to practice:
 - Specificity: when things are clearly and concretely identified.
 - Successive approximations: small steps to reach a goal.
 - Modeling: complex learning takes place through watching the behavior of others.
 - Performance: completing or actually doing makes the behavior more ingrained.
- Classical model of conditions: Pavlov, relationship between a stimulus and a response is unlearned or prewired, emphasis on antecedents.
- Operant model of conditions: Skinner, learning and reinforcement, emphasis on consequences.
- **Behavior Therapy / Modification**
 - Behavioral treatment is the most empirical of all treatment methods, relying heavily on research-based treatment that alters observable behaviors.
 - Became popular in the 1960's getting its roots from psychology and social psychology. Popularity came out of the need to prove the effectiveness of clinical practice.
 - Uses a quantitative response as opposed to a qualitative one to established effectiveness.
 - Behavior modification generally uses Nomothetic Methodology. Here an important emphasis is placed on: scientific protocol and technique; hypotheses are tested under strict rules and guidelines; tools of measurement are clearly defined; journals, diaries, homework, and participant observations are often used.
 - Continuum of Behavior theorists
 - Applied behavioral analysis (Skinner) ----- Cognitive behavior modification (Wolpe, Beck)
 - Work of B.F. Skinner "Knowledge is behavior, and thus all knowledge can be measured" through behavior.
 - Work of John Wolpe & others emphasizes the thoughts that seem to relate to the troublesome reaction
 - Reinforcement = behavior increase or strengthen behavior
 - Punishment = behavior decrease or weaken behavior
 - Negative "-" = to take something away, avoid or subtract
 - Positive "+" = to add/give something, add
 - **Reinforcer:** (to support) and **reinforcement** (behavior strengthen or increase) are two word that look alike but have two different meanings
 - **Reinforcer:** if the reinforce follows the behavior, the behavior is more likely to increase; therefore, reinforcement often strengthens a behavior
 - **Positive Reinforcer:** Present: Positive reinforcement (strengthens behavior) ; Withdraw: Punishment (weakens behavior)
 - **Negative Reinforcer:** Present: punishment (weakens behavior) ; Negative reinforcement (strengthens behavior)
 - **Stimulus Generalization:** The same response is given to various (possibly unrelated) stimuli.
 - **Aversive therapy:** (e.g. a dog with a shock collar to stop the dog from barking so much)
 - **Rational Emotive Behavioral Therapy (REBT) or Rational Emotive Therapy (RET)**
 - Principle founder is Albert Ellis
 - This is considered a humanistic, cognitive behavioral form of treatment.
 - Dysfunctional behaviors are the result of irrational thoughts and beliefs.
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 - Ellis uses the ABCDE model
 - A=objective facts & behaviors and individual encounters
 - B=the individual's beliefs about "A"

- C=the emotional and behavioral consequences of “A”
- D=therapist debates the irrational beliefs by asking specific why, where and how questions
- E=the cognitive emotional and behavioral effects associated with the irrational beliefs are examined
- Watch out for “should” and “Musts” which result in “musterbating” and don’t catastrophize!
- **The problem solving model**
 - Helen Harris Perlman developed this model that focuses on the here and now.
 - The four P’s of the problem solving approach. These must be identified and addressed in treatment: the place (where treatment was sanctioned), the person (identified client), the problem (stated in specific terms, partialized) and the process (what was to be done).
 - Used as a foundation for the development of brief therapy and crisis intervention.
- **Task-Centered social work**
 - Founder was William J Reid. This approach focused on tasks to be accomplished.
 - Problems generally reflect temporary breakdowns in problem coping that set in motion forces of change. Use client motivation and resources to assist in task centered problem solving. Problems are defined in specific elements for change.
 - Utilizes an empirical stance, client-defined problems and goals, intervention based on specific goal resolution, a caring but collaborative relationship, structured sessions, ends with problem solving in the session that leads to outside actions.
- **Solution Focused Social Work**
 - Emphasis is placed on developing solutions for addressing problem behaviors.
 - Change talk or change strategy is the focus of all intervention efforts
- **Brief Planned Treatment**
 - Two major issues debated hotly in the past in regard to social work practice are speed & effectiveness. Combination of this is the key to brief therapy.
 - Why did we or are we moving toward brief intervention?
 - People do not have the time, desire or money for long-term treatment
 - Agencies want it because funding sources want it (financial constraints)
 - Expanding demands for service and the deinstitutionalization of mental health clients within the community.
 - More people agree that to need therapy you do not have to be “crazy”
 - People drop out of treatment and approximately 80% will drop out after the sixth session. Research suggests that in practice there is a great deal of unplanned short term treatment.
 - Brief therapies have gained increased interest over the years and are referred to as brief treatment, brief psychotherapy, solution based treatment, etc.
 - Theoretical foundations/models for short-term therapy can vary. The main criteria are speed, effectiveness, time limited and reality focused.
 - Five essential characteristics of short-term therapy include: prompt intervention, a relatively high level of therapist activity, establishment of specific but limited goals, the identification and maintenance of a clear focus, and, the setting of a time limit
 - Eclecticism or Pluralism is generally the model used with short-term treatment. Can use any model of social work intervention that focuses on speed and effectiveness.
 - Fischer 1970’s eclectic model – used behavioral and cognitive methods as the basis but did not openly claim them.
 - Eclectic got a bad name because therapists just use pieces of a model, not really understanding the theoretical underpinnings.
- **Crisis Intervention**

- Time limited crisis intervention – is not identical to crisis theory.
- This model deals with the crisis period and restoring equilibrium for the client. This model deals with “healthy people falling apart” and with or without help the situation will resolve for better or for worse.
- Crisis is different from brief treatment because in brief treatment the focus is on learning new treatment strategies to move the client beyond equilibrium.
- Crisis by definition is short-term and overwhelming and involves a disruption of an individual’s normal and stable state where the usual methods of coping & problem solving do not work.
- Crisis intervention is generally characterized by:
 - Here & now orientation
 - Time limited course (typically 1-12 sessions)
 - A view of the clients behavior as understandable (rather than a pathological) reaction to stress
 - The therapist is very active and directive.
- Theoretical Framework:
 - Initial interest in crisis intervention grew out of military need to predict the performance of soldiers who might break under battlefield conditions.
 - Lindermann and Caplan were foremost in dealing with families who suffered from some type of crisis. Lindermann designed a program to help the family members of those that were involved in the coconut grove fire to deal with crisis without unresolved or pathological grieving. Caplan developed a core theory of intervention involving an individual facing an obstacle or important life goals/events considered insurmountable to customary problem solving methods.
 - Two types of crisis situations are identified: those precipitated by the normal life course (i.e., school entry, retirement and natural death), or those brought by an accident or hazardous events
 - Crisis intervention is strongly interdisciplinary and is believed to be the future in unifying mental health professionals from all disciplines.
 - All models of crisis intervention follow: assessment, implementation, termination.
- Basic Tenants of Crisis intervention:
 - The hazardous event. The individual is subjected to periods of stress, which disturb his/her sense of equilibrium.
 - The vulnerable state: the impact disturbs the individual & traditional problem solving and coping methods fail. Tension & anxiety continue to rise. Functioning is hampered.
 - The precipitating factor: the client is pushed into a state of active crisis marked by disequilibrium, disorganized and immobility (e.g. the last straw).
 - The active crisis state: the event becomes a threat, loss or challenge. These reactions can bring about a new energy for problem solving. The challenge stimulates a moderate degree of anxiety plus a kindling of hope & expectation. The actual state of disequilibrium will last 4—6 weeks until some type of adaptive or maladaptive solution is found. They say values can be changed at this stage.
 - The individual reintegrates and reaches equilibrium. Each particular crisis may follow a sequence of stages that can generally be predicted and mapped out. During crisis situations clients seem particularly amenable to help.
- Social Work Practice Principles for Crisis Intervention
 - Immediate intervention as cannot endure crisis for long periods of time.
 - Action. Be active in helping, exploring and resolving.
 - Limited goals. Focus only on goals related to the crisis.
 - Build hope & expectations. Resolution is possible.
 - Foster support because lack of it can lead to an adjustment reaction.
 - Focus on resolution of solving the problem underlying the crisis.
 - Build self-image and self-confidence. Focus on strengths.

- Build self-reliance and discourage complete support on professional, spiritual or family/friend support system.
- Strategies & Techniques in Crisis Intervention
 - The client may not present with the actual crisis event.
 - Assess both past & present coping behaviors. Crisis intervention is focused in the here and now stay away from the past issues or unresolved problems.
 - Overall strategy increases an individual's remobilization and return to the previous level of functioning.

3. Group Therapy

- The group worker's role in an educational group is to encourage group problem solving and facilitate discussion. It would not be useful to move toward insight-based techniques such as reflection which could be seen by group members as threatening, and a violation of their understanding of the group's purpose.
- Integrating a new member into a group is always problematic since the individual is likely to be in a somewhat different place emotionally, and has not had the shared group experiences that characterize group life. The worker's task is to mediate the adolescent's entry into the group in a way that helps the youth, while not subtly encouraging or allowing the group to lose its focus. Nothing in the question suggests acting out behavior is a problem. The worker would seek to protect the group member, but would rather use group behavior as a learning tool.
- Types of groups – insight oriented, supportive, task oriented, and task focused: GAD responds to a variety of treatments, depending on the individual, however, the mix usually includes some type of insight based, supportive or cognitive therapy and anti-anxiety medication. Supportive group TX would not ordinarily be used without some individual treatment, and task oriented group would be inappropriate. Medication without any additional intervention is normally not used for this disorder.
- Discussion group does not have the same contract as a therapy group. The members are not necessarily expected to address other group members' behavior. Thus, it is the responsibility of the leader to note the apparent discrepancy between tone and content. This makes explicit something which is present in the here and now. It also serves as a role model for the other adolescents, making it safe to acknowledge anger and providing members with an invitation to discuss issues that concern them.
- As in all therapeutic group situations, the focus of intervention is what is happening in the relationship at the moment.
- The worker needn't wait for the group to respond, but should respond directly. If this were a remedial group, it might be more appropriate to reflect the response back to the group, or attempt to interpret the behavior in the context of what is going on in the group. However, in the context of a recreational group, it is appropriate for the worker to respond.
- When working within a group, always "bring it back" to the group to address unless it involves mandatory reporting or a danger to self or others (i.e. a client is continually late for group, let the group address this. The power is with the group.
- Historical development of group work:
 - The settlement houses: the first settlement house was Toynbee Hall, established in London in 1884.
 - Jane Addams founded the Hull House, the first recognized settlement house in America.
 - The modern period of group work as we know it today began in the 1930's.
- Types of Groups:
 - Social conversation: these groups are rarely therapeutic. Professionals can use this to learn more about each other. This is sometimes referred to as a TEAM group or a team SUPPORT group.
 - Socialization: The "object" is generally to develop behaviors and responses in-group members that are socially responsible. These groups generally require a skilled-trained leader.

- Recreation skill building: combines the recreational and skill building groups.
- Education: all of these groups teach specialized skills and knowledge and are led by a professional person with expertise in that area. Groups are often larger.
- Self-help: this movement has become very popular over the years. They generally are self-directed and “cause” oriented. Examples include: AA
- Problem solving & decision making: there is a formal leader and each member has an interest and/or stake in the group
- Sensitivity and encounter training groups: this refers to a group experience where people are encouraged to relate to each other on an inter-personal basis and self-disclosure is required. There are three stages in these groups: 1. unfreezing, 2. Change, and 3. refreezing. The goal of these groups is to improve interpersonal awareness.
- Therapy groups: group members often have emotional or personal problems. Similar to individual therapy, individuals explore personal problems in relation to the group. Several advantages over individual therapy are that research supports that it is easier to change attitudes in a group setting; members can interchange roles and experience helping the other person; an, it saves on costs.
- For all groups: the focus of all groups is generally “here and now”
- Determining Objects and Goal setting
 - The following questions must be given careful consideration. Why is this group being formed? How will members be selected? What do you want to accomplish in the group?
 - Group goals are generally mutually negotiated (between therapist and group), and the group remains active in goal selection.
 - Group goals should always be operational and measurable. Operational goals can be directly translated into courses of action to achieve a goal (e.g. helping drill sergeants to better manage stress in their lives through learning specific techniques such as deep breathing. Measureable, simply means that we can show that they have learned what we hoped they would (i.e. drill sergeant is able to teach himself and/or another how to deep breathe).
 - Research has found group goals with the highest chance of success occur when: goals are clear, operationally defined and measurable; address both personal and group goals; members see the goals as attainable, meaningful and relevant, yet challenging with a moderate risk of failure; resources needed to achieve the goals are present, and a cooperative not competitive atmosphere is maintained.
- Important guidelines:
 - An individual interview prior to the first group meeting is strongly recommended where group goals are considered for presentation as well as assessment of motivation to participate. If the group has a semi-open agenda, all gathered ideas from members are formulated and ranked at the first group meeting.
 - Close-ended groups can function more effectively because the membership is constant and there is a specific limited time frame.
 - Addressing termination issues in both groups is essential.
 - Selection of members: several characteristics of the participants to consider include: age (for children use plus or minus two rule), gender, ethnic background, socio-economic status, intelligence, mental health status, and motivation and socialization skill levels.
 - Seating arrangements: circles are excellent for generating discussion, promoting openness and group cohesion. Tables can be helpful in providing a place to write or in working sessions, but can also be perceived as “formality” or a barrier to open communication. Classroom seating appears to be the most consistent with education groups as this discourages open discussion among members.
 - Introduction by group members: the group leader should always introduce him/her and modestly states professional qualifications for conducting the group.
 - Leadership styles: authoritative has absolute power. Democratic seeks the maximum involvement of the participants. Laissez faire group leaders minimally participate and group members function on their own.

- The more cohesive a group, the more likely it is to conform to group norms. As groups process-cohesion increases. Yalom believes that increasing self-disclosure and increased group cohesion are linked.
- Group factors:
 - Group size: smaller the group, the more individual satisfaction noted. Small groups average 5 to seven members. The larger the group, the more successful in solving complex problems. Odd numbers of members are most effective for enhancing communication. Ideal group size 8-10 people
 - Open-ended vs. closed ended groups: termination must be discussed in every session.

4. Family Therapy

- Family roles –
 - Role complementarity: Role complementarity occurs when two or more people have different roles that serve to preserve a type of interaction and relationship over time. For example, and over responsible mother and an irresponsible son.
 - pseudo mutuality: When members all agree that their behavior is for the benefit of all equally and the opposite is actually true, this is pseudo-mutuality.
 - family homeostasis: – Homeostasis involves symptoms tending to seek and maintain the same level of functioning as previously experienced. If one member starts to get better, another may begin to exhibit symptoms to maintain the family's previous level of functioning.
 - Family Fusion: Fusion involves an agreement among members that there will be no differentiation and every member will stay emotionally involved in all aspects of the family interaction.

5. Medications

- Prolixin – part of a class of antipsychotic drugs that include Thorazine, Mellaril, and Haldol. These drugs are sometimes referred to as neuroleptics.
- Lithium and Haldol are typically used with bipolar disorders and are effective with 80% of patients with this diagnosis. The medication seems to be effective with both the manic and depressive states of the disease and re used for short and long term management of the condition
- Ritalin (methylphenidate): ADHD
- Cylert (pemoline): ADHD
- Sinemet: the primary medication used for parkinson's disease
- Antipsychotic drugs AKA neuroleptic drugs: used to treat severe psychotic disorders (i.e. schizophrenia). Peak concentrations occur between 2-4 hours. Should not prescribe two anti-psychotics at the same time. After discharge, wait 3-6 months before you consider changing medication
 - Old or typical antipsychotic medications: chlorpromazine/Thorazine; thioridazin/mellaril; trifluoperazine/stelazine; phenazine/prolixin; haloperidol/Haldol. Side effects include: drowsiness / sleepiness; dystonia (stiff or thick tongue); akathisia inner restlessness; tardive dyskinesia: this is a permanent neurological condition that can result from using older antipsychotic medications
 - New or atypical anti-psychotic medications: clozapine/clozaril (can cause agranulocytosis – the inability of the bone marrow to make white blood cells); risperdone/Risperdal; olanzapine/Zyprexa
- Lithium: used to treat manic episodes of bipolar disorder and should diminish manic symptoms in 5-14 days. Need routine lithium levels and other recommended tests. The amount of lithium a person needs may also vary over time and lithium has a small range between a therapeutic dose and a toxic one. Side effects include: drowsiness, weakness, nausea and vomiting, fatigue and hand tremor
- Depakote (Valproic acid): work well with schizo affective disorders or agitated depression of a cyclic nature. Side effects include: nausea, indigestion, drowsiness or hair loss.

- Depakene work well with schizoaffective disorders or agitated depression of a cyclic nature. Side effects include: nausea, indigestion, drowsiness or hair loss.
- Clonazepam work well with schizoaffective disorders or agitated depression of a cyclic nature. Side effects include: nausea, indigestion, drowsiness or hair loss.
- Tricyclic's – class of medication for depression
- Tofranil / imipramine - depression
- Elavil/amitriptyline – depression
- MAO inhibitors: many dietary restrictions: no foods with the chemical tyramine (e.g., cheese, beef, chicken liver, pickled herring, red wine, chocolate, coffee, raisins, pineapple and bananas: Eldepryl / selegiline
- Eldepryl/ selegiline: depression
- Prozac / Fluoxetine (SSRI inhibitor): antidepressant – side effect includes sexual disinterest and orgasmic delay
- Paxil / Paroxetine hydrochloride (SSRI inhibitor): antidepressant – side effect includes sexual disinterest and orgasmic delay
- Zoloft (SSRI inhibitor): antidepressant - side effect includes sexual disinterest and orgasmic delay
- Alprazolam (Xanax): anti-anxiety
- Diazepam (valium)

6. General Terms

- Malingering tends not to be associated with major disorders since it requires a planned response to some undesirable activity that the client would like to avoid. Voluntary produce symptoms in presence of exaggerated voluntary physical symptoms, there is an obvious recognizable goal.
- Ego syntonic – means that behaviors, thoughts or feelings are completely acceptable and no conflict is experienced about them. Any discomfort is thought to emanate from external sources. This is the hallmark experience of PD. It can be contrasted to an Anxiety Disorder or Affective Disorder where the feelings or behaviors are experienced as alien or “ego dystonic” and cause guilt or discomfort.
- Although educational level can help in ego assessment, it isn't critical. Whereas developmental level is affected by age, cultural background gives information about how the world is viewed. Reality testing is one parameter of ego functioning important to the person's ability to make realistic choices for themselves.
- Factitious disorders vs. hypochondriasis vs. malingering- No other choice fits the criteria of voluntariness necessary for the diagnosis of malingering. Malingering always has a manipulative goal, usually designed to avoid unpleasant tasks or the consequences of negative behavior.
- **Defense mechanisms –**
 - **Primitive**
 - Denial – refusal to accept reality or fact, acting as if a painful event, thought or event did not exist. Some theories holds that people suffering from paranoid personality disorder deny their own unacceptable thoughts or feelings and project these on others.
 - Regression – the reversion to an earlier stage of development.
 - Acting out – performing an extreme behavior in order to express thoughts or feelings the person is incapable of otherwise expressing. Defensive acting out is not synonymous with “bad behavior” because it requires evidence that the behavior is related to emotional conflicts.
 - Dissociation – when a person loses track of time or a person, and instead finds another representation of themselves to continue with the moment.
 - Compartmentalizing – a lesser form of dissociation, whereas part of oneself is separated from awareness of other parts and behaving as if one had a separate set of values.
 - Projection – The misattribution of a person's undesired thoughts, feelings or impulses onto another person who does not have those thoughts, feelings, or impulses.

- Reaction formation – converting of unwanted or dangerous thoughts, feelings or impulses into their opposite. For example, a woman who is very unhappy with her boss & job will become overly kind & generous and may express a desire to stay at the job forever. Reaction formation occurs when unacceptable thoughts or impulses are expressed by their opposites. It is an immature defense and usually causes problems for the individual since the underlying aggression is never addressed.
- Repression – the unconscious blocking of unacceptable thoughts, feelings or impulses. The key to repression is that people do it unconsciously.
- Suppression – Involves voluntary setting aside of affect and memory, which can also be voluntarily retrieved. Sometimes we do this consciously by forcing the unwanted information out of our awareness, which is known as suppression. In most cases, however, this removal of anxiety-provoking memories from our awareness is believed to occur unconsciously. Dealing with emotional conflict or internal or external stressors by intentionally avoiding thinking about disturbing problems, wishes, feelings or experiences.
- Displacement – is the redirecting of thoughts, feelings, or and impulses directed at one person or object, but taking it out on another person or object.
- Intellectualizing – the overemphasis of on thinking when confronted with an unacceptable impulse, situation or behavior without employing any emotions whatsoever to help mediate and place the thoughts into an emotional, human context. Rather than deal with the pain associated with the emotions, a person might employ intellectualism, to distance themselves from the impulse.
- Rationalization - putting something into a different light or offering a different explanation for one's perceptions or behaviors in the face of a changing reality. For instance, a woman who starts dating a man she really, really likes and thinks the world of is suddenly dumped by the man for no reason. She reframes the situation in her mind with, "I suspected he was a loser all along."
- Undoing - the attempt to take back an unconscious behavior or thought that is unacceptable or hurtful. For instance, after realizing you just insulted your significant other unintentionally, you might spend the next hour praising their beauty, charm and intellect. By "undoing" the previous action, the person is attempting to counteract the damage done by the original comment, hoping the two will balance one another out. Undoing is a secondary defense mechanism that surfaces when unacceptable or frightening thoughts or actions break free into consciousness. Undoing is performed to reverse the consequences that flow from the action.
- Conversion involves changing the affect into another symptom, such as a physical disorder or problem.
- Sublimation - the channeling of unacceptable impulses, thoughts and emotions into more acceptable ones. For instance, when a person has sexual impulses they would like not to act upon, they may instead focus on rigorous exercise. Refocusing such unacceptable or harmful impulses into productive use helps a person channel energy that otherwise would be lost or used in a manner that might cause the person more anxiety.
- Compensation - process of psychologically counterbalancing perceived weaknesses by emphasizing strength in other arenas. By emphasizing and focusing on one's strengths, a person is recognizing they cannot be strong at all things and in all areas in their lives. For instance, when a person says, "I may not know how to cook, but I can sure do the dishes!" they're trying to compensate for their lack of cooking skills by emphasizing their cleaning skills instead. When done appropriately and not in an attempt to over-compensate, compensation is defense mechanism that helps reinforce a person's self-esteem and self-image.
- Assertiveness - the emphasis of a person's needs or thoughts in a manner that is respectful, direct and firm. Communication styles exist on a continuum, ranging from passive to aggressive, with assertiveness falling neatly in-between. People who are passive and communicate in a passive manner tend to be good listeners, but rarely speak up for themselves or their own needs in a

relationship. People who are aggressive and communicate in an aggressive manner tend to be good leaders, but often at the expense of being able to listen empathetically to others and their ideas and needs. People who are assertive strike a balance where they speak up for themselves, express their opinions or needs in a respectful yet firm manner, and listen when they are being spoken to. Becoming more assertive is one of the most desired communication skills and helpful defense mechanisms most people want to learn, and would benefit in doing so

- Affiliation - This involves turning to other people for support.
- Aim Inhibition - In this type of defense, the individual accepts a modified form of their original goal (i.e. becoming a high school basketball coach rather than a professional athlete.)
- Altruism - Satisfying internal needs through helping others. Unlike the self-sacrifice sometimes characteristic of reaction formation, the individual receives gratification either vicariously or from the response of others.
- Compensation - Overachieving in one area to compensate for failures in another.
- Humor - Pointing out the funny or ironic aspects of a situation.
- Passive-aggression - Indirectly expressing anger. Passive aggressive behaviors are characterized by indirect expressions of aggression and a denial of those feelings in the self. This behavior creates problems for others. Drawing attention to oneself indicates a need for mirroring which is characteristic of narcissistic disorders. Ideas of reference, are an indication of a thought disorder and is usually associated with Schizoid disorder
- Isolation of affect - dealing with emotional conflict or internal or external stressors by the separation of ideas from the feelings originally associated with them. The individual loses touch with the feelings associated with a given idea (e.g., traumatic event) while remaining aware of the cognitive elements of it (e.g., descriptive details)
- Devaluation - dealing with emotional conflict or internal or external stressors by attributing exaggerated negative quality to self or others.
- Idealization - dealing with emotional conflict or internal or external stressors by attributing exaggerated positive qualities to others.
- Omnipotence - dealing with emotional conflict or internal or external stressors by feeling or acting as if he or she possesses special powers or abilities and is superior to others.
- Autistic Fantasy - dealing with emotional conflict or internal or external stressors by excessive daydreaming as a substitute for human relationships, more effective action or problem solving.
- Projective identification - as in projection, is dealing with emotional conflict or internal or external stressors by falsely attributing to another his or her own unacceptable feelings, impulses or thoughts. Unlike simple projection, the individual does not fully disavow what is projected. Instead, the individual remains aware of his or her own affects or impulses, but misattributed them as justifiable reactions to the other person. Not infrequently, the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first.
- Splitting - dealing with emotional conflict or internal or external stressors by compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images. Because ambivalent affects cannot be experienced simultaneously, more balanced views and expectations of self or others are excluded from emotional awareness. Self and object images tend to alternate between polar opposites: exclusively loving, powerfully, worthy, nurturing, and kind – or exclusively bad, hateful, angry, destructive, rejecting or worthless.
- Help rejecting complaining - dealing with emotional conflict or internal or external stressors by complaining or making repetitive requests for help that disguise covert feelings of hostility or reproach toward others, which are then expressed by rejecting the suggestions, advice or help that

others offer. The complaints or requests may involve physical or psychological symptoms or life problems.

- Acting out - dealing with emotional conflict
- The most severe of all defense mechanisms are:
 - Delusional projection: holding on to beliefs even when evidence to the contrary is strong
 - Psychotic denial: where there is a complete split from reality based on interpretation of activities and events
 - Psychotic distortion: where the individual cannot see things as others see them and misinterprets much of what is happening to him or her.
- **Ego alien**- synonym for ego dystonic
- **Ego syntonic vs ego dystonic** the group is unusually focused on a single behavioral characteristic. Obsessive compulsive characteristics that inhibit the completion of work are often experienced by clients as appropriate attention to detail. In this sense, the goal of treatment is to help them experience this behavior as a problem – or ego dystonic.
 - **Ego syntonic**: traits of personality, thought behavior and values that are incorporated by the individual, who considers them acceptable and consistent with his or her overall true self.
 - **Ego dystonic**: traits of personality, behavior, thought or orientation considered to be unacceptable, repugnant or inconsistent with the individual's perception – conscious or unconscious- of himself.
- **Milieu therapy** – describes a community experience where the total environment is geared toward the therapeutic aims. A residential treatment program is an example of such an environment. Residential and inpatient settings with 24 hour care typically use milieu therapy as their primary helping strategy. Family and individual treatment and groups cannot create a residential milieu.
- While the behavior described in **double bind communication**, since there are directly conflicting messages, the double bind theory of schizophrenia is another matter. First formulated by Gregory Bateson, the theory held that double bind communication caused schizophrenia. Clinical research never supported the theory and it fell into disuse.
- Diminishing generational boundaries, role reversal, homeostasis, complementarity; there is nothing pathological about a child expressing empathy with the parent. As children mature, this emotionally sensitive behavior is to be expected and welcomed in an expression of normal development.
- Vicarious reinforcement, positive reinforcement, differential conditioning, shaping- shaping involves changing behavior in a predetermined way by rewarding steps toward the behavior. In this case, the final goal is speech. Intermediate goals such as vocalizations are rewarded. Shaping is sometimes known as successive approximation.
- Independent variable, dependent variable, parallel variable, causal variable this is a research design question. The intervention is the independent variable. The dependent variable is the change that is being measured. The other answers have no part in research design.
- Reciprocal vs remedial model
- Diagnosis deferred: info is inadequate to make a formal diagnostic judgment
- Culturally-bound syndromes: these conditions resemble the symptoms of a mental disorder but is related directed to the culture
 - Brain fag
 - Ataque de nervos
 - Ghost sickness
 - Rootwork
- **Ideas of reference**: incorrect interpretation of a causal incident as having a particular or unusual meaning to the person. An inaccurate belief that the behaviors of others or environmental phenomena appear to have some effect on the individual. I.e. a man sees to men talking and thinks that they are talking about him.
- **Wholeness**: changes in one part of a system change the whole system

- **Homeostasis:** when influenced by change, the system will react toward restoration of the status quo.
- **Negative feedback:** (in family therapy) takes family back to comfortable balance. As the family system reacts, negative feedback is used to bring family back into balance and maintain homeostasis. For example, if a woman wants to leave her young child at day care and go to work, her fear of family disapproval may be enough incentive to change her mind.
- **Positive feedback:** pushes family into changes and the family deviate around from its previous homeostatic state. Positive feedback is used to disturb or unbalance homeostasis. For example, if the same woman decided going to work outside of the home was her choice, positive feedback would be used to get her family to redefine their roles for the changes that must occur in the family system. Positive feedback is often used & created by family therapists in the therapeutic relationship to allow for a more functional family balance to emerge.
- **Non-summativity:** the family has an identity of its own; the family system is more than the sum of the individuals who comprise it. For treatment to be successful this family entity must be treated as a whole.
- **Entropy:** the natural tendency to move towards disorder and disorganization.
- **Equifinality:** same result can come from different causes
- **Equipotentiality:** once case can produce different results.
- **Transference:** refers to emotions transferred to therapist.
- **Counter-transference:** refers to emotions transferred from therapist to client.
- **Reflection:** the social worker helps the client to further realize and understand what s/he is feeling and encourages father understanding and expression, can paraphrase what client is saying, this is process associated, where summarization is outcome focused.
- **In kind assistance:** aid provided instead of cash for specific purposes. Reducing cost housing, food, medical care, and transportation are forms of in-kind assistance.
- **Erotomanic delusion:** belief that someone is in love with the person. AKA Clerambault-Kandinsky complex
- **Dyspareunia** – painful sexual relations
- **Countertransference** - an unconscious or excessive libidinal or aggressive feeling toward a client.
- **Magical thinking:** an individual attributes experience and perceptions to unnatural phenomenon. I.e. one's thoughts or desires influence the environment or cause events to occur.
- **Primary prevention:** actions taken to keep conditions known to result in disease or social problems from occurring.
- **Secondary prevention:** efforts to limit the extent of severity of a problem, the early identification of its existence, early case findings, isolation of the problem so that its effects on other people or situations are minimized.
- **Tertiary prevention:** rehabilitative efforts by the social worker or the professional to assist a client who has already experienced a problem to recuperate from its effects & develops sufficient strengths to preclude its return. Most forms of clinical intervention can be considered form of tertiary prevention.
- **Adlerian Theory:** humans have an inherent drive for power and strive from feeling inferior.

7. DSM-IV

- Essential features of Schizophrenia, Disorganized type, as disorganized speech and behavior and flat or inappropriate affect. If present, delusions are not organized into a coherent them. Echolalia, defined as a pathological repetition of words or phrases of one person by another, is more prevalent in schizophrenia, catatonic type.
- The answer to this question reflects repeated research results showing a predisposition toward alcohol abuse in the children of families with a history of alcohol abuse. None of the other answers are associated definably with alcohol abuse.
- Schizophreniform disorders are understood to be a shorter, more discrete episode of a condition similar to schizophrenia.

- Agoraphobia is the fear of public and open places. Social phobia is a fear of people. While panic often accompanies agoraphobia, this question specifically lists a group of public places. Panic disorder symptoms can be triggered as thoughts, as well as places and people. Since her symptoms are so severe, this is more than a stress disorder. The best diagnosis is agoraphobia.
- The question asks for the most characteristic trait associated with OCD. The rituals and obsessions associated with this disorder reflect a person's inability to move forward in any direction.
- Somatization, vs conversion, vs psychogenic pain disorder, vs hypochondriasis: Somatization disorders are defined as a "pattern of recurring, multiple clinically significant somatic complaints" that begin before the age 30. The ailments are not explained by any known medical diagnoses and the social and occupational disabilities are excessive for the disorders.
- (hebephrenic schizophrenia)
- Somatoform disorders are characterized by physical symptoms such as pain, nausea, dizziness. They cause significant emotional or physical distress, but do not have a medical explanation.
- The Five Axis:
 - Axis 1: Clinical syndromes, PDD, learning disorders, motor skills disorders, communication disorders, other disorders that may be the focus of clinical treatment
 - Axis 2: PD and MR diagnoses that start in childhood and adolescence and persists in a stable form into adulthood.
 - Axis 3: General medical conditions. Medical conditions that may be relevant to the condition being treated are listed.
 - Axis 4: Psychosocial & Environmental Problems/ Stressors (Problems with primary support, educational problems, housing problems, problems with access to health care, problems related to interaction with the legal system, other psychosocial problems, problems related to social environment, occupational problems, economic problems
 - Axis 5: GAF: 1-100 the higher number, the higher the level of functioning.
- Selected Disorders often Diagnosed in infancy, childhood or adolescence
 - MR: Individuals must have significantly sub-average intelligence & deficit in adaptive functioning. Must have an IQ of 70 or below. Slightly more common in males
 - Borderline intellectual functioning: IQ 71-84
 - Mild: IQ 55-70 (highway driving). Considered educable, able to perform at 6th grade level, can use minimal assistance. May need supervision and guidance, live in community or in supervised setting.
 - Moderate: IQ 35-55 (residential driving), considered trainable, able to perform at 2nd grade level, with moderate supervision, can attend to their own personal care, can perform unskilled or semi-skilled work, can live in the community.
 - Severe: IQ approximately 20-35 (school zone): generally institutionalized, have little or no communicative speech, possible group home.
 - Profound: IQ below 20, generally in total care.
 - Pervasive mental disorders: You can see it; it pervades every area of their life. Involves multiple functions & behaviors are not considered normal at any age. Qualitative impairment in: reciprocal interaction, verbal and nonverbal skills, imaginative activity, and intellectual skills.
 - Autistic Disorder: Severe form, onset in infancy or childhood, self-stimulating, self-injuring behaviors often present, poor prognosis, 2/3 of Autistics are mentally retarded/moderate range; 3x more common in males than females, Age of onset requirement in DSM is 3. Social work treatment is generally behavioral in nature.
 - Rett's Disorder: Only in females, deceleration of head growth starts out normal and 5-24 months, problems develop, loss of previously acquired hand skills, loss of social engagement, appearance of

- stereotyped movements, impaired language functioning generally associated with severe or profound mental retardation.
 - Childhood disintegrative disorder: normal development for 2 years then a drastic decline, followed by a loss of previously acquired skills, and development of autistic like symptoms.
 - Asperger's: autistic like symptoms without language impairment, severely impaired social interaction, these children often have normal to above normal intelligence.
- Learning Disabilities: these disorders have significant difficulties in acquisition of listening, speaking, reading, writing, reasoning and math.
 - Significant delay in skill level (2 standard deviations below the mean)
 - Generally noted between ages of 8 and 13
 - More common in boys than girls
 - Kids don't always catch up – continues into adulthood
 - Involve specific functions not multiple like pervasive, the behavior is characteristic of an earlier stage of development.
- ADHD: symptoms must persist for at least 6 months, the disorder has one criteria set with the 3 subtypes. Symptoms required in 2 or more situations: home, work or at school. Can occur in adulthood but must have onset in childhood (generally before 7). Individual has deficits in attention and concentration.
 - Subtypes include:
 - Predominately inattentive: poor grades in school
 - Hyperactivity/impulsive: often in trouble at school
 - Combined
 - SW treatment:
 - evaluate by a neurologist or physician
 - Medication Ritalin or Cylert
 - Medication will help to increase tolerance, decrease impulsivity and sustain attention, as well as, complaints of boredom and task irrelevance.
 - Help families deal with the child at home (i.e. identify parenting styles that can reinforce negative behaviors): help teachers deal with the child at school; may need academic catch up help, allow these children more time to complete tasks, address self-esteem issues in counseling, behavioral and cognitive techniques are often used.
- Conduct disorder: pattern of behavior that violates rights of others, symptoms now are grouped in four categories:
 - Aggression towards people and animals
 - Deceitfulness or theft
 - Destruction of property
 - Serious violations of rules
 - Social work treatment include: behavioral: identification of BC (Behaviors & consequences), family treatment required to reinforce BC's
- ODD: similar to conduct but not nearly as severe, does not repeatedly violate the rights of others. Social Worker TX: not as intense yet similar to conduct disorder
- Feeding and Eating Disorders of Infancy or Early Childhood:
 - PICA: repeated eating of non-nutritive substances for 1 month, onset age 1-2
 - Tourette's Disorder: this is characterized by vocal and motor tics all present at the same time; onset before 18, symptoms must last more than a year
 - Enuresis: elimination disorder that is not due to a physical disorder that involves elimination of urine during the day or night. Must be 5 before it can be diagnosed.

- Encopresis: elimination disorder involving repeated elimination of feces in inappropriate places; occurs one time a month for 3 months; must be at least 4 years of age to diagnose.
 - Separation Anxiety Disorder: involves excessive anxiety over separation from home or who attached, must last 4 weeks and begin before age 18, use early onset if before age 6.
 - Selective Mutism: must last at least 1 month in duration, exclusion during the first month of school, must impair functioning, exclude if due to language problem. Persistent refusal to talk, an inability to speak or understand spoken language.
- Delirium and Dementia
 - Delirium: Generally involves an abrupt onset of symptoms that fluctuate.
 - Delirium due to a general medical condition: e.g. UTI
 - Substance-induced delirium
 - Delirium due to multiple etiologies
 - Clouded sensorium: brief duration, can happen in young and old.
 - Dementia: Generally involves relatively stable symptoms (slow & stable onset), that do not fluctuate. Long duration, must have disturbance in occupational and social functioning, characterized by multiple cognitive deficits. Characterized by intellectual deterioration. To diagnose the following techniques are used: psychometric and other mental status testing, measurement ADL, and radiological techniques. Types of dementia include:
 - Dementia of the Alzheimer's type: 1907 Alois Alzheimer found abnormal nerve cells containing tangles and fibers (neurofibrillary tangles) and clusters of degenerating nerve endings (neuritic plaque)
 - Vascular dementia (used to be multi-infarct): small repeated strokes in the brain
 - Dementia due to other general medical conditions (I.e. HIV)
 - Parkinson's disease: slow progressing neurological disease characteristics: tremor, rigidity, etc. / localized damage, tremors. Sinemet is the primary medication uses (more movement focused).
 - Clinical diagnosis of dementia: involves memory disturbances, language, perception, praxis (behavior) disturbance, decreased problem solving, decreased judgment, social avoidance, fearfulness, paranoid symptoms, delusions, irritability, agitation, verbal, physical aggression, increasing loss of control
 - Assessment and SW intervention with dementia:
 - Measure memory (recent vs. remote) psychometric: short portable mental status questionnaire, 7 digit progression scale.
 - Measure judgment ability – usually first sign families note, use a family questionnaire to measure deficits
 - Understand orientation to person, place and time plus spatial orientation for utilization in treatment.
 - Look at affect – depression vs dementia are very difficult to assess in the early stages. Unfortunately, strokes tend to enhance negative personality traits.
 - Monitor intelligence & cognitive ability (confabulation) – often use the clock test
 - Use of the techniques such as reality orientation (what's today's date) or validity therapy (accepting the reality of the individual with dementia)
- Substance Related Disorders
 - When NOT working in the area of substance use/abuse, a social worker should never counsel a client actively using and influenced by a substance. The client should be referred for detox or rescheduled when not under the influence. Twelve months is required for a client to achieve sustained remission.
 - Since we do verbal therapy, we would never treat a client under the influence.
 - If an individual is in recovery, when behavioral change rapidly or unpredictably, always be careful to assess for relapse.
 - Substance use disorders:

- Abuse: these are viewed as less severe, continue to use knowing it is causing harm (does not apply to caffeine and nicotine)
 - Dependence: needs to take larger amounts with unsuccessful attempts to quit.
- Substance induced disorders:
 - Intoxications: the development of a substance specific (reversible) syndrome, condition related to recent ingestion of psychoactive substance
 - Withdrawal: maladaptive cognitive and behavioral declines due to reduction of a substance; generally, this category is usually associated with dependence. The two substances most problematic in withdrawal are alcohol and heroin
- Substances are generally associated with: abuse, dependence, intoxication or withdrawal. There are 11 classes of substances:
 - Alcohol
 - Amphetamines (cocaine)
 - Caffeine
 - Hallucinogens
 - Inhalants
 - Nicotine
 - Opioids
 - Phencyclidine (PCP)
 - Sedatives
 - Hypnotics
 - Anxiolytics
- Schizophrenic Disorders
 - Five types of schizophrenia are identified:
 - Disorganized type: marked incoherence, lack of systematized delusions, silly affect
 - Catatonic type: stupor, rigidity, bizarre posturing, waxy flexibility & excessive motor activity
 - Paranoid type: one or more systemized delusions, or auditory hallucinations with a similar theme
 - Undifferentiated type: “Garbage can” bits of other types
 - Residual type: not currently displaying symptoms displayed in the past.
 - Criteria for diagnosis includes: characteristic psychotic symptoms, deterioration in adaptive functioning, six months duration with active phasing lasting at least one month.
 - A’s generally associated with the diagnosis:
 - Associative disturbances
 - Autism
 - Avolition (lack of goal directed behavior)
 - Affective disturbances
 - Ambivalence
 - Alogia (poverty of speech)
 - Labile mood
 - Difference between mood & affect: Mood – general feeling vs. affect – how you show it (flat or blunted)
 - Other selected psychotic disorders include:
 - Brief psychotic disorder: AKA 3 day schizophrenia, symptoms have existed no longer than a month (at least a few hours) with a sudden onset linked to a psychosocial stressor
 - Schizophreniform disorder: time frame for episode is less than six month
 - Schizoaffective disorder: having a mixture of symptoms suggestive of both an affective (mood) disorder an schizophrenia
 - Shared psychotic disorder AKA induced psychotic disorder: Folie a Deux, two people share and create a delusional system

- Brief reactive psychosis < 1 month; Schizophreniform < six months; schizophrenia = 6 months +
 - Positive symptoms: refers to hallucinations and/or delusions
 - Delusions: strong beliefs held against strong contrary evidence
 - Hallucinations: inaccurate perceptions where inaccurate auditory stimuli is the most common
 - Negative symptoms: refers to lack of movement (Avolition) or speech (Alogia)
 - Types of treatments include: anti-psychotic medication (most common), psychodynamic, behavioral and social learning, family therapy, community based treatments (i.e., half way houses)
- Mood Disorders
 - Types include:
 - Manic episode (last one week): mood is persistently elevated, must also have at least 3 of these symptoms: increased psychomotor agitation, flight of ideas, decreased need for sleep, grandiosity, sexual preoccupation, positive symptoms
 - Hypomanic episode (4 days): similar to manic but symptoms are not severe enough to interfere with functioning, expansive, irritable and elevated mood that lasts at least four days.
 - Major depressive episode (2 weeks): depressed mood with 5 other associated features (changings in sleeping or eating, appetite disturbance, fatigue, reduced ability to concentrate, delusions are possible.
 - Mixed episode (1 week): alternating moods that meet criteria for both manic and depressive
 - Types of Mood Disorders:
 - Bipolar: Mixed, manic and depressed
 - Bipolar 1 Disorder: one or more manic episodes, usually with a history of depressive episodes (can have psychotic aspects)
 - Bipolar 2 disorder: one or more depressive episode with a least one hypomanic episode, no psychosis
 - Cyclothymic disorder: persistent mood disturbance lasting at least 2 years, must not be without for two months, less severe than bipolar
 - Bipolar NOS
 - Depressive Disorders AKA Unipolar depression, presence of one or more depressive episodes without history of manic or hypomanic episodes
 - Major depressive disorder: one or more major depressive episode, episodes must last at least 2 weeks
 - Dysthymia: two year history of depressed mood, must not be without for two months, less severe than major depression, constant for a period of two years
 - Treatments include: medication, ECT, psychotherapy is still considered best over medications
 - Endogenous depression is caused by internal events
 - Exogenous or environmental depression is caused by external events.
- Anxiety Disorders
 - Selected Anxiety Disorders
 - Panic Disorder with or without agoraphobia: attacks involving intense fear and apprehension lasting several minutes, either with or without agoraphobia.
 - Agoraphobia with hex of panic disorder: fear of being in places where escape may be difficult
 - Social phobia: persistent fear of one or more social situations in which person may come in contact with
 - Specific phobia: fear to an object or stimulus not general fear, easiest to treat through systematic desensitization
 - OCD: recurring obsessions (thoughts) and compulsions (behaviors) severe enough to affect social/occupational functioning (defense mechanism often exhibited is reaction formation. .

Obsessive compulsive personality disorder is characterized by orderliness, perseverance, indecisiveness, inflexibility and a strong perfectionist drive. Clients usually have difficulty making decision, have low self-esteem and are totally dedicated to their work, often to the exclusion of other activities. The perfectionism can be so prominent that it prevents the person from completing tasks, since the work would never achieve a sufficient level of quality.

- PTSD: symptoms must last at least 1 month, if more than 6 months after event you should specify delayed onset. Must be outside of range of usual experience, often relive situation.
- GAD: undue persistent worry for at least 6 months about at least 2 or more life circumstances.
- Acute stress disorder: addresses acute reactions to extreme stress (occurs within four weeks of the stressor and lasts 2 days to 4 weeks. This may help predict the development of PTSD).
- Anxiety disorder treatment:
 - Antianxiety medications. Potentially addictive & are best to be used 1. To address anxiety in relation to an identified stressor; 2 time limited course, several weeks in duration; 3. Better for exogenous factors rather than endogenous ones; and 4. Often a euphoric feeling results.
 - Counseling: explore stressors and worries, for treatment behavioral and cognitive methods are the most popular. Teach person to recognize and prepare for symptoms (i.e., relation training, etc. Systematic desensitization and crisis management are often used.
 - RMT: Repressed Memory Therapy: these involve memories from the past generally related to trauma that has been forgotten, these memories are images remembered through therapy which generally related to past events.
- In anxiety Fear = response to a real threat and anxiety = response without presence of a real threat
- Somatoform disorders (unconscious): these disorders consist of physical symptoms that have no known physiological cause, prior to diagnosis of a physical exam needs to be completed
 - Somatization disorder: recurrent and multiple somatic complaints. Begins in teens, onset before age 30.
 - Conversion disorder: a change or loss in physical functioning. Is not due to a physical condition, individual does not have voluntary control of symptoms.
 - Pain disorder: preoccupation with pain with no known underlying cause.
 - Hypochondriasis: unrealistic interpretation of physical symptoms as an abnormal, preoccupation with fear of being seriously ill. The person can acknowledge that there are not grounds for fear.
 - Body dysmorphic disorder: preoccupation with an imagine body flaw.
- Factitious disorders (conscious)
 - Factitious disorder with physical symptoms: AKA Munchausen syndrome, person is creating these physical symptoms for attention.
 - Factitious disorder NOS: AKA Munchausen by proxy, person is creating physical symptoms in others for attention.
- Dissociate Disorders
 - Dissociate amnesia: sudden inability to remember essential personal info, too extreme to be ordinary forgetfulness
 - Dissociative fugue
 - Dissociative identity disorder: must have a 5-year history of problem
 - Depersonalization disorder: one or more episodes of depersonalization causing significant distress for the individual, during episode, reality testing remains intact
- Gender Identity Disorders: must have discomfort with own sexual identity
 - Gender identity disorder NOS
 - Gender dysphoria: difficulty with gender –can become transsexual
 - Transient stress related cross dressing

- Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex.
- Selected sexual disorders
 - Paraphillias: strong sexual fantasies and strong urges involving:
 - Fetishism: use of non-living objects
 - Transvestitism: cross-dressing
 - Pedophilia: interest in pre-pubertal children, to be considered a perpetrator you must be five years older than the victim and the perpetrator must be at least 16 years of age.
 - Exhibitionism: feels guilty, but cannot stop
 - Voyeurism: observing others engaging in sex
 - Masochism: excitement through self-suffering
 - Sadism: excitement through pain infliction
 - Frotteurism: touching/rubbing against a non-consenting person.
 - Selected Sexual Dysfunctions: disturbances in the sexual response cycle, cannot be entirely due to organic factors
 - Male erectile disorder
 - Premature ejaculation
 - Dyspareunia: genital pain in male/female during/after sex.
 - Vaginismus: recurrent or persistent involuntary spasm of musculature that interferes with sex
 - Differences between the sexes:
 - Sexual fantasy: generally both men and women fantasize about sexual intimacy. Men are more likely to fantasize about a partner other than a present lover. Women are also more likely to envision themselves with another woman (25%), where men say they do not (90%)
 - Sensate focus exercises: work of Masters and Johnson, which focuses on progressive exercises, begins with non-genital touching only, leads to genital touching. Goal is to receive pleasure without pressure to perform and/or achieve orgasm
- Eating Disorders
 - Anorexia: Treatment – get client to gain weight, behavioral rewards contingent on eating, avoid group therapy with others that have the SAME condition. There is a strong genetic link.
 - Bulimia: 2 binges per week for 3 months. Treatment is often group confrontation.
- Impulse control disorders NOS
 - Pathological Gambling
 - Pyromania
 - Kleptomania
 - Intermittent explosive disorder
 - Trichotillomania: aversive therapy, rubber band
- Sleep Disorders:
 - Insomnia
 - Hypersomnia (e.g. narcolepsy)
 - Circadian Rhythm sleep disorder: mismatched cycle
 - Parasomnias: abnormal incidents during sleep
 - Nightmare disorder: remembers dreams
 - Sleep terror disorder: often do not remember dreams, sudden awakenings
 - Sleepwalking
- Adjustment Disorders
 - Maladaptive reaction to a psychosocial stressor, develops within 3 months and last 6 months or longer, must impair occupational/social functioning, diagnosis is made based on predominate symptoms

- Depressed mood
- Disturbance of conduct
- Mixed emotional features
- Withdrawal
- NOS
- Anxious mood
- Mixed disturbance of emotions and conduct
- Physical complaints
- Work (or academic) inhibition
- Personality Disorders
 - Cluster A: have odd/eccentric behavior & are socially isolated
 - Paranoid
 - Schizoid: very detached with a pattern of indifference (lack of desire for intimacy)
 - Schizotypal: more typical of schizophrenia, numerous social and interpersonal problems, (want intimacy, but just cannot get it together). Common ideas include: ideas of reference: incorrect interpretation of a causal incident as having a particular or unusual meaning to the person.
 - Cluster B: Wild / erratic behavior
 - Antisocial
 - Borderline: make sure to set clear boundaries and defuse crisis formulation in treatment, can use dialectical behavior therapy
 - Narcissistic: lack of empathy is a criterion
 - Histrionic
 - Cluster C: anxious or fearful behavior
 - Avoidant: pattern of social discomfort
 - Dependent
 - Obsessive compulsive: perfectionism and inflexibility; defense mechanism: reaction formation
- Important Info for Assessment and Intervention planning for HIV & AIDS
 - Approximately 12 weeks after infection a positive test can be obtained.
 - The disease can be transmitted very soon after infection
 - There are different strains of the virus, by pin pointing the strain type linkage can be made to who infected the person.
 - Normal t-cell count can vary from 400-1700, once HIV is diagnosed a t-cell count must be obtained
 - When t-cell count falls below 200, an individual become susceptible to opportunistic infections, the diagnosis of AIDS is pronounced.
 - In newborns, it take approximately 15 months to be sure whether or not baby is infected
 - Pregnant HIV positive women given HIV medication as a precaution have less chance of the baby developing positive HIV status
 - All medications, particularly AZT, can be given as a precautionary measure if someone suspects infection.

8. Best Practice / Treatment Ideas

- The treatment of choice for people with paranoid symptoms is to do the least threatening, most supportive interventions, so as to not trigger paranoid ideas about the social worker. A direct discussion could be very counterproductive and stimulate resistance.
- Children who are doing well in school are less likely to exhibit suicidal tendencies than those with a history of depression or hospitalization
- Late onset psychoses in adults that occur without any previous hex are usually of limited duration. Client generally recovers.

- An adolescent with a *severe* behavior disorder involving physical aggression and property destruction can be best helped in a residential program that is tightly supervised. Many programs use behavioral strategies and are effective at helping these clients manage their aggression and learn new behaviors
- For someone with avoidant or paranoid issues, the worker's behavior would confirm that their world view made sense. For clients with schizophrenia, the goal is to enhance ego functioning, not to increase discomfort. For clients with a passive aggressive personality, however, the goal is to make them conscious of their anger. Thus, creating discomfort might allow the client to "act out" discomfort in passive aggressive ways. Once this occurs in treatment, it can be addressed.
- While it may ultimately be necessary to notify the police, the first step is to keep the family informed since the client lives with them. If a suicide attempt seems imminent, the clinician would most likely seek to hospitalize the individual.
- Chronically stressful family lives, abuse and discord, are markers for aggression against self and others. While suicidal behavior often occurs in the context of a variety of stressors, the ability to contextualize stress and develop coping strategies, is in part related to family experiences. Children whose families are dysfunctional, filled with discord and violent often have few resources to deal with stress and may act out violently.
- Generally treatment for pedophiles & other sexual offenders is group treatment with other sexual offenders. These groups are often confrontational and have an unusual capacity for piercing the veil of denial that often characterizes sex offenders.
- Supportive therapy has been shown to be very effective for people with schizophrenia. The client is an individual who has a capacity for self-observation and who wishes to discuss his concerns. A supportive and educative (as needed) response as the client struggles to adjust to his illness is the best clinical response.
- Anecdotal evidence suggests that fantasizing about clients is common. Usually these fantasies can be controlled and managed. The best answer is 3, since the social worker can benefit from airing his feelings with a consultant or supervisor. There is no reason to end treatment, unless the worker believes that the fantasies interfere with the therapeutic relationships. The fundamental principle is to do what is best for the client. Ending the treatment would not be of help at this point.
- In assessing risk for child abuse, a social worker would consider parent's attitudes toward discipline, family history and child injuries as most important.
- As part of developing a case plan, it is useful to discuss, if only in general terms, what the client wants or needs as a goal of treatment. The possibility of terminating when certain goals are achieved can be raised during the case planning process.
- Sexual offenders often exhibit profound denial or minimization about their sexual behavior and therefore, their statements cannot always be accepted at face value. Moreover, they are highly motivated to dissemble since if they reoffend, it could lead to imprisonment.
- It is irresponsible for a SW to construct a DSM diagnosis from a social contact.
- Social services provisions should be both racially and ethnically neutral, unless the client has a preference. The answer suggests that the worker should begin the interview in the same way any other interview would begin without reference to different ethnic or racial backgrounds.
- Group, individual and mother daughter treatment is often employed in families recovering from sexual abuse. Mother-daughter treatment may be important if either or both feel betrayed by the other and need to repair the relationship.

9. Agency / Supervision Work

- Cost effectiveness is defined by the ability to mediate between costs and effectiveness. A cost effective service is one that provides service that works
- The last thing the worker should do when considering a new assignment is to negotiate the terms & conditions. This is done only when the new assignment is clearly understood by the worker and the supervisor, and when

there is an agreement on what is to be accomplished. After these are discussed, the worker will be in a position to decide whether the assignment is appropriate and desirable. After the decision is made, the worker can negotiate the proper terms.

- The goal of community practice is to build community groups that will become increasingly independent and engaged in local institutions or decision making structures. The community worker is, in part, a trainer, enabler and a modeler, helping people to act on behalf of their community.
- Civic associations generally have broad improvement purposes while social welfare and social service organization have more specific and targeted purposes.
- Overhead incorporates non program or service delivery expenses such as management costs, accounting fees, general insurance, rent, telephone and some office expenses. While all agencies use this category, the exact items incorporated in overhead may vary considerably
- Many cities and smaller communities establish organizations whose purposes and activities are guided by public decision making process. While strictly speaking, they are nonprofit organizations, they are more generally described as quasi-public organizations or institutions because of the close relationship they maintain with government.

10. Growth & Development

- Information review:
 - In developmental psychology we study the changes in behavior from conception until death
 - The maturation of an individual is generally based on age.
 - Learning is often related to experience.
 - Interactionism generally deals with the development of the individual with endogenous and environmental factors.
 - Key issues in developmental psychology include:
 - Critical periods for a specific experience to have its greatest impact
 - Mechanistic views (learning is related primarily to external factors) of development (i.e., social learning theory and behavioral theory) versus Organismic perspective (learning is related to primarily internal factors) of development (i.e., Piaget and Kohlberg's theory of cognitive development.
 - Long standing debate of nature vs. nurture.
 - When assessing problems the therapist should always take into account:
 - The age of the child & normal developmental milestones/behaviors
 - At times problems are more common to a particular gender.
- Stages of Development:
 - Birth – 2 months: probably can notice faces and bright objects
 - 2 months: social smile develops, generally can follow moving objects with eyes, pays attention to speaking voice, grunts and sighs.
 - Four months: recognizes familiar objects, can activate arms and vocalizes socially (coo's) enjoys having people around, holds a rattle for an extended period of time, and recognizes bottle and familiar faces.
 - Five months: grasps objects independently, stretches out arms when picked up.
 - Six months: teething begins, recognizes strangers but does not generally show fear, turns over from back to stomach.
 - Seven months: make polysyllabic vowel sounds, sits briefly can transfer objects from one hand to another.
 - Eight months: sits alone easily, clearly recognizes strangers and reacts to them negatively if feel unprotected. ** this is when stranger anxiety can first develop
 - Nine months: sits alone and creeps. Dada mama baba, responds to name
 - Ten months: pays attention, plays some games, stands with support

- 11 months: stands by self with support
- 12 months: walks with help, shows affection, jealousy, anger and other emotions. Enjoys some solid foods. "Walk by one, talk by two." The first words children generally express are nouns
- 15 months: walks well alone, generally expected to start walking at 14 months, names familiar pictures and objects.
- 18 months: walks and can run, know several words & small phrases
- 2 years: does not like to share possessions, great sense of everything is mine not yours, able to run, says at least 50 words, can use two word sentences point to objects in a book.
- 6 years: lose temporary teeth and permanent teeth begin to come in, good coordination and adequate speech, knows colors & numbers well, begin reading
- Ten -12 years: have ability to abstract think & understand many abstract processes.
- Stranger Anxiety: fear or apprehension of a very young child when around unfamiliar people
- Separation anxiety: the fear experienced when a child fears the loss of the primary caregiver.
- Psychosocial Development: Erikson
 - Erikson stresses the social rather than the sexual development.
 - 8 stages of psychosocial development
 - 1. Oral /sensory (0-12 to 18 months) Outcome: trust & optimism. Conflict: trust vs. mistrust
 - 2. Muscular anal (18 months -3 years) Outcome: self-assertion, self-control and feelings of adequacy. Conflict: autonomy vs. shame & doubt
 - 3. Locomotor genital (3-6 years) Outcome: sense of initiative, purpose and direction. Conflict: initiative vs. guilt.
 - 4. Latency (6-12 years) industry vs. Inferiority. Outcome: productive & competence in physical, intellectual and social skills
 - 5. Adolescence: 12-18 years: ego identity vs. role confusion. Outcome: integrated image of oneself as a unique person.
 - 6. Early Adulthood 19-40 years: intimacy vs. isolation. Outcome: ability to form closer personal relationships & make career commitments
 - 7. Middle adulthood 40-65 years: generativity vs. stagnation Outcome: concern for future generations.
 - 8. Maturity (65 to death) integrity vs. despair. Outcome: sense life satisfaction & to face death without despair.
 - Robert Peck: expanded on Erikson's stage of integrity vs. despair
 - Ego-differentiation vs. work role preoccupation
 - Body transcendence vs. body preoccupation
 - Ego transcendence vs. ego preoccupation
- Moral development: Kohlberg
 - Kohlberg's stages of moral development: Kohlberg is often the most cited moral development theorist. Piaget influences much of his work. According to Kohlberg, each stage arises from the one before it and is more complex. To measure moral development Kohlberg presented subjects with a series of moral dilemmas and asked them to evaluate them.
 - Preconventional morality (ages 4-10)
 - Stage 1: punishment-obedience orientation, moral judgment with the desire to avoid punishment
 - Stage 2: instrumental-relativism orientation, motivation is to satisfy own needs.
 - Conventional Morality (ages 10-13)
 - Stage 3: wants to avoid disapproval "good girl-nice boy"
 - Stage 4: law & order orientation, moral judgments are made in fear of perceived legitimate authority
 - Post-conventional morality (adolescent to adulthood)

- Stage 5: legalistic orientation, individual is concerned with fitting in the community and abiding societal mores, etc.
 - Stage 6: gains a sense of what it means to believe in a universal ethical principle orientation, where an individual's conscience determines the criterion for conduct. ***it is important to note that many individual do not reach this last stage*
- Locus of control: in understanding the concept of "locus of control" it is most often associated with perceived responsibility. Generally, this refers to a concept that defines where individuals feel control over their behavior or where the responsibility lies. This responsibility lies within themselves (internal) or outside themselves and is influenced by external environmental and system events.
- Cognitive Development: Piaget "big on test"
 - Piaget's original interests were in biology and epistemology and his theory reflects both of these. Piaget believed individual growth follows a predetermined sequence of stages. Development occurs through the use of:
 - Adaptation: finding and establishing a "goodness of fit"
 - Assimilation: the act of incorporating one's environment into the existing environment.
 - Accommodation: modify current thought structure to deal with new features of an environment. E.g. an individual might modify what s/he believes to make it easier to deal with another individual, group or society.
 - Equilibrium: which is the state of balance, an individual seeks. This need for balance is the primary organizing force behind cognitive growth and development.
 - Piagetian Theory of Cognitive Development: It postulates set stages of cognitive development that cannot be skipped. Research has found a great variation in what ages people reach these stages; however, these stages correlate well with intelligence testing.
 - Sensorimotor: (ages 0-2_ six substages, individuals look to environment in terms of sensory information and the actions that can be performed (e.g., sucking, grasping, and hitting ** Achieve object permanence.
 - Preoperational thought (ages 2-7) includes two substages: 1. Preconception (age 2-4) and intuitive (4-7). Individual engage in symbolic play and interpretation (e.g. use of language & modeling)
 - Achieve irreversibility (children are often considered egocentric/egocentrism before the age of 6.
 - Concrete Operational (ages 7-11) during this stage, individuals can understand abstract symbols. Here the child is realistic in his/her way of thinking
 - Achieve conservation (mass, liquid, volume, and weight)(
 - Formal Operations: the individual develops egocentrism and is able to self-admire and self-criticize, full abstract and logical deduction ability is reached.
 - Abstract thinking or "thinking about thinking" becomes possible
 - Only 1/2 of all adults achieve this stage.

11. Practice Evaluation and Utilization of Research

- Research and Program Design in Everyday Practice
 - Research design is viewed as a logical plan to help increase our knowledge in a particular area.
 - There are two major purposes for research design:
 - To provide answers to research questions
 - To control variance, insuring that the results obtained are as closely related to what is being studied.
 - This involves the confidence level that can be placed in accurately assessing the degree of cause and effect you have as a result of the research endeavor. This is often referred to as the **Maximincon** principle.

Maximize the variance of variables of the substantive research hypothesis (i.e. you want the experimental conditions to be as different as possible); to control extraneous variables (i.e. these are independent variables that are not necessarily related to your study (e.g. sex, race); and minimize error variance (i.e. This is the fluctuation that may occur in your results due to random events).

- A **variable** is any phenomena or characteristic that is free to vary with at least 2 conditions or levels. A constant is restricted to a single state.
- Demographic variables are used to define your sample
- Two types of important variables are the independent and dependent.
 - Independent variables are the presumed cause.
 - Dependent variables are the presumed effect and vary as related to the independent variable. Usually the treatment being tested is the independent variable.
- Research problems are stated in terms of a hypothesis.
 - A hypothesis is a proposition that is stated in testable form. It predicts a particular relationship between two or more variables. If we think a relationship exists, we must first generate a hypothesis and proceed to test it. There can be more than one hypothesis. Generally, a hypothesis follows an “if” then “this” will occur format. If such-and-such occurs then so-and-so results.
 - The null hypothesis (AKA statistical hypothesis) is often referred to as the hypothesis of “no difference.” This hypothesis is generally used in statistical analysis to be disproved. The research (AKA alternate hypothesis) or the working hypothesis is the hypothesis you will be testing. The research hypothesis is what you want to support.
- Random sample: Briefly state, it is a planned process that utilizes probability theory to ensure that the sample will represent the population. In the random sample each subject in the population has an equal chance of being selected.
- Generalizability: this is the true goal of all research. It is where you take what you know about a small group or sample of a population and apply it to explain the general population.
- Inferential statistics: these robust powerful statistics help the researcher make “inferences” or assumptions about a population. These have strong rules & strong guidelines. These include:
 - Parametric:
 - Analysis of variance aka ANOVA aka F test (compares means of more than two groups)
 - T test (compares means of two groups)
 - Pearson’s Phi or Pearson’s R (compares the association or correlation between two groups)
- Descriptive statistics : examples are nonparametric tests (no strong rules or guidelines, less confidence) include:
 - Chi-squared test (most common type, compares the observed value with the expected)
 - Spearman Rho (a non-parametric correlation)
- Correlation: Means there is an association between two variables:
 - Positive association: as one goes up, the other goes up; as one goes down, the other goes down.
 - Negative or inverse association: as one goes up, the other goes down; as one goes down, other goes up.
- Association measures trend:
 - Correlation measures the mathematical relationships between two variables.
 - When you have a perfect correlation it =1 (that means they go up /up down/down or up/down and down/up perfectly together. The closer the number to 1 the better the correlation. A .9 is a very good correlation. A .5 is pretty poor
- Statistical Significance:
 - This is your “educated quotient” the research standard is usually set at .05
 - A probability of .05 means that 5 times out of 100 you will be wrong.

- A 95 times out of 100 you will guess correctly.
- A probability of .02 means two times out of 100, you will be wrong
- 98 times you will be considered to have guessed correctly.
- Bell shaped curve: is a symmetrical distribution.
- Kurtosis curve: it is a skewed distribution
- The key word in this question is “statistically significant.” An experimental design is ordinarily not possible in a practice setting, as there are ethical, policy and practice constraints against denying services to people in need. Since a control group requires an equivalent population that did not receive the intervention, an experimental design is usually impractical for most practice setting. Quasi-experimental designs allow variations in the intervention, in time, and in the population served, and are more generally used in practice research. Type 2 refers to a category of statistical error.

12. Professional Values & Ethics and Professional Relationships

- Ethical codes: standards of moral conduct for a society or subgroup, such as social workers. A code of ethics for a profession contains standards of conduct subscribed to by members of a profession. These codes reflect concerns and define basic principles that “ought to guide” professional activities. Their purpose is to:
 - Provide a position on standards of practice to aid professionals in deciding how to act when areas of conflict arise.
 - Assist in clarifying professionals’ responsibility to clients and society.
 - Give society some guarantee that professionals will demonstrate a sensible regard for mores and expectations of the society.
 - Give professionals themselves grounds for safeguarding their freedom and integrity.
- Social workers must evaluate ethical practice based on three considerations:
 - Their professional moral judgment (does it make the worker uncomfortable)
 - Legal aspects (are there laws governing it)
 - The ethical implications (do ethical principle to which we abide apply).
- As members of NASW, we subscribe to NASW code of ethics. This code is provided as a guideline for ethical practice. This code is divided into six sections and only highlights of each will be discussed. NASW has been given the right to ensure and set ethical practice standards for social workers. The social work state licensing boards establish the minimum criteria or standards for competence for practice in the state.
- Ethical Principles:
 - Service the primary goal is to help people in need and address social problems.
 - Social justice: challenge social justice
 - Dignity and worth of the person: respect each individual
 - Importance of human relationships: recognize the importance of social relationships
 - Integrity: to behave in a trustworthy manner
 - Competence: practice within your area of competence and commit to further develop and enhance skill
- The social worker’s ethical responsibility to clients
 - Commitment to clients (first duty to client unless violates responsibility to larger society or legal sanctions) (e.g., client has abused a child, danger to self or others).
 - Client’s rights/prerogatives (client self-determination always come first unless a danger to self or others)
 - Informed consent: confidentiality and privacy needs to be ensured, be clear and always protect this right with informed consent or clear verbal instructions, etc. Access to records, limit access only if it could cause harm to the client. Must document reason for withholding as well as any client requests for records.
 - Fees should always be fair and reasonable. Consideration should always be given to client’s ability to pay. When accepting goods or services from a client, the social worker accepts the responsibility of defending this action if need be.

- Sexual relationships should not occur under any circumstances
- It is the social worker's responsibility to set clear appropriate & culturally sensitive boundaries with any client served.
- The social worker's ethical responsibility to colleagues
 - Treat them with respect, fairness and courtesy
 - Respect confidential information shared
 - Sexual relationships with other social workers that serve as educators or supervisors are discouraged, when professional authority is assumed
 - Report colleagues who do not take own action to protect clients.
- The social worker's ethical responsibility to employers and employing organizations
 - Commitments to the employing organization (must adhere)
- The social worker's ethical responsibility to the profession
 - Maintaining the integrity of the profession
 - Community service
 - Development of knowledge
- The social worker's ethical responsibility to society
 - Promoting general welfare
- Important professional/legal considerations
 - The right of the "least restrictive alternative"
 - If client is involuntarily admitted must receive treatment. Treatment must be cure or improvement orientated
 - Client must have right to due process and signed consent
 - Clients have a right to privacy.
 - Clients can sue if used in published case description without permission – if case is identifiable.
 - Confidentiality is generally meant in terms of therapy content. It is an ethical responsibility and must be provided to all clients and research participants. Names of clients should not be given out.
 - When to disclose info: if danger to self or others and in cases of child/elder abuse.
 - Privilege is a legal term similar to confidentiality although this term applies specifically to the courts and other legal proceedings. Only laws establish privilege. Privilege was traditionally held only by the client – not by the therapist. Generally, when working with adolescents, parents or legal guardians and emancipated minors are considered to possess privilege. The legally incompetent and minors (non-emancipated) do not.
 - Subpoenas – provided only the information required to provide. If testifying on behalf of a client, have them put request in writing.
 - Fee setting and collection generally involves setting reasonable fees and collecting them at either the beginning or end of each session. Never discharge a client b/c of inability to pay.
 - Clients should always sign a release of info before discussing cases with anyone, including other mental health professionals.
 - Co-optation entails "using" or "including" the person who opposes you or your program goals in completing your agenda. This helps to reduce opposition to get group or program goals accomplished.
 - Boundaries for treatment are simply stated – friendships & sexual relationships outside of the therapy session are prohibited.
 - Pro bono services are permitted by the NASW code of ethics & are now directly encouraged.
 - Policies and procedures governing practice:
 - Referrals: when making referrals, take into account the following perspectives:

- The reason the referral is made. How will the client benefit from this additional service; and how will the social worker handle the termination or continuation of practice once the referral has been made
- What will be needed to make an appropriate referral? Specification of the problem, availability of the types & requirements of resources to address it; and how to actually make the referral.
- How to make the referral: how will the info be made to the source & how will the client get there?
- How will confidentiality be handled?
 - Remember to consider the client's 1. Financial needs; 2. Social worker degree of competence, 3. Social worker clinical orientation, cultural match with the client and 5. Must abide by professional ethical code.
- If a member of the hospital staff knows that an individual is at risk and does nothing to protect the patient, the hospital can be held negligent. Since sexual contact among patients is prohibited, enforcing the rules against sexual contact can protect both patients.
- Although confidentiality laws apply to minors, it is good clinical practice to respect the concerns of the parents and to provide at least a general response. Letting the adolescent know of the parents' interest and enlisting her help in thinking about a response, allows her to determine the boundaries of shared material. It also reinforces the alliance between worker and client.
- Social worker-client communications are confidential. The social worker cannot reveal information (with some exceptions) without written client consent. Occasionally, judges order social worker to reveal material without consent, in effect asserting that the court's need for info trumps worker-client confidentiality. At that point, the social worker has a choice; obey the judge or risk a contempt citation and imprisonment.

13. History of Social Work

- Colonial poor laws derived from Elizabethan concepts which held that local government was responsible for the poor. It was not until the social security act of 1935 that most of the obligation was shifted to federal and state governments.
- The 19th century Charity Organization Societies were precursors to social casework. To individualize charity, they sent "friendly visitors" to offer guidance to the poor and to provide follow-up to the planned giving that was an essential component of scientific charity.
- The idea that the cause of poverty rested in the larger society rather than within the attributes of the individual, gained currency during the 1960's. The term "blaming the victim" came to be used to attack the culture of poverty theory.
- Deinstitutionalization was advanced as a major strategy only after psychotropic meds proved safe & effective. Prior to that time, there would have been little professional or political support for seriously ill patients.
- Social settlements are closely linked to group practice; the charity organizations of the late 19th century were the precursors of modern SW in that they advocated 'scientific casework' designed to rehabilitate the poor, rather than humanitarian aid for its own sake. The colonial poor laws are best understood as translation of Elizabethan poor law to an American context. They were not fully altered until many forms of public assistance became a federal function in 1935, with the passage of the social security act.
- The recent welfare reform law mandates a lifetime limit for welfare assistance, a feature that many in social work find short-sighted. Though the law also anticipates support services to help welfare families achieve independence, these supports have not been uniformly available. As states implement more restrictive policies, welfare caseloads have declined. As more clients reach their time limits for assistance, it is anticipated that welfare rolls will decline further.

14. General Test Taking Advice

- General social work principles when approaching questions: (EXPLORE / CLARIFY / ASSESS / REFER)
 - First, acknowledge then explore for feelings and to understand the dynamics of the situation.
 - If asked, get the client's perspective first
 - Assess the situation before referrals are considered (be sure if you assess, it is relevant to the question)
 - Identify what is happening before you clarify
 - Refer if it is outside of the social worker's expertise, clarify before you refer.
- Maintaining the relationship with the client is essential. Explore all options before referral to another worker.
- For the client to feel free to express feelings – and hear feedback – the worker must be seen as someone who accepts, and has regard for, the client.