

# **The NCE Mastery Guide**

## **FREE COMPANION**

*Flashcards, Extra Drills, and Practice Exam B (2027 Format)*

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THE LICENSURE PROFESSOR

### **The NCE Mastery Guide: Free Companion**

Flashcards, Extra Drills, and Practice Exam B (2027 Format)

A free companion to *The NCE Mastery Guide: A Complete Review of Every Domain, Updated for the 2027 Exam*

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Information current as of 2026. Practice Exam B is written to NBCC’s examination specifications for the NCE effective July 1, 2027.

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# How to Use This Companion

This free companion holds the study tools that did not fit in *The NCE Mastery Guide*: a second practice exam in the 2027 format, cut-out flashcards and extra drills for every chapter, and an extended glossary. Use it alongside the book. The book teaches each topic; this companion gives you more ways to practice it.

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## What is inside

- **Practice Exam B (2027 format).** 140 original three-option items, with an answer key, a rationale for every item, 2027 task codes, and a domain score grid that sends you back to the right chapters.
- **Flashcards and extra drills for Chapters 1–34.** Each chapter's section has two extra drills (fill-in-the-blank, sorting, matching, sequencing, and more), their answers, and that chapter's flashcards on cut-out sheets.
- **Extended glossary.** Terms from Chapters 1–9 that the book teaches but its printed glossary leaves out.

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## Practice Exam B

Practice Exam B is modeled on the scored items of the 2027 NCE, the version NBCC begins giving on July 1, 2027. It has **140 items with three options each**, the number of scored items on the 2027 exam. The real exam adds 30 unscored field-test items that look exactly like scored items, so your test day will be longer than this practice run.

- **Two halves of 70.** Part 1 is items 1–70 and Part 2 is items 71–140, with a break between them, the way the 2027 NCE is split into halves. Practice the 2027 rule: your Part 1 answers are final once you start Part 2.
- **Suggested time: 185 minutes** for all 140 items, not counting the break. That is the 2027 NCE's 225-minute limit for 170 items, scaled to 140 items (about 1.3 minutes per item).
- **When to take it.** If you will test on or after July 1, 2027, take Exam B first, when your study plan calls for a practice exam, and take Practice Exam A in the book afterward. If you will test before that date, start with Practice Exam A and use Exam B for extra practice.
- **Score it, then study from it.** Read the rationale for every item you missed or guessed on, fill in the domain score grid, and log your misses in your error log.

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## Flashcards

Each chapter's flashcards print on sheets of eight cards. Card fronts (the term or question) are on an odd-numbered page, and the backs (the answer) are on the even-numbered page right after it, arranged so that each back lands behind its front.

- **Print double-sided, flipping on the long edge**, at actual size (100%, not “fit to page”). If your printer cannot print double-sided, print the odd page, put that sheet back in the tray, and print the even page on its reverse; test the orientation with one sheet first.
- **Cut on the dashed lines**. Each card front carries its chapter and number (for example, *Ch. 5 · 3*), so a mixed deck is easy to sort.
- **Blank pages are deliberate**. A page left blank keeps the next chapter or sheet of fronts on an odd page. Print it along with everything else and the cards stay aligned.
- **Study actively**. Say the answer before you turn the card, sort the cards into “know it” and “not yet,” and review the “not yet” pile on the schedule in the book’s spaced-review tracker.

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## Extra drills

The drills continue the numbering in the book. Each chapter of the book prints its first drill (for example, Drill 1.1), so this companion begins with the next one (Drill 1.2). Each chapter’s drills fill one page, and their answers are on the next page, which is the back of the drill page when you print double-sided. Finish both drills before you turn the page, then check your answers and reread the book’s section on anything you missed.

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## A note on the source of these materials

Every item in this companion is original. **This companion is not affiliated with or endorsed by the National Board for Certified Counselors (NBCC)**, and no item is taken from any NBCC examination. Confirm exam dates, rules, and policies with NBCC before you register.

# Practice Exam B: The 2027 NCE Format

This practice exam is written for the 2027 NCE, the version NBCC begins giving on July 1, 2027. Take it if you will test on or after that date, or as a second practice exam after Practice Exam A in the book.

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## Instructions

- **140 items, three options each**, modeled on the 140 scored items of the 2027 NCE. The real exam adds 30 unscored field-test items (170 in all) that look exactly like scored items, so expect a longer sitting on test day.
- **Two halves of 70.** Part 1 is items 1–70 and Part 2 is items 71–140, with a break at the midpoint, the way the 2027 NCE is split into halves. Take a break of up to 15 minutes between them if you like.
- **Lock Part 1 at the break.** On the 2027 NCE, your first-half answers are final once you submit the first half. Practice the same rule: before the break, resolve every item you flagged in Part 1, and do not go back to Part 1 after you start Part 2.
- **Suggested time: 185 minutes** for the 140 items, about 92 minutes per part, not counting the break. That is the 2027 NCE's 225 minutes for 170 items, applied to 140 items. Set a timer and work in one sitting, with no notes, books, or phone.
- **Items are mixed across the six 2027 domains**, as on the real exam. Each domain is spread evenly through both parts, in about the proportions of the 2027 blueprint.
- **Answer every item.** There is no penalty for guessing. Choose the one BEST answer, and pay attention to qualifiers such as FIRST, BEST, and MOST.
- **Then score it.** Use the answer key, rationales, and domain score grid in Practice Exam B: Answers and Rationales. Log every item you missed or guessed on in your error log (see Study Plans and Test-Taking Strategy in the book).

**Part 1: Items 1–70**

1. Anoushka, 33, joins her scheduled video session from her car while driving on the highway. She says the commute is the only free time she has this week. What is the counselor's BEST response?
  - A. Switch to audio only so that Anoushka can keep her eyes on the road while they talk
  - B. Pause until Anoushka is parked in a safe, private place, or reschedule the session
  - C. Continue by video but keep to lighter topics until she reaches her destination
2. For two months, Tomás has counseled a woman whose young son died in a house fire. Between sessions he keeps picturing the fire as she described it, startles at the smell of smoke, and has begun to dread her appointments. His caseload is manageable, and the rest of his work still feels rewarding. Which step BEST addresses his strain?
  - A. Bring these reactions to supervision, and seek counseling of his own if they persist
  - B. Ask his supervisor to lighten his caseload and paperwork, since workload drives his strain
  - C. Transfer the client to a colleague, since his reactions show he cannot work with her
3. Teodor, 52, is referred by his physician, whose note reads "depression, rule out anxiety." The counselor has already reviewed informed consent and the limits of confidentiality with him. What should the counselor do NEXT?
  - A. Ask Teodor to describe, in his own words, what brings him in and why now
  - B. Give him a depression inventory to confirm the physician's diagnosis
  - C. Record the physician's note as the presenting problem and move to his history
4. In a couples session based on the Gottman method, Adaeze, 38, says to her husband, Chidi, "You never think about anyone but yourself. You left me alone with the kids all weekend again." Which intervention BEST fits the Gottman method at this point?
  - A. Ask Chidi to describe how blame was handled in his family of origin, to trace where the pattern began
  - B. Coach Adaeze to restate the complaint as a gentle start-up that names her feelings and what she needs
  - C. Suggest that the couple set the topic aside until both are calm, since raising complaints tends to escalate
5. Joanna, a counselor at a community agency, is covering for a colleague who is on unexpected medical leave. Her first appointment today is with Teodoro, 46, whom she has never met. He has been in counseling for depression for 5 months. What should Joanna do FIRST?
  - A. Review his treatment plan, recent progress notes, and latest risk assessment before he arrives
  - B. Conduct a full intake interview so her impressions are not shaped by another counselor's notes
  - C. Ask Teodoro at the start of the session to summarize what he has worked on so far

6. Thaddeus, a counselor at a community mental health agency, gets a call from the office of a psychiatrist who has just begun treating Thaddeus's client Dariusz, 47. The caller asks for Dariusz's most recent treatment summary and says Dariusz approved the request at his appointment. Agency policy requires a signed release on the agency's form before any record leaves the agency. What is Thaddeus's BEST response?
  - A. Explain the release requirement, and ask Dariusz to sign a release before sending the summary
  - B. Send the summary today, since HIPAA permits disclosures to another provider for treatment
  - C. Decline, and tell the caller that Dariusz must request his records from the agency in person
7. Esperanza, 44, seeks counseling for insomnia, frequent arguments with her adult son, grief over her sister's death last spring, and stress at work. A risk screening finds no suicidal thoughts, substance misuse, or safety concerns. She says, "If I could just sleep, I could handle the rest." Which approach to ordering her concerns is BEST?
  - A. Begin with her grief, since unresolved loss most likely underlies the other three problems she describes
  - B. Begin with her sleep, since she ranks it first and it appears to worsen the other problems
  - C. Rotate among all four concerns from week to week, so that no single problem goes unaddressed for long
8. A pediatric primary care clinic screens every patient age 12 and older with the Ask Suicide-Screening Questions (ASQ). Sienna, 14, answers yes to the item about wishing she were dead in the past few weeks and no to the other three items. Asked whether she is having thoughts of killing herself right now, she says no. What should happen NEXT?
  - A. Arrange immediate emergency transport for a full psychiatric evaluation
  - B. Record a negative screen, since she has no current thoughts of killing herself
  - C. Complete a brief suicide safety assessment with her before she leaves the clinic
9. Ji-woo, a licensed counselor who completed training in dialectical behavior therapy last year, wants a more experienced colleague's help using behavior chain analysis with a client's binge-eating episodes. Which approach to this consultation is MOST consistent with the ACA Code of Ethics?
  - A. Send the colleague the client's full record so the advice reflects the whole case
  - B. Ask the colleague to direct the client's treatment until Ji-woo is confident with the technique
  - C. Share only the details the question requires, without identifying the client absent consent

10. Ms. Lindqvist says her son, Erik, 14, ignores every rule she sets, and her husband agrees that the boy “walks all over her.” A structural family counselor wants to see, and begin to change, how the parents handle rule-setting. Which intervention BEST fits this approach?
  - A. Have the parents agree on Erik’s curfew together in the session while the counselor keeps Erik from interrupting
  - B. Meet with each family member alone, so that each one can describe the conflict without being interrupted by the others
  - C. Ask each parent to draw a three-generation genogram showing how rules were handled in the families they grew up in
11. Ingrid holds a full license in her home state, a member of the Counseling Compact, and a privilege to practice in a neighboring member state, where she sees four clients by telehealth. After a record-keeping complaint, her home-state board places her license on probation that restricts her practice. What happens to her privilege to practice in the neighboring state?
  - A. It continues unchanged, because the neighboring state’s board has taken no action against her
  - B. It continues for her current clients there, but she may not accept new clients in that state
  - C. It is lost until her home license is unencumbered and 2 years pass, so she must transition those clients
12. A counselor’s draft objective for Seo-yeon, 15, reads: “Seo-yeon will participate more in class.” Which revision BEST meets SMART criteria?
  - A. Seo-yeon will feel much more comfortable speaking up in her classes by the end of the semester
  - B. Seo-yeon will give a 10-minute talk to the entire student body at an assembly by the end of next week
  - C. Seo-yeon will answer a question aloud in class on 4 of 5 days, per a teacher log, by March 1
13. Tomasz, 58, started a new antidepressant 4 weeks ago. In a session his wife attends at his invitation, he says the medication “has no side effects.” His wife says he has been dizzy when he stands up and nearly fell twice this week. How should the counselor document this?
  - A. Record only Tomasz’s statement, since only the client’s own report of medication effects belongs in his record
  - B. Record his wife’s account as the finding, since family observations are more objective than self-report
  - C. Record both accounts, attributing each to its source, and with his consent inform his prescriber
14. At the end of an intake, Nnenna, 39, a home health aide with no health insurance, says she wants weekly counseling. She adds that at the practice’s full fee she could afford only one session a month. What should the counselor do before setting up ongoing sessions?
  - A. Offer monthly sessions at the full fee, since the practice’s fees should be the same for every client
  - B. Discuss the cost openly and explore options such as a reduced fee, if the practice allows one, or an affordable community program
  - C. Begin weekly sessions now and take up the question of payment once she has seen whether counseling helps

15. Hyun-woo, 29, a Korean American graduate student, seeks help for anxiety. In the first session he says his parents believe that seeing a counselor brings shame on a family, and he has not told them he is coming. Which response BEST explores the impact of his cultural context?
  - A. “Attitudes about counseling have changed a great deal, so try not to let your parents’ view worry you.”
  - B. “Because that view is common in Korean families, we could call these sessions academic coaching if they ask.”
  - C. “What is it like to come here, knowing how your parents see it, and how does that shape what you hope for?”
16. Akira’s agency subscribes to an online service that scores the MMPI-3 and produces a narrative interpretive report. Akira has never been trained on the MMPI-3, but a co-worker tells him the report “does the interpreting for you.” What should Akira do?
  - A. Give the test and rely on the report, since the publisher’s software has been validated
  - B. Get training in the MMPI-3 before using it, or refer clients who need it to a qualified colleague
  - C. Give the test and hand the client the report, so the client can judge its accuracy
17. Kwesi’s practice uses an AI tool, with each client’s written consent, that drafts progress notes from session audio. In the draft for his session with Mirela, 52, he finds the line “Client denied suicidal ideation,” although suicide never came up in the session. What should Kwesi do FIRST?
  - A. Correct the draft so that it reflects only what happened in the session before signing it
  - B. Sign the draft, since recording no suicidal ideation is a safe default when no risk was observed
  - C. Delete the draft and leave the session undocumented until the vendor corrects the tool
18. Ezekiel, 71, a deacon in his Baptist church, began counseling after the death of his wife of 45 years. He says, “The Lord doesn’t give us more than we can bear, so I shouldn’t need to be here.” His counselor does not share his faith. Which response BEST fits?
  - A. Ask how his faith has carried him through hard times before and whether he wants it to be part of counseling
  - B. Gently point out that the belief is irrational, since it turns needing help into a failure of faith
  - C. Steer the conversation back to his grief symptoms, since religious beliefs fall outside the counselor’s role
19. Partway through an intake, Gloria, 70, mentions that last night she saw a man standing in her dark bedroom. When she switched on the lamp, she realized it was her coat hanging on the closet door, and she laughs about it now. On the mental status examination, this experience is BEST recorded as:
  - A. An illusion
  - B. A visual hallucination
  - C. A delusion

20. Yolanda, 52, was referred by her physician after blood tests showed elevated liver enzymes that the physician links to her drinking. At intake she says her drinking is “no worse than anyone else’s” and that she came only because her doctor insisted. Which initial treatment plan BEST fits her presentation?
- A. A goal of complete abstinence within 30 days, with daily attendance at mutual-help meetings
  - B. Objectives for exploring her own views of her drinking and its effects, using motivational interviewing
  - C. A referral to residential treatment, since her denial shows that outpatient counseling is unlikely to help
21. Soraya, an associate counselor, joined a group practice last month, and her application to a large insurer’s network is still pending. The practice owner, a fully licensed counselor in that network, proposes listing herself as the rendering provider on claims for Soraya’s sessions with clients on that plan. The insurer’s contract makes no provision for billing the services of supervised clinicians. What is Soraya’s BEST response?
- A. Agree, because the owner supervises Soraya and is responsible for her clinical work
  - B. Decline, because a claim must name the clinician who actually provided the service
  - C. Agree for now, and resubmit the claims under Soraya’s name once she is credentialed
22. Lorena, a counselor in a rural county, still uses the referral list she compiled when she opened her practice 3 years ago. Which practice BEST keeps the list useful for her clients?
- A. Adding every provider in the state’s on-line directory so that clients have more choices
  - B. Checking entries at set intervals for changes in services, fees, insurance, wait times, and languages
  - C. Replacing the list with the number of a statewide information line, since lists go out of date
23. Ngozi, a counselor at a rural clinic, learns that a bill before the state legislature would close the only crisis stabilization unit in her region. Without identifying any client, she meets with her state legislators and testifies at a committee hearing about how the closure would affect people like her clients. In the ACA Advocacy Competencies, Ngozi’s action is:
- A. Systems advocacy
  - B. Collective action
  - C. Social/political advocacy
24. Kofi, 33, tells his counselor, “Work, my landlord, my car—everything is falling apart.” The counselor is teaching him a structured problem-solving method and has explained that problems are a normal part of life that can be worked on step by step. What should the counselor help Kofi do NEXT?
- A. Brainstorm as many possible solutions as he can, without judging any of them yet
  - B. Choose one problem and state it in specific, concrete terms, including the outcome he wants
  - C. Weigh the likely costs and benefits of each option and select the most workable one

25. Ezra, 24, has an intellectual disability, and his mother is his court-appointed guardian. She has signed the consent forms for counseling. In the first session, Ezra seems unsure why he is there. What should the counselor do?
- A. Proceed with counseling, because his guardian's signature completes informed consent
  - B. Explain counseling in words Ezra can understand and seek his agreement to take part
  - C. Postpone counseling until a court evaluates whether Ezra can consent for himself
26. Midway through an evening group at a community agency, the building's fire alarm sounds. The agency's emergency preparedness plan directs group leaders to take the attendance roster, lead members out by the posted route, and account for everyone at a designated meeting point. What should Rhys, the group leader, do FIRST?
- A. Lock the cabinet holding the group's clinical files so that the records stay protected
  - B. Ask members to wait while he calls the front desk to learn whether the alarm is a drill
  - C. Take the roster and lead the members out by the posted route to the meeting point
27. Ifeoma, 45, wants to stop yelling at her teenage sons. At intake she mentions that two years ago she quit smoking by logging her cravings in a notebook and calling her sister whenever an urge hit. How should the counselor use this information in her treatment plan?
- A. Set it aside as unrelated history, because quitting smoking calls for different skills than managing anger
  - B. Build on it as a strength, adapting her logging and call-for-support method to her urges to yell
  - C. Record it as a barrier, because leaning on her sister suggests that her own self-control is limited
28. Halfway through a session, Keanu describes the highway crash that injured his daughter. His counselor, who was hurt in a serious crash last year, notices her chest tightening and her thoughts drifting to her own accident. What should the counselor do FIRST?
- A. Slow her breathing and ground herself, then return her full attention to Keanu
  - B. Tell Keanu briefly about her own crash so that he knows she understands
  - C. Steer the conversation toward a less distressing topic for the rest of the hour
29. Over three sessions, Gustavo, 46, has learned progressive muscle relaxation and can calm himself with it in the office. He reports that when his supervisor criticizes him, "the relaxation does nothing." He has not practiced between sessions. What is the BEST next step?
- A. Replace relaxation with a different coping skill, since this one has not worked for him under real stress
  - B. Advise him to save the technique for his most stressful moments, so that it stays effective when needed
  - C. Have him practice daily while calm, then use it in mildly stressful moments before harder ones

30. Rafael, 23, is on an inpatient psychiatric unit after a suicide attempt. At a team meeting, the counselor learns that the team plans to discharge him tomorrow, when his insurance authorization ends, without a scheduled outpatient appointment. The counselor believes this puts Rafael at risk. What should the counselor do FIRST?
- Raise the concern with the team and propose arranging an aftercare appointment before discharge
  - Report the team's decision to the state licensing board as a possible ethics violation
  - Tell Rafael privately that the plan is unsafe and that he should refuse to leave
31. Ignacio, 47, has drunk heavily every day for 2 years and reports 2 months of low mood, poor sleep, and guilt. Which information would MOST help the counselor determine whether his depression is alcohol-induced or an independent depressive disorder?
- How high his score falls on a standardized depression inventory compared with its norms
  - Whether his drinking now meets the criteria for a severe alcohol use disorder
  - Whether his low mood began before the heavy drinking or lasts about a month after he stops
32. Rosalba receives an order signed by a judge requiring her to produce the counseling records of Nadira, 38, in Nadira's lawsuit against a driver who injured her. Nadira objects to releasing what she discussed in counseling about her childhood. What is Rosalba's BEST course of action?
- Refuse to produce the records, because Nadira has not given written consent to their release
  - Inform Nadira, ask an attorney about seeking to limit the order, and release only what it requires
  - Send the complete file right away, because a judge's order overrides every confidentiality obligation
33. Brynn, 31, sought counseling for "stress at work." Her intake PCL-5 score is well above the level that suggests probable PTSD, and a clinical interview confirms the diagnosis. Her GAD-7 score is in the mild range. How should the counselor use these results in her treatment plan?
- Discuss the results with Brynn and, if she agrees, use the PCL-5 score as a baseline for a trauma objective
  - Build the plan around work stress alone, since that is the concern she named when she first came in
  - File the scores but leave them out of the plan, since a single administration is only a snapshot in time
34. Olusegun, 30, is learning dialectical behavior therapy (DBT) interpersonal effectiveness skills. He wants to ask his older brother to repay a loan but worries about "ruining things" between them. Before helping him plan what to say, which question should the counselor ask FIRST?
- "Why do you think your brother hasn't paid you back yet?"
  - "Which matters most here: the money, the relationship, or your self-respect?"
  - "Would letting the loan go keep the peace between the two of you?"
35. Marguerite must complete continuing education before her license renewal next spring. Her caseload has shifted toward older adults, a population she has had little training to serve. Which plan BEST fits the purpose of continuing education?
- Courses on aging and late-life concerns from a provider her state board accepts
  - A free webinar series on brain health in aging, sponsored by a supplement company
  - Board-accepted courses in her long-standing specialty, since any approved hours count

36. Benedikt is retiring next month and closing his private practice. For 12 years he has carried a claims-made professional liability policy. Which step BEST protects him if a former client files a malpractice claim after he retires about work he did this year?
- Securing tail (extended reporting) coverage when the claims-made policy ends
  - Letting the policy lapse, since it covers any incident that occurred while it was in force
  - Switching to an occurrence-based policy for his final month to cover all of his past work
37. Saoirse, 37, has seen her counselor in person for 3 months and asks to switch to video sessions after a job change. She shares a one-room studio apartment with her sister, who works from home. The counselor's video platform meets HIPAA requirements and is covered by a business associate agreement. As they review consent for video sessions, which issue is MOST essential to settle?
- Where and when she can talk without being overheard, and what she will do if her privacy is interrupted
  - A reminder that the consent she signed at intake already covers every format of service the counselor offers
  - A signed release authorizing the platform company to access and store her health information
38. Hye-jin, 31, is in counseling for panic disorder. Which progress note entry BEST reflects sound documentation practice?
- "Client overreacts to ordinary body sensations, likely for attention, and remains resistant to treatment."
  - "Client reports 3 panic attacks this week (6 at intake). Practiced interoceptive exposure; plan: daily practice."
  - "Client described her sister's affair and marital problems in detail; full account recorded for context."
39. Ayesha, 27, texts her boyfriend repeatedly whenever he does not reply within an hour, then accuses him of losing interest. He has begun to pull away, and she wants to keep the relationship. Which intervention BEST helps her manage the relationship?
- Help her notice the fear behind the texting, practice tolerating the wait, and state her need to him directly
  - Suggest that she answer his messages just as slowly for a while, so that he learns how the waiting feels
  - Advise her to end the relationship, since his slow replies show an avoidant style that is unlikely to change
40. Tamika, 38, a single mother who works two jobs, is in counseling for depression. Her counselor proposes evening walks in her neighborhood as part of behavioral activation. Tamika says the streets near her apartment are not safe after dark and that her only free time is late at night, after her children are asleep. The BEST response is to:
- Ask which valued activities fit her schedule and surroundings, and build the plan around those
  - Keep the walks in the plan, because physical activity has strong research support for depression
  - Postpone behavioral activation until her work hours change and she has more free time in her week

41. Callum, 34, tells his counselor that he plans to kill himself tonight with a firearm he keeps at home. He refuses voluntary hospitalization and says he is leaving. The counselor's state allows an emergency psychiatric evaluation without consent when a person poses an imminent danger to self. What is the counselor's BEST action?
- A. Let Callum leave, because a competent adult cannot be hospitalized against his will
  - B. Sign an order committing Callum to a hospital, as licensed counselors may do for clients in danger
  - C. Initiate the emergency evaluation process the state's law provides, such as calling a mobile crisis team
42. Asked about alcohol at intake, Paulo, 63, says he drinks "socially, like everybody." What is the BEST follow-up?
- A. "Do you think your drinking has become a problem for you or for the people around you?"
  - B. "That's common enough. Let's move on, then, and talk about how you've been sleeping."
  - C. "On days you drink, how many drinks do you usually have, and how many days a week?"
43. A prospective client calls Gideon, a counselor in solo practice, to ask about starting individual counseling. Which circumstance MOST clearly makes Gideon unsuitable as this person's counselor?
- A. The caller is 30 years older than Gideon and grew up in a different era
  - B. The caller is the estranged husband of a current client, and the two are in a contested divorce
  - C. The caller holds political views that Gideon strongly opposes and finds offensive
44. Three weeks into a closed interpersonal counseling group, Haruto tells Simone, "You always turn the conversation back to yourself." Simone answers sharply, the room goes tense, and the other members look to the leader. Which leader response BEST fosters the group's therapeutic process?
- A. Remind members of the group's norm of respect and move to a new topic, so that everyone feels safe again
  - B. State which of the two members was more out of line, so that the group learns what feedback is acceptable
  - C. Help Haruto and Simone speak directly to each other about what just happened, then invite others' reactions
45. A group practice is replacing the desktop computers on which counselors stored client notes before the practice moved to a cloud-based EHR. The office manager plans to donate the old computers to a local school after deleting the client folders and emptying the recycle bin. What is the BEST plan for the old computers?
- A. Donate them as planned, since the school has no reason to search for client files
  - B. Have the drives securely wiped or destroyed before the computers leave, and document it
  - C. Keep them in storage indefinitely, since devices that once held records must be retained

46. Nadège, 35, moved from Haiti 8 years ago and speaks English at work. In her second session, she says she can “get by” in English but that talking about her son’s death feels impossible in any language but Haitian Creole. Her counselor does not speak Haitian Creole. The BEST response is to:
- A. Continue in English, since Nadège is proficient enough to work and to give informed consent
  - B. Invite her cousin, who is fluent in both languages, to interpret at the next session
  - C. Arrange a qualified interpreter, or offer a referral to a counselor who speaks Haitian Creole
47. After two assessment sessions, a counselor has diagnosed Grady, 26, with generalized anxiety disorder and is preparing his first insurance claim. Grady has not yet been told the diagnosis. Before submitting the claim, the counselor should:
- A. Submit it as prepared, since clients can learn their diagnosis whenever they request their records
  - B. Hold off on sharing the diagnosis until near the end of treatment, so that the label does not discourage him
  - C. Explain the diagnosis, how it will guide his plan, and that it will be reported to his insurer
48. The Delgado family begins counseling after Andrés, 15, is suspended from school. Both parents and Andrés’s sister, Luz, 8, will attend. Which approach to informed consent is BEST?
- A. Have both parents sign the consent forms, since neither child can legally consent and children need not take part in the consent process
  - B. Explain counseling to each member at their level, get the parents’ consent and the children’s assent, and agree on a policy for private disclosures
  - C. Treat Andrés as the identified client, obtain consent from him and his parents, and include Luz in sessions only when the counselor finds it useful
49. Devika wants to use a general-purpose generative AI chatbot to help draft treatment-plan wording for her clients. What should she do FIRST?
- A. Paste in the intake details after deleting the client’s name, which removes the identifying information
  - B. Rely on the vendor’s statement that the tool is “HIPAA compliant” and safe for client data
  - C. Learn how the tool stores entered data, how it can err or show bias, and which rules apply
50. In an open outpatient group for adults with opioid use disorder, a new member, Dwayne, says he has relapsed “a hundred times” and doubts that anything will work for him. The leader invites two members with more than a year of recovery to describe how their recovery began and what has kept it going. Which therapeutic factor is the leader drawing on MOST?
- A. Universality
  - B. Imparting information
  - C. Instillation of hope

51. Toshiro ended counseling with Tobias 2 years ago. At a community fundraiser, Toshiro meets Tobias's adult sister, Elise, who has never been Toshiro's client, and the two want to start dating. Under the ACA Code of Ethics, such a relationship is:
- A. Prohibited until at least 5 years after Toshiro's last professional contact with Tobias
  - B. Permitted, because the Code's restrictions apply only to former clients themselves
  - C. Permitted if Tobias consents in writing and Toshiro documents that it is not exploitative
52. Three months ago a neighbor's dog attacked Ilan, 5, leaving bites that needed stitches. Since then he has played out the same scene again and again, making a toy dog "bite" a small doll. He seems calm while playing, but he now wakes at night and clings to his parents at bedtime. How should the counselor understand the repeated play?
- A. As a possible intrusion symptom, which young children may express through play reenactment
  - B. As evidence that he has worked through the attack, since he stays calm while playing it out
  - C. As ordinary pretend play for his age, with no bearing on the trauma assessment
53. Noemi, 24, wants help with a fear of needles; she has fainted during three blood draws. Her counselor plans to teach progressive muscle relaxation for Noemi to use during graded exposure to needles. Why should the counselor reconsider this plan?
- A. Exposure is contraindicated for blood-injection-injury fears, so relaxation training should be used alone
  - B. Relaxation can deepen the drop in blood pressure that causes fainting, so applied tension is used instead
  - C. Her fainting shows the fear is too severe for outpatient work, so a higher level of care is needed first
54. Ten months after a sexual assault, Bianca, 26, meets the criteria for posttraumatic stress disorder (PTSD). She often says, "It happened because I drank too much. I should have known better." Which approach BEST targets this belief with an empirically supported treatment?
- A. Cognitive processing therapy, which helps her examine and challenge stuck points such as self-blame
  - B. A single structured debriefing session in which she describes the assault in detail and vents her feelings
  - C. Supportive counseling that steers away from the assault, since discussing it is likely to retraumatize her

55. Tavita, 22, has attention-deficit/hyperactivity disorder and is in counseling for depression. She lives with the grandmother who raised her and asks that her grandmother help her remember her between-session activities. What should the counselor do FIRST?
- Clarify with Tavita what she wants shared and her grandmother's role, and document her consent
  - Give her grandmother access to her progress notes so that she can follow the plan
  - Explain that involving family members would compromise the confidentiality of her counseling
56. Anders left a strict religious community in his twenties. He now counsels a client who is deciding whether to leave her own faith community. After each session, he journals about his reactions and examines with his supervisor how his history may shape what he emphasizes with her. Anders is practicing:
- Reflexivity
  - Reflection of meaning
  - Parallel process
57. Ximena bills most individual sessions with CPT code 90837, the code for about 60 minutes of psychotherapy. Her progress notes record the date, interventions, and the client's response, but not how long each session lasted. Which change BEST ensures that her claims are supported by her documentation?
- Adding estimated session lengths to her past notes from memory before an insurer audits them
  - Billing every session as 90834, the 45-minute code, so that she never overstates her time
  - Recording each session's start and stop times and billing the code that the time supports
58. A primary care clinic gives every adult the two-item Patient Health Questionnaire-2 (PHQ-2) at each annual visit. Bongani, 52, scores at the screen's cutoff. What is the BEST next step?
- Record a diagnosis of major depressive disorder and refer him for medication
  - Follow up with a fuller measure, such as the PHQ-9, and a clinical interview
  - Rescreen him at next year's visit, since a two-item screen is too brief to act on
59. For 8 months, Arnav, 52, has had trouble falling and staying asleep most nights. His 2-week sleep diary shows that he spends about 9 hours in bed each night but sleeps only about 6. A medical evaluation found no sleep apnea or other medical cause. Which recommendation reflects the sleep restriction component of cognitive behavioral therapy for insomnia (CBT-I)?
- Stay in bed later on weekends to make up the sleep he loses during the week, so that his sleep debt does not build
  - Keep a fixed wake time and limit his time in bed to about 6 hours, adding time back as his sleep grows more efficient
  - Practice progressive muscle relaxation in bed each night until he falls asleep, however long that takes
60. A counselor using strategic family therapy is considering a paradoxical directive, prescribing the symptom, for Jade, 15. Her parents report that she has cut her arms several times this month after family arguments. Which principle should guide the counselor's decision?
- Paradoxical directives work best with resistant adolescents, so the intervention suits Jade well
  - Paradoxical directives may proceed once both of Jade's parents give informed consent to the technique
  - Paradoxical directives are contraindicated when the symptom is dangerous, so safety comes first

61. Maeve, 29, who is Deaf and communicates in American Sign Language (ASL), asks a small private practice to provide an ASL interpreter for weekly counseling. The interpreter's fee is higher than the practice's fee for a session. What is the practice's BEST response?
- A. Arrange a qualified ASL interpreter for each session at no charge to Maeve
  - B. Offer video sessions with the platform's automatic captions in place of an interpreter
  - C. Propose exchanging written notes, since the interpreter costs more than the session earns
62. Hannah, a licensed counselor who has worked only with adults, has completed graduate coursework in play therapy and wants to begin seeing children ages 4 to 8. Which arrangement BEST supports ethical practice while she develops this specialty?
- A. Consulting a colleague whenever a child's case becomes difficult or confusing
  - B. Studying current play therapy literature and reviewing her own session recordings
  - C. Ongoing supervision of her play therapy cases by an experienced play therapist
63. Selam, 30, has been in counseling for 6 months for nightmares and depression that began after she fled violence in her home country. With Selam's signed release, her immigration attorney asks the counselor for a letter to support her asylum application. The counselor's BEST response is to:
- A. Write that Selam's account of persecution is credible and that she meets the standard for asylum
  - B. Decline, explaining that only a forensic evaluator may write letters for a legal proceeding
  - C. Write a factual letter on her symptoms, diagnosis, and treatment, without offering a legal opinion
64. Noor, 39, comes to individual counseling about constant arguments with her husband, who refuses to attend. She asks for "exercises to make him communicate better." Which approach BEST fits the individual modality?
- A. Focus on her own part in the pattern, and leave room for joint sessions later if her husband agrees
  - B. Write treatment goals for changing her husband's communication, since she describes his withdrawal as the main problem
  - C. Explain that relationship problems can be treated only in couples counseling, and refer her to a couples counselor
65. Tavi, 11, entered foster care 2 months ago. His foster mother brings him to counseling but knows little about his history. Which step BEST fills in the gaps?
- A. Ask Tavi to describe, in detail, the events that led to his removal from his birth parents' home
  - B. Request records from his child welfare caseworker, with authorization from whoever can legally consent for him
  - C. Call his birth parents directly for his developmental history, since they have known him the longest
66. Nkechi, a counseling intern, starts at an agency before her account in the agency's EHR has been set up. Her site supervisor tells her to log in with the supervisor's username and password to enter her notes for the next week. What is Nkechi's BEST response?
- A. Use the supervisor's login, starting each note with her own name so that authorship is clear
  - B. Decline to use the shared login, and ask how to document sessions until her account is active
  - C. Use the supervisor's login, since the supervisor is responsible for everything the intern records

67. Henrik, 39, has finished two assessment sessions for panic attacks. When his counselor turns to setting goals, he says, “You’re the expert. Just tell me what my goals should be.” What is the BEST response?
- A. Set his goals from the assessment findings, since he has asked the counselor to take the lead
  - B. Postpone goal setting until he feels ready to propose goals of his own for the counselor to review
  - C. Ask what he hopes will be different after counseling, and shape the goals and objectives with him
68. Two weeks into counseling, Rhiannon sends her counselor a friend request on the counselor’s personal social media account. The counselor’s BEST response is to:
- A. Decline the request and, at the next session, explain her social media policy and why it exists
  - B. Accept the request but limit contact to occasional “likes” so Rhiannon does not feel rejected
  - C. Ignore the request without mentioning it, so Rhiannon is spared any embarrassment

69. Several weeks after moving to video sessions, a counselor notices that Gerald, 38, seldom responds to her reflections and twice reacted as if he had misread her tone. Only his face is visible on screen. Which adjustment BEST aligns her approach with the video modality?
- A. Switch to audio-only calls, so that he can focus on her words without the distraction of the screen
  - B. Keep her usual in-person style, since a strong working alliance carries over to video without changes
  - C. Check in aloud more often about how her words land, since many cues are hidden off screen
70. Theo, 58, divorced last year and lost his job in the spring. At intake he says he is “fine” and denies suicidal thoughts. Later he mentions that last week he gave his fishing gear and his dog to his brother “since I won’t be needing them.” What should the counselor do NEXT?
- A. Accept his denial, document low risk, and reassess his mood at the next scheduled session
  - B. Schedule sessions twice a week so that his mood can be monitored closely over the next month
  - C. Ask directly about suicidal thoughts, plans, and access to means, and explore his comment

**End of Part 1.** Check your flagged items now. When you start your break, your Part 1 answers are final.

## Part 2: Items 71–140

*Begin Part 2 only after you have finished Part 1 and taken your break. Do not return to Part 1.*

71. Two months after ending counseling, Celestine, 41, calls her former counselor and asks that her records be destroyed because she worries about who might read them someday. Agency policy, consistent with state law, requires keeping adult records for 7 years after the last service. What is the counselor's BEST response?
- A. Shred the records, because clients own the information in their counseling files
  - B. Remove the most sensitive pages and keep the rest to satisfy the retention policy
  - C. Explain the retention rule, how the records are protected, and document her request
72. After a session with Omar, 52, his counselor writes a DAP note. Which sentence belongs in the Assessment section?
- A. "Omar reports using time-outs twice this week and says arguments at home have decreased."
  - B. "Omar's use of time-outs and fewer arguments suggest progress toward his anger-management goal."
  - C. "Omar will rate his anger daily and bring the log to next week's session."
73. After 8 weeks, Takeshi, 46, has met most of his objectives for work-related anxiety. Today he says his wife was just diagnosed with breast cancer, and he wants to focus on coping with her illness and supporting their children. The counselor should:
- A. Revise the plan with Takeshi to add goals for the new concern, recording the date and reason
  - B. Finish the anxiety objectives first, and then write a new plan once the original plan is complete
  - C. Refer him to a cancer support group, since the new concern falls outside his current treatment plan
74. At intake, Florencia, 37, gives vague answers about her address and job, glances at the door, and asks who will be able to see her file. Later she mentions that she is undocumented. Which response BEST integrates her context into the counseling relationship?
- A. Promise her that nothing she says will ever leave the room, so that she feels safe enough to open up to the counselor
  - B. Acknowledge that sharing may feel risky, explain who can see her file and the limits, and let her set the pace
  - C. Document her vague answers as guardedness, and turn to lighter topics until she becomes more forthcoming with details
75. Joaquín, a counselor in a primary care clinic, sees many adults with chronic insomnia. Before adding an intervention to his practice, he wants to know which counseling approaches have the strongest research support. Which source should he give the MOST weight?
- A. A detailed case study by a well-known sleep expert describing one client's dramatic improvement
  - B. A recent meta-analysis of randomized controlled trials comparing treatments for insomnia
  - C. Satisfaction ratings from thousands of people who use a popular sleep-tracking app

76. A counselor's intake summary for Joel, 50, describes his depressed mood, his prior counseling, his coping strategies, and a family history of depression. Which addition would MOST complete the summary as a biopsychosocial assessment?
- His medical conditions and medications, and his work, finances, housing, and relationships
  - A more detailed timeline of his depressive episodes and of what set off each one
  - Results from a projective technique to uncover the conflicts beneath his low mood
77. Aarav's group practice uses a telehealth platform covered by a business associate agreement. The office manager turns on a new setting that automatically records every video session to the platform's cloud storage so that "notes can be checked later." What is Aarav's BEST response?
- Leave recording on, because the business associate agreement already covers the stored recordings
  - Ask that the setting be turned off unless a client consents to recording for a specific purpose
  - Leave recording on, and mention it when the practice next updates its privacy notice
78. Mónica, 34, seeks counseling after months of sexual harassment by a male supervisor. Her counselor, a man, notices that she sits close to the door and answers briefly. Which response BEST reflects broaching?
- Name their gender difference in light of what she has faced, and ask how it feels to talk about it with him
  - Leave gender unmentioned, so that she does not feel he is assuming her discomfort has anything to do with him
  - Arrange a transfer to a woman colleague, since her discomfort suggests that she would do better with a woman
79. Before a session, a counselor reviews her notes on Renata, 38. Last week Renata reported passive suicidal thoughts, and her safety plan included having her brother store her handgun before today's appointment. How should this review MOST shape today's session?
- Wait for Renata to raise the topic so that she continues to set the agenda
  - Follow the planned agenda and review the safety plan if time remains at the end
  - Ask early in the session whether the handgun was moved, and update the plan as needed
80. Mr. Ortiz, 31, has an intellectual disability and lives in a group home. A functional assessment found that he screams to get staff attention. Under his plan, day staff ignore the screaming and respond right away when he taps a staff member's arm, the replacement behavior he was taught. Evening staff, however, rush to calm him whenever he screams. Screaming has dropped on day shifts but not on evenings. The BEST revision is to:
- Add a loss-of-privileges consequence for any screaming that occurs during evening shifts
  - Train evening staff to follow the same plan, and compare behavior data across all shifts
  - Write a separate evening plan that lets staff use whatever approach calms him the fastest

81. Mariana learns from the state board's website that her counseling license expired 5 days ago because she forgot to submit her renewal. The board's rules provide no grace period, and she has 14 clients scheduled this week. What is her BEST course of action?
- A. Stop providing licensed services, arrange coverage or rescheduling, and begin reinstatement
  - B. Keep seeing clients while she renews, since her training and competence have not changed
  - C. Keep seeing clients, but hold all insurance claims until the board reactivates her license
82. At the start of her intake, Mariel, 29, receives the practice's eight-page policy packet, which covers fees, cancellations, records, after-hours contact, and the limits of confidentiality. She signs the last page without reading it and says, "I trust you. Let's just get started." What should the counselor do?
- A. Accept her signature, since the signed packet documents that she has agreed to the policies
  - B. Begin the session as she asks and give her the packet to read at home before the next appointment
  - C. Go over the key policies with her in plain language, invite her questions, and note the discussion in her record
83. Keisha's caseload at a sexual assault services center now consists almost entirely of survivors of sexual violence. She feels well but wants to stay alert to how the work affects her over time. Which plan BEST fits that goal?
- A. Wait to evaluate herself until symptoms such as intrusive images or new fears appear
  - B. Self-assess regularly with a structured measure and review her exposure in supervision
  - C. Steer clients away from traumatic details so that her own exposure stays manageable
84. Bogdan, 50, came to counseling for work stress at his daughter's urging and has never seen a counselor. He arrives unsure of what to expect. Which first-session step is MOST likely to reduce the chance that he drops out early?
- A. Let him lead the session without structure, so that he does not feel the counselor is imposing an agenda
  - B. Give him a thorough packet on stress management, so that he leaves the session with something concrete
  - C. Explain how sessions work, what each of them will do, and that progress is often uneven
85. Loretta holds a master's degree in clinical mental health counseling and a doctorate in music education. For her new private practice, she plans to use the title "Dr." on her website and in her advertising. Under the ACA Code of Ethics, how should she present her credentials?
- A. Use "Dr." in all her advertising, since any earned doctorate entitles her to the title
  - B. Use "Dr." as long as her website notes that music is used in some counseling approaches
  - C. List her counseling master's as her highest counseling degree and not use "Dr." in her counseling work

86. During counseling for depression, Evelyn, 67, mentions that her husband, who has Parkinson's disease, now needs help bathing and dressing, and that she has not had a day off in months. Which referral approach is BEST?
- A. Give her the number of a national caregiver hotline and suggest she call it when she has a free moment
  - B. Ask what help she wants, offer specific respite and caregiver-support options, and follow up next session
  - C. Contact her husband's neurologist to begin arranging a nursing home placement so that she can rest
87. A school counselor is helping a teacher evaluate a new plan for Elias, 7, whose tantrums last anywhere from 2 to 25 minutes. The team's goal is to shorten the tantrums, not to change how often they occur. Which observation method fits BEST?
- A. Event recording
  - B. Duration recording
  - C. Momentary time sampling
88. The director of a new residential treatment center visits Yusuf, a counselor in private practice, and offers him \$200 for each client he refers, asking in return that the center be featured on Yusuf's referral list. Yusuf's BEST response is to:
- A. Accept the payment, provided he tells each referred client about the arrangement
  - B. Decline the payment and judge the center by the standards he applies to other resources
  - C. Accept the payment but refer only clients whose needs clearly call for residential care
89. Ruth practices in a small rural town, where she often sees clients at the grocery store, school events, and church. Asked how she handles these overlaps, she says she "goes with her gut." After an ethics training, which change would MOST strengthen her practice?
- A. Declining all contact with clients outside the office, since overlapping roles violate the Code
  - B. Continuing to trust her intuition, since it has kept her free of complaints so far
  - C. Using a decision-making model for these situations, consulting, and documenting her reasoning
90. Rosalía, 28, is about to begin cognitive behavioral therapy (CBT) for depression. Which approach BEST orients her to CBT?
- A. Assign a thought record right away, since she will learn how CBT works most quickly by actually doing it
  - B. Use an example from her week to link thoughts, feelings, and actions, and describe how sessions and homework work
  - C. Explain that early sessions will explore her childhood in depth before any work on her current problems begins
91. Yesenia, 36, began video counseling after her husband pushed her during an argument. Halfway through today's session, her answers grow short, and she keeps glancing off-screen. Earlier she mentioned that her husband stayed home sick today. What should the counselor do FIRST?
- A. Ask Yesenia to describe last week's argument in detail so that the risk can be documented
  - B. Check whether she can talk privately, using questions she can answer with yes or no
  - C. End the session and call the police to request a welfare check at Yesenia's home

92. Aaliyah, 26, meets full criteria for posttraumatic stress disorder (PTSD) after an assault in a parking garage. She has had several panic attacks, each set off by a reminder such as entering a garage or hearing footsteps behind her; none has come out of the blue. Which diagnostic record is MOST accurate?
- A. PTSD, with panic attacks
  - B. PTSD and panic disorder
  - C. PTSD and agoraphobia, since she avoids garages
93. Tyler, 19, is finishing a 28-day residential program for alcohol use disorder. He plans to move back into an apartment with two roommates who drink heavily most nights. Which aftercare plan BEST supports his recovery?
- A. Outpatient counseling only, since where he chooses to live is a personal matter outside the plan
  - B. A return to the apartment, since facing drinking at home will strengthen the skills he learned in treatment
  - C. Outpatient care and mutual-help meetings, plus exploring recovery housing or another alcohol-free home
94. Midway through a family session, Mr. Castellanos stands, raises his voice, and steps toward his 15-year-old daughter, who shrinks back in her chair. He has no weapon. What should the counselor do FIRST?
- A. Encourage him to let all of his anger out, since expressing it fully will help him calm down sooner
  - B. Ask his daughter what she said that upset him, so that the conflict can be resolved quickly
  - C. In a calm, firm voice, ask him to step back and sit down, and offer a short break outside the room
95. At intake, Farah, 34, tells the male counselor assigned to her that, because of her religious values, she would feel more comfortable discussing her marriage with a woman. She reports no safety concerns, and a female counselor at the agency has an opening in two weeks. The counselor's BEST response is to:
- A. Assure her that his multicultural training prepares him to help her, and begin the assessment
  - B. Explain that the agency's nondiscrimination policy rules out assignments based on gender
  - C. Honor her preference by arranging the female counselor, and give her crisis resources meanwhile
96. Lakshmi, 50, begins counseling at an integrated primary care clinic. Her counselor, her physician, a nurse care manager, and a consulting psychiatrist review shared cases weekly. At the first session, what must the counselor make sure Lakshmi understands?
- A. Who is on the team, what information they will share, and why it is shared
  - B. Nothing beyond the clinic's privacy notice, since sharing among treating providers is routine
  - C. Only the psychiatrist's involvement, since the other members do not provide mental health care
97. Kalani wants to recommend a free mindfulness app that her clients can use between sessions. Which step is MOST important before she recommends it?
- A. Reviewing the app's research support and privacy policy, and discussing its limits with clients
  - B. Confirming that the app is labeled "HIPAA compliant," since that label keeps clients' data private
  - C. Checking the app's store ratings, since high ratings from many users show that it is effective

98. A counselor is preparing the informed consent discussion for a closed 10-week counseling group for adults going through divorce. Beyond what individual clients are told, which topic is MOST specific to the group format?
- The counselor's credentials, training, and theoretical approach
  - The fee, the cancellation policy, and how insurance claims are filed
  - Expectations about members' contact with one another outside group sessions
99. Fifteen minutes after seeing a serious car crash in front of the school, Mateo, 16, is brought to the school counselor. He is shaking, breathing fast, and says he "can't stop seeing it." What should the counselor do FIRST?
- Help him slow his breathing and notice his surroundings, and stay with him until he is calmer
  - Give him the PCL-5 to screen for post-traumatic stress disorder while the reactions are fresh
  - Reassure him that the shaking is nothing to worry about, and send him back to class to keep his routine
100. Near the end of counseling for social anxiety, Valentina, 28, says, "You fixed me. I don't know how I'll manage without these sessions." The counselor's BEST response is to:
- Reassure her that she can keep coming weekly for as long as she feels she needs the support
  - Accept the credit warmly, since her trust in counseling will help her if she ever needs to return
  - Help her name the steps she took that produced the change and plan how she will keep using them
101. Faisal will be deposed as a fact witness in a workers' compensation case brought by his client, Ilse, 49, who has signed a release. Reviewing his notes, Faisal sees that several entries are brief and could be misread. Which preparation is BEST?
- Adding clarifying details to the brief entries so that the record is complete before he testifies
  - Bringing his full file and offering it to the opposing attorney to show he has nothing to hide
  - Leaving the records unchanged, consulting an attorney, and testifying only to facts he knows
102. According to the ACA Code of Ethics, counselor self-care is BEST described as:
- A personal matter that falls outside the Code's professional standards
  - A way to maintain well-being so that counselors can meet their professional responsibilities
  - An obligation that begins only after a counselor has been found to be impaired
103. A school counselor wants a standardized measure of depressive symptoms for Ella, 9. The only depression measure the school owns is the Beck Depression Inventory-II (BDI-II), which was developed for ages 13 to 80. What should the counselor do?
- Give Ella the BDI-II and read the items aloud so that she can understand them
  - Choose a depression measure developed and normed for children her age
  - Ask her parents to complete the BDI-II, rating the symptoms they see in her

104. Grace, 27, takes a second-generation antipsychotic for bipolar I disorder, and her prescriber raised the dose 10 days ago. Since then, she reports an inner restlessness and an urge to keep moving, and she paces during the session. She has signed a release for her prescriber. Which response is BEST?
- A. Teach progressive muscle relaxation, since the restlessness most likely reflects anxiety
  - B. Suggest that she return to her previous dose until she can see her prescriber
  - C. Document her report and its timing, and with her knowledge contact the prescriber promptly
105. Halima, 29, has had three panic attacks, and each time she was sure she was having a heart attack. Her physician has ruled out heart disease. Which psychoeducation BEST fits the cognitive model of panic?
- A. Because her heart is healthy, the attacks are imaginary and will fade once she fully accepts that fact
  - B. The sensations are the body's alarm response, and reading them as danger feeds a cycle that intensifies the attack
  - C. She should avoid exercise and other activities that raise her heart rate, so that she does not trigger another attack
106. An ice storm cut power to a counseling practice for 3 days. The practice's emergency preparedness plan told counselors to call clients from the contact list in the EHR, which no one could open without power or internet. Now that the office has reopened, what is the BEST next step?
- A. Review the plan with staff and add secure offline access to client contact information
  - B. Keep the plan as written, since outages lasting several days are rare in the area
  - C. Have each counselor keep printed copies of full client records at home for emergencies
107. Odalys, 35, has spent 3 weeks in a partial hospitalization program for major depressive disorder. Which finding BEST indicates that she is ready for discharge to outpatient care?
- A. She has used all of the program days her insurance plan will authorize for this year
  - B. She has met her program objectives, denies suicidal intent, and has an outpatient appointment set
  - C. She reports feeling much better after one good weekend and asks to return to work right away
108. Dmitri, who has no military background, joins a clinic that serves veterans and their families. Which step BEST prepares him to work with this population?
- A. Train in military culture and examine his own assumptions about military service
  - B. Rely on his graduate multicultural course, since the same principles apply to every group
  - C. Ask his veteran clients to teach him about military culture during their sessions
109. Hollis, 45, completed an anxiety inventory at intake, and his score falls in the severe range. When the counselor shares the result, Hollis frowns and says, "That's not me. I'm just a busy guy." What should the counselor do?
- A. Explain that the inventory is well validated, so his reaction most likely reflects minimizing
  - B. Drop the score from his record, since his disagreement shows that the result is invalid
  - C. Explore his reaction, review the items behind the score, and weigh it with the interview

110. Kiri, 48, has just learned that her father, who lives with her, has Alzheimer's disease. She asks her counselor what she should expect as his caregiver. Which approach to psychoeducation is BEST?
- A. Refer all of her questions to his neurologist, since teaching about a medical diagnosis is outside a counselor's scope
  - B. Give her a comprehensive written guide to the disease, and invite her to call with any questions after reading it
  - C. Share information in small, plain-language pieces tied to her situation, such as caregiver strain, and check understanding
111. Lachlan, 15, comes alone to a community counseling clinic, asks for help with anxiety, and says he does not want his parents to know. What MOST determines whether the counselor may begin counseling him without a parent's consent?
- A. The ACA Code of Ethics, which allows minors who understand the services to consent for themselves
  - B. The state's law on minors' consent to outpatient mental health care, along with clinic policy
  - C. HIPAA, which gives minors age 14 and older the right to consent to their own health care
112. A community counseling agency now serves many Dari-speaking families who arrived in the past year. Its intake packet and consent forms exist only in English. Which plan BEST provides language access to these written materials?
- A. Have a qualified translator translate the forms, and use qualified interpreters to review them with clients
  - B. Run the forms through a free online translation tool and print the results for clients
  - C. Ask a bilingual current client to translate the forms in exchange for reduced fees
113. Delphine, 42, is preparing to end counseling after recovering from her third episode of major depression. Reviewing her history, she notices that each episode began with sleeping late, skipping choir rehearsals, and letting friends' calls go unanswered. How should the counselor use this pattern?
- A. Build it into her relapse prevention plan as early warning signs, each linked to steps she will take
  - B. Advise her to seek help only if full symptoms last 2 weeks, so that ordinary low days cause no alarm
  - C. Treat it as past history, because her current scores are in the nonclinical range and she is ready to end
114. For six sessions, Delia, 45, has given the Session Rating Scale the highest possible marks, yet she often arrives late and has canceled twice. What is the BEST way for the counselor to get more useful feedback?
- A. Stop using the scale, since her uniformly perfect ratings show it is not providing useful information
  - B. Tell her that criticism is welcome and helpful, and ask specifically what would make sessions fit her better
  - C. Treat the lateness and cancellations as resistance, and add a goal about attendance to her treatment plan
115. Brandon, 33, is in counseling after his girlfriend ended their relationship. He says he is furious and "can't stop thinking about what she did," but he denies any plan to hurt her. Which part of his history would MOST raise the counselor's concern about his risk of violence toward her?
- A. An arrest 2 years ago for assaulting a previous girlfriend
  - B. A diagnosis of bipolar II disorder made in his twenties
  - C. Tears and a raised voice when he describes the breakup

116. Nadia, licensed for six years, is asked by her agency director to begin supervising two associate counselors toward licensure next month. She is a skilled clinician but has never been trained in supervision. Her BEST response is to:
- A. Complete training in supervision and meet her state board's supervisor requirements first
  - B. Begin supervising, since clinical skill is the main qualification for a supervisor
  - C. Meet with the associates but call it consultation until she finishes training
117. To make counseling more affordable, Ambrose, who is in network with several insurers, tells all his clients that he will waive their copays and bill each insurer his full contracted fee. Which statement BEST describes this practice?
- A. It is encouraged, because the ACA Code asks counselors to consider clients' financial situations
  - B. It is acceptable as long as each client signs a form agreeing to have the copay waived
  - C. It can misrepresent his fees to insurers; waivers should follow a case-by-case hardship policy
118. Desta, 20, a community college student recently diagnosed with attention-deficit/hyperactivity disorder (ADHD), is failing two courses. She did not know that colleges offer disability services. Which response BEST supports her in advocating for her own needs?
- A. Help her learn which accommodations exist and rehearse requesting them from the disability services office
  - B. With her permission, call her instructors to explain her diagnosis and request extensions on her behalf
  - C. Recommend that she drop to part-time enrollment, so that her course load better fits her attention difficulties
119. Staff Sergeant Kim, 29, a member of the Army National Guard, is midway through counseling for PTSD when he learns he will spend 4 months at a training site in another state. His counselor is licensed only in Kim's home state and has no privilege or other legal authority to practice in the state where the site is located. What should the counselor do?
- A. Plan with him for the gap: crisis resources such as 988, a provider near the site, and a date to resume
  - B. Continue weekly video sessions while he is at the training site, since his legal residence remains in the home state
  - C. Close his case before he leaves and invite him to begin counseling again once he is back home
120. Jae-won, 41, has attended weekly outpatient counseling for alcohol use disorder for 4 months. Despite real effort, he has returned to heavy drinking several times. He has no history of withdrawal symptoms or medical problems, his wife does not drink and supports his recovery, and he wants to keep his job. He asks for "more help." Which level of care is MOST appropriate?
- A. Continued weekly outpatient counseling, since he is not in medical danger
  - B. An intensive outpatient program that meets several evenings a week
  - C. A 30-day residential program to remove him from his drinking triggers

121. Tunde, 41, tells his counselor that her typing during sessions makes him feel “like a case file” rather than a person. Her agency requires that each progress note be completed on the day of the session. The counselor’s BEST response is to:
- A. Explain that notes must be typed during the session for the record to be accurate
  - B. Acknowledge his reaction, keep in-session notes brief, and finish the note right after the session
  - C. Begin audio-recording sessions so that the notes can be written from the recordings later
122. After Mireille’s intake, an AI feature in Ravi’s EHR suggests “borderline personality disorder” as a diagnosis, based on his intake note. Ravi has not yet assessed for personality disorders. What is the BEST way for Ravi to use the suggestion?
- A. Treat it as one hypothesis to check against DSM-5-TR criteria in his own assessment
  - B. Record it as a provisional diagnosis, since AI trained on large data sets is more objective
  - C. Turn off the EHR’s AI features, since the ACA Code of Ethics forbids AI in diagnosis
123. Marisol, 29, is court-ordered to counseling, and her counselor sends attendance and progress reports to her probation officer. Marisol agrees with every suggestion and has never voiced a goal of her own. Which response BEST reflects the counselor’s awareness of power dynamics in this relationship?
- A. Take her agreement as a sign of strong motivation and move quickly to interventions
  - B. Confront her about complying on the surface simply to satisfy the court
  - C. Acknowledge how the reporting role may affect what she says, and invite her goals
124. Annika, 41, says, “I’m such a nag. I remind my son about his insulin five times a day.” Which counselor response is a reframe?
- A. “You’re frustrated with yourself for reminding him so often.”
  - B. “How does your son react when you remind him?”
  - C. “Those reminders show how much his health matters to you.”
125. Ayodele, a newly licensed counselor, joins a group practice where she will bill Medicaid and several commercial insurers for the first time. Her graduate program covered ethics but not billing. Which step BEST prepares her to bill in compliance with the rules?
- A. Relying on the practice’s billing staff, since coding accuracy is the biller’s responsibility
  - B. Completing training on payer rules, coding, documentation, and fraud prevention before she bills
  - C. Submitting claims and learning from any denials, since insurers explain what they will not pay
126. Desmond, 31, who is Black, scores well above average on a personality inventory scale that reflects suspiciousness and mistrust of others. In the interview, he describes being stopped by police many times in his own neighborhood. He is guarded early in the session but grows more open as it goes on. Which interpretation is MOST appropriate?
- A. Report the elevation as evidence of paranoid traits, since the scale has strong validity evidence
  - B. Set aside the whole inventory, since personality tests cannot be used fairly with Black clients
  - C. Consider that the score may partly reflect realistic wariness, and weigh it with other data

127. Agency policy requires a treatment plan review every 90 days. Counselor Cyrus completes each review in the electronic health record after hours, working from his notes, and then asks clients to sign the form at their next session. Which change BEST reflects sound practice?
- A. Shorten the review interval to every 30 days so that each client's progress is checked more often
  - B. Have his supervisor complete the reviews so that the ratings of each client's progress stay objective
  - C. Complete the review in session, going over each objective with the client and deciding next steps together
128. Wen, a licensed counselor, wants to spend some of her volunteer time on advocacy for the counseling profession itself. Which activity BEST fits that goal?
- A. Helping a client prepare to request a workplace accommodation from her employer
  - B. Urging state legislators, through her state counseling association, to adopt the Counseling Compact
  - C. Calling a client's insurer, with the client's consent, to appeal a denied claim
129. Ana, 29, is in counseling for posttraumatic stress disorder. She is also working with a domestic violence advocate at a local shelter on a safety plan and a protective order, and she asks that her counselor and her advocate "be on the same page." Which action BEST supports this collaboration?
- A. With Ana's signed release, coordinate goals with the advocate and share only what Ana approves
  - B. Send the advocate Ana's complete counseling record so the safety plan reflects her history
  - C. Leave the coordination to Ana, since advocates are not part of her clinical care
130. In a bereavement group, each time Lucía begins to cry while describing her son's death, Martin quickly says, "It gets easier. Don't cry," and Lucía stops talking. Which leader response BEST fits?
- A. Thank Martin for his kindness, and move on to the next member so that Lucía can collect herself privately
  - B. Gently stop Martin's reassurance, invite Lucía to continue, and later explore what her tears stir in Martin
  - C. Wait to see whether other members address the pattern, since a group should learn to manage itself over time
131. Two sessions into counseling for job stress, Corbin, 30, asks his counselor for a letter stating that he needs an emotional support animal so that his landlord will waive a no-pets rule. The counselor has not assessed whether Corbin has a disability or a disability-related need for the animal. What is the counselor's BEST response?
- A. Write the letter now, since a client's request is enough to document the need
  - B. Decline, since counselors may not write letters supporting clients' housing requests
  - C. Explain that a letter must rest on an assessment of his need, and decide after assessing

132. Agnes, 61, describes her house as “a little cluttered, like anyone’s.” With Agnes’s consent, her daughter shows the counselor recent photos: stacks of newspapers, mail, and boxes fill the kitchen and living room, and Agnes now sleeps in a recliner because her bed is buried. Agnes grows distressed at any suggestion of throwing things out, saying she may need them someday. She reports no intrusive thoughts or other rituals, and her physician has found no medical or cognitive problems. Which diagnosis BEST fits all the available data?
- A. Obsessive-compulsive disorder
  - B. Hoarding disorder
  - C. No diagnosis, since she does not see the clutter as a problem
133. Rashad, 48, began counseling for depression after a layoff. At intake, he and his counselor set the goal of resuming his job search by applying for at least two jobs a week. After 12 sessions, his score on a standardized depression measure has fallen by more than half, but he has not yet applied for any jobs. Which evaluation of his progress is MOST accurate?
- A. His symptoms have improved, but his functional goal is unmet, so the plan needs review with him
  - B. Treatment has succeeded, since a drop of more than half shows that his depression has resolved
  - C. Treatment has failed, since he has not met his intake goal, so a referral elsewhere is needed
134. With 2 minutes left in a session, Arturo, 52, stands to leave and says, “Oh, by the way, my wife told me last night that she wants a divorce.” He denies thoughts of harming himself or anyone else. What is the BEST response?
- A. Acknowledge how big the news is, confirm his support for the week, and plan to begin the next session with it
  - B. Extend the session by 45 minutes so that he can fully process the news while it is still fresh and raw
  - C. End the session on time without comment, so that he learns to raise important issues earlier in a session
135. Reviewing a year of her clients’ outcome measures, Lorraine sees that clients with anxiety improve steadily, but most clients referred for anger concerns stop attending after two or three sessions. Which response BEST reflects an accurate assessment of her strengths and limitations?
- A. Conclude that clients referred for anger are often unmotivated, and keep her current approach
  - B. Seek peer supervision on these cases and pursue training in anger-focused interventions
  - C. Stop accepting anger referrals and list anxiety as her only area of practice
136. Lupe, a home-based family counselor, carries paper consent forms and session notes between client visits. Which practice BEST protects these records?
- A. Leaving them in the trunk of her car between visits, since the trunk keeps them out of sight
  - B. Carrying only what each visit needs in a locked case, returned to secure storage that day
  - C. Photographing the forms with her personal phone and shredding the originals to avoid carrying paper

137. Doris, 68, has missed three sessions since she stopped driving. She has tried, without success, to enroll in the county's senior transportation program on her own. What is the BEST next step?
- A. Give Doris a printed list of transportation programs and ask her to call them before next week
  - B. Reduce Doris's sessions to once a month until she solves her transportation problem
  - C. With Doris's consent, call the program together during the session to start her enrollment
138. At intake, Jonah, 40, describes depressed mood, loss of interest, insomnia, poor concentration, and feelings of worthlessness, but he cannot say how long they have lasted: "maybe a week, maybe longer." His husband, who will join the next session with Jonah's consent, can clarify the timeline. The counselor strongly expects that Jonah will meet full criteria for major depressive disorder. Which diagnosis is BEST to record for now?
- A. Major depressive disorder, provisional
  - B. Unspecified depressive disorder
  - C. Adjustment disorder with depressed mood
139. In the second session, a counselor asks Rhea, 33, "How does your husband feel about the move?" Rhea answers curtly, "My wife is fine with it," and her answers stay short for the next 10 minutes. What is the BEST response?
- A. Continue without mentioning the slip, so that it does not become a bigger issue than it needs to be
  - B. Acknowledge the assumption, apologize briefly, and ask how it affected her and how the session feels now
  - C. Explain that the intake form was unclear and that the counselor fully supports same-sex marriages
140. In their second session, Farid, 33, a sales representative whose fear of flying has cost him promotions, agrees with his counselor on how they will know counseling is complete. Which termination criterion is MOST appropriate?
- A. Farid completes two round-trip work flights, rating his peak fear at 4 or lower out of 10 on each
  - B. The counselor judges that the unconscious conflicts underlying Farid's fear of flying have been fully resolved
  - C. Farid has used all 12 of the sessions that his insurance plan covers for the current calendar year

**End of Practice Exam B.** Score your answers with Practice Exam B: Answers and Rationales.

# Practice Exam B: Answers and Rationales

Score Practice Exam B in three steps. First, mark each answer right or wrong with the key table. Second, read the rationale for every item you missed or guessed on, including why the wrong answers tempted you. Third, fill in the domain score grid to see which parts of the 2027 blueprint need more study, and go back to the chapters it names.

Task codes follow the 2027 NCE examination specifications (National Board for Certified Counselors [NBCC], 2026). The task code shown in the table is the main task each item tests; the rationale lists any secondary tasks. The chapter shown first is where the book teaches the main point.

A raw percentage on a practice exam cannot be converted to an NCE score. The 2027 NCE reports a scaled score from 100 to 500, with 360 to pass on every form, so use your results here to find weak areas, not to predict a pass.

## Answer key

Domains: 1 Professional Development & Counselor Self-Awareness; 2 Intake & Assessment; 3 Treatment Planning & Continuity of Care; 4 Provision of Counseling Interventions; 5 Indirect Client Care; 6 Legal & Ethical Compliance.

### Part 1: Items 1–70

| Item | Key | 2027 domain                | Task | Chapter      |
|------|-----|----------------------------|------|--------------|
| 1    | B   | 6 Legal & Ethical          | 6.4  | 4            |
| 2    | A   | 1 Professional Development | 1B.1 | 3 (also 1)   |
| 3    | A   | 2 Intake & Assessment      | 2A.3 | 5 (also 8)   |
| 4    | B   | 4 Interventions            | 4.1  | 28           |
| 5    | A   | 5 Indirect Care            | 5.6  | 4 (also 21)  |
| 6    | A   | 6 Legal & Ethical          | 6.2  | 2 (also 4)   |
| 7    | B   | 3 Treatment Planning       | 3A.1 | 20 (also 13) |
| 8    | C   | 2 Intake & Assessment      | 2B.2 | 5 (also 29)  |
| 9    | C   | 1 Professional Development | 1A.1 | 3 (also 1)   |
| 10   | A   | 4 Interventions            | 4.1  | 28           |
| 11   | C   | 6 Legal & Ethical          | 6.13 | 4 (also 1)   |
| 12   | C   | 3 Treatment Planning       | 3A.2 | 20           |
| 13   | C   | 5 Indirect Care            | 5.4  | 14 (also 4)  |
| 14   | B   | 2 Intake & Assessment      | 2A.2 | 5 (also 4)   |
| 15   | C   | 4 Interventions            | 4.2  | 33 (also 34) |
| 16   | B   | 1 Professional Development | 1B.8 | 8 (also 7)   |
| 17   | A   | 6 Legal & Ethical          | 6.19 | 4            |
| 18   | A   | 4 Interventions            | 4.2  | 34 (also 15) |

| Item | Key | 2027 domain                | Task | Chapter          |
|------|-----|----------------------------|------|------------------|
| 19   | A   | 2 Intake & Assessment      | 2B.5 | 5                |
| 20   | B   | 3 Treatment Planning       | 3A.3 | 20 (also 12, 27) |
| 21   | B   | 6 Legal & Ethical          | 6.7  | 4                |
| 22   | B   | 5 Indirect Care            | 5.5  | 21               |
| 23   | C   | 1 Professional Development | 1A.5 | 33               |
| 24   | B   | 4 Interventions            | 4.3  | 26 (also 20)     |
| 25   | B   | 2 Intake & Assessment      | 2A.1 | 2                |
| 26   | C   | 6 Legal & Ethical          | 6.1  | 4 (also 29)      |
| 27   | B   | 3 Treatment Planning       | 3A.4 | 20               |
| 28   | A   | 1 Professional Development | 1B.6 | 3 (also 29)      |
| 29   | C   | 4 Interventions            | 4.3  | 26 (also 25)     |
| 30   | A   | 5 Indirect Care            | 5.3  | 21 (also 5)      |
| 31   | C   | 2 Intake & Assessment      | 2B.6 | 12 (also 6, 10)  |
| 32   | B   | 6 Legal & Ethical          | 6.17 | 2 (also 1)       |
| 33   | A   | 3 Treatment Planning       | 3A.5 | 20 (also 8, 11)  |
| 34   | B   | 4 Interventions            | 4.4  | 26 (also 13)     |

| Item | Key | 2027 domain                | Task | Chapter             |
|------|-----|----------------------------|------|---------------------|
| 35   | A   | 1 Professional Development | 1A.3 | 4 (also 1)          |
| 36   | A   | 6 Legal & Ethical          | 6.12 | 1                   |
| 37   | A   | 2 Intake & Assessment      | 2A.7 | 4 (also 2)          |
| 38   | B   | 5 Indirect Care            | 5.8  | 4 (also 11)         |
| 39   | A   | 4 Interventions            | 4.4  | 16 (also 28)        |
| 40   | A   | 3 Treatment Planning       | 3A.6 | 20 (also 10)        |
| 41   | C   | 6 Legal & Ethical          | 6.3  | 21 (also 5, 29)     |
| 42   | C   | 2 Intake & Assessment      | 2B.3 | 5 (also 12)         |
| 43   | B   | 1 Professional Development | 1B.7 | 3 (also 28, 1)      |
| 44   | C   | 4 Interventions            | 4.5  | 30 (also 31)        |
| 45   | B   | 6 Legal & Ethical          | 6.16 | 4 (also 2)          |
| 46   | C   | 5 Indirect Care            | 5.7  | 4 (also 21, 33, 34) |
| 47   | C   | 3 Treatment Planning       | 3A.7 | 20 (also 2, 6)      |
| 48   | B   | 2 Intake & Assessment      | 2A.6 | 2 (also 28)         |
| 49   | C   | 1 Professional Development | 1A.7 | 4                   |
| 50   | C   | 4 Interventions            | 4.5  | 31 (also 12)        |
| 51   | A   | 6 Legal & Ethical          | 6.5  | 3                   |

## Part 2: Items 71–140

| Item | Key | 2027 domain                | Task  | Chapter         |
|------|-----|----------------------------|-------|-----------------|
| 71   | C   | 6 Legal & Ethical          | 6.2   | 2               |
| 72   | B   | 5 Indirect Care            | 5.8   | 4               |
| 73   | A   | 3 Treatment Planning       | 3A.10 | 20 (also 21)    |
| 74   | B   | 4 Interventions            | 4.8   | 34 (also 2, 33) |
| 75   | B   | 1 Professional Development | 1A.4  | 9               |
| 76   | A   | 2 Intake & Assessment      | 2B.4  | 5 (also 20)     |
| 77   | B   | 6 Legal & Ethical          | 6.9   | 4 (also 2)      |
| 78   | A   | 4 Interventions            | 4.8   | 22 (also 33)    |
| 79   | C   | 5 Indirect Care            | 5.6   | 4 (also 5)      |
| 80   | B   | 3 Treatment Planning       | 3A.11 | 20 (also 25)    |
| 81   | A   | 6 Legal & Ethical          | 6.6   | 4 (also 1)      |
| 82   | C   | 2 Intake & Assessment      | 2A.5  | 2 (also 5)      |
| 83   | B   | 1 Professional Development | 1B.2  | 3               |
| 84   | C   | 4 Interventions            | 4.9   | 22              |
| 85   | C   | 6 Legal & Ethical          | 6.20  | 1 (also 4)      |
| 86   | B   | 3 Treatment Planning       | 3B.1  | 21 (also 15)    |
| 87   | B   | 2 Intake & Assessment      | 2B.8  | 8 (also 25)     |
| 88   | B   | 5 Indirect Care            | 5.5   | 21 (also 4)     |
| 89   | C   | 1 Professional Development | 1A.6  | 1 (also 3)      |

| Item | Key | 2027 domain                | Task  | Chapter         |
|------|-----|----------------------------|-------|-----------------|
| 52   | A   | 2 Intake & Assessment      | 2B.1  | 11 (also 5)     |
| 53   | B   | 3 Treatment Planning       | 3A.8  | 20 (also 11)    |
| 54   | A   | 4 Interventions            | 4.6   | 11              |
| 55   | A   | 5 Indirect Care            | 5.1   | 21 (also 2)     |
| 56   | A   | 1 Professional Development | 1B.11 | 3 (also 32, 22) |
| 57   | C   | 6 Legal & Ethical          | 6.10  | 4               |
| 58   | B   | 2 Intake & Assessment      | 2B.9  | 5 (also 8)      |
| 59   | B   | 4 Interventions            | 4.6   | 13              |
| 60   | C   | 3 Treatment Planning       | 3A.8  | 20 (also 28, 5) |
| 61   | A   | 6 Legal & Ethical          | 6.14  | 4               |
| 62   | C   | 1 Professional Development | 1A.2  | 1 (also 3)      |
| 63   | C   | 5 Indirect Care            | 5.2   | 1 (also 2)      |
| 64   | A   | 4 Interventions            | 4.7   | 20 (also 28)    |
| 65   | B   | 2 Intake & Assessment      | 2A.4  | 5 (also 2)      |
| 66   | B   | 6 Legal & Ethical          | 6.18  | 4               |
| 67   | C   | 3 Treatment Planning       | 3A.9  | 20              |
| 68   | A   | 1 Professional Development | 1B.9  | 3 (also 4)      |
| 69   | C   | 4 Interventions            | 4.7   | 4 (also 22)     |
| 70   | C   | 2 Intake & Assessment      | 2B.2  | 5               |

| Item | Key | 2027 domain                | Task  | Chapter         |
|------|-----|----------------------------|-------|-----------------|
| 90   | B   | 4 Interventions            | 4.9   | 26 (also 22)    |
| 91   | B   | 6 Legal & Ethical          | 6.4   | 4 (also 29)     |
| 92   | A   | 2 Intake & Assessment      | 2B.6  | 11 (also 6)     |
| 93   | C   | 3 Treatment Planning       | 3B.2  | 21 (also 12)    |
| 94   | C   | 4 Interventions            | 4.10  | 29 (also 28)    |
| 95   | C   | 1 Professional Development | 1B.5  | 3 (also 33)     |
| 96   | A   | 5 Indirect Care            | 5.3   | 21 (also 2)     |
| 97   | A   | 6 Legal & Ethical          | 6.11  | 4               |
| 98   | C   | 2 Intake & Assessment      | 2A.6  | 31 (also 2, 30) |
| 99   | A   | 4 Interventions            | 4.10  | 29 (also 11)    |
| 100  | C   | 3 Treatment Planning       | 3B.3  | 21 (also 25)    |
| 101  | C   | 6 Legal & Ethical          | 6.17  | 2 (also 1)      |
| 102  | B   | 1 Professional Development | 1B.10 | 1 (also 3)      |
| 103  | B   | 2 Intake & Assessment      | 2B.11 | 8 (also 7)      |
| 104  | C   | 5 Indirect Care            | 5.4   | 14              |
| 105  | B   | 4 Interventions            | 4.11  | 11              |
| 106  | A   | 6 Legal & Ethical          | 6.15  | 4               |
| 107  | B   | 3 Treatment Planning       | 3B.4  | 21              |
| 108  | A   | 1 Professional Development | 1A.8  | 33 (also 15)    |
| 109  | C   | 2 Intake & Assessment      | 2B.10 | 8               |

| Item | Key | 2027 domain                | Task           | Chapter          |
|------|-----|----------------------------|----------------|------------------|
| 110  | C   | 4 Interventions            | 4.11           | 15 (also 13, 26) |
| 111  | B   | 6 Legal & Ethical          | 6.3            | 2                |
| 112  | A   | 5 Indirect Care            | 5.7            | 4 (also 34)      |
| 113  | A   | 3 Treatment Planning       | 3B.5           | 21 (also 10)     |
| 114  | B   | 4 Interventions            | 4.12           | 22 (also 21)     |
| 115  | A   | 2 Intake & Assessment      | 2B.2           | 5 (also 2)       |
| 116  | A   | 1 Professional Development | 1B.3           | 3 (also 1)       |
| 117  | C   | 6 Legal & Ethical          | 6.7            | 4                |
| 118  | A   | 4 Interventions            | 4.13           | 33 (also 13)     |
| 119  | A   | 3 Treatment Planning       | 3B.6           | 21 (also 4)      |
| 120  | B   | 2 Intake & Assessment      | 2B.7           | 21 (also 12)     |
| 121  | B   | 5 Indirect Care            | 5.8            | 4 (also 2, 22)   |
| 122  | A   | 6 Legal & Ethical          | 6.19           | 4 (also 6)       |
| 123  | C   | 1 Professional Development | 1B (knowledge) | 3 (also 27)      |
| 124  | C   | 4 Interventions            | 4.14           | 22               |

| Item | Key | 2027 domain                | Task  | Chapter           |
|------|-----|----------------------------|-------|-------------------|
| 125  | B   | 6 Legal & Ethical          | 6.8   | 4                 |
| 126  | C   | 2 Intake & Assessment      | 2B.11 | 7 (also 6, 8, 33) |
| 127  | C   | 3 Treatment Planning       | 3B.7  | 21                |
| 128  | B   | 1 Professional Development | 1A.5  | 1 (also 33, 4)    |
| 129  | A   | 5 Indirect Care            | 5.1   | 21 (also 2)       |
| 130  | B   | 4 Interventions            | 4.14  | 31                |
| 131  | C   | 6 Legal & Ethical          | 6.5   | 4 (also 1)        |
| 132  | B   | 2 Intake & Assessment      | 2B.12 | 11 (also 6)       |
| 133  | A   | 3 Treatment Planning       | 3B.8  | 21 (also 20, 7)   |
| 134  | A   | 4 Interventions            | 4.14  | 22                |
| 135  | B   | 1 Professional Development | 1B.4  | 1 (also 21)       |
| 136  | B   | 6 Legal & Ethical          | 6.16  | 2 (also 4)        |
| 137  | C   | 5 Indirect Care            | 5.2   | 21 (also 33)      |
| 138  | A   | 2 Intake & Assessment      | 2B.12 | 6                 |
| 139  | B   | 4 Interventions            | 4.15  | 22 (also 33)      |
| 140  | A   | 3 Treatment Planning       | 3B.9  | 21                |

## Rationales

### Part 1: Items 1–70

1. **B.** Telemental health requires a setting that is both safe and private, and a client driving on a highway has neither, so the counselor waits until Anoushka is parked somewhere private or reschedules; this expectation belongs in telemental health consent and in the counselor's judgment that the format suits the client's circumstances (American Counseling Association [ACA], 2014, Standards H.2.a, H.4.c).

**Why the wrong answers tempt you:** A pulls because hands-free calls are common, but emotional material still divides her attention and audio does nothing for privacy, and C feels like a compromise, yet lighter topics make driving no safer and the car no more private.

- Chapter(s): 4
  - 2027 NCE: 6.4 (also 2A.7)
  - Source(s): American Counseling Association (2014), Standards H.2.a, H.4.c; Barnett and Kolmes (2016)
2. **A.** Intrusive images, a startle response, and dread tied to one client's traumatic story are marks of secondary traumatic stress, the fear-driven part of compassion fatigue that comes from work-related exposure to people who have lived through traumatic events (Figley, 1995; Stamm, 2010). Supervision is the first place to bring such reactions, and counseling of his own is a sound next step if they persist.
- Why the wrong answers tempt you:** B pulls because lightening the load is the remedy for burnout, which builds gradually from chronic job demands (Maslach & Leiter, 2016; Stamm, 2010), but his caseload is manageable and his reactions trace to one client's trauma; C treats the reaction as disqualifying, when referral fits only if he cannot keep it from harming the client, a judgment supervision helps him make.
- Chapter(s): 3 (Counselor wellness: three different kinds of wear; Self-regulation and self-care); also 1 (Impairment)
  - 2027 NCE: 1B.1 (also skill: recognizing vicarious trauma and burnout)

- Source(s): Figley (1995); Maslach and Leiter (2016); Stamm (2010)

3. **A.** Once consent is complete, the counselor hears the presenting problem in the client's own words, including why he is seeking help now, because client self-report is the primary source of intake data and a referral note is someone else's impression (NBCC, 2026, task 2A.3).

**Why the wrong answers tempt you:** B pulls because an instrument seems to add objectivity, but a screen flags a possible problem and cannot confirm a diagnosis, and C saves time yet replaces Teodor's account with his physician's.

- Chapter(s): 5 (Tasks and their order; Self-report, barriers, and collateral information); also 8 (screens)
  - 2027 NCE: 2A.3 (skill: conducting a clinical/diagnostic interview)
  - Source(s): NBCC (2026)
4. **B.** Adaeze's opening attacks Chidi's character rather than a behavior, which is criticism, and the Gottman antidote is a gentle start-up: an "I" statement about a specific situation plus a positive need (The Gottman Institute, 2013).
- Why the wrong answers tempt you:** A pulls because family-of-origin patterns matter in many models, but it is a Bowenian move that skips the in-the-moment skill the Gottman method builds, and C sounds calming, and Gottman does teach taking a break, but as the antidote to stonewalling when someone is flooded, which nothing here shows; for criticism the antidote is to complain without blame, not to set the complaint aside.
- Chapter(s): 28 (The Gottman method)
  - 2027 NCE: 4.1
  - Source(s): The Gottman Institute (2013)
5. **A.** Reviewing the record before the session lets the plan, the latest risk assessment, and any open commitments shape the hour, and records exist to support continuity of care

when a different counselor steps in (American Counseling Association [ACA], 2014, Standard A.1.b).

**Why the wrong answers tempt you:** B sounds like admirable objectivity, but re-interviewing a client 5 months into treatment ignores the record and any risk history in it, and C is a reasonable thing to do once he arrives but not a replacement for preparing beforehand.

- Chapter(s): 4 (also 21, disruption of service)
- 2027 NCE: 5.6
- Source(s): American Counseling Association (2014), Standard A.1.b

6. **A.** HIPAA permits a disclosure to another provider for treatment without the client's authorization, but it does not require one, and the same rule lets a covered entity obtain the client's consent first (Uses and Disclosures to Carry Out Treatment, Payment, or Health Care Operations, 2026). HIPAA is a floor: the agency's stricter policy and the Code's expectation of written permission before records go to third parties (Standard B.6.g) govern here, and a signed release also confirms that Dariusz actually agreed.

**Why the wrong answers tempt you:** B is the strongest distractor because its statement of HIPAA is accurate (Uses and Disclosures to Carry Out Treatment, Payment, or Health Care Operations, 2026), yet task 6.2 is about following the agency's own procedure, and C overcorrects by blocking a legitimate request instead of obtaining the release that allows it.

- Chapter(s): 2 (also 4)
- 2027 NCE: 6.2 (also 6.3, 5.3)
- Source(s): American Counseling Association (2014), Standard B.6.g; Uses and Disclosures to Carry Out Treatment, Payment, or Health Care Operations, 45 C.F.R. § 164.506(b)(1), (c)(2) (2026)

7. **B.** Once safety and basic needs are cleared, problems are ordered by the client's own priorities weighed against what causes the most impairment or keeps other problems going, and her insomnia meets both tests (NBCC, 2026, task 3A.1).

**Why the wrong answers tempt you:** A substitutes the counselor's untested root-cause theory for the client's ranking (her grief stays on the

plan; it simply does not go first), and C sounds even-handed but avoids prioritizing at all.

- Chapter(s): 20 (sleep concerns: 13)
- 2027 NCE: 3A.1
- Source(s): NBCC (2026)

8. **C.** A yes to any of the four ASQ screening items makes the screen positive; a no to the acuity question ("right now") makes it a non-acute positive, which calls for a brief suicide safety assessment before the patient leaves, to decide whether a full mental health evaluation is needed (Horowitz et al., 2012; National Institute of Mental Health [NIMH], n.d.).

**Why the wrong answers tempt you:** A fits an acute positive (a yes to thoughts of killing herself right now), which calls for an urgent full safety evaluation, so it overreacts to her answers, while B treats the acuity question as the whole screen and ignores the yes the screen exists to catch.

- Chapter(s): 5 (Suicide and violence risk: Ask directly); also 29
- 2027 NCE: 2B.2 (also 2B.9)
- Source(s): Horowitz et al. (2012); NIMH (n.d.)

9. **C.** When consulting, counselors share only what the consultation requires and do not disclose information that could identify the client without the client's prior consent, unless disclosure cannot be avoided (American Counseling Association [ACA], 2014, Standards B.7.a, B.7.b). The consultee keeps responsibility for the client's care.

**Why the wrong answers tempt you:** A pulls because more information seems to produce better advice, but the full record discloses far more than a question about one technique needs; B confuses consultation with supervision or a transfer of care, when a consultant advises and the counselor stays responsible.

- Chapter(s): 3 (Consultation: what makes it consultation); also 1 (Consultation as the default move)
- 2027 NCE: 1A.1
- Source(s): ACA (2014), Standards B.7.a, B.7.b

10. **A.** An enactment brings the problem interaction into the room so the counselor can see it and reshape it on the spot, and having the

parents agree together while Erik is kept out strengthens the parental subsystem and its boundary (Minuchin, 1974; Minuchin & Fishman, 1981).

**Why the wrong answers tempt you:** B gathers each person's account but hides the live interaction a structural counselor works with, and C is a Bowenian assessment of multigenerational patterns rather than a structural intervention on present-day hierarchy.

- Chapter(s): 28 (Minuchin: structural family therapy)
- 2027 NCE: 4.1
- Source(s): Minuchin (1974); Minuchin and Fishman (1981)

11. **C.** A Compact privilege rests on an unencumbered home-state license; probation that restricts practice is an encumbrance, and it ends the privilege in every remote state until the home license is no longer encumbered and she has had no encumbrance for 2 years (Counseling Compact, Section 4.E; Counseling Compact Commission, n.d.). Ingrid must stop practicing in the neighboring state and transition those clients so that they are not abandoned (Standard A.12).

**Why the wrong answers tempt you:** A pulls because the remote state took no action, but the privilege depends on the home license, and B borrows the familiar idea of letting current clients finish, which the Compact does not provide.

- Chapter(s): 4 (also 1)
- 2027 NCE: 6.13 (also 6.6)
- Source(s): Counseling Compact Commission (n.d.); American Counseling Association (2014), Standard A.12

12. **C.** A SMART objective names an observable behavior, a count, a data source, and a deadline, and it sets a target the client can realistically reach (NBCC, 2026).

**Why the wrong answers tempt you:** A includes a deadline, so it looks time-bound, but "feel more comfortable" cannot be counted, while B is specific, measurable, and dated yet neither attainable nor realistic as a first step for a teen whose aim is to participate more in class.

- Chapter(s): 20
- 2027 NCE: 3A.2
- Source(s): NBCC (2026)

13. **C.** Task 5.4 asks the counselor to record the client's self-reported medication effects, and an accurate record also includes a family member's report, attributed to its source rather than dropped or promoted to a finding (Standard A.1.b). Dizziness with near-falls is information the prescriber needs, and passing it on with Tomasz's consent keeps the counselor in role, since judging whether the medication is the cause belongs to the prescriber (Standard C.2.a).

**Why the wrong answers tempt you:** A pulls because task 5.4 centers on the client's self-report, but leaving out a safety-relevant report makes the record incomplete, and B sounds rigorous, yet the counselor cannot know which account is accurate and should record each as reported.

- Chapter(s): 14 (also 4)
- 2027 NCE: 5.4 (also 5.1, 5.3)
- Source(s): American Counseling Association (2014), Standards A.1.b, C.2.a

14. **B.** Evaluating barriers to service, cost among them, is a named 2027 intake task, and when a counselor's usual fees would create undue hardship, the Code allows adjusting the fee where legally permissible or helping the client find comparable, affordable services (NBCC, 2026, task 2A.2; American Counseling Association [ACA], 2014, Standard A.10.c).

**Why the wrong answers tempt you:** A sounds fair and consistent, but it lets cost rather than her needs set the schedule without exploring the options the Code names, and C seems generous, yet fees and billing arrangements belong in informed consent before services begin (Standard A.2.b), and postponing the question builds a debt she has already said she cannot pay.

- Chapter(s): 5 (Self-report, barriers, and collateral information); also 4 (Fees and the client)
- 2027 NCE: 2A.2 (knowledge: barriers to service)
- Source(s): NBCC (2026); ACA (2014), Standards A.2.b, A.10.c

15. **C.** Exploring culture means asking what his family's view means to him and how it affects his goals, rather than assuming its weight or its source (Ratts et al., 2016; Sue et al., 2022).

**Why the wrong answers tempt you:** A sounds supportive but dismisses a value that clearly matters to him, and B looks culturally sensitive but stereotypes Korean families and builds a cover story he never asked for.

- Chapter(s): 33 (worldview; acculturation); also 34
  - 2027 NCE: 4.2
  - Source(s): Ratts et al. (2016); Sue et al. (2022)
16. **B.** Counselors use only assessments they are trained and competent to use, and a counselor who relies on a computer-generated interpretation must first be trained in the construct and the specific instrument. The counselor, not the software, remains responsible for interpretation (ACA, 2014, Standards E.2.a, E.2.b).
- Why the wrong answers tempt you:** A pulls because publisher software sounds authoritative, but validated scoring does not make an untrained user able to judge whether the narrative fits this client; C hands an uninterpreted report to the person least equipped to evaluate it, when clients are owed an explanation of results and the basis for conclusions (Standard E.1.b).
- Chapter(s): 8 (Using tests ethically: competence); also 7
  - 2027 NCE: 1B.8
  - Source(s): ACA (2014), Standards E.1.b, E.2.a, E.2.b
17. **A.** The counselor is accountable for every note he signs, and records must accurately reflect the services provided (Standard A.1.b), so an AI draft that documents an assessment that never took place is corrected before signing; Kwesi can then report the error to the practice and decide whether to assess risk next session (ACA, 2024; NBCC, 2024).
- Why the wrong answers tempt you:** B pulls because no risk was observed, but “denied suicidal ideation” records an answer to a question that was never asked, a false entry that could mislead anyone who later relies on the record, and C trades one documentation failure for another.
- Chapter(s): 4
  - 2027 NCE: 6.19 (also 6.11, 5.8)

- Source(s): American Counseling Association (2014), Standard A.1.b; American Counseling Association (2024); National Board for Certified Counselors (2024)

18. **A.** Counselors explore a client’s spiritual beliefs as possible sources of strength and let the client decide whether and how they enter counseling, without imposing their own values (American Counseling Association [ACA], 2014, Standard A.4.b; Cashwell & Watts, 2010).

**Why the wrong answers tempt you:** B borrows a disputing technique, but labeling a client’s faith irrational imposes the counselor’s worldview, and C feels like staying in one’s lane, yet avoiding religion ignores what is shaping how he grieves and whether he feels entitled to help.

- Chapter(s): 34 (Religion and spirituality); also 15
  - 2027 NCE: 4.2
  - Source(s): ACA (2014), Standard A.4.b; Cashwell and Watts (2010)
19. **A.** An illusion is a misperception of a real stimulus (the coat), whereas a hallucination is a perception with no external stimulus at all.
- Why the wrong answers tempt you:** B pulls because she “saw a man” who was not there, but she misread a real object, and C confuses perception with thought content, since a delusion is a fixed false belief held despite contrary evidence, while Gloria dropped the idea as soon as the light came on.
- Chapter(s): 5 (The mental status examination)
  - 2027 NCE: 2B.5
  - Source(s): Standard MSE terminology as taught in Chapter 5; no outside source needed
20. **B.** Yolanda’s statements fit the precontemplation stage, so an initial plan matched to her readiness targets awareness and ambivalence, the work motivational interviewing is built for, rather than action goals she has not chosen (Prochaska & DiClemente, 1983; Miller & Rollnick, 2023).

**Why the wrong answers tempt you:** A sets the outcome her physician hopes for, but goals imposed before she is ready invite the discord that motivational interviewing works to avoid, and

C treats low readiness as if it set the level of care, although placement rests on a multidimensional assessment, not on readiness alone (Mee-Lee et al., 2013).

- Chapter(s): 20 (stages of change and level of care: 12; motivational interviewing: 27)
- 2027 NCE: 3A.3
- Source(s): Prochaska and DiClemente (1983); Miller and Rollnick (2023); Mee-Lee et al. (2013)

21. **B.** Counselors report their professional activities accurately to insurers (Standard C.6.b), and a claim that names a rendering clinician who did not provide the service, under a contract that does not allow supervised billing, is a false claim that can amount to insurance fraud, however closely the owner supervises. Until Soraya is credentialed, these clients can see an in-network clinician or use an arrangement the plan permits.

**Why the wrong answers tempt you:** A pulls because supervisors really are responsible for supervisees' work, but supervision does not make the owner the provider of a session she did not conduct, and C feels like a harmless bridge, yet each interim claim is false when it is submitted.

- Chapter(s): 4
- 2027 NCE: 6.7 (also 6.10)
- Source(s): American Counseling Association (2014), Standard C.6.b

22. **B.** Counselors must know culturally and clinically appropriate referral resources (Standard A.11.a), and a list stays useful only if it is checked regularly for the details that decide fit: services, cost, insurance, availability, and language.

**Why the wrong answers tempt you:** A feels generous, but an unvetted list of names hands clients the work of finding a fit, and C pulls because information lines are helpful, yet they do not replace the counselor's own knowledge of local resources and their fit for each client.

- Chapter(s): 21
- 2027 NCE: 5.5
- Source(s): American Counseling Association (2014), Standard A.11.a

23. **C.** Acting on behalf of clients in the public arena, such as meeting with legislators and testifying about a bill, is social/political advocacy

in the ACA Advocacy Competencies (Toporek & Daniels, 2018).

**Why the wrong answers tempt you:** B pulls because it is the other public-arena domain and can also involve lobbying legislators, but in collective action the counselor joins, as a group member, an affected group or community that has chosen to advocate, while Ngozi acts on her own and speaks *for* her clients; A, systems advocacy, operates at the school, community, or organization level, such as changing an agency's policy.

- Chapter(s): 33 (Advocacy)
- 2027 NCE: 1A.5 (knowledge: levels of advocacy and social justice)
- Source(s): Toporek and Daniels (2018); ACA (2014), Standards A.7.a, A.7.b

24. **B.** In D'Zurilla and Goldfried's (1971) problem-solving sequence, a general orientation to problems is followed by defining and formulating one problem concretely, then generating alternatives, deciding, and verifying the result.

**Why the wrong answers tempt you:** A is the very next stage after definition, so it feels like the start of the "real" work, but brainstorming for a vague "everything" produces unfocused options, and C comes later still, after alternatives exist.

- Chapter(s): 26 (skill teaching; stress inoculation); also 20
- 2027 NCE: 4.3
- Source(s): D'Zurilla and Goldfried (1971)

25. **B.** When a client cannot legally consent, the counselor obtains the guardian's consent and also seeks the client's assent, explaining services in language he can understand and including him in decisions as far as he is able (ACA, 2014, Standards A.2.c, A.2.d).

**Why the wrong answers tempt you:** A is tempting because the legal requirement has been met, but the Code asks for the client's assent as well as the guardian's signature, and C sounds protective, yet a court has already appointed a guardian, and a new competency proceeding is not how a counselor gains a client's participation.

- Chapter(s): 2 (Capacity, consent, and assent)
- 2027 NCE: 2A.1

- Source(s): ACA (2014), Standards A.2.c, A.2.d
26. **C.** Task 6.1 is to follow (activate) the practice's emergency plan when an incident occurs, and a fire alarm calls for immediate evacuation; taking the roster lets Rhys account for every member at the meeting point.
- Why the wrong answers tempt you:** A pulls on counselors' strong instinct to protect confidentiality, but records never come before people's safety, and B sounds prudent, yet the plan calls for evacuation when the alarm sounds, not after a check, and calling first delays it.
- Chapter(s): 4 (also 29)
  - 2027 NCE: 6.1
  - Source(s): National Board for Certified Counselors (2026)
27. **B.** Past successes, skills, and supports are strengths to build into the plan, and her self-monitoring and support-seeking transfer directly to managing urges to yell (NBCC, 2026, task 3A.4).
- Why the wrong answers tempt you:** A assumes each new problem needs brand-new skills, and C recasts healthy support-seeking as a personal deficit.
- Chapter(s): 20
  - 2027 NCE: 3A.4
  - Source(s): NBCC (2026)
28. **A.** Self-regulation is the in-the-moment skill of noticing a personal reaction in the body and steadying it, through slow breathing or grounding, so that attention returns to the client. The counselor then takes the reaction to supervision or consultation after the session (NBCC, 2026, skill: reflexivity/bracketing, e.g., emotional regulation).
- Why the wrong answers tempt you:** B pulls because shared experience can feel like empathy, but disclosing her crash while she is still activated moves the focus to her own story; C protects her comfort at the cost of the topic Keanu needs to explore.
- Chapter(s): 3 (Self-regulation and self-care); also 29 (De-escalation: regulate yourself first)
  - 2027 NCE: 1B.6
  - Source(s): NBCC (2026)

29. **C.** A coping skill has to be overlearned under low stress before it can hold up under high stress, so practice moves from calm moments to mild stressors to harder ones, as in the application phase of stress inoculation training (Meichenbaum, 1985).
- Why the wrong answers tempt you:** A treats a skill that was never practiced as one that failed, and B sounds like saving the tool for when it counts, but an unrehearsed skill is least available at peak arousal.
- Chapter(s): 26 (Meichenbaum: self-talk and stress inoculation); also 25
  - 2027 NCE: 4.3
  - Source(s): Meichenbaum (1985)
30. **A.** When a team decision raises an ethical concern, counselors first try to resolve it within the team and pursue other avenues only if that fails (Standard D.1.d). An aftercare appointment before discharge matters because suicide risk is elevated in the period after psychiatric discharge (Chung et al., 2017).
- Why the wrong answers tempt you:** B pulls because the concern is serious, but going outside the team is the step for after internal resolution fails, and C feels protective, yet it undermines the team and puts the burden of the dispute on Rafael.
- Chapter(s): 21 (also 5)
  - 2027 NCE: 5.3 (also 3B.2, 3B.4)
  - Source(s): American Counseling Association (2014), Standard D.1.d; Chung et al. (2017)
31. **C.** DSM-5-TR treats depression as an independent disorder rather than substance-induced when the symptoms began before the substance use or persist for a substantial period, about 1 month, after acute withdrawal or severe intoxication ends (American Psychiatric Association [APA], 2022).
- Why the wrong answers tempt you:** A pulls because a high score looks decisive, but severity cannot reveal the cause of the symptoms, and B describes his drinking rather than the origin of his depression, since a person with severe alcohol use disorder can have either kind.
- Chapter(s): 12 (Intoxication, withdrawal, and substance-induced disorders); also 6 (Differential diagnosis and comorbidity) and 10

- 2027 NCE: 2B.6 (knowledge: differential diagnoses, co-occurring diagnoses, and comorbidities)
  - Source(s): APA (2022)
32. **B.** A judge's order compels a response, but the Code still asks the counselor to seek the client's written consent or to take steps to have the disclosure prohibited or limited as narrowly as possible (Standard B.2.d), and to release only the information required (Standard B.2.e); legal advice tells Rosalba how to ask the court to narrow the order.
- Why the wrong answers tempt you:** A applies the rule for a subpoena, where the counselor asserts privilege until consent or a court order arrives, but this is the order, and C is right that the order must be obeyed but wrong that it erases the duty to limit what is disclosed.
- Chapter(s): 2 (also 1)
  - 2027 NCE: 6.17 (also 6.3)
  - Source(s): American Counseling Association (2014), Standards B.2.d, B.2.e
33. **A.** Assessment results become baselines and targets in the plan, and discussing them first lets the client decide what she wants to work on (NBCC, 2026, tasks 3A.5 and 2B.10).
- Why the wrong answers tempt you:** B honors her stated reason for coming but never tells her about a confirmed diagnosis, and C mistakes a reason to re-measure later for a reason to ignore the data now.
- Chapter(s): 20 (also 8 and 11)
  - 2027 NCE: 3A.5
  - Source(s): NBCC (2026)
34. **B.** DBT interpersonal effectiveness starts by clarifying priorities, deciding whether the objective, the relationship, or self-respect matters most in this situation, because that choice shapes which skills he uses and how hard he presses (Linehan, 2015).
- Why the wrong answers tempt you:** A feels like gathering useful context but invites mind reading about his brother's motives, and C offers relief from the anxiety by dropping the request, which is avoidance rather than skill.
- Chapter(s): 26 (DBT); also 13
  - 2027 NCE: 4.4
  - Source(s): Linehan (2015)
35. **A.** Continuing education exists to keep counselors current and competent in the areas where they actually practice, including work with diverse populations (ACA, 2014, Standard C.2.f). Courses aimed at her new caseload, from a provider her board accepts, serve both renewal and competence.
- Why the wrong answers tempt you:** C pulls because approved hours in any topic usually satisfy renewal, but they leave her gap with older adults unaddressed; B covers the right topic, but a series sponsored by a company that sells products to the same audience raises a conflict of interest, and selecting appropriate continuing education resources is a named Domain 1 skill (NBCC, 2026).
- Chapter(s): 4 (Licensure maintenance and continuing education); also 1 (Boundaries of competence)
  - 2027 NCE: 1A.3 (skill: selecting appropriate continuing education resources)
  - Source(s): ACA (2014), Standard C.2.f; NBCC (2026)
36. **A.** A claims-made policy covers only claims filed while it is in force, so a claim filed after the policy ends is uncovered unless Benedikt secures tail (extended reporting) coverage, which covers incidents during the policy period that are reported after it ends; depending on the insurer, the tail may be free when certain requirements are met or bought for a set period (Healthcare Providers Service Organization, n.d.).
- Why the wrong answers tempt you:** B describes an occurrence-based policy, the most common mix-up between the two types, and C sounds clever, but a new occurrence policy covers only incidents during its own policy period, not past work.
- Chapter(s): 1
  - 2027 NCE: 6.12
  - Source(s): Healthcare Providers Service Organization (n.d.)
37. **A.** Counselors determine whether distance services suit the client's circumstances, and telemental health consent covers the limits of confidentiality online; for someone who shares a one-room home, a private time and place to talk is the first condition for video sessions to work, alongside the other dis-

tance-specific elements such as a plan for technology failure and emergency procedures (ACA, 2014, Standards H.2.a, H.2.c, H.4.c; NBCC, 2026, task 2A.7).

**Why the wrong answers tempt you:** B is tempting because consent was already obtained, but consent is ongoing (Standard A.2.a) and distance services add elements that in-person consent did not cover (Standard H.2.a), and C confuses a client release with the business associate agreement, which is the HIPAA mechanism that already governs the vendor's handling of her information (Security and Privacy, 2025).

- Chapter(s): 4 (Telemental health: Suitability; Informed consent for distance services; Location, identity, and platforms); also 2 (Elements and timing)
- 2027 NCE: 2A.7 (knowledge: client suitability for telemental health services)
- Source(s): ACA (2014), Standards A.2.a, H.2.a, H.2.c, H.4.c; NBCC (2026); 45 C.F.R. pts. 160, 164

38. **B.** A sound note is factual, measurable, and tied to the treatment plan, so that it accurately reflects the client's progress and the services provided (Standard A.1.b).

**Why the wrong answers tempt you:** A sounds like a clinical impression, but it is a judgmental guess about motive that the client could read and that no data support, and C feels thorough, yet it records private details about a third person that the treatment does not need.

- Chapter(s): 4 (also 11)
- 2027 NCE: 5.8
- Source(s): American Counseling Association (2014), Standard A.1.b

39. **A.** Repeated texting and accusations are hyperactivating strategies typical of anxious attachment, so the work helps her recognize the fear, tolerate uncertainty, and ask for reassurance directly, which tends to draw closeness rather than push it away (Mikulincer & Shaver, 2016).

**Why the wrong answers tempt you:** B gives her a sense of control but adds game playing to the cycle, and C pulls because it borrows attachment language, but it labels someone who is not in the room and overrides her stated goal.

- Chapter(s): 16 (attachment, adult styles); also 28
- 2027 NCE: 4.4
- Source(s): Mikulincer and Shaver (2016)

40. **A.** Behavioral activation schedules activities the client values and can actually do, so her schedule, safety, and resources shape the plan (Martell et al., 2001; NBCC, 2026, task 3A.6).

**Why the wrong answers tempt you:** B leans on the evidence base, but support for an activity does not override the client's context, and C leaves her depression untreated while waiting for circumstances that may never change.

- Chapter(s): 20 (behavioral activation: 10)
- 2027 NCE: 3A.6
- Source(s): Martell et al. (2001); NBCC (2026)

41. **C.** When a client at imminent risk refuses voluntary care, the counselor initiates the emergency evaluation process that state law provides, which may run through a mobile crisis team, a designated examiner, or law enforcement, and does not leave the client alone if it is safe to stay; commitment itself is ordered under state law by a judge or someone acting in a judicial capacity, not by a counselor's signature (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

**Why the wrong answers tempt you:** A applies the respect for autonomy that ordinarily governs, but state laws allow emergency evaluation without consent when a person is an imminent danger to self, and B overstates the counselor's role: who may start an emergency hold varies by state, but commitment beyond a short hold generally requires a judicial process.

- Chapter(s): 21 (also 5, 29)
- 2027 NCE: 6.3 (also 2B.2, 4.10)
- Source(s): Substance Abuse and Mental Health Services Administration (2019)

42. **C.** A vague answer about drinking is clarified with specific, matter-of-fact questions about quantity and frequency, the same facts the first AUDIT items ask about (Babor et al., 2001).

**Why the wrong answers tempt you:** A feels respectful, and his own view of his drinking does matter later (for example, in gauging readiness to change), but as a follow-up it is a yes-or-no request for a self-diagnosis that invites a defen-

sive “no” and still leaves “socially” undefined, and B avoids awkwardness, yet “socially” can mean anything from an occasional glass to hazardous daily use, so dropping the topic leaves risk unassessed.

- Chapter(s): 5 (Substance use screening); also 12
- 2027 NCE: 2B.3
- Source(s): Babor et al. (2001)

43. **B.** Counseling one spouse while already counseling the other through a contested divorce creates a conflict of interest that compromises objectivity and confidentiality. When roles may conflict, the Code directs counselors to clarify, adjust, or withdraw from them (ACA, 2014, Standard A.8).

**Why the wrong answers tempt you:** C pulls because strong disagreement feels like a poor fit, but a difference in personal values alone is not grounds to decline or refer a prospective client (Standard A.11.b); A, an age difference, is a cultural consideration to explore, not a barrier to competent care.

- Chapter(s): 3 (Bracketing and self-reflection: client-counselor suitability); also 28 (Standard A.8) and 1 (Personal values and referral)
- 2027 NCE: 1B.7
- Source(s): ACA (2014), Standards A.8, A.11.b

44. **C.** Conflict is expected in the transition stage, and leaders foster the group process by helping members address each other directly and by using the conflict as here-and-now material for the whole group (Corey et al., 2018; Yalom & Leszcz, 2020).

**Why the wrong answers tempt you:** A restores comfort quickly but teaches members that honest feedback is unsafe, and B sounds like modeling good feedback, but a leader acting as judge shuts down the exchange and invites members to take sides.

- Chapter(s): 30 (Stages of group development); also 31
- 2027 NCE: 4.5
- Source(s): Corey et al. (2018); Yalom and Leszcz (2020)

45. **B.** Deleting files and emptying the recycle bin usually leaves data recoverable, so drives that held client information are securely wiped or destroyed before the hardware is

reused or given away, and the disposal is documented (Standard B.6.h; Security Standards for the Protection of Electronic Protected Health Information, 2026).

**Why the wrong answers tempt you:** A pulls because the risk seems remote, but recoverable client records leaving the practice can be a breach whatever the recipient intends, and C confuses retaining records, which the EHR now does, with keeping old hardware.

- Chapter(s): 4 (also 2)
- 2027 NCE: 6.16 (also 6.18)
- Source(s): American Counseling Association (2014), Standard B.6.h; Security Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. pt. 164, subpt. C (2026)

46. **C.** Task 5.7 is about the client’s preferred language, not only the language a client can manage, and counselors arrange qualified interpreters when language limits understanding (Standard A.2.c; NBCC, 2026). Grief work depends on Nadège saying what she means, so a qualified interpreter or a Haitian Creole-speaking counselor serves her best. The referral is offered, not imposed, so it does not abandon her: Nadège chooses, and if she accepts, the counselor completes the transfer and keeps communication open with her and the new counselor (Standard A.11.d).

**Why the wrong answers tempt you:** A pulls because she functions in English at work, but managing workplace English is not the same as expressing grief, and B feels warm and convenient, yet an untrained relative may soften or omit painful material and brings a family relationship into confidential sessions.

- Chapter(s): 4 (also 21, 33, 34)
- 2027 NCE: 5.7
- Source(s): American Counseling Association (2014), Standards A.2.c, A.11.d; National Board for Certified Counselors (2026)

47. **C.** Informed consent covers the implications of a diagnosis and the intended use of reports, so the counselor explains the diagnosis, its role in the plan, and its disclosure to the insurer before billing, which also lets

Grady choose whether to use his insurance (American Counseling Association [ACA], 2014, Standard A.2.b).

**Why the wrong answers tempt you:** B sounds protective, but withholding the diagnosis denies Grady an informed choice, and A treats the diagnosis as a billing detail rather than something to review with the client.

- Chapter(s): 20 (also 2 and 6)
- 2027 NCE: 3A.7
- Source(s): ACA (2014)

48. **B.** With a family, the counselor explains services in developmentally appropriate language, obtains the parents' consent and the children's assent, clarifies who the client is, and gets everyone's written agreement on how information shared by one member will be handled (ACA, 2014, Standards A.2.c, A.2.d, B.4.b).

**Why the wrong answers tempt you:** A is tempting because parents usually hold the legal right to consent for minors, but leaving the children out ignores assent, and C feels natural because Andrés's suspension prompted the referral and Standard B.4.b does let the parties define who the client is, yet C has the counselor decide that alone, leaves Luz, who will be in the room, out of the consent process, and sets no shared rule for private disclosures; absent an agreement to the contrary, the family is the client.

- Chapter(s): 2 (Couples and families; Capacity, consent, and assent); also 28 (ethics of couples and family work)
- 2027 NCE: 2A.6 (also 2A.1)
- Source(s): ACA (2014), Standards A.2.c, A.2.d, B.4.b

49. **C.** Competence comes before use: a counselor adopting a technology first learns its technical, ethical, and legal implications, including how it stores data and how it can produce biased or inaccurate content (ACA, 2014, Standards C.2.f, H.1.a; ACA, 2024; NBCC, 2024).

**Why the wrong answers tempt you:** A pulls because deleting a name feels like de-identification, but intake details such as dates, places, and family facts can still identify a client, and HIPAA's de-identification standard requires removing far more (Other Requirements Relating to Uses and Disclosures of Protected Health

Information, 2026); B accepts a vendor's marketing claim in place of the counselor's own review of how the tool handles client data.

- Chapter(s): 4 (Artificial intelligence)
- 2027 NCE: 1A.7 (also 6.19)
- Source(s): ACA (2014), Standards C.2.f, H.1.a; ACA (2024); NBCC (2024); 45 C.F.R. § 164.514(b)

50. **C.** Seeing others who have improved with the same problem is how Yalom describes instillation of hope, and the leader chose members with long recovery to show Dwayne that change is possible (Yalom & Leszcz, 2020).

**Why the wrong answers tempt you:** A pulls because hearing peers' stories can ease his sense of being alone, but universality answers the belief that no one else shares the problem; Dwayne's doubt is whether anything will work, and the leader chose members with long recovery to answer it with proof that recovery is possible. B fits didactic teaching or advice rather than personal stories of progress.

- Chapter(s): 31 (Yalom's therapeutic factors); also 12
- 2027 NCE: 4.5
- Source(s): Yalom and Leszcz (2020)

51. **A.** The 5-year prohibition on sexual or romantic relationships after the last professional contact covers former clients' family members as well as the clients themselves, and even after 5 years the counselor must show forethought and document that the relationship is not exploitative (Standard A.5.c).

**Why the wrong answers tempt you:** B pulls because Elise was never a client, but the Code names family members explicitly, and C borrows the language of documentation and consent, which applies only after the 5 years have passed and never through the former client's permission.

- Chapter(s): 3
- 2027 NCE: 6.5 (also 1B.9)
- Source(s): American Counseling Association (2014), Standard A.5.c

52. **A.** DSM-5-TR notes that in children 6 and younger, intrusive memories may be expressed through play reenactment and may not appear distressing; his new sleep problems and clinging add to a picture that warrants a fuller trauma assessment (APA, 2022).

**Why the wrong answers tempt you:** B pulls because calm play looks like mastery, but the criteria specifically warn that young children's reenactment may not look distressed, and C is tempting because pretend play with toy animals is common at his age, yet play that repeats the same trauma scene alongside new symptoms is assessment data.

- Chapter(s): 11 (Trauma- and stressor-related disorders: PTSD; separate criteria for children 6 and younger); also 5 (Trauma and adverse childhood experiences)
- 2027 NCE: 2B.1 (knowledge: symptoms of trauma)
- Source(s): APA (2022)

53. **B.** Blood-injection-injury fears often bring a vasovagal drop in blood pressure that leads to fainting, so exposure is paired with applied tension, which raises blood pressure, rather than with relaxation (American Psychiatric Association, 2022; Öst & Sterner, 1987).

**Why the wrong answers tempt you:** A reverses the point, since exposure is the treatment and relaxation is the contraindicated piece, and C mistakes a typical feature of this phobia for a sign that outpatient care cannot work.

- Chapter(s): 20 (also 11)
- 2027 NCE: 3A.8
- Source(s): American Psychiatric Association (2022); Öst and Sterner (1987)

54. **A.** Cognitive processing therapy is a first-line PTSD treatment that targets “stuck points,” including self-blame for the trauma, through structured examination of the belief (Resick & Schnicke, 1992; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2023).

**Why the wrong answers tempt you:** B sounds like a chance to process the event, but single-session debriefing has not been shown to prevent or treat PTSD (Rose et al., 2002), and C rests on the myth that trauma-focused therapy re-traumatizes, which leaves her with a less effective treatment.

- Chapter(s): 11 (trauma-focused treatments table)
- 2027 NCE: 4.6
- Source(s): Resick and Schnicke (1992); Rose et al. (2002); U.S. Department of Veterans Affairs and U.S. Department of Defense

(2023)

55. **A.** Counselors consider enlisting family members as supports when appropriate and with the client's consent (Standard A.1.d), so the first step is to settle with Tavita what will be shared and what her grandmother will do, sharing only what serves that purpose (Standard B.2.e).

**Why the wrong answers tempt you:** B pulls because her grandmother is already part of her daily life, but full access to her notes far exceeds the role Tavita requested, and C sounds protective of confidentiality, yet the Code treats a consenting client's support network as a resource.

- Chapter(s): 21 (also 2)
- 2027 NCE: 5.1
- Source(s): American Counseling Association (2014), Standards A.1.d, B.2.e

56. **A.** Reflexivity, which the 2027 specification pairs with bracketing, is the ongoing examination of how the counselor's own history, values, and reactions shape the work; journaling and supervision are standard tools for it (NBCC, 2026).

**Why the wrong answers tempt you:** B pulls because the words sound alike, but reflection of meaning is a response to the client's message, not an examination of the counselor's own influence; C involves supervision, but parallel process means counseling dynamics replaying in the supervisory relationship, which the stem does not describe.

- Chapter(s): 3 (Bracketing and self-reflection; parallel process); also 32 (The counselor as a person) and 22 (reflection of meaning)
- 2027 NCE: 1B.11 (skill: reflexivity/bracketing)
- Source(s): NBCC (2026)

57. **C.** Psychotherapy codes are time-based (90837 requires at least 53 minutes), so each note should show the time spent, and each claim should carry the code that the documented time supports (First Coast Service Options, 2025).

**Why the wrong answers tempt you:** A is the most dangerous choice, because adding undated details to past notes before an audit looks like falsifying records (a genuine addition is a

dated, labeled late entry), and B feels safely conservative, yet billing a code that does not match the service is also inaccurate.

- Chapter(s): 4
- 2027 NCE: 6.10 (also 6.7, 5.8)
- Source(s): First Coast Service Options (2025)

58. **B.** A positive PHQ-2 is a signal for a closer look; its developers recommend following a positive result with the PHQ-9 or a clinical interview to determine whether a depressive disorder is present (Kroenke et al., 2003, p. 1291).

**Why the wrong answers tempt you:** A treats a two-item screen as a diagnosis and skips the assessment that should follow it, and C sounds cautious, but brevity is the point of a first-stage screen, and ignoring a positive result defeats the purpose of screening everyone.

- Chapter(s): 5 (Screening versus assessment); also 8 (Symptom and outcome measures)
- 2027 NCE: 2B.9
- Source(s): Kroenke et al. (2003)

59. **B.** Sleep restriction builds sleep drive and consolidates sleep by limiting time in bed to the person's average sleep time, estimated from a sleep diary, then adjusting it as sleep efficiency improves (Edinger et al., 2021); a fixed wake time, also part of stimulus control, anchors the schedule.

**Why the wrong answers tempt you:** A feels like repaying a sleep debt, but extra time in bed loosens the schedule and weakens the sleep drive that restriction builds, and C uses relaxation, a real CBT-I tool, but lying in bed awake for as long as it takes keeps the bed linked with wakefulness, which runs against stimulus control.

- Chapter(s): 13 (sleep-wake disorders and CBT-I)
- 2027 NCE: 4.6
- Source(s): Edinger et al. (2021)

60. **C.** Prescribing a symptom that causes injury invites harm, so self-harm calls for risk assessment and safety planning rather than paradox (ACA, 2014, Standard A.4.a).

**Why the wrong answers tempt you:** A rests on paradox's reputation with resistant clients, and B treats parental consent as if it could make a

harmful technique appropriate.

- Chapter(s): 20 (paradoxical directives: 28; self-harm risk: 5)
- 2027 NCE: 3A.8
- Source(s): ACA (2014)

61. **A.** Under Title III of the Americans with Disabilities Act, a private practice provides the auxiliary aids needed for effective communication, such as a qualified interpreter, may not charge the client for them, and weighs undue burden against its overall resources rather than the fee for one session (Nondiscrimination on the Basis of Disability by Public Accommodations, 2026; U.S. Department of Justice, 2020).

**Why the wrong answers tempt you:** C pulls because written notes can be an effective aid for brief, simple exchanges, but counseling is long and complex, and B looks like a modern fix, yet automatic captions render English text, which may not be Maeve's strongest language, and they do not replace an interpreter.

- Chapter(s): 4
- 2027 NCE: 6.14 (also 5.7)
- Source(s): Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 28 C.F.R. pt. 36 (2026); U.S. Department of Justice (2020)

62. **C.** Counselors practice in a specialty new to them only after appropriate education, training, and supervised experience, and they protect clients while their skills develop (ACA, 2014, Standard C.2.b). Ongoing supervision by a qualified play therapist supplies the supervised experience her coursework lacks.

**Why the wrong answers tempt you:** A pulls because consultation is so often the keyed move, but occasional, nonevaluative advice on hard cases does not provide the ongoing oversight a new specialty requires; B builds knowledge but gives her no feedback from someone competent in the specialty.

- Chapter(s): 1 (Boundaries of competence); also 3 (Clinical supervision)
- 2027 NCE: 1A.2 (also 1B.3)
- Source(s): ACA (2014), Standard C.2.b

63. **C.** With a release, a treating counselor may give an attorney factual treatment information (Standards B.2.e, B.6.g), but counselors do not evaluate current clients for forensic purposes (Standard E.13.c), and whether Selam's account is credible or meets the legal standard for asylum is for the officials deciding her case, not her counselor (Standard C.2.a).

**Why the wrong answers tempt you:** A pulls because the counselor believes Selam and wants to help, but vouching for events the counselor did not witness and reaching a legal conclusion turn the treating counselor into a forensic evaluator, and B overcorrects, since working with a client's attorney within a release is part of task 5.2 and a factual treatment letter is not a forensic evaluation.

- Chapter(s): 1 (also 2)
  - 2027 NCE: 5.2 (also 6.17)
  - Source(s): American Counseling Association (2014), Standards B.2.e, B.6.g, C.2.a, E.13.c
64. **A.** In individual counseling the client is the person in the room, so the work targets what Noor can change in her own part of the cycle, and couples work remains an option if both spouses later choose it (ACA, 2014, Standard A.1.c).
- Why the wrong answers tempt you:** B takes her framing at face value, but no plan can set goals for someone who is not a client, and C sounds appropriately specialized, yet relationship concerns are routinely and effectively addressed in individual counseling.
- Chapter(s): 20 (Anatomy of a treatment plan: modality); also 28 (Ethics with more than one client)
  - 2027 NCE: 4.7
  - Source(s): ACA (2014), Standard A.1.c

65. **B.** Child and family services are a named source of collateral information at intake, and obtaining records requires authorization from the person or agency with legal authority to consent for a child in care (NBCC, 2026, task 2A.4; ACA, 2014, Standard B.5.c).

**Why the wrong answers tempt you:** A seems to honor the child's own account, but pressing an 11-year-old for a detailed trauma narrative at intake risks retraumatizing him (Substance Abuse and Mental Health Services Administration

[SAMHSA], 2014), and C is tempting because birth parents know his early history, but calling them without authorization discloses that he is in counseling and may cut across the court's and agency's authority over his care.

- Chapter(s): 5 (Self-report, barriers, and collateral information); also 2 (Minors; Releases of information)
- 2027 NCE: 2A.4
- Source(s): NBCC (2026); ACA (2014), Standard B.5.c; SAMHSA (2014)

66. **B.** The HIPAA Security Rule requires a unique user identification for each person who uses an electronic record system, so that access and entries can be traced through audit logs (Security Standards for the Protection of Electronic Protected Health Information, 2026), and an intern's notes must show who actually provided the service.

**Why the wrong answers tempt you:** A sounds like a workable fix, but the system would still attribute every entry to the supervisor, and C rests on a real fact, the supervisor's responsibility for the intern's work, which does not extend to sharing credentials.

- Chapter(s): 4
- 2027 NCE: 6.18 (also 6.16)
- Source(s): Security Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. pt. 164, subpt. C (2026)

67. **C.** Counselors and clients work jointly in devising counseling plans (ACA, 2014, Standard A.1.c), so a client who defers is drawn into the process with questions about what he wants to change, rather than handed goals or left to set them alone; goal consensus and collaboration are linked to better outcomes (Tryon et al., 2018).

**Why the wrong answers tempt you:** A honors his request and draws on real assessment data, but setting goals for him skips the joint work the Code calls for (offering possible goals for him to react to and revise would be part of that joint work), and B sounds respectful of his autonomy but stalls treatment and leaves him to do alone what the counselor should do with him.

- Chapter(s): 20
- 2027 NCE: 3A.9

- Source(s): ACA (2014); Tryon et al. (2018)
68. **A.** Counselors may not have personal virtual relationships with current clients, including through social media, and they keep personal and professional online presences separate (ACA, 2014, Standards A.5.e, H.6.a). Explaining the social media policy in session, as informed consent should already have done, protects the relationship (Standard H.6.b).
- Why the wrong answers tempt you:** B pulls because it seems to spare Rhiannon's feelings, but even limited contact is a personal virtual relationship the Code prohibits; C avoids an awkward moment, yet silence leaves her to guess at its meaning and misses a chance to discuss the boundary.
- Chapter(s): 3 (Prohibited relationships); also 4 (Marketing and social media)
  - 2027 NCE: 1B.9
  - Source(s): ACA (2014), Standards A.5.e, H.6.a, H.6.b
69. **C.** Counselors who work at a distance consider how electronic communication differs from face-to-face contact, including lost visual and vocal cues, and work to prevent and address the misunderstandings that follow (ACA, 2014, Standard H.4.f); checking aloud more often how her words land is one way to do that.

## Part 2: Items 71–140

71. **C.** Counselors keep records after termination as federal and state laws and governing policies require (Standard B.6.h); clients have a right of access to their records (Standard B.6.e), not a right to early destruction, so the counselor explains the requirement and the safeguards and documents Celestine's request.
- Why the wrong answers tempt you:** A pulls because the file is about Celestine, but the agency maintains the record and the client holds access rights, and B looks like a compromise, yet removing pages alters the record and still violates the retention policy.
- Chapter(s): 2
  - 2027 NCE: 6.2 (also 6.16)
  - Source(s): American Counseling Association (2014), Standards B.6.e, B.6.h

**Why the wrong answers tempt you:** A sounds like reducing distraction, but it removes the facial cues that remain, and B rests on the real strength of the alliance, but it ignores the signs that the medium itself is causing misreadings.

- Chapter(s): 4 (telemental health); also 22
  - 2027 NCE: 4.7
  - Source(s): ACA (2014), Standard H.4.f
70. **C.** Giving away important possessions is a recognized warning sign of suicide, and warning signs, unlike longer-standing risk factors, point to near-term risk; a verbal denial does not cancel one, so the counselor asks directly about suicidal thoughts, plans, intent, and access to means and explores what “since I won’t be needing them” meant (NIMH, 2025; Rudd et al., 2006).
- Why the wrong answers tempt you:** A is tempting because Theo has denied suicidal thoughts, but denial alongside preparatory behavior is a reason to ask more, not less, and B adds contact that may belong in the plan but postpones the assessment his comment calls for today.
- Chapter(s): 5 (Suicide and violence risk: Ask directly; Safety planning, lethal means, and 988)
  - 2027 NCE: 2B.2 (knowledge: risk assessment and risk factors or symptoms)
  - Source(s): NIMH (2025); Rudd et al. (2006)

72. **B.** In a DAP note, the Assessment section holds the counselor's interpretation of the data, including progress toward treatment goals.

**Why the wrong answers tempt you:** A pulls because it describes progress, but it reports what Omar said and so belongs in Data, and C describes next steps, which belong in Plan.

- Chapter(s): 4
  - 2027 NCE: 5.8
  - Source(s): none needed beyond the chapter
73. **A.** Counselors and clients review and revise counseling plans together (ACA, 2014, Standard A.1.c; NBCC, 2026, task 3A.10), for

example when goals are met, a new problem arises, or the client asks, and the revision is dated and explained in the record.

**Why the wrong answers tempt you:** B sounds orderly but makes his most pressing concern wait, and C treats the plan as fixed, sending away a concern the counselor can address (a support group could be added, not substituted).

- Chapter(s): 20 (also 21)
- 2027 NCE: 3A.10
- Source(s): ACA (2014); NBCC (2026)

74. **B.** Her caution makes sense in her context, and honest, specific information about records and the limits of confidentiality, offered at a pace she controls, builds trust while respecting her right to decide what to share (ACA, 2014, Standards A.2.b, B.1.d; Sue et al., 2022).

**Why the wrong answers tempt you:** A seems the fastest route to trust, but confidentiality has legal limits, and promising otherwise is inaccurate, while C pathologizes a reasonable, context-driven wariness.

- Chapter(s): 34 (Age, social class, and immigration); also 2 (Confidentiality and its exceptions), 33
- 2027 NCE: 4.8
- Source(s): ACA (2014), Standards A.2.b, B.1.d; Sue et al. (2022)

75. **B.** Randomized controlled trials are the standard for causal conclusions about whether an intervention works (APA Presidential Task Force on Evidence-Based Practice, 2006), and a meta-analysis pools many of them, which is why levels-of-evidence hierarchies place systematic reviews and meta-analyses of randomized trials at the top (Burns et al., 2011).

**Why the wrong answers tempt you:** A pulls because of the expert's reputation and the vivid result, but a single case cannot rule out other explanations for the change; C impresses with its large numbers, yet satisfaction ratings from self-selected users measure liking, not whether a treatment works.

- Chapter(s): 9 (Evidence-based practice and reading research)
- 2027 NCE: 1A.4
- Source(s): APA Presidential Task Force on Evidence-Based Practice (2006); Burns et al. (2011)

76. **A.** A biopsychosocial assessment covers biological factors (medical conditions, medications, sleep, substance use), psychological factors, and social factors (work, finances, housing, relationships, culture), and Joel's summary so far is almost entirely psychological (Engel, 1977).

**Why the wrong answers tempt you:** B pulls because more detail feels more thorough, but it deepens the psychological domain already covered, and C sounds sophisticated, yet a projective technique adds nothing about the missing biological and social domains.

- Chapter(s): 5 (The biopsychosocial assessment); also 20
- 2027 NCE: 2B.4
- Source(s): Engel (1977)

77. **B.** Counselors obtain clients' permission before recording sessions (Standard B.6.c), and some states' laws require every party's consent to a recording, so a platform is used lawfully only when its settings match what clients have agreed to.

**Why the wrong answers tempt you:** A pulls because the agreement does obligate the vendor to protect stored data, but it supplies no client consent, and C treats a privacy notice, which describes practices, as if it were informed consent to be recorded.

- Chapter(s): 4 (also 2)
- 2027 NCE: 6.9 (also 6.11)
- Source(s): American Counseling Association (2014), Standard B.6.c

78. **A.** Broaching means the counselor takes the initiative to raise sociopolitical factors, such as race, that may bear on the client's concern and on the relationship, and invites the client to say how they matter (Day-Vines et al., 2007); here the factor is gender and the power difference it carries.

**Why the wrong answers tempt you:** B pulls because it avoids presuming, but silence leaves her to raise the issue alone, which is the avoidant style broaching replaces, and C decides for her without asking, when she may prefer to continue; a transfer can be the right step if she asks for one once the topic is open.

- Chapter(s): 22 (Broaching); also 33
- 2027 NCE: 4.8
- Source(s): Day-Vines et al. (2007)

79. **C.** Reviewing documentation before a session is meant to carry open commitments into it, and checking on a lethal means step is part of following through on a safety plan (Stanley & Brown, 2012). Asking early leaves time to revise the plan if the handgun is still accessible.

**Why the wrong answers tempt you:** A feels client-centered, but safety follow-up is the counselor's responsibility, not something to leave to chance, and B keeps the agenda on track while risking that the check is rushed or skipped.

- Chapter(s): 4 (also 5)
- 2027 NCE: 5.6 (also 2B.2)
- Source(s): Stanley and Brown (2012)

80. **B.** A behavioral management plan works only when everyone applies it the same way; evening attention reinforces screaming on an intermittent schedule, which makes the behavior more resistant to extinction (Ferster & Skinner, 1957).

**Why the wrong answers tempt you:** A adds punishment instead of fixing the inconsistent reinforcement, and C sounds responsive but keeps paying off screaming with the very attention the plan is designed to withhold.

- Chapter(s): 20 (also 25)
- 2027 NCE: 3A.11
- Source(s): Ferster and Skinner (1957)

81. **A.** Without a current license Mariana may not practice under state licensure law, and she may claim only licenses that are current and in good standing (Standard C.4.b), so she stops licensed services, protects her clients from abandonment by arranging coverage or rescheduling (Standard A.12), and starts the board's reinstatement process.

**Why the wrong answers tempt you:** B pulls because her skills are unchanged, but the license, not competence, is the legal authority to practice, and C treats the lapse as a billing problem, yet seeing clients without a license is unlicensed practice whoever pays.

- Chapter(s): 4 (also 1)
- 2027 NCE: 6.6 (also 6.3)
- Source(s): American Counseling Association (2014), Standards A.12, C.4.b

82. **C.** Counselors review clients' rights and responsibilities both in writing and verbally, use clear and understandable language, and document informed consent discussions; a signature on an unread packet does not show that she understands the policies, including the limits of confidentiality, that may shape what she chooses to share (ACA, 2014, Standards A.2.a, A.2.c; NBCC, 2026, task 2A.5).

**Why the wrong answers tempt you:** A treats a signature as if it were understanding, and B honors her wish to start and can seem to fit the Code's description of consent as ongoing, yet counselors explain the limits of confidentiality at the start of counseling (Standard B.1.d), and B would have her begin disclosing under policies she has not read.

- Chapter(s): 2 (Informed consent: Elements and timing); also 5 (Tasks and their order)
- 2027 NCE: 2A.5 (skill: explaining policies and procedures)
- Source(s): ACA (2014), Standards A.2.a, A.2.c, B.1.d; NBCC (2026)

83. **B.** Vicarious trauma builds gradually from cumulative exposure to clients' traumatic material and can shift a counselor's beliefs about safety and trust (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), so the protective plan is ongoing self-assessment, for example with a structured measure such as the Professional Quality of Life Scale (ProQOL), which screens for compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2010), plus supervision that reviews her exposure and caseload balance.

**Why the wrong answers tempt you:** A pulls because it avoids worrying over nothing, but waiting for symptoms means changes in her beliefs about safety and trust may already be under way; C protects the counselor by silencing clients, which can signal to survivors that their experiences are too terrible to speak about.

- Chapter(s): 3 (Counselor wellness: three different kinds of wear; Self-regulation and self-care)
- 2027 NCE: 1B.2 (skill: recognizing vicarious trauma and burnout)
- Source(s): McCann and Pearlman (1990); Pearlman and Saakvitne (1995); Stamm (2010)

84. **C.** Role induction, which explains how counseling works, each person's role, and what to expect about the course of progress, is one of the research-based recommendations for reducing premature termination (Swift et al., 2012).
- Why the wrong answers tempt you:** A sounds client-centered, but a newcomer with no idea what to expect is left to guess, and B gives him something concrete, but information about stress does not tell him how counseling itself will work.
- Chapter(s): 22 (Orienting the client)
  - 2027 NCE: 4.9
  - Source(s): Swift et al. (2012)
85. **C.** Counselors state their highest earned degree in counseling or a closely related field and do not use "Dr." in a counseling context to imply doctoral-level competence when the doctorate is in an unrelated field (Standard C.4.d); Loretta may still list the music doctorate accurately as a degree outside counseling (Standard C.4.a).
- Why the wrong answers tempt you:** A pulls because the doctorate is genuinely earned, but in a counseling ad the title implies counseling expertise she earned at the master's level (Standard C.3.a), and B tries to bridge the fields with a disclaimer, yet music education is not a closely related field, and the title still misleads.
- Chapter(s): 1 (also 4)
  - 2027 NCE: 6.20 (also 6.5)
  - Source(s): American Counseling Association (2014), Standards C.3.a, C.4.a, C.4.d
86. **B.** A referral is a process: explore what the client wants, offer specific community options such as respite care and caregiver support, and confirm that she connected (NBCC, 2026, task 3B.1).
- Why the wrong answers tempt you:** A is technically a referral but leaves an exhausted caregiver to do all the work, and C jumps to a major decision that belongs to the couple and discloses client information to a physician without consent (ACA, 2014, Standard B.1.c).
- Chapter(s): 21 (caregiving: 15)
  - 2027 NCE: 3B.1
  - Source(s): ACA (2014); NBCC (2026)
87. **B.** Duration recording measures how long each episode lasts, which matches a goal of shorter tantrums (Cooper et al., 2020).
- Why the wrong answers tempt you:** A is the most familiar method, but event recording counts how often tantrums occur, which the team is not trying to change, and C estimates the share of time a behavior is present by checking at set moments, so it does not capture the length of each episode.
- Chapter(s): 8 (Formal and informal observation); also 25
  - 2027 NCE: 2B.8 (skill: conducting formal assessments)
  - Source(s): Cooper et al. (2020)
88. **B.** Counselors do not give or receive commissions, rebates, or any other remuneration for referrals (Standard A.10.b), and a resource earns a place on the list by fitting clients' needs, not by paying for it.
- Why the wrong answers tempt you:** A pulls because transparency usually cures conflicts, but the Code bars referral payments outright, and C feels clinically sound, yet appropriate referrals do not make accepting the payment acceptable.
- Chapter(s): 21 (also 4)
  - 2027 NCE: 5.5 (also 6.5)
  - Source(s): American Counseling Association (2014), Standard A.10.b
89. **C.** Facing an ethical dilemma, counselors use and document an ethical decision-making model, with consultation as part of the process (ACA, 2014, Standard I.1.b), and Kitchener (1984) described sound ethical reasoning as moving beyond immediate intuition to a critical-evaluative level of rules and principles.
- Why the wrong answers tempt you:** B pulls because Kitchener did treat intuition as the first level of ethical reasoning, but intuition alone gives Ruth no way to test or defend a choice; A sounds safely conservative, yet the Code does not forbid unavoidable community contact, and it asks counselors to weigh risks and benefits and take precautions rather than impose a blanket ban (Standard A.6.b).
- Chapter(s): 1 (Ethical decision-making); also 3 (Extending boundaries and nonprofessional interactions)
  - 2027 NCE: 1A.6

- Source(s): ACA (2014), Standards A.6.b, I.1.b; Kitchener (1984)
90. **B.** Socializing the client to CBT means teaching the cognitive model with her own example and explaining the structured, collaborative format, including between-session practice, so she knows what the work involves (Beck, 2021).
- Why the wrong answers tempt you:** A captures CBT's emphasis on action, but homework assigned before she understands the model often goes undone, and C describes a psychodynamic orientation rather than CBT's present-focused approach.
- Chapter(s): 26 (The cognitive model); also 22
  - 2027 NCE: 4.9
  - Source(s): Beck (2021)
91. **B.** In telehealth the counselor cannot see who else is in the room, and a client living with violence may face greater danger if she is overheard, so the first step is to check privacy with questions she can answer safely, then shift to neutral topics, a prearranged code phrase, or a safer time if she cannot talk freely (NYC Mayor's Office to End Domestic and Gender-Based Violence, 2020; Pennsylvania Coalition Against Rape, 2020).
- Why the wrong answers tempt you:** A pulls because documenting risk matters, but detailed questions could endanger her if her husband is listening, and C feels protective, yet nothing suggests imminent danger, and an unrequested police visit could escalate the situation and override her choices.
- Chapter(s): 4 (also 29)
  - 2027 NCE: 6.4 (also 2B.2)
  - Source(s): Barnett and Kolmes (2016); NYC Mayor's Office to End Domestic and Gender-Based Violence (2020); Pennsylvania Coalition Against Rape (2020)
92. **A.** Panic attacks can occur within any mental disorder and are then recorded with the "with panic attacks" specifier, while panic disorder requires recurrent unexpected attacks and is not diagnosed when attacks occur only in response to trauma reminders, as in PTSD (APA, 2022).

**Why the wrong answers tempt you:** B is tempting because she has both PTSD and panic attacks, but cued attacks do not make a second disorder, and C pulls because she avoids garages, yet avoiding trauma reminders is already a PTSD symptom.

- Chapter(s): 11 (Panic attacks and panic disorder; PTSD); also 6 (Differential diagnosis and comorbidity)
  - 2027 NCE: 2B.6
  - Source(s): APA (2022)
93. **C.** An aftercare plan carries treatment gains into the client's everyday environment, and a home with heavy drinking most nights is a serious relapse risk, so the plan pairs continuing care with a safer place to live (Mee-Lee et al., 2013, recovery environment dimension; NBCC, 2026, task 3B.2).
- Why the wrong answers tempt you:** A respects his autonomy, but the counselor can name the living situation as a risk and explore options while the choice stays with Tyler, and B borrows the logic of exposure therapy, yet nightly, unplanned contact with drinking in early recovery is a high-risk situation, not a treatment (Marlatt & Gordon, 1985).
- Chapter(s): 21 (also 12)
  - 2027 NCE: 3B.2
  - Source(s): Mee-Lee et al. (2013); Marlatt and Gordon (1985); NBCC (2026)
94. **C.** Verbal de-escalation uses a calm voice, a clear limit, and an offered choice, and with a child in his path the first step is to stop the approach and lower the stimulation (Richmond et al., 2012).
- Why the wrong answers tempt you:** A draws on the popular idea of catharsis, but venting anger tends to increase it (Bushman, 2002), and B treats the moment as a content problem to solve while the daughter's safety is at stake.
- Chapter(s): 29 (De-escalation); also 28
  - 2027 NCE: 4.10
  - Source(s): Richmond et al. (2012); Bushman (2002)
95. **C.** Suitability includes the client's needs and sociocultural considerations; honoring a preference grounded in her religious values respects her autonomy and worldview, and accommodating client preferences is associ-

ated with lower dropout (Swift et al., 2018). The interim crisis resources cover the two-week wait.

**Why the wrong answers tempt you:** A pulls because the counselor may well be competent, but competence does not override what the client says she needs to speak openly; B misreads nondiscrimination, which bars counselors from discriminating against clients (Standard C.5), not from honoring a client's request.

- Chapter(s): 3 (Bracketing and self-reflection: client-counselor suitability); also 33 (Culture in the plan and ethics)
- 2027 NCE: 1B.5
- Source(s): ACA (2014), Standard C.5; Swift et al. (2018)

96. **A.** When an interdisciplinary or treatment team is involved, the client is told the team exists, who is on it, what information is shared, and why (Standard B.3.b).

**Why the wrong answers tempt you:** B pulls because HIPAA lets providers share information for treatment without an authorization (Uses and Disclosures to Carry Out Treatment, Payment, or Health Care Operations, 2026), but the ACA Code still requires telling the client about the team, and C wrongly treats the physician and care manager as outside the client's care.

- Chapter(s): 21 (also 2)
- 2027 NCE: 5.3
- Source(s): American Counseling Association (2014), Standard B.3.b; Uses and Disclosures to Carry Out Treatment, Payment, or Health Care Operations (2026)

97. **A.** Counselors use interventions with a theoretical or empirical foundation (Standard C.7.a), understand the technology they use (Standard H.1.a), and inform clients of its benefits and limitations (Standard H.4.a); for an app, that means knowing its evidence and what data it collects and shares.

**Why the wrong answers tempt you:** B pulls because "HIPAA compliant" sounds like a guarantee, but it is a vendor's marketing claim, not a review of what the app shares, and C mistakes popularity for evidence.

- Chapter(s): 4
- 2027 NCE: 6.11 (also 1A.4)

- Source(s): American Counseling Association (2014), Standards C.7.a, H.1.a, H.4.a

98. **C.** Group consent covers matters that do not arise in individual counseling, including how members' contact with one another outside sessions will be handled; ASGW guidance has leaders explain this in advance, and Yalom asks members to bring meaningful outside contact back into the group (McCarthy et al., 2022; Yalom & Leszcz, 2020).

**Why the wrong answers tempt you:** A and B pull because both are real elements of informed consent, but they apply to every client and are not specific to group work.

- Chapter(s): 31 (Contact outside the group); also 2 (Groups) and 30
- 2027 NCE: 2A.6
- Source(s): McCarthy et al. (2022); Yalom and Leszcz (2020)

99. **A.** Psychological first aid calls for staying with an overwhelmed survivor and helping him stabilize, for example by slowing his breathing and orienting to the present surroundings, before anything else (Brymer et al., 2006).

**Why the wrong answers tempt you:** B sounds thorough, but PTSD cannot be diagnosed until symptoms last more than a month, so screening 15 minutes after the event is premature (American Psychiatric Association, 2022), and C restores routine before he is stable and dismisses a normal acute stress reaction.

- Chapter(s): 29 (Disaster response); also 11
- 2027 NCE: 4.10
- Source(s): Brymer et al. (2006); American Psychiatric Association (2022)

100. **C.** Gains last when clients credit the change to their own efforts and know how they will keep using what worked; such mastery experiences (performance accomplishments) are a principal source of self-efficacy (Bandura, 1977).

**Why the wrong answers tempt you:** A feels supportive but prolongs counseling she may no longer need (ACA, 2014, Standard A.11.c), and B is gracious but confirms her belief that the change came from the counselor.

- Chapter(s): 21 (self-efficacy: 25)
- 2027 NCE: 3B.3

- Source(s): Bandura (1977); ACA (2014)

101. **C.** Records are never rewritten after the fact, least of all before testimony, and any genuine amendment is noted as an amendment (Standard A.1.b); Faisal reviews them as they are, gets legal consultation (often available through a liability insurer), and, as a fact witness, testifies only to what he observed and did (Wheeler & Bertram, 2019).

**Why the wrong answers tempt you:** A pulls because the notes really are thin and the Code does allow properly noted amendments (Standard A.1.b), but A writes new details into the original entries to prepare for testimony, which looks like tampering; Faisal can explain a brief entry when he testifies, and B confuses transparency with disclosure, since the release, not the opposing attorney's interest, defines what may be shared (Standard B.2.e).

- Chapter(s): 2 (also 1)
- 2027 NCE: 6.17 (also 6.16)
- Source(s): American Counseling Association (2014), Standards A.1.b, B.2.e; Wheeler and Bertram (2019)

102. **B.** The introduction to Section C of the Code says counselors engage in self-care to maintain and promote their mental, emotional, physical, and spiritual well-being so that they can best meet their professional responsibilities (ACA, 2014).

**Why the wrong answers tempt you:** C pulls because the Code does address impairment directly (Standard C.2.g), but self-care is meant to come first and help prevent it; A treats self-care as private, when the Code ties it to the counselor's duty to clients.

- Chapter(s): 1 (Self-care and planning for the unexpected); also 3 (Self-regulation and self-care)
- 2027 NCE: 1B.10
- Source(s): ACA (2014), Section C introduction, Standard C.2.g

103. **B.** Counselors select instruments whose validity, reliability, and norms fit the client, including the client's age, and the BDI-II was developed for ages 13 to 80 (ACA, 2014, Standards E.6.a, E.8; Beck et al., 1996).

**Why the wrong answers tempt you:** A pulls because reading aloud seems to solve the problem, and the BDI-II may be given orally, but

reading the items to her does not make norms built on ages 13 to 80 fit a 9-year-old, and C swaps in a different rater, so the scores no longer mean what the self-report norms assume.

- Chapter(s): 8 (Symptom and outcome measures; Before testing); also 7 (norms)
- 2027 NCE: 2B.11 (developmental considerations)
- Source(s): ACA (2014), Standards E.6.a, E.8; Beck et al. (1996)

104. **C.** Inner restlessness and pacing that begin within weeks of an antipsychotic dose increase fit medication-induced acute akathisia (American Psychiatric Association, 2022). The counselor documents what Grace reports and when it began and promptly notifies the prescriber, who decides any change to the medication.

**Why the wrong answers tempt you:** A pulls because restlessness looks like anxiety, but the timing points to the medication, and B sounds sensible, yet changing a dose is outside a counselor's scope.

- Chapter(s): 14
- 2027 NCE: 5.4 (also 5.3)
- Source(s): American Psychiatric Association (2022)

105. **B.** In the cognitive model of panic, attacks escalate when normal bodily sensations are misinterpreted as signs of catastrophe, so explaining the alarm response and that cycle is the core psychoeducation (Clark, 1986).

**Why the wrong answers tempt you:** A starts from the right medical fact, but calling the sensations imaginary is inaccurate and dismissive, and C sounds protective, but avoiding sensations maintains the fear that drives panic.

- Chapter(s): 11 (Panic attack, panic disorder, agoraphobia; Exposure, the common engine).
- 2027 NCE: 4.11
- Source(s): Clark (1986)

106. **A.** Task 6.15 is to review and update the emergency preparedness plan, and the outage exposed a single point of failure, so the practice revises the plan to include secure offline access to contact information and reviews it on a schedule; the HIPAA Security Rule likewise

calls for contingency plans with procedures for testing and revising them (Security Standards for the Protection of Electronic Protected Health Information, 2026).

**Why the wrong answers tempt you:** B pulls because rare events seem like poor planning targets, but this plan just failed, and C restores access at the cost of security by scattering full records in counselors' homes (Standard B.6.b).

- Chapter(s): 4
  - 2027 NCE: 6.15 (also 6.1, 3B.6)
  - Source(s): American Counseling Association (2014), Standard B.6.b; Security Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. pt. 164, subpt. C (2026)
107. **B.** Discharge readiness rests on the criteria set in the discharge plan: objectives met, risk managed, and the next level of care in place (NBCC, 2026, task 3B.4).
- Why the wrong answers tempt you:** A reflects a real-world pressure, but an authorization limit is not clinical readiness, and C rightly values her report but treats one good weekend as if it met the criteria.
- Chapter(s): 21
  - 2027 NCE: 3B.4
  - Source(s): NBCC (2026)
108. **A.** Examining his own assumptions and training in military culture join the first two domains of the Multicultural and Social Justice Counseling Competencies, counselor self-awareness and knowledge of the client's worldview (Ratts et al., 2016), and the Code expects counselors to stay informed about best practices with diverse populations (ACA, 2014, Standard C.2.f). Military life has its own norms, hierarchy, and language that civilian counselors need to learn (Hall, 2011).
- Why the wrong answers tempt you:** C pulls because cultural humility treats clients as the experts on their own lives, but making clients his main teachers spends their session time on his education; B assumes general principles are enough and skips the population-specific learning that task 1A.8 names.
- Chapter(s): 33 (Cultural humility and the MCO framework; From multicultural competence to social justice); also 15 (military families)

- 2027 NCE: 1A.8
- Source(s): ACA (2014), Standard C.2.f; Ratts et al. (2016); Hall (2011)

109. **C.** Clients have a right to understand their results, and good feedback invites the client's reaction and treats a score as one source of data to weigh with others, such as the interview, while noting any doubts about validity (ACA, 2014, Standards E.1.b, E.6.a, E.9.a).

**Why the wrong answers tempt you:** A leans on the test's reputation and turns the client's disagreement into a symptom, and B swings the other way, letting his reaction alone overrule data that may well be accurate.

- Chapter(s): 8 (Sharing results and planning)
  - 2027 NCE: 2B.10
  - Source(s): ACA (2014), Standards E.1.b, E.6.a, E.9.a
110. **C.** Providing psychoeducation is a listed counselor task (NBCC, 2026, task 4.11). Small, plain-language pieces tied to her own situation, with a check on what she took in, let the counselor fit the information to her concerns and correct misunderstandings as they arise.
- Why the wrong answers tempt you:** A pulls because the diagnosis is medical, but explaining what caregiving may involve and pointing to resources is within a counselor's scope, while detailed medical questions can still go to the physician, and B is thorough but one-way, so it cannot fit her concerns or catch misunderstandings.
- Chapter(s): 15 (Life transitions: caregiving); also 13 (Neurocognitive disorders), 26 (Teaching skills: psychoeducation versus skill development)
  - 2027 NCE: 4.11
  - Source(s): NBCC (2026)
111. **B.** Whether a minor may consent to outpatient counseling without a parent depends on state law, which varies in the ages and conditions it sets, and on clinic policy; the Code asks counselors to balance minors' rights with parents' legal rights and responsibilities (Standard A.2.d).
- Why the wrong answers tempt you:** A pulls because the Code values a minor's assent and participation, but it does not grant minors consent authority, and C invents a federal age of con-

sent, when HIPAA generally defers to state law on when a minor may consent (Uses and Disclosures of Protected Health Information: General Rules, 2026).

- Chapter(s): 2
- 2027 NCE: 6.3 (also 2A.1)
- Source(s): American Counseling Association (2014), Standard A.2.d; Uses and Disclosures of Protected Health Information: General Rules, 45 C.F.R. § 164.502(g) (2026)

112. **A.** When clients have difficulty understanding the language counselors use, counselors arrange a qualified interpreter or translator (Standard A.2.c); translators handle written materials, and interpreters handle spoken communication. For health programs that receive federal financial assistance, such as Medicaid payments, the Section 1557 rule requires qualified translators and human review of machine translations of critical documents (Meaningful Access for Individuals With Limited English Proficiency, 2026).

**Why the wrong answers tempt you:** B pulls because it is free and fast, but errors in consent forms carry real consequences, and C uses a willing bilingual speaker, yet the agency rather than the client proposes the barter (Standard A.10.e), the client is not a qualified translator, and the arrangement adds a second relationship.

- Chapter(s): 4 (also 34)
- 2027 NCE: 5.7 (also 2A.1)
- Source(s): American Counseling Association (2014), Standards A.2.c, A.10.e; Meaningful Access for Individuals With Limited English Proficiency (2026)

113. **A.** A relapse prevention plan lists the client's personal early warning signs and high-risk situations, ties each to coping steps and supports, and states when to seek help (NBCC, 2026, task 3B.5).

**Why the wrong answers tempt you:** B borrows the 2-week duration that defines a major depressive episode (American Psychiatric Association, 2022), but relapse prevention aims to act before full criteria return, and C overlooks that the time to plan is while she is well.

- Chapter(s): 21 (also 10)
- 2027 NCE: 3B.5

- Source(s): American Psychiatric Association (2022)

114. **B.** Counselors often miss clients who are not doing well, which is why routine client feedback, especially on the relationship, matters (Lambert & Shimokawa, 2011). When perfect ratings clash with late arrivals and cancellations, the counselor makes clear that criticism is welcome and asks concrete questions, so that the top of the scale does not hide a problem.

**Why the wrong answers tempt you:** A notices a real limitation, a ceiling effect, but abandons feedback instead of making it safer to give, and C locates the problem in the client before asking whether sessions are meeting her needs.

- Chapter(s): 22 (Soliciting feedback); also 21
- 2027 NCE: 4.12
- Source(s): Lambert and Shimokawa (2011)

115. **A.** A history of violent behavior is among the strongest predictors of future violence, whereas a psychiatric diagnosis by itself says little about an individual's risk (Monahan et al., 2001). Brandon's past assault was also against a girlfriend, the same role as the woman he is now furious with.

**Why the wrong answers tempt you:** B draws on the stereotype linking mental illness and violence, which the research does not support as a predictor on its own, and C is tempting because visible emotion can seem dangerous, but tears and a raised voice while describing a breakup are expectable feelings, not evidence of intent.

- Chapter(s): 5 (Violence and abuse); also 2 (Tarasoff and the duty to protect)
- 2027 NCE: 2B.2 (knowledge: risk assessment and risk factors or symptoms)
- Source(s): Monahan et al. (2001)

116. **A.** Before offering supervision, counselors are trained in supervision methods and techniques (ACA, 2014, Standard F.2.a), and state licensing boards set their own, varying requirements for supervisors whose hours count toward licensure.

**Why the wrong answers tempt you:** B pulls because clinical skill does matter, but supervision is a distinct competence with its own models, evaluation duties, and gatekeeping responsibilities (Bernard & Goodyear, 2019); C relabels supervision as consultation, which misrepresents

the arrangement, since consultation is nonevaluative and would not meet the associates' licensure requirements.

- Chapter(s): 3 (What supervision is; Ethical and legal duties of supervisors); also 1 (Boundaries of competence)
  - 2027 NCE: 1B.3
  - Source(s): ACA (2014), Standard F.2.a; Bernard and Goodyear (2019)
117. **C.** Routinely waiving copays while billing insurers as if clients paid them can misrepresent the actual fee, breach network contracts, and, with federal health programs, raise fraud concerns (Office of Inspector General, 1994); a written policy for documented financial hardship, applied case by case, honors the Code's call to consider clients' finances (Standard A.10.c) without misstating fees.
- Why the wrong answers tempt you:** A pulls because the Code does ask counselors to consider finances, but not by misstating fees to payers, and B adds client consent, which cannot cure a misrepresentation made to the insurer.
- Chapter(s): 4
  - 2027 NCE: 6.7 (also 6.10)
  - Source(s): American Counseling Association (2014), Standard A.10.c; Office of Inspector General (1994)
118. **A.** Client empowerment in the ACA Advocacy Competencies means helping a client recognize a barrier and build the knowledge and skills to advocate for herself, and a college, unlike a school district, does not have to identify students with disabilities, so the student must tell the school and request accommodations through its procedures, often through a disability services office (Toporek & Daniels, 2018; U.S. Department of Education, Office for Civil Rights, 2011).
- Why the wrong answers tempt you:** B is real advocacy and includes consent, but it acts for her when she is able to act, bypasses the office that grants accommodations, and discloses more than needed, and C adjusts her to the barrier instead of addressing it.
- Chapter(s): 33 (ACA Advocacy Competencies); also 13 (ADHD)
  - 2027 NCE: 4.13

- Source(s): Toporek and Daniels (2018); U.S. Department of Education, Office for Civil Rights (2011)

119. **A.** A plan for disruption of service keeps care going through an interruption with crisis resources, an alternative provider, and a plan to resume, consistent with the duty to arrange continued care during interruptions (ACA, 2014, Standard A.12).

**Why the wrong answers tempt you:** B pulls because his residence has not changed, and the Code itself mentions the client's "place of residence" (Standard H.1.b), but that standard names laws a counselor may also be subject to; authority to practice by telehealth generally depends on where the client is located during the session, and this counselor has no license, Counseling Compact privilege, or other legal authority in that state (Counseling Compact Commission, n.d.). C ends care midstream when an interruption calls for a bridge.

- Chapter(s): 21 (telehealth jurisdiction: 4)
- 2027 NCE: 3B.6
- Source(s): ACA (2014); Counseling Compact Commission (n.d.)

120. **B.** Clients step up to a more intensive level of care when a lower level is not working, and an intensive outpatient program adds structure several days a week while he keeps his job and stays in a supportive, alcohol-free home (Mee-Lee et al., 2013).

**Why the wrong answers tempt you:** A rightly notes that he is not in medical danger, but staying at a level that has failed several times ignores the evidence, and C pulls because it removes triggers, yet with no withdrawal risk, a supportive home, and a job to protect, residential care is more restrictive than his needs require.

- Chapter(s): 21 (Levels of care); also 12 (Level of care: the ASAM Criteria)
- 2027 NCE: 2B.7
- Source(s): Mee-Lee et al. (2013)

121. **B.** Task 5.8 covers documentation written during or after sessions, so the counselor can respond to Tunde's feedback and still meet the same-day rule by writing the note promptly after the session, while details are fresh (Standard A.1.b).

**Why the wrong answers tempt you:** A pulls because accuracy matters, but a note finished right after the session is accurate and timely, and insisting on typing dismisses his feedback, and C sounds efficient, yet recording requires his permission (Standard B.6.c), creates a more sensitive record, and does nothing about his sense of being processed rather than heard.

- Chapter(s): 4 (also 2, 22)
- 2027 NCE: 5.8 (also 4.12, 4.15)
- Source(s): American Counseling Association (2014), Standards A.1.b, B.6.c

122. **A.** An AI suggestion is a hypothesis, not a diagnosis: Ravi remains responsible for proper diagnosis (Standard E.5.a) and for recognizing historical and social prejudices in diagnosis (Standard E.5.c), which tools trained on past records can reproduce (ACA, 2024; NBCC, 2024).

**Why the wrong answers tempt you:** B pulls because large data sets sound objective, but they also carry the biases in past diagnoses, and C overcorrects, since the 2014 Code predates generative AI and does not forbid it.

- Chapter(s): 4 (also 6)
- 2027 NCE: 6.19 (also 2B.12)
- Source(s): American Counseling Association (2014), Standards E.5.a, E.5.c; American Counseling Association (2024); National Board for Certified Counselors (2024)

123. **C.** When a counselor's reports reach a court, the power differential grows, so naming the reporting role openly and inviting the client to shape the goals narrows the gap and makes honest engagement possible (ACA, 2014, Standards A.1.c, A.2.e).

**Why the wrong answers tempt you:** A pulls because agreeable clients look motivated, but blanket agreement from someone whose freedom depends on reports more likely reflects the power differential; B confronts a response the counselor's own role helped create and tends to increase discord (Miller & Rollnick, 2013).

- Chapter(s): 3 (Power dynamics); also 2 (informed consent with mandated clients) and 27 (motivational interviewing)
- 2027 NCE: 1B (knowledge statement: power dynamics in the counseling relationship); nearest task 1B.11

- Source(s): ACA (2014), Standards A.1.c, A.2.e; Miller and Rollnick (2013)

124. **C.** A reframe offers a new, more useful meaning for the same behavior, here recasting "nagging" as evidence of her care for her son's health (Ivey et al., 2023).

**Why the wrong answers tempt you:** A is accurate and empathic, but a reflection of feeling mirrors her view rather than offering a new one, and B is an open question that explores without changing the frame.

- Chapter(s): 22 (Influencing skills)
- 2027 NCE: 4.14
- Source(s): Ivey et al. (2023)

125. **B.** Task 6.8 names compliance training in insurance, credentialing, billing, and payment, and the clinician whose service and documentation support a claim shares responsibility for its accuracy, so Ayodele learns payer rules and fraud prevention before she bills (NBCC, 2026).

**Why the wrong answers tempt you:** A pulls because billers do submit the claims, but they rely on the clinician's documentation and code choice, and C treats denials as a teacher, yet the costly errors are the wrong claims that get paid, which audits can later require her to repay.

- Chapter(s): 4
- 2027 NCE: 6.8 (also 6.7, 1A.3)
- Source(s): National Board for Certified Counselors (2026)

126. **C.** Counselors recognize how culture and experiences of discrimination shape test responses, stay alert to the history of pathologizing marginalized groups, and place results in perspective with other data; cultural mistrust among African Americans can be a learned response to racism that is misread as paranoia (ACA, 2014, Standards E.5.b, E.5.c, E.8; Whaley, 2001).

**Why the wrong answers tempt you:** A trusts the scale's general validity evidence over the context of this client's life, and B overcorrects, because concern about fairness calls for careful, contextual interpretation rather than discarding every result.

- Chapter(s): 7 (Test bias and fairness); also 6 (Culture and diagnosis), 8, and 33
- 2027 NCE: 2B.11 (also knowledge: cultural implications of diagnosis)

- Source(s): ACA (2014), Standards E.5.b, E.5.c, E.8; Whaley (2001)
127. **C.** Task 3B.7 calls for engaging the client in reviewing progress at planned intervals, and counseling plans are reviewed and revised jointly with clients (ACA, 2014, Standard A.1.c).
- Why the wrong answers tempt you:** A changes how often reviews happen but not who takes part, and B trades the client's voice for a different kind of objectivity.
- Chapter(s): 21
  - 2027 NCE: 3B.7
  - Source(s): ACA (2014)
128. **B.** Advocacy for the profession works to strengthen counseling itself, for example through a shared professional identity, a positive public image, and each counselor's participation in advocacy (Myers et al., 2002). Urging lawmakers, through a professional association, to adopt the Counseling Compact, which improves license portability, fits that aim.
- Why the wrong answers tempt you:** C pulls because challenging an insurer feels like taking on the system, but appealing one client's claim is advocacy on behalf of that client; A is client empowerment, helping her act for herself.
- Chapter(s): 1 (Professional associations; Portability and the Counseling Compact); also 33 (Advocacy) and 4 (The Counseling Compact in practice)
  - 2027 NCE: 1A.5
  - Source(s): Myers et al. (2002)
129. **A.** Collaborating with a client's advocate toward shared goals is task 5.1, done only with the client's consent, here a signed release (Standards B.1.c, B.6.g), and limited to the information she approves (Standard B.2.e).
- Why the wrong answers tempt you:** B pulls because more information seems to help safety planning, but sending the whole record discloses far more than the purpose requires, and C feels respectful of her autonomy, yet she has asked for coordination, and advocates are named support systems in the task.
- Chapter(s): 21 (also 2)
  - 2027 NCE: 5.1 (also 5.2)
- Source(s): American Counseling Association (2014), Standards B.1.c, B.2.e, B.6.g
130. **B.** Blocking stops a behavior that harms the group's work, here premature reassurance that shuts down Lucia's grief, while protecting the person affected and later exploring the behavior with the member who did it (Corey et al., 2018).
- Why the wrong answers tempt you:** A sounds kind to both members, but it rewards the rescue and confirms that tears should be hidden, and C trusts the group's growth, but leaving a harmful pattern unchecked lets it become a norm.
- Chapter(s): 31 (Leader skills in the room)
  - 2027 NCE: 4.14
  - Source(s): Corey et al. (2018)
131. **C.** A support letter is a report to a third party, so it must be accurate and rest on the counselor's own assessment, within her competence and scope (Standards C.2.a, C.6.b); she explains this to Corbin and decides after assessing whether he has a disability-related need for the animal.
- Why the wrong answers tempt you:** A pulls because the request is sincere and the counselor wants to help, but a letter written on request alone is an unsupported claim, and B overcorrects, since counselors may write such letters when an assessment supports them.
- Chapter(s): 4 (also 1)
  - 2027 NCE: 6.5 (also 6.3)
  - Source(s): American Counseling Association (2014), Standards C.2.a, C.6.b; Fair Housing Act, 42 U.S.C. § 3601 et seq. (1968), § 3604(f)(3)(B)
132. **B.** Hoarding disorder requires persistent difficulty discarding possessions because of a perceived need to save them and distress at discarding, clutter that congests active living areas and substantially compromises their use, and clinically significant distress or impairment (here, a bed she can no longer use); it is not diagnosed when a medical condition or another mental disorder, such as obsessions in OCD or cognitive deficits in a neurocognitive disorder, better explains the hoarding (APA, 2022). Her daughter's photos supply what her self-report leaves out.

**Why the wrong answers tempt you:** A pulls because hoarding disorder sits in the obsessive-compulsive and related disorders chapter, but Agnes reports no obsessions or other compulsions, and C trusts her self-report alone, although DSM-5-TR's insight specifiers allow for a person who is convinced the clutter is not a problem despite evidence to the contrary.

- Chapter(s): 11 (Obsessive-compulsive and related disorders); also 6 (Differential diagnosis and comorbidity)
- 2027 NCE: 2B.12
- Source(s): APA (2022)

133. **A.** Effectiveness is judged against all of the plan's goals, functioning as well as symptoms, so marked symptom relief with an unmet functional goal is a partial response that calls for exploring barriers and revising the plan with the client (ACA, 2014, Standard A.1.c; NBCC, 2026, task 3B.8).

**Why the wrong answers tempt you:** B treats a large score drop as full recovery, but a sizable improvement is not the same as remission and a symptom score alone does not show restored functioning, and C overlooks real progress and jumps to referral before Rashad and the counselor have examined what is blocking his job search.

- Chapter(s): 21 (also 20; outcome measures: 7)
- 2027 NCE: 3B.8
- Source(s): ACA (2014); NBCC (2026)

134. **A.** Session management means honoring both the client's disclosure and the session's time frame: acknowledge the news, check that he has support until the next meeting, and make it the first item next time, extending only if safety requires it (NBCC, 2026, Domain 4 skill statements).

**Why the wrong answers tempt you:** B feels caring, but with no risk present it abandons the time boundary and teaches that last-minute disclosures extend sessions, and C keeps the boundary but ignores a major disclosure and shames him for its timing.

- Chapter(s): 22 (Silence and intense feelings: managing time so intense material is not opened in the final minutes)
- 2027 NCE: 4.14
- Source(s): NBCC (2026)

135. **B.** Counselors continually monitor their effectiveness, take steps to improve when necessary, and seek peer supervision to evaluate their efficacy (ACA, 2014, Standard C.2.d). A dropout pattern confined to one kind of concern points to a specific skill area to strengthen.

**Why the wrong answers tempt you:** C pulls because Standard C.2.a limits practice to the boundaries of competence, but one weak result is a reason to take steps to improve, as Standard C.2.d directs, before narrowing her practice; A explains the pattern away by blaming clients, which leaves her own contribution unexamined.

- Chapter(s): 1 (Boundaries of competence: monitoring effectiveness); also 21 (Measurement-based care)
- 2027 NCE: 1B.4
- Source(s): ACA (2014), Standards C.2.a, C.2.d

136. **B.** Counselors keep records in any medium secure and accessible only to authorized persons (Standard B.6.b), so a home-based counselor carries only what each visit needs, keeps it locked, and returns it to secure storage promptly.

**Why the wrong answers tempt you:** A pulls because the trunk hides the papers, but cars are stolen and broken into, and C trades paper for an unsecured personal phone and destroys originals before they reach the official record.

- Chapter(s): 2 (also 4)
- 2027 NCE: 6.16 (also 6.2)
- Source(s): American Counseling Association (2014), Standard B.6.b

137. **C.** A referral to a community resource is a process, not a phone number. When a client cannot make the connection alone, counselors advocate to remove barriers that block access to services (Standard A.7.a), and they get the client's consent before advocating for her (Standard A.7.b). Calling the program together, with Doris's consent and disclosing only what enrollment requires (Standard B.2.e), turns the referral into access.

**Why the wrong answers tempt you:** A feels empowering, and independence matters, but Doris has already tried to enroll on her own without success, so another list repeats a step that has

failed and leaves the barrier in place, and B adjusts the schedule to the barrier instead of addressing it.

- Chapter(s): 21 (also 33)
- 2027 NCE: 5.2 (also 3B.1)
- Source(s): American Counseling Association (2014), Standards A.7.a, A.7.b, B.2.e

138. **A.** The provisional specifier is used when there is a strong presumption that full criteria for a specific disorder will be met but not enough information is yet available, here the duration that his husband can help clarify (APA, 2022).

**Why the wrong answers tempt you:** B is tempting because DSM-5-TR's unspecified category does cover presentations with too little information for a more specific diagnosis (its example is an emergency room), but it names no disorder, so it fits when the counselor cannot yet tell which disorder applies; when one specific disorder is strongly presumed and the missing fact is expected soon, the provisional specifier records both the expectation and the uncertainty, and C misuses adjustment disorder as a placeholder when no identifiable stressor is described.

- Chapter(s): 6 (Writing the diagnosis)
- 2027 NCE: 2B.12
- Source(s): APA (2022)

139. **B.** The counselor's heteronormative assumption set off a withdrawal rupture, marked by Rhea's curt, short answers, and repair works best when the counselor names the slip, owns it without defending, and invites the client's experience of it (Safran & Muran, 2000; Eubanks et al., 2018).

**Why the wrong answers tempt you:** A hopes to spare her awkwardness, but her short answers show that the strain is already present, and C sounds reassuring, but it defends the counselor and centers the counselor's feelings rather than hers.

- Chapter(s): 22 (Ruptures and repair); also 33
- 2027 NCE: 4.15
- Source(s): Safran and Muran (2000); Eubanks et al. (2018)

140. **A.** Termination criteria are agreed on early, observable, and tied to the client's own goal, so both people can tell when counseling is complete (NBCC, 2026, task 3B.9).

**Why the wrong answers tempt you:** C is concrete but lets a benefit limit stand in for clinical criteria, and B rests on an unobservable judgment the counselor makes alone.

- Chapter(s): 21
- 2027 NCE: 3B.9
- Source(s): NBCC (2026)

## Domain score grid

Circle each item you missed, count the misses in each row, and subtract them from the row's total. Any domain where your percentage falls well below your other domains is a priority: start with the chapters listed for it below, then rework the items you missed.

| 2027 domain (weight)                                                   | Items                                                                                                                 | Missed | Correct   |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------|-----------|
| <b>1 Professional Development &amp; Counselor Self-Awareness</b> (15%) | 2, 9, 16, 23, 28, 35, 43, 49, 56, 62, 68, 75, 83, 89, 95, 102, 108, 116, 123, 128, 135                                |        | ___ / 21  |
| <b>2 Intake &amp; Assessment</b> (18%)                                 | 3, 8, 14, 19, 25, 31, 37, 42, 48, 52, 58, 65, 70, 76, 82, 87, 92, 98, 103, 109, 115, 120, 126, 132, 138               |        | ___ / 25  |
| <b>3 Treatment Planning &amp; Continuity of Care</b> (15%)             | 7, 12, 20, 27, 33, 40, 47, 53, 60, 67, 73, 80, 86, 93, 100, 107, 113, 119, 127, 133, 140                              |        | ___ / 21  |
| <b>4 Provision of Counseling Interventions</b> (20%)                   | 4, 10, 15, 18, 24, 29, 34, 39, 44, 50, 54, 59, 64, 69, 74, 78, 84, 90, 94, 99, 105, 110, 114, 118, 124, 130, 134, 139 |        | ___ / 28  |
| <b>5 Indirect Client Care</b> (12%)                                    | 5, 13, 22, 30, 38, 46, 55, 63, 72, 79, 88, 96, 104, 112, 121, 129, 137                                                |        | ___ / 17  |
| <b>6 Legal &amp; Ethical Compliance</b> (20%)                          | 1, 6, 11, 17, 21, 26, 32, 36, 41, 45, 51, 57, 61, 66, 71, 77, 81, 85, 91, 97, 101, 106, 111, 117, 122, 125, 131, 136  |        | ___ / 28  |
| <b>Total</b>                                                           | 140                                                                                                                   |        | ___ / 140 |

**Chapters to review, by domain.** Listed from most to fewest Exam B items whose main point each chapter teaches.

- **1 Professional Development & Counselor Self-Awareness:** Chapters 3, 1, 4, 33, 8, 9
- **2 Intake & Assessment:** Chapters 5, 2, 8, 11, 4, 6, 7, 12, 21, 31
- **3 Treatment Planning & Continuity of Care:** Chapters 20, 21
- **4 Provision of Counseling Interventions:** Chapters 22, 26, 11, 28, 29, 31, 33, 34, 4, 13, 15, 16, 20, 30
- **5 Indirect Client Care:** Chapters 4, 21, 14, 1
- **6 Legal & Ethical Compliance:** Chapters 4, 2, 1, 3, 21

**Part check.** Compare your two halves as well. Part 1 (items 1–70) \_\_\_ / 70; Part 2 (items 71–140) \_\_\_ / 70. Both parts cover the six domains in about the same proportions, so a much lower Part 2 score may reflect fatigue or pacing rather than content. If it does, rehearse the pacing plan in the book's Study Plans and Test-Taking Strategy section before your next timed practice.

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## CHAPTER 1

# Professional Identity and the Ethical Core

## Extra drills

### Drill 1.2 • Fill in the blank.

1. A license is granted by a \_\_\_\_\_; the NCC is granted by \_\_\_\_\_.
2. CACREP accredits \_\_\_\_\_, not individuals.
3. The Code section that governs distance counseling and social media is Section \_\_\_\_\_.
4. Counselors may not refer clients based solely on the counselor's personally held \_\_\_\_\_.
5. When a colleague's apparent violation has not caused substantial harm, the first step is \_\_\_\_\_ resolution.
6. The principle of telling the truth is \_\_\_\_\_; keeping promises is \_\_\_\_\_.
7. A malpractice claim requires duty, breach, \_\_\_\_\_, and \_\_\_\_\_.
8. A \_\_\_\_\_ act protects a professional title; a \_\_\_\_\_ act restricts the activity itself.

**Drill 1.3 • Timeline.** Fill in the missing year or event, then check your answers against the Key Names and Dates boxes in Chapter 1 of the book.

| Year  | Event                                                               |
|-------|---------------------------------------------------------------------|
| 1908  | Parsons opens the Vocation Bureau; Beers publishes his memoir       |
| _____ | APGA is founded                                                     |
| 1958  | _____                                                               |
| 1963  | _____                                                               |
| _____ | Virginia passes the first counselor licensure law                   |
| 1981  | _____                                                               |
| _____ | NBCC is established                                                 |
| 1992  | The association takes its current name: _____                       |
| _____ | California becomes the last state to pass a counselor licensure law |

## Answers to the Chapter 1 drills

**Drill answers.** 1.2: (1) state licensing board; NBCC. (2) programs. (3) H. (4) values (or attitudes, beliefs, or behaviors; Standard A.11.b names all four). (5) informal. (6) veracity; fidelity. (7) harm (damages); causation, in either order. (8) title; practice. 1.3: 1952; NDEA funds school counselor training after Sputnik; Community Mental Health Centers Act; 1976; CACREP established; 1982; AACD renamed the American Counseling Association; 2009.

Ch. 1 · 1

**Licensure vs. certification  
vs. accreditation**

Ch. 1 · 2

**Frank Parsons**

Ch. 1 · 3

**Clifford Beers**

Ch. 1 · 4

**Williamson vs. Rogers**

Ch. 1 · 5

**NDEA (1958)**

Ch. 1 · 6

**APGA → AACD → ACA**

Ch. 1 · 7

**First and last licensure states**

Ch. 1 · 8

**Culturally encapsulated counselor**

Ch. 1 · 2

Vocation Bureau, Boston, 1908; *Choosing a Vocation*, 1909. Know yourself, know the work, reason about the fit. Father of guidance; trait-and-factor.

Ch. 1 · 1

Licensure: state board, mandatory, individual. Certification: professional body (e.g., NBCC's NCC), voluntary, individual. Accreditation: CACREP, programs only.

Ch. 1 · 4

Williamson (1930s): directive, counselor-led, trait-and-factor. Rogers (1942): nondirective, then client-centered; the relationship drives change.

Ch. 1 · 3

*A Mind That Found Itself* (1908). Launched the mental hygiene movement: humane treatment, prevention, early intervention.

Ch. 1 · 6

1952 → 1983 → 1992. The association's three names.

Ch. 1 · 5

Passed after Sputnik; funded large-scale training of school counselors.

Ch. 1 · 8

Wrenn (1962): a counselor who assumes their own cultural values are universal and judges clients by them.

Ch. 1 · 7

Virginia, 1976 (first). California, 2009 (last).

Ch. 1 · 9

**ACA Code sections A–I**

Ch. 1 · 10

**The six moral principles**

Ch. 1 · 11

**Ethics vs. law (Standard I.1.c)**

Ch. 1 · 12

**Values-based referral (Standard A.11.b)**

Ch. 1 · 13

**Impairment (Standard C.2.g)**

Ch. 1 · 14

**Colleague misconduct sequence**

Ch. 1 · 15

**Four elements of malpractice**

Ch. 1 · 16

**Cottone vs. Kitchener**

Ch. 1 · 10

Autonomy, nonmaleficence, beneficence, justice, fidelity, veracity. Most ethics items pit two of them against each other.

Ch. 1 · 9

A Relationship; B Confidentiality and privacy; C Professional responsibility; D Other professionals; E Assessment; F Supervision, training, teaching; G Research; H Technology and social media; I Resolving ethical issues.

Ch. 1 · 12

Prohibited when based solely on the counselor's personal values. Refer for competence gaps; address values through supervision and training.

Ch. 1 · 11

Make your commitment to the Code known and try to resolve the conflict; if it cannot be resolved, you may follow the law.

Ch. 1 · 14

Informal resolution first (I.2.a) unless substantial harm or a confidentiality breach makes it inappropriate; then report (I.2.b). Consult when unsure (I.2.c).

Ch. 1 · 13

Functioning has declined enough to affect client care. Seek help; limit, suspend, or end services until safe. Distress alone is not impairment.

Ch. 1 · 16

Cottone (2001): social constructivism; decisions negotiated between people. Kitchener (1984): moral principles; intuitive and critical-evaluative levels.

Ch. 1 · 15

Duty, breach of the standard of care, harm, and causation. All four are required; intent is not.

## CHAPTER 2

# Confidentiality, Informed Consent, and Records

## Extra drills

### Drill 2.2 • Fill in the blank.

1. Privileged communication belongs to the \_\_\_\_\_, who alone can waive it.
2. The second *Tarasoff* ruling (1976) described a duty to \_\_\_\_\_.
3. Mandated reporting requires reasonable \_\_\_\_\_, not proof.
4. A minor's agreement to take part in counseling is called \_\_\_\_\_.
5. Clients' access to records may be limited only with \_\_\_\_\_ evidence of harm.
6. In group counseling, the leader explains that confidentiality cannot be \_\_\_\_\_.
7. The federal law that added breach notification requirements in 2009 is \_\_\_\_\_.
8. A school counselor's personal memory-aid notes are \_\_\_\_\_ records under FERPA.
9. When state law is more protective of privacy than HIPAA, \_\_\_\_\_ law applies.
10. A \_\_\_\_\_ requires a response but does not by itself override privilege; a \_\_\_\_\_ can compel disclosure.

**Drill 2.3 • Sorting: disclose, protect, or hold?** For each situation, write **D** (disclose: the client's written authorization or a court order permits or requires release now), **P** (a protective or reporting step is required), or **H** (hold: keep confidential, and take the step in parentheses if one is given).

1. \_\_\_\_ A client says he "could kill" his brother-in-law for missing a family dinner, laughs, and has no history of violence (assess further).
2. \_\_\_\_ A competent adult client gives written authorization for records to go to her new psychiatrist.
3. \_\_\_\_ A 10-year-old describes being burned with a cigarette by a babysitter.
4. \_\_\_\_ An attorney calls asking whether a person is your client.
5. \_\_\_\_ A client names a coworker, describes a plan, and shows you the gun he has bought.
6. \_\_\_\_ A competent adult client says her husband pushed her last month; no children live in the home (safety planning).
7. \_\_\_\_ A court order, after your attempt to limit it, requires release of specific records.
8. \_\_\_\_ A client's sister emails asking how he is doing.

## Answers to the Chapter 2 drills

**Drill answers.** 2.2: (1) client. (2) protect. (3) suspicion (also accept *cause* or *belief*; state laws word the standard differently, such as “reason to believe”). (4) assent. (5) compelling. (6) guaranteed (also accept *assured* or *promised*). (7) HITECH. (8) sole-possession (not education). (9) state. (10) subpoena; court order. 2.3: 1-H (assess seriousness, intent, plan, and history; consult if unsure). 2-D. 3-P (mandated report). 4-H (neither confirm nor deny without a release). 5-P (duty to protect). 6-H (in most states, competent-adult domestic violence is not a mandated report; check state law). 7-D (only what the order requires). 8-H (no release).

Ch. 2 · 1

**Privacy vs. confidentiality  
vs. privilege**

Ch. 2 · 2

***Jaffee v. Redmond* (1996)**

Ch. 2 · 3

**Exceptions to confidentiality**

Ch. 2 · 4

**Minimal disclosure (B.2.e)**

Ch. 2 · 5

***Tarasoff* 1974 vs. 1976**

Ch. 2 · 6

**Duty-to-protect checklist**

Ch. 2 · 7

**Mandatory vs. permissive states**

Ch. 2 · 8

**Mandated reporting**

Ch. 2 · 2

U.S. Supreme Court recognized a psychotherapist–patient privilege in federal courts, including licensed social workers.

Ch. 2 · 1

Privacy: the person's right. Confidentiality: the counselor's ethical duty. Privilege: a legal protection from disclosure in court; the client holds it and alone can waive it.

Ch. 2 · 4

When disclosure is required, reveal only essential information and, when possible, tell the client first and involve them.

Ch. 2 · 3

Serious and foreseeable harm; suspected abuse or neglect; court order or law; client consent; communicable, life-threatening disease (permissive); team sharing with the client informed.

Ch. 2 · 6

Who? (identifiable victim) How bad? (serious harm) How likely? (foreseeable). Then assess, consult, take the least intrusive protective step, document.

Ch. 2 · 5

1974: duty to warn an identifiable victim. 1976: broadened to a duty to protect (warn, notify police, hospitalize, or other reasonable steps).

Ch. 2 · 8

Reasonable suspicion, not proof. Don't investigate. Report yourself; telling a supervisor is not a report. Good-faith immunity. Document.

Ch. 2 · 7

Mandatory: must act when conditions are met. Permissive: may disclose, with good-faith protection (e.g., Texas, *Thapar v. Zezulka*, 1999). A few states: no duty-to-warn law.

Ch. 2 · 9

**Communicable disease (B.2.c)**

Ch. 2 · 10

**Elements of informed consent (A.2.b)**

Ch. 2 · 11

**Consent vs. assent**

Ch. 2 · 12

**Four abilities of capacity**

Ch. 2 · 13

**Mandated clients (A.2.e)**

Ch. 2 · 14

**Couples, families, groups**

Ch. 2 · 15

**Client access to records (B.6.e)**

Ch. 2 · 16

**Psychotherapy notes**

Ch. 2 · 10

Process, risks, benefits; credentials; continuity if counselor is incapacitated; technology; diagnosis and tests; fees; confidentiality limits; records; right to refuse.

Ch. 2 · 9

May disclose to an identifiable third party at serious, foreseeable risk, after assessing whether the client will tell them or keep engaging in risky behavior. Permissive, not required; follow state law.

Ch. 2 · 12

Express a choice, understand, appreciate, reason (Appelbaum & Grisso, 1988). Capacity is decision-specific; competence is a legal finding.

Ch. 2 · 11

Consent: legal authorization from a competent adult or a guardian. Assent: agreement from a minor or a person who cannot legally consent. Both are sought.

Ch. 2 · 14

Couples and families: define the client and the secrets policy first (B.4.b). Groups: explain the importance and limits of confidentiality (B.4.a) and that it cannot be guaranteed.

Ch. 2 · 13

Before starting: what will be shared, with whom, and the consequences of refusing services.

Ch. 2 · 16

Process notes kept separate from the record; separate authorization for most disclosures; no HIPAA right of access. Diagnosis, plan, meds, and dates do not qualify.

Ch. 2 · 15

Reasonable access for competent clients; limit only with compelling evidence of harm; document the request and rationale; offer help interpreting.

Ch. 2 · 17

**HIPAA, HITECH, Part 2, FERPA**

Ch. 2 · 18

**Subpoena vs. court order**

Ch. 2 · 18

Subpoena knocks: respond, contact client, consult attorney, assert privilege. Court order opens the door: seek to limit (B.2.d), then release only what is ordered.

Ch. 2 · 17

HIPAA: PHI floor; stricter state law wins.  
HITECH: breach notification, penalties. 42  
CFR Part 2: substance use programs. FERPA:  
school records; sole-possession notes exempt.

## CHAPTER 3

# Boundaries, Supervision, Consultation, and Counselor Self-Awareness

## Extra drills

### Drill 3.2 • Fill in the blank.

1. The 5-year prohibition on romantic relationships with former clients begins at the last \_\_\_\_\_ contact.
2. A gift is evaluated by the relationship, its monetary value, the client's motivation, and the \_\_\_\_\_ motivation.
3. A barter must be requested by the \_\_\_\_\_ and documented in a written \_\_\_\_\_.
4. Ending services with no notice, referral, or coverage is \_\_\_\_\_.
5. In the IDM, the three markers of supervisee growth are self- and other-awareness, \_\_\_\_\_, and \_\_\_\_\_.
6. Caplan's term for a consultee's loss of objectivity rooted in a personal issue is \_\_\_\_\_.
7. Bergan's behavioral consultation moves through problem identification, problem \_\_\_\_\_, plan \_\_\_\_\_, and evaluation.
8. Kurpius's four consultation modes are provision, prescription, \_\_\_\_\_, and \_\_\_\_\_.
9. Bordin's working alliance in supervision has three parts: goals, tasks, and \_\_\_\_\_.
10. Holding a supervisor legally responsible for a supervisee's actions, even without the supervisor's own fault, is \_\_\_\_\_ liability.

### Drill 3.3 • Sort it. Label each scenario **S** (supervision), **CN** (consultation), **CL** (collaboration), or **A** (advocacy).

1. \_\_\_\_ A licensed counselor reviews a provisional licensee's recorded sessions and completes the quarterly evaluation the board requires.
2. \_\_\_\_ A school counselor helps a teacher design a reinforcement plan; the teacher decides whether to use it.
3. \_\_\_\_ A counselor, a psychiatrist, and a case manager share responsibility for a client's discharge plan.
4. \_\_\_\_ With a client's consent, a counselor writes to a landlord to challenge a housing policy that excludes people with psychiatric disabilities.
5. \_\_\_\_ A counselor asks a trusted peer for ideas about an unfamiliar exposure technique; the peer has no authority over her work.
6. \_\_\_\_ A clinical supervisor recommends that a practicum student not continue after remediation fails.
7. \_\_\_\_ A counselor testifies before a county board about the lack of bilingual crisis services.
8. \_\_\_\_ A counselor and a school nurse jointly run a health and wellness group and share responsibility for its outcome.

## Answers to the Chapter 3 drills

**Drill answers.** 3.2: (1) professional. (2) counselor's. (3) client; contract. (4) abandonment. (5) motivation; autonomy (either order). (6) theme interference. (7) analysis; implementation. (8) collaboration; mediation (either order). (9) bond (or bonds). (10) vicarious (also accept imputed or *respondeat superior*).  
3.3: 1-S, 2-CN, 3-CL, 4-A, 5-CN, 6-S, 7-A, 8-CL.

Ch. 3 · 1

**Five-year rule (Standard A.5.c)**

Ch. 3 · 2

**ACA vs. psychologists' waiting period**

Ch. 3 · 3

**Extending boundaries (Standards  
A.6.b–A.6.c)**

Ch. 3 · 4

**Boundary crossing vs. violation**

Ch. 3 · 5

**Kitchener's (1988) three risk factors**

Ch. 3 · 6

**Gifts (Standard A.10.f)**

Ch. 3 · 7

**Bartering (Standard A.10.e)**

Ch. 3 · 8

**Termination vs. abandonment**

Ch. 3 · 2

ACA (counselors): 5 years since the 2005 Code (the 1995 Code said 2). American Psychological Association (psychologists): 2 years. The NCE tests the current ACA rule.

Ch. 3 · 1

No sexual or romantic relationship with a former client, or the client's spouse, significant other, or family member, for 5 years after the last professional contact. Afterward, documented forethought about exploitation is still required.

Ch. 3 · 4

Crossing: a harmless or helpful departure from usual practice. Violation: a crossing that harms or exploits the client (Gutheil & Gabbard, 1993).

Ch. 3 · 3

Ceremony, purchase of a client's service, hospital visit. Weigh risks and benefits, consult, document the rationale beforehand when feasible, and attempt to remedy any unintentional harm.

Ch. 3 · 6

No dollar limit. Consider the relationship, the gift's value, the client's motivation, and the counselor's motivation; respect cultural meaning.

Ch. 3 · 5

Harm in overlapping roles grows with incompatible expectations, divergent obligations, and a larger power and prestige difference.

Ch. 3 · 8

Terminate when no need, no benefit, or harm (may also for danger or nonpayment), with pretermination counseling and referrals when necessary (A.11.c). Abandonment: no notice, no referral, no coverage (A.12).

Ch. 3 · 7

Client requests it; not exploitative or harmful; accepted practice among professionals in the community; clear written contract.

Ch. 3 · 9

**Transference vs. countertransference**

Ch. 3 · 10

**Burnout vs. compassion fatigue  
vs. vicarious trauma**

Ch. 3 · 11

**IDM levels (Stoltenberg)**

Ch. 3 · 12

**Bernard's discrimination model**

Ch. 3 · 13

**Supervisor duties (Section F)**

Ch. 3 · 14

**Caplan's four types**

Ch. 3 · 15

**Schein's three models**

Ch. 3 · 16

**Consultation vs. supervision  
vs. collaboration**

Ch. 3 · 10

Burnout: job exhaustion, depersonalization, low accomplishment (Maslach). Compassion fatigue: secondary traumatic stress (Figley). Vicarious trauma: changed beliefs about self, others, and the world (McCann & Pearlman).

Ch. 3 · 9

Transference: client's past-relationship feelings directed at the counselor.  
Countertransference: counselor's reactions rooted in the counselor's own history.

Ch. 3 · 12

Roles: teacher, counselor, consultant. Foci: intervention, conceptualization, personalization. Nine combinations.

Ch. 3 · 11

Level 1: anxious, motivated, dependent, self-focused. Level 2: wavering, dependence vs. autonomy, client-focused. Level 3: stable, autonomous. 3i: integrated across areas.

Ch. 3 · 14

Client-centered case; consultee-centered case (theme interference); program-centered administrative; consultee-centered administrative.

Ch. 3 · 13

Monitor client welfare (F.1.a); supervisees disclose status (F.5.c); trained supervisors (F.2.a); no counseling of supervisees (F.6.c); gatekeeping and remediation (F.6.b).

Ch. 3 · 16

Consultation: voluntary, nonevaluative, consultee keeps responsibility. Supervision: evaluative, hierarchical, ongoing. Collaboration: shared responsibility.

Ch. 3 · 15

Purchase of expertise (buy a solution); doctor-patient (consultant diagnoses and prescribes); process consultation (consultee learns to solve its own problems).

## CHAPTER 4

# Practice Management: Documentation, Billing, Telemental Health, and Technology

## Extra drills

**Drill 4.2 • Sort the SOAP note.** Write S, O, A, or P beside each statement from a progress note.

1. “I’ve had three panic attacks this week, mostly at work.” \_\_\_\_
2. Client’s GAD-7 score was 15, up from 11 two weeks ago. \_\_\_\_
3. Symptoms are consistent with worsening anxiety linked to new job demands. \_\_\_\_
4. Practice diaphragmatic breathing daily; review panic log next session. \_\_\_\_
5. Client fidgeted throughout the session and spoke rapidly. \_\_\_\_
6. Client said she has been avoiding the elevator at work. \_\_\_\_
7. Progress toward Goal 2 has stalled, likely because the exposure steps were too large. \_\_\_\_
8. Counselor will coordinate with the client’s physician, with her signed release. \_\_\_\_

**Drill 4.3 • New in 2027: match the task to its code.** Write the code beside each task. Each code is used once.  
Codes: 1A.3, 1A.7, 2A.7, 3B.6, 5.7, 6.6, 6.8, 6.9, 6.13, 6.15, 6.18, 6.19, 6.20.

| Task (paraphrased)                                                         | Code |
|----------------------------------------------------------------------------|------|
| 1. Obtain informed consent for telemental health                           | ---- |
| 2. Use an EHR or EMR system                                                | ---- |
| 3. Practice in line with license portability, such as the Compact          | ---- |
| 4. Secure translation services for the client’s preferred language         | ---- |
| 5. Train in the ethical and legal use of AI                                | ---- |
| 6. Use AI within your practice                                             | ---- |
| 7. Develop a plan for disruption of service                                | ---- |
| 8. Review and update an emergency preparedness plan                        | ---- |
| 9. Market a counseling business appropriately                              | ---- |
| 10. Complete continuing education                                          | ---- |
| 11. Engage in activities to maintain licensure                             | ---- |
| 12. Complete compliance training (insurance, credentialing, billing)       | ---- |
| 13. Use telemental health platforms that comply with state and federal law | ---- |

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## Answers to the Chapter 4 drills

**Drill answers.** 4.2: (1) S. (2) O: the client fills in the GAD-7, but a score is measured data (saw, heard, or scored = O). (3) A. (4) P. (5) O. (6) S. (7) A. (8) P. 4.3: (1) 2A.7. (2) 6.18. (3) 6.13. (4) 5.7. (5) 1A.7. (6) 6.19. (7) 3B.6. (8) 6.15. (9) 6.20. (10) 1A.3. (11) 6.6. (12) 6.8. (13) 6.9.

Ch. 4 · 1

**SOAP note**

Ch. 4 · 2

**DAP vs. BIRP vs. GIRP**

Ch. 4 · 3

**S or O?**

Ch. 4 · 4

**Late entry**

Ch. 4 · 5

**Medical necessity**

Ch. 4 · 6

**NPI, CPT, ICD-10-CM**

Ch. 4 · 7

**CAQH**

Ch. 4 · 8

**Billing fraud patterns**

Ch. 4 · 2

DAP: Data, Assessment, Plan. BIRP: Behavior, Intervention, Response, Plan. GIRP: Goal, Intervention, Response, Plan.

Ch. 4 · 1

Subjective (what the client reports) · Objective (what the counselor observes or scores) · Assessment (clinical impression) · Plan (next steps).

Ch. 4 · 4

Written now, dated now, labeled as referring to the earlier session. Never backdate or rewrite a note.

Ch. 4 · 3

If the client said it, it is subjective, even a symptom. If the counselor saw, heard, or scored it, it is objective.

Ch. 4 · 6

NPI = who provided the service (10 digits). CPT = what service. ICD-10-CM = why it was needed.

Ch. 4 · 5

Covered diagnosis + impaired functioning + appropriate treatment and level of care + documented progress. Notes must support every claim (6.10).

Ch. 4 · 8

Upcoding · billing missed sessions · false or inflated diagnosis · billing under another clinician's NPI · routinely waiving copays without telling the insurer (hardship waivers are case by case).

Ch. 4 · 7

Credentialing database many insurers check before paneling a counselor (renamed DataSpring in 2026; its profile tool, ProView, was renamed the Provider Data Portal in 2023). Keep it current and re-attest every 120 days (180 in Illinois).

Ch. 4 · 9

**Telemental health consent (H.2.a)**

Ch. 4 · 10

**The location rule**

Ch. 4 · 11

**Dropped session with a client at risk**

Ch. 4 · 12

**AI in practice (1A.7, 6.19)**

Ch. 4 · 13

**Three plans**

Ch. 4 · 14

**ADA in a private practice**

Ch. 4 · 15

**Interpreter vs. translator**

Ch. 4 · 16

**Counseling Compact**

Ch. 4 · 10

Authority to practice depends on where the client is located during the session. Confirm location at the start of every session.

Ch. 4 · 9

Credentials and location · confidentiality limits online · technology failure and backup contact · response time · emergency procedures · time-zone and cultural differences · insurance limits · social media policy.

Ch. 4 · 12

Competence · disclose and get consent (B.6.c for recording) · BAA and no client data in public tools · review every AI-drafted note · human makes clinical decisions.

Ch. 4 · 11

Follow the agreed backup plan (call the phone on file) → complete the risk assessment → if unreachable, emergency contact and local resources → document.

Ch. 4 · 14

Title III public accommodation: reasonable modifications and effective communication (e.g., ASL interpreter) at no charge to the client.

Ch. 4 · 13

Emergency preparedness = the practice (6.1 follow, 6.15 update). Disruption of service = each client (3B.6). Professional will = counselor's death or incapacity (C.2.h).

Ch. 4 · 16

Full home-state license → privilege to practice in member states → follow the remote state's laws. Home license encumbered = privileges lost until it clears and two years pass without a new encumbrance. Nonmember states not covered.

Ch. 4 · 15

Interpreter: spoken or signed language in real time. Translator: written documents. Use qualified professionals, never the client's child (A.2.c; Task 5.7).

Ch. 4 · 17

**Ethical marketing (6.20)**

Truthful ads (C.3.a); no solicited testimonials from clients (C.3.b); separate personal and professional online presence (H.6.a); never confirm a client relationship when replying to reviews.

## CHAPTER 5

# The Intake, Risk Assessment, and Mental Status

## Extra drills

**Drill 5.2 • Matching: which tool fits?** Write the letter of the tool next to each situation. Each letter is used once.

| Situation                                                                           | Tool                                     |
|-------------------------------------------------------------------------------------|------------------------------------------|
| 1. A 16-year-old's pediatrician wants a brief substance screen                      | ___ A. ASQ<br>-                          |
| 2. A primary care clinic wants a 10-item alcohol screen with risk zones             | ___ B. Genogram<br>-                     |
| 3. A hospital nurse needs four quick suicide screening questions                    | ___ C. DAST-10<br>-                      |
| 4. A counselor wants to rate suicidal ideation and behavior in a structured way     | ___ D. AUDIT<br>-                        |
| 5. An adult client's use of drugs other than alcohol needs screening                | ___ E. CRAFFT<br>-                       |
| 6. A counselor wants to map substance use across three generations of a family      | ___ F. C-SSRS<br>-                       |
| 7. A client and counselor list warning signs, coping steps, and contacts in writing | ___ G. ACE questionnaire<br>-            |
| 8. A counselor wants to count categories of childhood adversity                     | ___ H. Safety Planning Intervention<br>- |

**Drill 5.3 • Fill in the blank.**

1. Informed consent, including the limits of \_\_\_\_\_, comes before the client discloses anything substantive.
2. The factor that answers "why now?" in a formulation is the \_\_\_\_\_ factor.
3. Screens are designed for high \_\_\_\_\_, so they catch most true cases and accept some false positives.
4. A positive screen leads to \_\_\_\_\_, not straight to a diagnosis.
5. Thoughts of wishing to be dead, without thoughts of killing oneself, are \_\_\_\_\_ ideation.
6. The final step of the Safety Planning Intervention is making the \_\_\_\_\_ safe.
7. Where state law imposes one, a credible threat of violence toward an identifiable person triggers the duty to \_\_\_\_\_; warning the intended victim is only one way to meet it.
8. Ask about domestic violence \_\_\_\_\_, never in front of the spouse or significant other.
9. In the MSE, the client's own description of how they feel is recorded as \_\_\_\_\_.
10. A fixed false belief is recorded under thought \_\_\_\_\_, not perception.

---

## Answers to the Chapter 5 drills

**Drill answers.** 5.2: 1-E, 2-D, 3-A, 4-F, 5-C, 6-B, 7-H, 8-G. 5.3: (1) confidentiality. (2) precipitating. (3) sensitivity. (4) assessment (a fuller evaluation). (5) passive. (6) environment (the lethal means step). (7) protect (“warn” was the 1974 *Tarasoff* term; the 1976 ruling broadened it). (8) privately (alone or separately). (9) mood. (10) content.

Ch. 5 · 1

**Order of a first session**

Ch. 5 · 2

**Structured vs. semi-structured  
vs. unstructured interview**

Ch. 5 · 3

**Collateral information (2027 task  
2A.4)**

Ch. 5 · 4

**Biopsychosocial domains**

Ch. 5 · 5

**The four Ps**

Ch. 5 · 6

**Genogram**

Ch. 5 · 7

**Screening vs. assessment**

Ch. 5 · 8

**Suicide inquiry checklist**

Ch. 5 · 2

Fixed questions in fixed order / set topics in flexible order (most agency intakes) / follows the client.

Ch. 5 · 1

Consent and confidentiality limits → presenting problem (why now) → risk screen → history, observing mental status → barriers, shared summary, next steps. Acute crisis: safety first.

Ch. 5 · 4

Biological: health, medications, sleep, substances. Psychological: problem history, prior treatment, trauma, coping, strengths. Social: family, work, housing, culture, supports.

Ch. 5 · 3

Information from family, prior providers, schools, clergy, or legal services. Requires a written release first.

Ch. 5 · 6

At least three generations: structure, relationships (closeness, conflict, cutoff), and recurring patterns such as substance use or suicide.

Ch. 5 · 5

Predisposing (why this person), precipitating (why now), perpetuating (why still), protective (what helps).

Ch. 5 · 8

Ideation (passive or active), plan, means and access, intent, timeline, preparation, prior attempts, self-injury. Ask directly; asking does not plant the idea.

Ch. 5 · 7

Screen: brief, universal, sensitive; asks “look closer?” Assessment: longer, targeted, describes nature and severity. Positive screen → assessment, not diagnosis.

Ch. 5 · 9

**Risk factors vs. warning signs**

Ch. 5 · 10

**C-SSRS vs. ASQ**

Ch. 5 · 11

**Safety Planning Intervention  
(Stanley & Brown)**

Ch. 5 · 12

**Lethal means counseling**

Ch. 5 · 13

**No-suicide contract**

Ch. 5 · 14

**Trauma screening at intake**

Ch. 5 · 15

**ACE score**

Ch. 5 · 16

**Substance screens**

Ch. 5 · 10

C-SSRS: Columbia scale for ideation and behavior; screener needs no mental health training. ASQ: four yes/no questions for medical settings; any yes → “thoughts of suicide right now?”

Ch. 5 · 9

Risk factors raise risk over time (static or dynamic). Warning signs signal near-term danger (talk of dying or being a burden, seeking a method, saying goodbye).

Ch. 5 · 12

A collaborative conversation that puts time and distance between the person and the method (relative holds a firearm; medications locked). Not a confiscation.

Ch. 5 · 11

1 warning signs · 2 internal coping · 3 distracting people and places · 4 people to ask for help · 5 professionals and crisis lines (988) · 6 making the environment safe.

Ch. 5 · 14

Event, experience, effects (SAMHSA). Screen exposure and current effects; let the client control detail; don't press for the full story.

Ch. 5 · 13

Never the best answer: no evidence of effectiveness, and never a substitute for risk assessment. Replace with a collaborative safety plan.

Ch. 5 · 16

AUDIT: 10 items, 8 or more. CAGE: 4 items, 2 or more. DAST-10: drugs other than alcohol. CRAFFT: ages 12 to 21, 2 or more. SBIRT: screen, brief intervention, referral.

Ch. 5 · 15

Counts categories of childhood abuse, neglect, and household challenges (10 in the familiar version). Graded link to adult health risk; flags risk, does not diagnose.

Ch. 5 · 17

**MSE confusable pairs**

Mood (said) vs. affect (seen). Circumstantial (arrives) vs. tangential (never returns).  
Hallucination (no stimulus) vs. illusion (real stimulus misread) vs. delusion (false belief).  
Insight (understanding) vs. judgment (decisions).

## CHAPTER 6

# Diagnosis: DSM-5-TR and ICD

## Extra drills

### Drill 6.2 • Fill in the blank.

1. DSM-5 replaced the multiaxial system and the GAF; it suggests the \_\_\_\_\_ to rate functioning.
2. A subtype is chosen from a list of mutually \_\_\_\_\_ options.
3. “Other specified” records the \_\_\_\_\_ that full criteria are not met.
4. The U.S. diagnosis code set on insurance claims is \_\_\_\_\_.
5. ICD-11 moved gender incongruence to a chapter on \_\_\_\_\_.
6. A problem that is a focus of care but not a mental disorder is usually recorded with a \_\_\_\_\_ code.
7. The CFI has \_\_\_\_\_ questions in four domains.
8. Of the three kinds of cultural concepts of distress, *susto* (illness blamed on a fright) is a cultural \_\_\_\_\_.
9. Faking symptoms for an external reward is called \_\_\_\_\_.
10. When criteria for both DMDD and ODD are met, only \_\_\_\_\_ is diagnosed.

**Drill 6.3 • Sorting: diagnose, Z code, or rule out first?** For each situation, write **D** (a mental disorder diagnosis is supported), **Z** (record a Z code; no disorder is described), or **R** (rule something out before diagnosing).

1. \_\_\_\_ A client sleeps poorly and feels sad 3 weeks after her brother’s death but is working and seeing friends.
2. \_\_\_\_ A client with no psychiatric history develops anxiety, a tremor, and weight loss over 2 months.
3. \_\_\_\_ A client has had 6 months of excessive, hard-to-control worry most days, with restlessness, fatigue, and poor concentration, that impairs his work; medical causes and substances have been ruled out.
4. \_\_\_\_ Early in an evaluation, a client seeking a disability payment reports symptoms that change whenever the evaluator leaves the room; whether the symptoms are feigned has not yet been assessed.
5. \_\_\_\_ A couple seeks help for frequent arguments; neither meets criteria for a disorder.
6. \_\_\_\_ A client’s panic-like episodes began when she started a new prescription; whether the drug can cause them is not yet known.
7. \_\_\_\_ A recent immigrant struggles to adjust to a new language and workplace but has no impairing symptoms.
8. \_\_\_\_ A client has had unexpected panic attacks for 2 months and avoids driving for fear of another; caffeine, medication, and medical causes have been excluded.

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## Answers to the Chapter 6 drills

**Drill answers.** 6.2: (1) WHODAS 2.0. (2) exclusive. (3) reason. (4) ICD-10-CM. (5) sexual health. (6) Z. (7) 16. (8) explanation (a perceived cause). (9) malingering. (10) DMDD. 6.3: 1-Z (uncomplicated bereavement). 2-R (medical evaluation, e.g., thyroid). 3-D (generalized anxiety disorder). 4-R (a disability claim plus symptoms that shift when unobserved make malingering a strong suspicion, not a finding; assess it before diagnosing anything. Z is the trap: malingering is coded Z76.5 only once it is established). 5-Z (relational problem). 6-R (rule out a medication cause with the prescriber; if confirmed, the diagnosis is substance/medication-induced anxiety disorder, not panic disorder). 7-Z (acculturation difficulty). 8-D (panic disorder).

Ch. 6 · 1

**DSM-III (1980)**

Ch. 6 · 2

**DSM-5 (2013)**

Ch. 6 · 3

**DSM-5-TR (2022)**

Ch. 6 · 4

**Mental disorder (DSM)**

Ch. 6 · 5

**Subtype vs. specifier vs. provisional**

Ch. 6 · 6

**Other specified vs. unspecified**

Ch. 6 · 7

**Recording a diagnosis**

Ch. 6 · 8

**ICD-10-CM**

Ch. 6 · 2

Dropped the five axes; stressors noted with Z codes; GAF dropped (WHODAS 2.0 offered); “not otherwise specified” replaced by other specified and unspecified.

Ch. 6 · 1

Introduced explicit diagnostic criteria, the multiaxial system, and a stance neutral about causes.

Ch. 6 · 4

Clinically significant disturbance in thinking, emotion regulation, or behavior reflecting a dysfunction, usually with distress or impairment. Expectable responses to loss are not disorders.

Ch. 6 · 3

Text revision: updated text and codes; added prolonged grief disorder and unspecified mood disorder; codes for suicidal behavior and nonsuicidal self-injury; review for racism and stigmatizing language.

Ch. 6 · 6

Other specified shows its work: the reason criteria are not met is recorded. Unspecified leaves it blank, often for lack of information (emergency department).

Ch. 6 · 5

Subtype: mutually exclusive, choose one. Specifier: course, features, severity; combine freely. Provisional: full criteria expected once more information arrives.

Ch. 6 · 8

U.S. clinical modification of ICD-10; required diagnosis code set on claims since October 1, 2015; most DSM disorders are F codes. The DSM prints these codes; it has none of its own.

Ch. 6 · 7

ICD-10-CM code, then the DSM name and specifiers. Principal diagnosis (inpatient) or reason for visit (outpatient) first. Example: F10.20 is written “alcohol use disorder, moderate.”

Ch. 6 · 9

**ICD-11**

Ch. 6 · 10

**Z codes**

Ch. 6 · 11

**Cultural Formulation Interview**

Ch. 6 · 12

**Cultural concepts of distress**

Ch. 6 · 13

**Six-step differential (First, 2014)**

Ch. 6 · 14

**Medical red flags**

Ch. 6 · 15

**Comorbidity rules**

Ch. 6 · 16

**Ethics of diagnosis**

Ch. 6 · 10

Conditions that may be a focus of clinical attention but are not mental disorders: relational, abuse, educational, occupational, housing, economic problems; acculturation difficulty; uncomplicated bereavement. Alone or beside a diagnosis.

Ch. 6 · 9

WHO; in effect January 1, 2022; not yet on U.S. claims. Diagnostic requirements instead of strict counts; complex PTSD, prolonged grief, gaming disorder; dimensional personality disorder; gender incongruence moved to a sexual health chapter.

Ch. 6 · 12

Syndromes (ataque de nervios, taijin kyofusho), idioms of distress (nervios), and cultural explanations (susto).

Ch. 6 · 11

16 questions, 4 domains: What is it? Why is it happening? How have you coped? What would help now? Informant version and supplementary modules. Never the sole basis for a diagnosis.

Ch. 6 · 14

Sudden onset, prominent physical symptoms, first episode late in life, a medication change. Refer for a medical evaluation before settling on a diagnosis (e.g., thyroid disease).

Ch. 6 · 13

Rule out malingering and factitious disorder → substance → medical condition; then name the primary disorder → adjustment vs. residual categories → no disorder at all.

Ch. 6 · 16

E.5.a proper diagnosis; E.5.b culture; E.5.c historical prejudice; E.5.d may refrain; C.6.b honest reports (no up- or down-coding); A.2.b and 2027 task 3A.7: review the diagnosis with the client.

Ch. 6 · 15

Allowed when criteria for each are met. Mania or hypomania ever → not MDD. DMDD + ODD → DMDD only. Autism + ADHD → both allowed (not in DSM-IV).

## CHAPTER 7

# Measurement Foundations

## Extra drills

**Drill 7.2 • Matching: which kind of evidence?** Write the letter of the reliability or validity evidence next to each study. Each letter is used once.

| Study                                                                        | Evidence                                |
|------------------------------------------------------------------------------|-----------------------------------------|
| 1. The same inventory is given to the same clients 3 weeks apart             | ___ A. Inter-rater reliability<br>-     |
| 2. Two observers independently code the same recorded play session           | ___ B. Content validity<br>-            |
| 3. Students take Form A on Monday and Form B on Tuesday                      | ___ C. Predictive validity<br>-         |
| 4. Coefficient alpha is computed from one administration                     | ___ D. Test-retest reliability<br>-     |
| 5. Experts compare exam items with a national work analysis                  | ___ E. Discriminant validity<br>-       |
| 6. Admission test scores are correlated with grades 2 years later            | ___ F. Alternate-forms reliability<br>- |
| 7. A new anxiety scale correlates strongly with an established anxiety scale | ___ G. Internal consistency<br>-        |
| 8. The new anxiety scale shows almost no correlation with a vocabulary test  | ___ H. Convergent validity<br>-         |

**Drill 7.3 • Fill in the blank (quick calculations).**

1. A test has an SD of 10 and a reliability of .91. Its SEM is \_\_\_\_\_.
2. Using that SEM, a T-score of 60 has a 95 percent band of about \_\_\_\_\_ to \_\_\_\_\_.
3. If a test's reliability rises, its SEM \_\_\_\_\_.
4. A reliability of .81 caps the validity coefficient at \_\_\_\_\_.
5. A validity coefficient of .60 means the test accounts for \_\_\_\_\_ percent of the variance in the criterion.
6. Of 60 test takers, 45 answer an item correctly. The item difficulty index is \_\_\_\_\_.
7. Eighty percent of the upper group and 40 percent of the lower group answer an item correctly. Its discrimination index is \_\_\_\_\_.
8. Stanine 5 contains about \_\_\_\_\_ percent of scores.
9. A z-score of -1.5 equals a T-score of \_\_\_\_\_.
10. A split-half coefficient of .70, corrected with the Spearman-Brown formula, becomes about \_\_\_\_\_.

---

## Answers to the Chapter 7 drills

**Drill answers.** 7.2: 1-D, 2-A, 3-F, 4-G, 5-B, 6-C, 7-H (it could also be called concurrent evidence, which is not listed; paired with item 8, it is construct evidence), 8-E. 7.3: (1) 3 ( $10 \times \sqrt{.09} = 10 \times .3$ ). (2) 54 to 66 ( $60 \pm 2 \times 3$ ). (3) falls. (4) .90 ( $\sqrt{.81}$ ; a less reliable criterion lowers the ceiling further). (5) 36 ( $.60^2 = .36$ , the variance the test and criterion share). (6) .75 ( $45 \div 60$ ). (7) .40 ( $.80 - .40$ ). (8) 20. (9) 35 ( $50 + 10 \times -1.5$ ). (10) .82 ( $2 \times .70 \div 1.70$ ).

Ch. 7 · 1

**Four scales of measurement**

Ch. 7 · 2

**Norm- vs. criterion-referenced  
vs. ipsative**

Ch. 7 · 3

**A good norm group**

Ch. 7 · 4

**Normal curve areas**

Ch. 7 · 5

**Percentile anchors**

Ch. 7 · 6

**Standard score systems**

Ch. 7 · 7

**Stanines**

Ch. 7 · 8

**Reliability coefficient**

Ch. 7 · 2

Norm-referenced: compared with a group.  
 Criterion-referenced: compared with a fixed standard (the NCE). Ipsative: compared with the person's own profile.

Ch. 7 · 1

Nominal (categories; mode) · ordinal (rank order; median, percentiles) · interval (equal units, no true zero; mean, SD; IQ, T-scores) · ratio (true zero; "twice as much"). Stevens (1946).

Ch. 7 · 4

About 34, 14, and 2 percent per side between successive SDs; about 68, 95, and 99.7 percent within 1, 2, and 3 SD.

Ch. 7 · 3

Recent, representative, and relevant to the client. Instruments normed on other populations are used with caution (Standard E.8).

Ch. 7 · 6

z (mean 0, SD 1) · T (50, 10) · deviation IQ (100, 15) · stanine (5, about 2). Any score = its mean + ( $z \times$  its SD).

Ch. 7 · 5

$-2$  SD  $\approx$  2nd ·  $-1$  SD  $\approx$  16th · mean = 50th ·  $+1$  SD  $\approx$  84th ·  $+2$  SD  $\approx$  98th. Percentile ranks are ordinal and are not percent correct.

Ch. 7 · 8

Proportion of observed-score variance that is true-score variance ( $.85 = 85$  percent). Not squared.

Ch. 7 · 7

Nine bands; each band except 1 and 9 is half an SD wide; stanine 5 holds the middle 20 percent.

Ch. 7 · 9

### **Four kinds of reliability**

Ch. 7 · 10

### **Internal-consistency statistics**

Ch. 7 · 11

### **Cohen's kappa**

Ch. 7 · 12

### **Standard error of measurement**

Ch. 7 · 13

### **Three standard errors**

Ch. 7 · 14

### **Measuring change (2T)**

Ch. 7 · 15

### **Validity evidence**

Ch. 7 · 16

### **Reliability and validity**

Ch. 7 · 10

Split-half, corrected upward with Spearman-Brown · KR-20 for right/wrong items · coefficient alpha for rating-scale items. Avoid split-half on speeded tests.

Ch. 7 · 9

Test-retest (stability over time) · alternate forms (equivalence) · internal consistency (one administration) · inter-rater (agreement among scorers).

Ch. 7 · 12

$SEM = SD \times \sqrt{1 - \text{reliability}}$ . Score  $\pm 1$  SEM  $\approx 68$  percent band;  $\pm 2$  SEM (1.96)  $\approx 95$  percent band. Higher reliability, smaller SEM.

Ch. 7 · 11

Agreement between two raters on categories, corrected for chance agreement (Cohen, 1960).

Ch. 7 · 14

Reliable change index: change  $\div$  standard error of the difference; beyond  $\pm 1.96$  is unlikely to be error alone (Jacobson & Truax, 1991). Extreme scorers regress toward the mean on retest.

Ch. 7 · 13

SEM: one person's score (reliability). Standard error of the mean: sample means (research). Standard error of estimate: error predicting a criterion (validity).

Ch. 7 · 16

Reliability is necessary but not sufficient. Validity coefficient  $\leq \sqrt{\text{reliability}}$  (reliability .64  $\Rightarrow$  validity at most .80). Square a validity coefficient for shared variance.

Ch. 7 · 15

Content (expert review vs. blueprint) · criterion-related: concurrent (now) or predictive (later) · construct: convergent and discriminant. Face validity is not technical evidence.

Ch. 7 · 17

**Sensitivity vs. specificity**

Ch. 7 · 18

**Item analysis**

Ch. 7 · 18

Difficulty  $p$  = proportion correct (higher = easier; near .50 spreads scores best).  
Discrimination  $D$  = upper-group minus lower-group proportion; negative = miskeyed or ambiguous.

Ch. 7 · 17

Sensitivity: share of true cases the screener flags. Specificity: share of non-cases it clears. When high scores signal the condition, lowering the cut score raises sensitivity and lowers specificity.

## CHAPTER 8

# Tests and Instruments

## Extra drills

### Drill 8.2 • Fill in the blank.

1. A test that predicts future performance is an \_\_\_\_\_ test.
2. The deviation IQ has a mean of \_\_\_\_\_ and a standard deviation of \_\_\_\_\_.
3. A 10-year-old with a mental age of 12 has a ratio IQ of \_\_\_\_\_.
4. The Wechsler scale for ages 6 to 16 is the \_\_\_\_\_.
5. The original MMPI selected items by empirical \_\_\_\_\_ keying.
6. On the MMPI-3, the \_\_\_\_\_ scales are reviewed before any clinical elevation.
7. The PCL-5 asks about symptoms over the past \_\_\_\_\_.
8. The highest possible PHQ-9 score is \_\_\_\_\_.
9. A rater error in which one impression colors every rating is the \_\_\_\_\_ effect.
10. Release of identified test data requires the client's \_\_\_\_\_ and a recipient \_\_\_\_\_ to interpret it.

**Drill 8.3 • Sorting: what kind of instrument?** For each instrument, write **AB** (ability: intelligence, aptitude, or achievement), **OP** (objective personality inventory), **PR** (projective), or **SY** (brief symptom-severity scale).

1. \_\_\_\_ Wechsler Adult Intelligence Scale
2. \_\_\_\_ Thematic Apperception Test
3. \_\_\_\_ GAD-7
4. \_\_\_\_ NEO PI-3
5. \_\_\_\_ Armed Services Vocational Aptitude Battery
6. \_\_\_\_ Kinetic Family Drawing
7. \_\_\_\_ MMPI-3
8. \_\_\_\_ Beck Depression Inventory-II
9. \_\_\_\_ Wide Range Achievement Test
10. \_\_\_\_ Myers-Briggs Type Indicator

## Answers to the Chapter 8 drills

**Drill answers.** 8.2: (1) aptitude. (2) 100; 15 (older Stanford-Binet editions used 16). (3) 120. (4) WISC. (5) criterion. (6) validity. (7) month. (8) 27. (9) halo (a negative version is sometimes called the horns effect). (10) consent; qualified. 8.3: 1-AB, 2-PR, 3-SY, 4-OP, 5-AB, 6-PR, 7-OP (it covers psychopathology, but it is a broad 335-item true/false inventory, not a brief symptom scale), 8-SY (its answers are fixed too, but it is a brief scale of depression severity), 9-AB, 10-OP.

Ch. 8 · 1

**Ability vs. personality measures**

Ch. 8 · 2

**Aptitude vs. achievement**

Ch. 8 · 3

**Speed vs. power test**

Ch. 8 · 4

**Intelligence theorists**

Ch. 8 · 5

**Ratio IQ vs. deviation IQ**

Ch. 8 · 6

**Wechsler scales by age**

Ch. 8 · 7

**Intellectual disability: two kinds of evidence**

Ch. 8 · 8

**Objective vs. projective**

Ch. 8 · 2

Aptitude predicts future performance (SAT, GRE, ASVAB). Achievement measures what has been learned (WIAT, WRAT). Purpose, not content, separates them.

Ch. 8 · 1

Ability: “do your best” (maximal performance): intelligence, aptitude, achievement. Personality and interests: “how you usually are” (typical performance).

Ch. 8 · 4

Spearman: *g*. Thurstone: primary mental abilities. Cattell and Horn: fluid vs. crystallized. Gardner: multiple intelligences. Sternberg: analytical, creative, practical.

Ch. 8 · 3

Speed: many easy items, strict time limit.  
Power: items of rising difficulty, ample time.

Ch. 8 · 6

WPPSI: about 2½ to 7½. WISC: 6 to 16. WAIS: 16 to 90. Full Scale IQ plus index scores.

Ch. 8 · 5

Ratio:  $\text{mental age} \div \text{chronological age} \times 100$  (Terman’s Stanford-Binet, 1916). Deviation: comparison with same-age peers, mean 100, SD 15 (Wechsler).

Ch. 8 · 8

Objective: fixed answers scored the same way (MMPI-3, NEO PI-3, MBTI). Projective: ambiguous stimuli, open responses (Rorschach, TAT, sentence completion, drawings).

Ch. 8 · 7

Intellectual deficits (IQ about 2 SD below the mean, roughly 65–75) plus adaptive deficits (e.g., Vineland), both beginning in the developmental period. Severity follows adaptive functioning.

Ch. 8 · 9

## **MMPI-3**

Ch. 8 · 10

## **Empirical criterion keying**

Ch. 8 · 11

## **MBTI vs. NEO PI-3**

Ch. 8 · 12

## **Rorschach and TAT**

Ch. 8 · 13

## **Symptom measures at a glance**

Ch. 8 · 14

## **PHQ-9 item 9**

Ch. 8 · 15

## **Formal vs. informal observation**

Ch. 8 · 16

## **ACA Section E essentials**

Ch. 8 · 10

Items kept because they separated clinical groups, regardless of content. The method behind the original MMPI (Hathaway and McKinley, 1943).

Ch. 8 · 9

335 true/false items, adults 18+, T scores (2020). Validity scales first: inconsistency (VRIN, TRIN, CRIN), overreporting (F family), underreporting (L, K).

Ch. 8 · 12

Rorschach (1921): 10 inkblots. TAT (Morgan and Murray, 1935): stories about picture cards. Both projective; need extensive training.

Ch. 8 · 11

MBTI: Jungian types, four preference pairs, 16 types; preferences, not ability or pathology. NEO PI-3: Big Five domains plus 30 facets.

Ch. 8 · 14

Any endorsement of thoughts of death or self-harm calls for a same-day suicide risk assessment, whatever the total score.

Ch. 8 · 13

PHQ-9 (0–27), GAD-7 (0–21), BDI-II (0–63): past 2 weeks. BAI (0–63): mostly physical anxiety symptoms, past week. PCL-5 (0–80): past month. Ceiling = items × top rating.

Ch. 8 · 16

Competent with that instrument (E.2.a); responsible for software interpretations (E.2.b); explain before testing (E.3.a); release identified data only with consent, to qualified persons, with interpretation (E.3.b, E.4); report with the client's background in mind (E.9.a).

Ch. 8 · 15

Formal has a form: rating scales, recording methods, structured interviews, MSE. Informal: body language, affect, waiting-room behavior; generates hypotheses.

## CHAPTER 9

# Research, Statistics, and Program Evaluation

## Extra drills

**Drill 9.2 • Matching: name the threat.** A counseling center tests a stress-reduction workshop with a September pretest and a December posttest. Write the letter of the threat to validity that each event illustrates. Each letter is used once.

| Event                                                                                         |          | Threat                    |
|-----------------------------------------------------------------------------------------------|----------|---------------------------|
| 1. A new campus wellness app launches in October and many students use it                     | ___<br>- | A. Testing                |
| 2. The center switches to a different stress questionnaire for the posttest                   | ___<br>- | B. Statistical regression |
| 3. First-year students adjust to college life over the semester, workshop or not              | ___<br>- | C. Mortality              |
| 4. Students invited for extreme pretest scores score closer to average in December            | ___<br>- | D. Diffusion of treatment |
| 5. Workshop students teach the breathing exercises to their roommates in the comparison group | ___<br>- | E. History                |
| 6. Students remember the September items and answer differently in December                   | ___<br>- | F. Selection              |
| 7. The workshop group volunteered; the comparison group did not                               | ___<br>- | G. Instrumentation        |
| 8. A third of the workshop group stops attending before December                              | ___<br>- | H. Maturation             |

**Drill 9.3 • Fill in the blank.**

1. The variable a researcher manipulates is the \_\_\_\_\_ variable.
2. A design with manipulation but no random assignment is \_\_\_\_\_.
3. For income data with a few very high values, the best measure of center is the \_\_\_\_\_.
4. A correlation of .60 means the two variables share \_\_\_\_\_ percent of their variance.
5. Rejecting a null hypothesis that is true is a Type \_\_\_\_\_ error.
6. Power equals 1 minus \_\_\_\_\_.
7. Comparing the means of four groups on one outcome calls for a one-way \_\_\_\_\_.
8. The qualitative tradition that builds a theory from the data is \_\_\_\_\_.
9. Evaluation conducted while a program runs, to improve it, is \_\_\_\_\_ evaluation.
10. The committee that reviews research with human participants is the \_\_\_\_\_.

---

## Answers to the Chapter 9 drills

**Drill answers.** 9.2: 1-E, 2-G, 3-H, 4-B, 5-D, 6-A, 7-F, 8-C. 9.3: (1) independent. (2) quasi-experimental. (3) median. (4) 36. (5) I. (6) beta (the probability of a Type II error). (7) ANOVA. (8) grounded theory. (9) formative (or process; the chapter pairs the terms). (10) institutional review board (IRB).

Ch. 9 · 1

**Random assignment vs. random selection**

Ch. 9 · 2

**What each design can conclude**

Ch. 9 · 3

**Other designs to know**

Ch. 9 · 4

**Threats to internal validity (Campbell & Stanley, 1963)**

Ch. 9 · 5

**More threats and effects**

Ch. 9 · 6

**Central tendency and skew**

Ch. 9 · 7

**Correlation**

Ch. 9 · 8

**p-value and alpha**

Ch. 9 · 2

True experiment (manipulated IV + random assignment): cause. Quasi-experiment (intact groups): cause, tentatively. Ex post facto: group differences. Correlational: relationship and prediction.

Ch. 9 · 1

Assignment (to conditions by chance) earns cause. Selection (from a population by chance) earns generalization. A study can have one without the other.

Ch. 9 · 4

History, maturation, testing, instrumentation, statistical regression, selection, mortality (attrition), and their interactions. Each could explain change without the treatment.

Ch. 9 · 3

Solomon four-group (Solomon, 1949): shows whether the pretest changed results. Factorial: two or more IVs; detects interactions. Single-case: A = baseline, B = treatment; ABAB reversal; multiple baseline.

Ch. 9 · 6

Skewed data: median. Mean follows the tail; the tail names the skew. Positive skew: tail right, mean highest. Negative skew: tail left, mean lowest.

Ch. 9 · 5

Diffusion of treatment, compensatory rivalry (John Henry), resentful demoralization (Cook & Campbell, 1979). Hawthorne: change from being studied. Placebo: change from expectation. Blinding controls placebo and expectancy effects.

Ch. 9 · 8

Alpha (.05 or .01) is set first.  $p$  is the probability of results at least this extreme if the null is true.  $p < \alpha$ : reject the null (statistically significant).

Ch. 9 · 7

-1.00 to +1.00. Sign = direction; absolute value = strength (-.72 beats +.58).  $r$  squared = shared variance (.70  $\rightarrow$  49 percent). Not causation.

Ch. 9 · 9

**Type I vs. Type II error**

Ch. 9 · 10

**Power**

Ch. 9 · 11

**Effect size and clinical significance**

Ch. 9 · 12

**Which statistical test?**

Ch. 9 · 13

**Qualitative traditions**

Ch. 9 · 14

**Trustworthiness (Lincoln & Guba,  
1985)**

Ch. 9 · 15

**Program evaluation sequence**

Ch. 9 · 16

**Research ethics**

Ch. 9 · 10

1 – beta; the chance of detecting a real effect. Rises with larger samples, larger effects, higher alpha, one-tailed tests, less error. Target .80 (Cohen, 1992).

Ch. 9 · 9

Type I: reject a true null; false positive; probability alpha. Type II: fail to reject a false null; missed effect; probability beta. Lower alpha → fewer Type I, more Type II.

Ch. 9 · 12

Counts in categories: chi-square. Two means: *t* (independent or paired). Three or more: ANOVA. Two IVs: factorial ANOVA. Relationship: Pearson or Spearman. Prediction: regression.

Ch. 9 · 11

Significance is not size. Cohen's *d*: .20 small, .50 medium, .80 large. Clinical significance: reliable change plus ending in the nonclinical range (Jacobson & Truax, 1991).

Ch. 9 · 14

Credibility, transferability, dependability, confirmability. Built through triangulation, member checking, thick description, prolonged engagement, and an audit trail.

Ch. 9 · 13

Phenomenology: lived experience, bracketing. Grounded theory: theory from data, constant comparison. Ethnography: culture, participant observation. Case study: one bounded case.

Ch. 9 · 16

Belmont: respect for persons, beneficence, justice. IRB review. ACA Section G: consent, withdraw without penalty, clients free to decline, debrief, report unfavorable results, student as lead author.

Ch. 9 · 15

Needs assessment → logic model (inputs, activities, outputs, outcomes) → formative evaluation (during, improve) → summative evaluation (end, keep or cut). Scriven (1967) named formative vs. summative.

## CHAPTER 10

# Depressive, Bipolar, and Related Disorders

## Extra drills

### Drill 10.2 • Fill in the blank.

1. A major depressive episode lasts at least \_\_\_\_\_ weeks.
2. A hypomanic episode lasts at least \_\_\_\_\_ consecutive days.
3. A manic episode lasts at least \_\_\_\_\_ week, or any length if the person is \_\_\_\_\_.
4. Persistent depressive disorder requires \_\_\_\_\_ years in adults and \_\_\_\_\_ year in children and adolescents.
5. DMDD onset must occur before age \_\_\_\_\_.
6. PMDD is confirmed by prospective daily ratings across at least \_\_\_\_\_ symptomatic cycles.
7. The peripartum onset specifier covers onset during pregnancy or within \_\_\_\_\_ weeks after delivery.
8. Bipolar II requires at least one hypomanic episode and at least one \_\_\_\_\_ episode.
9. Hopelessness theory emphasizes \_\_\_\_\_ and \_\_\_\_\_ explanations of negative events.
10. MBCT is designed for people with recurrent depression that is currently in \_\_\_\_\_.

### Drill 10.3 • Sorting: which diagnosis? Write **MDD**, **PDD**, **BP-I** (bipolar I), **BP-II** (bipolar II), **CYC** (cyclothymic disorder), **DMDD**, or **NONE** (no mood disorder is described).

1. \_\_\_\_ Six days of euphoria, no sleep, racing thoughts, and grandiose plans end in a psychiatric hospitalization.
2. \_\_\_\_ Three weeks of low mood nearly every day, with poor sleep, fatigue, guilt, and poor concentration that disrupt work; no past highs.
3. \_\_\_\_ A 10-year-old with near-daily irritability and outbursts several times a week since age 7.
4. \_\_\_\_ Two and a half years of frequent hypomanic and depressive symptoms, present most of the time and straining relationships, that never reach a full episode.
5. \_\_\_\_ A past 5-day stretch of elevated mood, high energy, little need for sleep, rapid speech, and racing thoughts that coworkers noticed, plus a major depressive episode last winter.
6. \_\_\_\_ Four years of depressed mood on most days, with low energy and low self-esteem, never meeting full episode criteria.
7. \_\_\_\_ Three weeks after her father's death, a client cries in waves when reminded of him, still enjoys her grandchildren, and feels good about herself.
8. \_\_\_\_ A manic episode last year and no depressive episode ever.

---

## Answers to the Chapter 10 drills

**Drill answers.** 10.2: (1) 2. (2) 4. (3) 1; hospitalized. (4) 2; 1. (5) 10. (6) two. (7) 4. (8) major depressive. (9) stable; global (not internal: internality belonged to the earlier learned helplessness reformulation; helplessness theory centers on stable and global causes). (10) remission (“recovery” is also correct). 10.3: 1-BP-I (hospitalization makes it mania regardless of duration). 2-MDD (five symptoms, including low mood, nearly every day for at least 2 weeks, with impairment). 3-DMDD. 4-CYC (subthreshold highs and lows at least half the time for 2+ years, with distress or impairment; mild mood swings alone are not a disorder). 5-BP-II (5 days without hospitalization is too short for mania, so the high is hypomanic). 6-PDD. 7-NONE (expectable grief; a Z code may record bereavement). 8-BP-I (depression is not required).

Ch. 10 · 1

**Major depressive episode**

Ch. 10 · 2

**The nine symptoms**

Ch. 10 · 3

**Grief vs. depression**

Ch. 10 · 4

**Persistent depressive disorder**

Ch. 10 · 5

**Double depression (DSM-5-TR)**

Ch. 10 · 6

**PMDD**

Ch. 10 · 7

**DMDD**

Ch. 10 · 8

**Manic episode**

Ch. 10 · 2

Depressed mood · anhedonia · appetite or weight change · insomnia or hypersomnia · agitation or slowing · fatigue · worthlessness or guilt · poor concentration · thoughts of death or suicide.

Ch. 10 · 1

Five of nine symptoms in the same 2 weeks, most nearly every day; one must be depressed mood or loss of interest or pleasure. Youth: mood may be irritable. MDD also requires that mania or hypomania never occurred.

Ch. 10 · 4

Depressed mood more days than not for 2 years (1 in youth) plus two of six symptoms; never symptom-free over 2 months. Merged dysthymia and chronic major depression.

Ch. 10 · 3

Grief: waves tied to reminders, positive emotion possible, self-esteem intact. Depression: pervasive low mood, little anticipated pleasure, worthlessness. DSM-5 removed the bereavement exclusion.

Ch. 10 · 6

Five or more symptoms in the week before menses, easing after onset and minimal the week after; confirmed by prospective daily ratings over at least two cycles.

Ch. 10 · 5

A full major depressive episode during PDD. DSM-5-TR clarified that MDD is diagnosed in addition to PDD.

Ch. 10 · 8

Elevated, expansive, or irritable mood plus increased energy; at least 1 week (any length if hospitalized); three of seven symptoms (four if only irritable); marked impairment, hospitalization, or psychosis.

Ch. 10 · 7

Severe outbursts about three or more times a week plus irritability between them; 12 months; two or more settings; first diagnosed at 6 to 18; onset before 10. Overrides ODD; any mania or hypomania rules it out.

Ch. 10 · 9

**Hypomanic episode**

Ch. 10 · 10

**Bipolar I vs. II vs. cyclothymic**

Ch. 10 · 11

**The 4–7–14 ladder**

Ch. 10 · 12

**Specifiers**

Ch. 10 · 13

**Antidepressant-emergent mania**

Ch. 10 · 14

**Rule-outs**

Ch. 10 · 15

**Hopelessness**

Ch. 10 · 16

**Loneliness**

Ch. 10 · 10

I: one manic episode (depression not required). II: hypomanic + major depressive episode, never mania; not a milder bipolar I. Cyclothymic: 2 years (1 in youth) of subthreshold highs and lows.

Ch. 10 · 9

Same symptoms for at least 4 consecutive days; a change others can see; no marked impairment, hospitalization, or psychosis.

Ch. 10 · 12

Anxious distress · mixed features · melancholic · atypical · psychotic features · catatonia · peripartum onset (pregnancy or 4 weeks after delivery) · seasonal pattern · rapid cycling (4+ episodes in 12 months; bipolar I and II only).

Ch. 10 · 11

Hypomania 4 days · mania 7 days · major depressive episode 14 days. PDD and cyclothymic disorder: 2 years in adults, 1 in youth.

Ch. 10 · 14

Substances and medical causes (thyroid) first · adjustment disorder (within 3 months of a stressor) · schizoaffective disorder (2 weeks of psychosis without a mood episode) · chronic irritability → DMDD, not bipolar.

Ch. 10 · 13

Mania that starts during antidepressant treatment and persists at full strength beyond the drug's effect counts as mania: bipolar I. Screen for past highs before any depression plan (2027 task 3A.8).

Ch. 10 · 16

Subjective, distressing gap between wanted and actual connection; social isolation is objective. Interventions targeting maladaptive social cognition (expecting rejection) did best (Masi et al., 2011).

Ch. 10 · 15

Beck's cognitive triad: self, world, future. Hopelessness theory: stable ("always") and global ("everything") explanations (Abramson et al., 1989). Hopelessness predicted eventual suicide (Beck et al., 1985) → assess risk.

Ch. 10 · 17

## **Depression treatment**

Ch. 10 · 18

## **Bipolar treatment**

Ch. 10 · 18

Prescriber's medication (mood stabilizers such as lithium) is the foundation; add psychoeducation (family or group formats), CBT, family, or interpersonal work.  
Counselor: warning signs (less sleep), regular routines, family involvement with consent, ongoing risk assessment.

Ch. 10 · 17

Adults: psychotherapy (behavioral, CBT, MBCT, IPT, psychodynamic, supportive) or a second-generation antidepressant; combined: CBT or IPT + antidepressant. Teens: CBT or IPT-A. IPT's four areas: grief, role disputes, role transitions, interpersonal deficits. MBCT: relapse prevention in remission.

## CHAPTER 11

# Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders

## Extra drills

### Drill 11.2 • Fill in the blank.

1. A panic attack peaks within \_\_\_\_\_ and can be added as a specifier to any DSM disorder.
2. Panic disorder requires recurrent \_\_\_\_\_ panic attacks, at least one followed by 1 month or more of worry or behavior change.
3. OCD requires obsessions or compulsions that take more than about \_\_\_\_\_ a day or cause marked distress or impairment.
4. Even with \_\_\_\_\_ insight (complete conviction that the obsessional belief is true), the diagnosis remains OCD rather than a psychotic disorder.
5. In OCD, giving repeated reassurance works like a \_\_\_\_\_.
6. Exposure to trauma through television or news counts toward PTSD only when it is \_\_\_\_\_-related.
7. The PTSD specifier for full criteria first met 6 months or more after the event is \_\_\_\_\_ expression.
8. Clients with blood-injection-injury phobia learn \_\_\_\_\_ tension rather than relaxation.
9. TF-CBT teaches coping skills before the trauma \_\_\_\_\_.
10. Malingering differs from factitious disorder because the person seeks an \_\_\_\_\_ reward.

### Drill 11.3 • Timeline sort. Write **A** (acute stress disorder), **P** (PTSD), **J** (adjustment disorder), or **N** (no trauma- or stressor-related diagnosis yet). Assume symptom counts and impairment are met unless the item suggests otherwise.

1. \_\_\_\_ Two weeks after a crash that seriously injured her, Keiko has nightmares, flashbacks, numbness, avoidance of driving, and a strong startle response.
2. \_\_\_\_ Keiko's symptoms are unchanged 3 months after the crash.
3. \_\_\_\_ Six weeks after his divorce, Malik is tearful and missing work; no other disorder fits.
4. \_\_\_\_ Two days after being mugged at knifepoint, Ruth is shaky and sleeping poorly, but she has gone back to work and says she is coping.
5. \_\_\_\_ A paramedic who has repeatedly recovered children's bodies has had 6 weeks of flashbacks, avoidance, self-blame, and hypervigilance.
6. \_\_\_\_ Three weeks after watching a friend fall to his death, Andre has intrusive images, feels unreal, avoids the trail, and cannot sleep.
7. \_\_\_\_ Darius lost his job 5 months ago. Two weeks later he developed impairing anxiety that has not lifted; no other disorder fits.
8. \_\_\_\_ A veteran first met full criteria 9 months after returning from combat.

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## Answers to the Chapter 11 drills

**Drill answers.** 11.2: (1) minutes (DSM-IV's "10 minutes" is outdated). (2) unexpected (attacks only with a cue suggest a phobia or social anxiety). (3) an hour. (4) absent (the specifier "with absent insight/delusional beliefs"; with poor insight the belief is thought only probably true). (5) compulsion ("ritual" or "safety behavior" is also correct). (6) work. (7) delayed. (8) applied. (9) narrative. (10) external. 11.3: 1-A (Criterion A trauma; within the first month). 2-P (beyond 1 month). 3-J (stressor is not Criterion A trauma). 4-N (acute stress disorder needs at least 3 days; adjustment disorder has no waiting period, but her reaction is proportionate and not impairing; keep monitoring). 5-P (repeated exposure to details at work counts). 6-A (within the first month; dissociation is among its symptoms). 7-J (job loss is not Criterion A trauma; onset came within 3 months of the stressor). 8-P (with delayed expression).

Ch. 11 · 1

**Anxiety durations**

Ch. 11 · 2

**Generalized anxiety disorder**

Ch. 11 · 3

**Panic attack vs. panic disorder  
vs. agoraphobia**

Ch. 11 · 4

**Phobia and social anxiety specifiers**

Ch. 11 · 5

**OCD essentials**

Ch. 11 · 6

**OCD-related disorders**

Ch. 11 · 7

**Obsession vs. OCPD vs. GAD worry**

Ch. 11 · 8

**PTSD Criterion A**

Ch. 11 · 2

Hard-to-control worry about many matters, more days than not, for at least 6 months, plus three of six symptoms (one in children): restless, tired, unfocused, irritable, tense, poor sleep.

Ch. 11 · 1

Typically 6 months: specific phobia, social anxiety, agoraphobia, adult separation anxiety; at least 6 months: GAD. One month: panic disorder (after an attack), selective mutism, separation anxiety in youth (4 weeks).

Ch. 11 · 4

Specific phobia: animal, natural environment, blood-injection-injury, situational, other. Social anxiety: “performance only”; in children, fear must occur with peers, not only adults.

Ch. 11 · 3

Attack: fear peaking within minutes, 4 of 13 symptoms; a specifier. Disorder: unexpected attacks plus 1 month of worry or avoidance. Agoraphobia: 2 of 5 situations; diagnosed separately.

Ch. 11 · 6

Body dysmorphic disorder (perceived flaw; mirror checking), hoarding disorder (difficulty discarding), trichotillomania (hair pulling), excoriation disorder (skin picking).

Ch. 11 · 5

Obsessions (intrusive, unwanted) and/or compulsions (rituals to neutralize distress); time-consuming (e.g., over 1 hour a day), distressing, or impairing; no minimum duration. Insight: good/fair, poor, absent/delusional.

Ch. 11 · 8

Actual or threatened death, serious injury, or sexual violence: experienced, witnessed in person, learned about for a loved one (death violent or accidental), or repeated exposure to details at work. Media counts only through work.

Ch. 11 · 7

Obsession: an unwanted intruder that drives rituals. OCPD: perfectionism and control the person endorses, no true obsessions or rituals. GAD: worry about real-life matters.

Ch. 11 · 9

## **PTSD clusters and specifiers**

Ch. 11 · 10

## **Trauma timeline**

Ch. 11 · 11

## **Reactive attachment vs. disinhibited social engagement**

Ch. 11 · 12

## **Complex PTSD (ICD-11)**

Ch. 11 · 13

## **Sorting somatic presentations**

Ch. 11 · 14

## **Dissociative disorders**

Ch. 11 · 15

## **Exposure toolkit**

Ch. 11 · 16

## **Trauma-focused therapies**

Ch. 11 · 10

Acute stress disorder: 3 days to 1 month, nine of 14 symptoms. PTSD: more than 1 month. Adjustment disorder: any stressor, onset within 3 months, resolves within 6 months after it or its consequences end.

Ch. 11 · 9

Intrusion, avoidance, negative changes in thinking and mood, arousal and reactivity; more than 1 month. Specifiers: with dissociative symptoms; with delayed expression (full criteria at 6 months or later).

Ch. 11 · 12

Core PTSD symptoms plus severe emotion dysregulation, a worthless or ashamed self-view, and relationship difficulties, usually after prolonged or repeated trauma. Not a DSM-5-TR diagnosis.

Ch. 11 · 11

Both follow severe early neglect. Reactive attachment: withdrawn, rarely seeks comfort. Disinhibited social engagement: approaches strangers and may wander off with them.

Ch. 11 · 14

Dissociative identity disorder: two or more personality states, memory gaps. Dissociative amnesia: lost personal memories, fugue as a specifier. Depersonalization/derealization: detachment with reality testing intact.

Ch. 11 · 13

Faked for an external reward: malingering (not a disorder). Faked, no reward: factitious disorder. Real symptoms plus excessive worry: somatic symptom disorder. Little symptom, big worry: illness anxiety disorder. Neurological mismatch: functional neurological symptom disorder.

Ch. 11 · 16

PE (Foa): imaginal and in vivo exposure. CPT (Resick): challenging stuck points. EMDR (Shapiro): memory plus bilateral stimulation. TF-CBT (Cohen, Mannarino, Deblinger): ages 3–18 with a caregiver.

Ch. 11 · 15

Systematic desensitization (Wolpe): relaxation plus a graded hierarchy. Flooding: start at the top. Interoceptive: body sensations, for panic. ERP: trigger without ritual, for OCD. Habit reversal: hair pulling and skin picking.

Ch. 11 · 17

**Contraindications (2027 task 3A.8)**

Safety before trauma processing. No single-session debriefing for everyone. No benzodiazepines for PTSD. No reassurance for OCD. Applied tension, not relaxation, for blood-injection-injury phobia.

## CHAPTER 12

# Substance Use and Addictive Disorders

## Extra drills

### Drill 12.2 • Fill in the blank.

1. A substance use disorder with 5 criteria met is rated \_\_\_\_\_.
2. DSM-5 added the criterion of \_\_\_\_\_ and dropped legal problems.
3. Sustained remission requires \_\_\_\_\_ months or longer without criteria except craving.
4. Withdrawal from alcohol and \_\_\_\_\_ can be fatal.
5. \_\_\_\_\_ reverses an opioid overdose.
6. Gambling disorder requires at least \_\_\_\_\_ of 9 criteria.
7. The model that treats addiction as a chronic, progressive illness is linked to \_\_\_\_\_ (1960).
8. Unlike methadone, buprenorphine is a \_\_\_\_\_ agonist with a ceiling effect.
9. The ASAM Criteria choose the \_\_\_\_\_ intensive level that is safe and effective.
10. Treating both a substance use disorder and depression at the same time, in one coordinated plan, is called \_\_\_\_\_ treatment.

### Drill 12.3 • Name the stage. Write **PC** (precontemplation), **C** (contemplation), **P** (preparation), **A** (action), or **M** (maintenance).

1. \_\_\_\_ “I’ve cut out my after-work drinks for five weeks now.”
2. \_\_\_\_ “I’ll admit vaping costs a lot. I’m just not sure I’m ready to give it up.”
3. \_\_\_\_ “My wife is the one with the problem, not me.”
4. \_\_\_\_ “I set a quit date for the first of the month and told my sister.”
5. \_\_\_\_ “Two years sober. I still go to my Thursday meeting.”
6. \_\_\_\_ “I know the gambling is hurting us, and I keep thinking about quitting, but it’s the only fun I have.”

## Answers to the Chapter 12 drills

**Drill answers.** 12.2: (1) moderate. (2) craving. (3) 12. (4) sedatives (also correct: benzodiazepines, barbiturates, or sedative-hypnotics). (5) Naloxone (also correct: Narcan, a brand name, or nalmefene, a newer reversal drug). (6) 4. (7) Jellinek. (8) partial (methadone is a full agonist). (9) least. (10) integrated (not parallel, which runs at the same time but in separate systems). 12.3: 1-A. 2-C. 3-PC. 4-P. 5-M. 6-C (sees the harm and is thinking about quitting, but is ambivalent).

Ch. 12 · 1

**Substance use disorder severity**

Ch. 12 · 2

**What DSM-5 changed**

Ch. 12 · 3

**Prescribed-medication exclusion**

Ch. 12 · 4

**Early vs. sustained remission**

Ch. 12 · 5

**Which withdrawal can kill?**

Ch. 12 · 6

**Substance-induced vs. independent  
disorder**

Ch. 12 · 7

**Gambling disorder**

Ch. 12 · 8

**Models of addiction**

Ch. 12 · 2

Merged abuse and dependence into one substance use disorder, added craving, dropped legal problems, and moved gambling into the chapter.

Ch. 12 · 1

At least 2 of 11 criteria in 12 months. Mild 2–3, moderate 4–5, severe 6 or more. Severity starts on the even numbers.

Ch. 12 · 4

Early: 3 to under 12 months with no criteria except craving. Sustained: 12 months or longer. Specifiers: in a controlled environment; on maintenance therapy (opioids, tobacco).

Ch. 12 · 3

Tolerance and withdrawal do not count when a medication is taken as prescribed under medical supervision. Physical dependence is not addiction.

Ch. 12 · 6

Symptoms that began before use, or persist about 1 month after withdrawal or intoxication ends, suggest an independent disorder.

Ch. 12 · 5

Alcohol and sedatives (benzodiazepines, barbiturates): seizures and delirium; medically managed. Opioids: miserable but rarely fatal; the danger is overdose, reversed by naloxone. Stimulants: crash, depressed mood.

Ch. 12 · 8

Moral (failure of will; discredited). Disease (Jellinek, 1960; abstinence). Behavioral (learned habit). Biopsychosocial (today's consensus). Public health (reduce harm).

Ch. 12 · 7

Only non-substance addictive disorder. At least 4 of 9 criteria in 12 months (mild 4–5, moderate 6–7, severe 8–9). Chasing losses. Rule out mania. Internet gaming disorder: Section III.

Ch. 12 · 9

**Harm reduction**

Ch. 12 · 10

**Stages of change and the counselor's  
job**

Ch. 12 · 11

**Motivational interviewing**

Ch. 12 · 12

**ASAM Criteria**

Ch. 12 · 13

**MOUD**

Ch. 12 · 14

**Medications for alcohol use disorder**

Ch. 12 · 15

**Relapse prevention**

Ch. 12 · 16

**Contingency management, mutual  
help, co-occurring care**

Ch. 12 · 10

Precontemplation: a reason. Contemplation: a tipping point. Preparation: a plan. Action: skills. Maintenance: a guard. Relapse means recycling, not starting over.

Ch. 12 · 9

Reduce the damage of use that continues: naloxone, syringe services, medications. Like abstinence, a legitimate goal chosen with the client.

Ch. 12 · 12

Six dimensions (third edition): withdrawal, biomedical, emotional/behavioral, readiness, relapse potential, recovery environment. Levels 0.5 to 4. Choose the least intensive safe level.

Ch. 12 · 11

Miller (1983). Evoke change talk; respond to sustain talk without arguing; OARS (open questions, affirmations, reflections, summaries). Confrontational counseling is contraindicated: more confrontation, more drinking (Miller et al., 1993).

Ch. 12 · 14

Disulfiram (drinking causes flushing and nausea), naltrexone (reduces reward and craving), acamprosate (eases early abstinence).

Ch. 12 · 13

Methadone: full agonist, certified opioid treatment programs. Buprenorphine: partial agonist, ceiling effect, office-based. Naltrexone: antagonist; start only when opioid-free.

Ch. 12 · 16

Contingency management: rewards for verified abstinence; strong for stimulants. AA, NA (twelve steps), SMART Recovery (secular), Al-Anon (families). Co-occurring disorders: integrated, not sequential or parallel.

Ch. 12 · 15

Marlatt and Gordon (1985). High-risk situations and coping. Lapse is a slip; relapse is a return to the pattern. Abstinence violation effect: "I've blown it."

## CHAPTER 13

# Other Diagnostic Groups

## Extra drills

**Drill 13.2 • Matching: name the diagnosis.** Write the letter of the diagnosis next to each description. Each letter is used once.

| Description                                                                          | Diagnosis                                             |
|--------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. Prefers solitude and seems indifferent to praise or criticism                     | ___ A. Delirium<br>-                                  |
| 2. Longs for friends but avoids them for fear of rejection                           | ___ B. Binge-eating disorder<br>-                     |
| 3. Has restricted food since a choking episode; no concern about body shape          | ___ C. Schizoid personality disorder<br>-             |
| 4. Became confused over 2 days after surgery; worse at night, clearer by morning     | ___ D. Delusional disorder<br>-                       |
| 5. Struggles with social conversation; no repetitive behaviors or fixed interests    | ___ E. Avoidant personality disorder<br>-             |
| 6. Psychotic symptoms for 3 weeks after a sudden loss, then full recovery            | ___ F. Brief psychotic disorder<br>-                  |
| 7. Distressing binges weekly for 4 months, with no purging or fasting                | ___ G. Avoidant/restrictive food intake disorder<br>- |
| 8. For 5 months, fixed belief that a spouse is unfaithful; works and socializes well | ___ H. Social (pragmatic) communication disorder<br>- |

**Drill 13.3 • Sorting: what comes first?** For each situation, write **R** (refer for medical or prescriber evaluation first), **C** (counsel or intervene now for a likely diagnosis in this group), or **N** (no diagnosis in this group is warranted; reassure, or give the service requested).

1. \_\_\_\_ An adult reports loud snoring, gasping at night, and heavy daytime sleepiness.
2. \_\_\_\_ An otherwise healthy 4-year-old wets the bed several nights a week.
3. \_\_\_\_ An 82-year-old became suddenly confused and inattentive over the past 2 days.
4. \_\_\_\_ A transgender client who is comfortable with their identity asks for career counseling.
5. \_\_\_\_ An adult has had trouble falling asleep 4 nights a week for 5 months; no medical red flags.
6. \_\_\_\_ A 9-year-old whose pediatric exam found no medical cause has wet the bed most nights for the past year.
7. \_\_\_\_ A 15-year-old with significantly low weight has begun fainting.
8. \_\_\_\_ A client with no medical or medication cause asks for help with lifelong, distressing low sexual desire.

## Answers to the Chapter 13 drills

**Drill answers.** 13.2: 1-C, 2-E, 3-G, 4-A, 5-H, 6-F, 7-B, 8-D. 13.3: 1-R (possible sleep apnea). 2-N (enuresis is not diagnosed before age 5; reassure the parents). 3-R (possible delirium, an emergency). 4-N (no distress from incongruence, so no gender dysphoria; give the career counseling requested). 5-C (meets insomnia disorder, 3 nights a week for 3 months; with no red flags, start CBT-I). 6-C (meets enuresis: age 5 or older, at least twice a week for 3 months, no medical cause; start an enuresis alarm with family support; no punishment). 7-R (medical monitoring comes first). 8-C (start with PLISSIT's early levels).

Ch. 13 · 1

**ADHD rules**

Ch. 13 · 2

**ADHD treatment by age**

Ch. 13 · 3

**Executive functions**

Ch. 13 · 4

**Autism vs. social (pragmatic)  
communication disorder**

Ch. 13 · 5

**Intellectual and learning disorders**

Ch. 13 · 6

**Psychosis by duration**

Ch. 13 · 7

**Schizoaffective vs. mood disorder  
with psychotic features**

Ch. 13 · 8

**Responding to a delusion**

Ch. 13 · 2

Under 6: behavioral parent training first. Age 6 and older: medication and behavior therapy together, plus classroom supports (CDC, 2026).

Ch. 13 · 1

Six symptoms of inattention and/or hyperactivity-impulsivity (five from age 17) for 6 months; several before age 12; several in two or more settings. Presentations: combined, predominantly inattentive, predominantly hyperactive/impulsive.

Ch. 13 · 4

Both: social communication deficits. Only autism: restricted, repetitive behaviors (two of four). Autism is rated Level 1, 2, or 3 per domain by support needed.

Ch. 13 · 3

Inhibitory control, working memory, cognitive flexibility (Diamond, 2013). Not a diagnosis. Externalize them: planners, timers, checklists, tasks broken into steps.

Ch. 13 · 6

Brief psychotic disorder: 1 day to under 1 month. Schizophreniform: 1 to under 6 months. Schizophrenia: 6 months (1 month active). Delusional disorder: delusions for 1 month or more.

Ch. 13 · 5

Intellectual developmental disorder: intellectual + adaptive deficits, developmental onset; severity by adaptive functioning. Specific learning disorder: persists 6 months despite targeted help; no IQ-achievement discrepancy required.

Ch. 13 · 8

Neither argue nor agree. Acknowledge the distress, say you do not share the experience, assess safety (command hallucinations), arrange a psychiatric evaluation.

Ch. 13 · 7

Psychosis for 2 weeks or more without a mood episode, with mood episodes for most of the illness: schizoaffective. Psychosis only during mood episodes: mood disorder with psychotic features.

Ch. 13 · 9

**Personality clusters**

Ch. 13 · 10

**Commonly confused personality  
pairs**

Ch. 13 · 11

**Dialectical behavior therapy (DBT)**

Ch. 13 · 12

**Eating disorders: weight decides**

Ch. 13 · 13

**Insomnia and CBT-I**

Ch. 13 · 14

**Delirium vs. neurocognitive disorder**

Ch. 13 · 15

**ODD vs. conduct disorder**

Ch. 13 · 16

**Elimination disorders**

Ch. 13 · 10

Schizoid: does not want relationships.  
 Avoidant: wants them, fears rejection. OCPD: perfectionism seen as reasonable. OCD: unwanted obsessions and compulsions.  
 Antisocial: age 18+, conduct disorder before 15.

Ch. 13 · 9

A keeps apart: paranoid, schizoid, schizotypal. B starts a blaze: antisocial, borderline, histrionic, narcissistic. C stays careful: avoidant, dependent, obsessive-compulsive.

Ch. 13 · 12

Anorexia: significantly low weight (purging makes it binge-eating/purging type). Bulimia: typical or above. Binge-eating disorder: no compensation. ARFID: no body-image concern. Young people with anorexia: family therapy; adults with bulimia or binge eating: CBT (NICE, 2020).

Ch. 13 · 11

Most researched treatment for borderline personality disorder (Storebø et al., 2020); developed by Linehan (1993). Individual therapy, skills groups (mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness), phone coaching, consultation team.

Ch. 13 · 14

Delirium: hours to days, fluctuating attention, medical cause, emergency. Major neurocognitive disorder: independence lost. Mild: independence kept with effort. MMSE screens (Folstein et al., 1975).

Ch. 13 · 13

Insomnia disorder: 3 nights a week for 3 months. CBT-I first: stimulus control, sleep restriction, cognitive work, relaxation. Sleep hygiene alone is not recommended (Edinger et al., 2021).

Ch. 13 · 16

Enuresis: age 5, twice a week for 3 months. Encopresis: age 4, monthly for 3 months. Rule out medical causes. Bell-and-pad alarm (Mowrer & Mowrer, 1938): classical conditioning.

Ch. 13 · 15

ODD: four symptoms of anger, defiance, or vindictiveness for 6 months. Conduct disorder: 3 of 15 in 12 months, violating rights; childhood-onset (before 10) is worse. IED: from age 6.

Ch. 13 · 17

## **Gender dysphoria**

Ch. 13 · 18

## **Sexual dysfunctions**

Ch. 13 · 18

About 6 months plus distress; lifelong or acquired, generalized or situational; rule out medications. Sensate focus (Masters & Johnson, 1970). PLISSIT (Annon, 1976): Permission, Limited Information, Specific Suggestions, Intensive Therapy.

Ch. 13 · 17

Distress from incongruence for 6 months. Children: 6 of 8 indicators, including a strong desire to be another gender. Adolescents and adults: 2 of 6. The identity itself is not a disorder.

## CHAPTER 14

# Psychopharmacology for Counselors

## Extra drills

### Drill 14.2 • Fill in the blank.

1. According to the National Institute of Mental Health (NIMH), antidepressants usually take \_\_\_\_\_ weeks to work.
2. The antidepressant boxed warning covers suicidality in people under age \_\_\_\_\_.
3. Before a depression medication referral, the counselor screens for past \_\_\_\_\_ or hypomania.
4. Long-term use of first-generation antipsychotics can cause \_\_\_\_\_ dyskinesia.
5. Second-generation antipsychotics call for monitoring of weight, glucose, and \_\_\_\_\_, such as cholesterol and triglycerides.
6. According to NIMH, bupirone must be taken every day for \_\_\_\_\_ weeks to reach its full effect.
7. Buprenorphine is a \_\_\_\_\_ agonist at the opioid receptor.
8. A client must be free of opioids before starting \_\_\_\_\_.
9. Since December 2022, prescribing buprenorphine no longer requires a special federal \_\_\_\_\_.
10. Outside emergencies, counselors ask the client to sign a \_\_\_\_\_ before coordinating with an outside prescriber.

### Drill 14.3 • Sorting: in scope or out of scope? Write **I** (in the counselor's scope) or **O** (outside it) for each action.

1. \_\_\_\_ Writing down that a client reports dizziness since a dose change and, with a release, telling the prescriber.
2. \_\_\_\_ Telling a client to cut a pill in half to reduce side effects.
3. \_\_\_\_ Explaining that antidepressants often take several weeks to work.
4. \_\_\_\_ Recommending that a client switch from one SSRI to another.
5. \_\_\_\_ Using motivational interviewing to explore a client's ambivalence about medication.
6. \_\_\_\_ Advising a client on buprenorphine to taper off before joining a counseling group.
7. \_\_\_\_ Getting a client with lithium toxicity signs to emergency care.
8. \_\_\_\_ Telling a client a supplement is safe to combine with an antidepressant.

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## Answers to the Chapter 14 drills

**Drill answers.** *14.2:* (1) 4–8 (NIMH’s figure; other sources give nearby ranges, and sleep, energy, and appetite often improve before mood lifts). (2) 25. (3) mania. (4) tardive. (5) lipids. (6) 3–4 (NIMH’s figure; other sources give nearby ranges, and the point is weeks of daily use, not as needed). (7) partial. (8) naltrexone. (9) waiver. (10) release (Standards A.3, B.1.c). *14.3:* 1-I (task 5.4). 2-O (dosing advice). 3-I (psychoeducation). 4-O (medication choice belongs to the prescriber). 5-I. 6-O (MOUD taken as prescribed is treatment). 7-I (emergency response). 8-O (refer the question to the prescriber).

Ch. 14 · 1

**The counselor's role with medication**

Ch. 14 · 2

**Task 5.4 (2027 NCE)**

Ch. 14 · 3

**ACA Standards A.3 and C.2.a**

Ch. 14 · 4

**Antidepressant onset**

Ch. 14 · 5

**Antidepressant boxed warning**

Ch. 14 · 6

**Screen before a medication referral  
for depression**

Ch. 14 · 7

**Antidepressant discontinuation  
syndrome**

Ch. 14 · 8

**Lithium**

Ch. 14 · 2

Document the self-reported effects of a client's medication: what the client reports, since when, and how it affects functioning. Descriptive, not diagnostic.

Ch. 14 · 1

Notice, note, notify: observe effects and adherence, document them in the client's words, and share them with the prescriber under a release. Never start, stop, or change a dose.

Ch. 14 · 4

Usually 4–8 weeks. Sleep, energy, and appetite often improve before mood lifts.

Ch. 14 · 3

A.3: when a client sees another mental health professional, request a release and work to build a collaborative relationship. C.2.a: practice within the boundaries of competence.

Ch. 14 · 6

Ask about past mania or hypomania. A full manic episode that emerges during antidepressant treatment and persists beyond the drug's effect supports bipolar I.

Ch. 14 · 5

Suicidal thoughts and behaviors in children, adolescents, and young adults under 25, especially early in treatment and after dose changes. Issued 2004; extended to young adults 2007.

Ch. 14 · 8

Mood stabilizer. Blood levels, kidney, and thyroid are monitored. Toxic levels sit close to therapeutic levels; dehydration, NSAIDs, and some blood pressure drugs raise levels.

Ch. 14 · 7

Symptoms that can follow abruptly stopping an antidepressant; DSM-5-TR lists it among adverse effects of medication.

Ch. 14 · 9

**Lithium toxicity signs**

Ch. 14 · 10

**First- vs. second-generation  
antipsychotics**

Ch. 14 · 11

**Benzodiazepines**

Ch. 14 · 12

**Buspirone**

Ch. 14 · 13

**Stimulants**

Ch. 14 · 14

**Serotonin syndrome vs. NMS**

Ch. 14 · 15

**Methadone, buprenorphine,  
naltrexone**

Ch. 14 · 16

**Alcohol use disorder medications and  
naloxone**

Ch. 14 · 10

First: movement effects (dystonia, akathisia, parkinsonism) and tardive dyskinesia.  
 Second: weight, glucose, and lipids.  
 Clozapine: regular blood tests. All: boxed warning for older adults with dementia.

Ch. 14 · 9

Vomiting, diarrhea, tremor, poor coordination, slurred speech, confusion.  
 Response: medical care now.

Ch. 14 · 12

An anti-anxiety medication taken daily for 3–4 weeks to reach full effect; not used as needed.

Ch. 14 · 11

Fast relief; dependence with steady use; abrupt stopping can cause seizures; overdose risk with opioids or alcohol (boxed warning updated 2020).

Ch. 14 · 14

Serotonin syndrome: combined serotonergic drugs, onset within hours, twitching and overactive reflexes, fever. NMS: antipsychotics, builds over days, rigidity, fever. Both are emergencies.

Ch. 14 · 13

Methylphenidate, amphetamines. Appetite loss, trouble sleeping, faster heart rate, higher blood pressure. Boxed warning updated 2023: misuse, addiction, overdose; never share; store securely.

Ch. 14 · 16

Alcohol: naltrexone, acamprosate, disulfiram.  
 Naloxone: an opioid antagonist that reverses an overdose.

Ch. 14 · 15

Full agonist (dispensed for opioid use disorder only by certified opioid treatment programs); partial agonist (no special federal waiver since December 2022); antagonist (started after withdrawal).

## CHAPTER 15

# Grief, Loss, and Life Transitions

## Extra drills

### Drill 15.2 • Fill in the blank.

1. Kübler-Ross drew her five stages from interviews with \_\_\_\_\_ patients.
2. In the dual process model, healthy coping \_\_\_\_\_ between loss and restoration.
3. DSM-5-TR prolonged grief disorder requires at least \_\_\_\_\_ months for adults and \_\_\_\_\_ months for children.
4. Expectable grief with no mental disorder may be recorded as \_\_\_\_\_ (Z63.4).
5. Grief that others refuse to recognize is called \_\_\_\_\_ grief.
6. A parent with advanced dementia fits the “here but \_\_\_\_\_” form of ambiguous loss.
7. A key risk factor for children after divorce is ongoing \_\_\_\_\_.
8. Schlossberg’s four S’s are situation, self, \_\_\_\_\_, and \_\_\_\_\_.

### Drill 15.3 • Sorting: support, assess, or treat? Write **S** (support, normalize, and monitor), **A** (assess now for another disorder or risk), or **T** (consider prolonged grief disorder and targeted grief treatment).

1. \_\_\_\_ Widowed one month; cries daily but works and sees friends.
2. \_\_\_\_ Fifteen months after her son’s death, she yearns for him daily, says “part of me died,” still cannot believe he is gone, feels intensely alone, and cannot work.
3. \_\_\_\_ Two months after a death, a client says, “I’m worthless; everyone would be better off without me.”
4. \_\_\_\_ A 10-year-old, eight months after his father died of cancer, is preoccupied with how he died, yearns for him intensely every day, still can’t believe he is gone, avoids his photos, and has quit his team and his friends.
5. \_\_\_\_ A woman caring for her husband with dementia feels exhausted and guilty about moments of wishing his illness were over; she still enjoys time with friends and denies hopelessness.
6. \_\_\_\_ Three weeks after witnessing a violent death, a client has flashbacks of the scene, nightmares, and hypervigilance.
7. \_\_\_\_ Six months after his wife’s death, a retiree talks to her photo each morning, laughs at memories, and stays active.
8. \_\_\_\_ Four months after his divorce, a father is drinking heavily every night.

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## Answers to the Chapter 15 drills

**Drill answers.** 15.2: (1) dying (terminally ill). (2) oscillates (or alternates). (3) 12; 6. (4) uncomplicated bereavement. (5) disenfranchised. (6) gone (or absent). (7) parental conflict. (8) support; strategies (either order). 15.3: 1-S. 2-T (past the 12-month adult threshold, with daily yearning, three of the eight symptoms, and impairment). 3-A (assess suicide risk and depression now). 4-T (the threshold for children is 6 months; in children, preoccupation may center on how the person died). 5-S (anticipatory grief and caregiver strain; she still enjoys friends and denies hopelessness, so nothing points to a disorder; normalize mixed feelings; connect to respite and support groups). 6-A (assess for acute stress disorder; trauma, not grief, is driving the symptoms). 7-S (continuing bonds). 8-A (assess substance use).

Ch. 15 · 1

**Kübler-Ross (1969)**

Ch. 15 · 2

**Worden's four tasks**

Ch. 15 · 3

**Grief counseling vs. grief therapy**

Ch. 15 · 4

**Dual process model**

Ch. 15 · 5

**Continuing bonds**

Ch. 15 · 6

**Disenfranchised grief**

Ch. 15 · 7

**Ambiguous loss**

Ch. 15 · 8

**Anticipatory grief**

Ch. 15 · 2

Accept the reality of the loss; process the pain; adjust to a world without the deceased; find an enduring connection while living on (Worden, 2018; first edition 1982).

Ch. 15 · 1

Five stages (denial, anger, bargaining, depression, acceptance) drawn from interviews with dying patients. Not linear, not universal, and not a prescription for mourners.

Ch. 15 · 4

Stroebe and Schut (1999): healthy coping oscillates between loss-oriented and restoration-oriented stressors. Time away from grieving is adaptive.

Ch. 15 · 3

Worden: grief counseling supports people with uncomplicated grief; grief therapy addresses complicated grief reactions.

Ch. 15 · 6

Doka (1989): grief that is not recognized or supported. Examples: a former spouse, a coworker, a miscarriage, a pet.

Ch. 15 · 5

Klass, Silverman, and Nickman (1996): an ongoing inner bond with the deceased can be healthy. Challenges the older ideal of “letting go.”

Ch. 15 · 8

Grief that begins before an expected death, as with terminal illness or a loved one's dementia. Common in caregivers.

Ch. 15 · 7

Boss (1999). Gone but here: a missing person, a deployed parent, a birth parent after adoption. Here but gone: dementia, addiction, brain injury. Goal: live with ambiguity, not closure.

Ch. 15 · 9

**Prolonged grief disorder (DSM-5-TR)**

Ch. 15 · 10

**Prolonged grief disorder (ICD-11)**

Ch. 15 · 11

**Grief vs. major depression**

Ch. 15 · 12

**What helps after a death**

Ch. 15 · 13

**Children of divorce**

Ch. 15 · 14

**Stepfamilies and adoption**

Ch. 15 · 15

**Schlossberg's transition model**

Ch. 15 · 16

**End-of-life clients and the ACA Code  
(2014)**

Ch. 15 · 10

Code 6B42. At least 6 months after the loss; grief clearly beyond social, cultural, or religious norms (WHO, 2024).

Ch. 15 · 9

At least 12 months since the death (6 for children and adolescents); yearning or preoccupation nearly every day for at least a month; 3 of 8 symptoms; distress or impairment; beyond cultural norms.

Ch. 15 · 12

Normal grief: support, normalize, monitor. Universal intervention shows little lasting benefit (Currier et al., 2008). Complicated grief treatment outperformed interpersonal psychotherapy in a trial (Shear et al., 2005).

Ch. 15 · 11

Grief: waves tied to reminders, self-esteem intact, wish to join the deceased. Depression: pervasive low mood, worthlessness. DSM-5 (2013) dropped the bereavement exclusion. No disorder: Z63.4, uncomplicated bereavement.

Ch. 15 · 14

Stepfamily: the parent disciplines first while the stepparent builds a bond; loyalty binds are expected (Papernow, 2013). Adoption triad: adoptee, birth family, adoptive family; tell the child early.

Ch. 15 · 13

Most are resilient. Risk rises with ongoing parental conflict, weaker parenting, lost contact with a parent, and economic decline (Kelly & Emery, 2003). High conflict: parallel parenting.

Ch. 15 · 16

Standard B.2.b: with a terminally ill client considering hastening death, counselors may keep confidentiality, depending on law and after consultation. A.11.b bars referral based solely on personal values. The 2005 Code's A.9.b, which let counselors decline end-of-life work, was dropped in 2014.

Ch. 15 · 15

Transitions are anticipated, unanticipated, or nonevents. Coping depends on four S's: situation, self, support, strategies (Anderson et al., 2012).

## CHAPTER 16

# Theories of Human Development

## Extra drills

**Drill 16.2 • Fill in the blank.**

1. Changing a schema to fit new information is called \_\_\_\_\_.
2. Erikson's crisis of middle adulthood is generativity vs. \_\_\_\_\_.
3. The virtue of Erikson's adolescent stage is \_\_\_\_\_.
4. Knowing that a hidden toy still exists is called \_\_\_\_\_.
5. Kohlberg's Stage 4 is often called \_\_\_\_\_.
6. Gilligan contrasted an ethic of \_\_\_\_\_ with Kohlberg's focus on justice.
7. Main and Solomon added the \_\_\_\_\_ attachment pattern.
8. In Bronfenbrenner's model, cultural values and laws make up the \_\_\_\_\_.

**Drill 16.3 • Name the stage.** Name the stage in the theory given in parentheses.

1. \_\_\_\_ A 2-year-old insists on putting on her own shoes and melts down when helped. (Erikson)
2. \_\_\_\_ "I won't cheat, because the teacher would give me detention." (Kohlberg)
3. \_\_\_\_ A 15-year-old solves a science problem by testing one variable at a time. (Piaget)
4. \_\_\_\_ A 74-year-old looks back on his life with acceptance and peace. (Erikson)
5. \_\_\_\_ "I'll help you study if you do my chores." (Kohlberg)
6. \_\_\_\_ A 4-year-old says the moon follows her car because it wants to play. (Piaget)
7. \_\_\_\_ "Laws should be changed through fair, agreed procedures when they stop protecting people's basic rights." (Kohlberg)
8. \_\_\_\_ A 27-year-old keeps others at a distance and feels cut off from friends. (Erikson)

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## Answers to the Chapter 16 drills

**Drill answers.** 16.2: (1) accommodation. (2) stagnation (also accepted: self-absorption, used in some texts). (3) fidelity. (4) object permanence. (5) law and order (also accepted: social system and conscience; authority and social-order maintaining). (6) care. (7) disorganized. (8) macrosystem. 16.3: 1, autonomy vs. shame and doubt. 2, Stage 1, obedience and punishment. 3, formal operational (systematic hypothesis testing). 4, integrity vs. despair. 5, Stage 2, instrumental exchange. 6, preoperational (animism and egocentrism). 7, Stage 5, social contract (laws are agreements, changed by agreed procedures, that exist to protect rights; Stage 6 would rest on conscience and self-chosen universal principles, not on procedures). 8, intimacy vs. isolation.

Ch. 16 · 1

**Freud's psychosexual stages**

Ch. 16 · 2

**Erikson's first four crises**

Ch. 16 · 3

**Erikson's last four crises**

Ch. 16 · 4

**Freud vs. Erikson**

Ch. 16 · 5

**Piaget's four stages**

Ch. 16 · 6

**Assimilation vs. accommodation**

Ch. 16 · 7

**Zone of proximal development**

Ch. 16 · 8

**Scaffolding**

Ch. 16 · 2

Trust vs. mistrust (hope); autonomy vs. shame and doubt (will); initiative vs. guilt (purpose); industry vs. inferiority (competence).

Ch. 16 · 1

Oral (birth to about 1), anal (1-3), phallic (3-6; Oedipal conflict, superego forms), latency (6 to puberty), genital (puberty on). Fixation ties adult traits to a stage.

Ch. 16 · 4

Freud: drives, five stages ending with the genital stage at puberty, fixation. Erikson: social tasks, eight stages across the whole lifespan; crises can be revisited.

Ch. 16 · 3

Identity vs. role confusion (fidelity); intimacy vs. isolation (love); generativity vs. stagnation (care); integrity vs. despair (wisdom).

Ch. 16 · 6

Assimilation: fit a new experience into an existing schema. Accommodation: change the schema. Equilibration balances the two and drives stage change.

Ch. 16 · 5

Sensorimotor 0-2 (object permanence); preoperational 2-7 (symbols, egocentrism, centration, no conservation); concrete operational 7-11 (conservation, reversibility); formal operational 11+ (abstract, hypothetical).

Ch. 16 · 8

Support matched to need and faded as skill grows. Term introduced by Wood, Bruner, and Ross (1976); the exam pairs it with Vygotsky's ZPD.

Ch. 16 · 7

Vygotsky: the gap between what a learner can do alone and what the learner can do with guidance from someone more skilled.

Ch. 16 · 9

**Piaget vs. Vygotsky**

Ch. 16 · 10

**Kohlberg's levels and stages**

Ch. 16 · 11

**Gilligan**

Ch. 16 · 12

**Bowlby and Harlow**

Ch. 16 · 13

**Strange Situation patterns**

Ch. 16 · 14

**Adult attachment styles**

Ch. 16 · 15

**Bronfenbrenner's systems**

Ch. 16 · 16

**Resilience**

Ch. 16 · 10

Preconventional (1 punishment, 2 exchange); conventional (3 approval, 4 law and order); postconventional (5 social contract, 6 universal principles). Score the reason, not the choice.

Ch. 16 · 9

Piaget: the child discovers by acting alone; self-talk is egocentric. Vygotsky: learning happens through others and language; private speech guides thinking.

Ch. 16 · 12

Bowlby: attachment is biologically based; internal working model; secure base (Ainsworth's concept) and safe haven. Harlow (1958): monkeys chose the cloth surrogate; contact comfort, not food.

Ch. 16 · 11

Ethic of care: own survival, then goodness as self-sacrifice, then balanced care for self and others. Critiqued Kohlberg's all-boy samples and justice focus.

Ch. 16 · 14

Bartholomew and Horowitz (1991): secure (self +, others +), preoccupied (self -, others +), dismissing (self +, others -), fearful (self -, others -).

Ch. 16 · 13

Secure: seeks comfort, settles (sensitive care). Avoidant: ignores at reunion (rejecting care). Ambivalent: clings and resists (inconsistent care). Disorganized: no coherent strategy (Main & Solomon, 1990).

Ch. 16 · 16

Positive adaptation despite adversity. Werner's Kauai study: easy temperament, one caring adult, outside support. Masten (2001): "ordinary magic," not a rare trait.

Ch. 16 · 15

Micro: settings the person is in. Meso: links between them. Exo: settings never entered that still matter (a parent's job). Macro: culture and laws. Chrono: change over time.

## CHAPTER 17

# Development Across the Lifespan

## Extra drills

### Drill 17.2 • Fill in the blank.

1. Thomas and Chess's idea that outcomes depend on the match between child and environment is called \_\_\_\_\_.
2. Rules without reasons describe \_\_\_\_\_ parenting.
3. Exploring without committing is identity \_\_\_\_\_.
4. Bullying involves repeated aggression and an imbalance of \_\_\_\_\_.
5. A student who needs accommodations but not specialized instruction usually receives a \_\_\_\_\_ plan.
6. Knowledge and vocabulary, which hold up with age, are \_\_\_\_\_ intelligence.
7. The theory that older adults and society withdraw from each other is \_\_\_\_\_ theory.
8. In Carter and McGoldrick's model, families with adolescents must make boundaries more \_\_\_\_\_.
9. The most frequently identified type of child maltreatment is \_\_\_\_\_.
10. The third phase of Walker's cycle of violence, before tension builds again, is loving \_\_\_\_\_.

### Drill 17.3 • Sorting: typical or a concern? Write **T** (typical for the age; normalize and monitor) or **C** (a concern; assess further, intervene, or follow reporting law).

1. \_\_\_\_ A 79-year-old takes longer to learn a new phone but manages her bills and medications.
2. \_\_\_\_ A 74-year-old has stopped bathing, lost weight, and says life is pointless.
3. \_\_\_\_ A 16-year-old tries out new friend groups and questions her family's religion.
4. \_\_\_\_ A 10-year-old has been excluded and mocked online by the same group for weeks.
5. \_\_\_\_ An 82-year-old's nephew now holds his debit card, and the utilities have been shut off.
6. \_\_\_\_ A 2-year-old insists on doing things herself and says "no" often.
7. \_\_\_\_ A 12-year-old has stomachaches every school morning and begs to stay home.
8. \_\_\_\_ A 45-year-old reconsiders his career goals during a midlife transition; his mood and work are unchanged.

## Answers to the Chapter 17 drills

**Drill answers.** 17.2: (1) goodness of fit. (2) authoritarian. (3) moratorium. (4) power. (5) Section 504. (6) crystallized. (7) disengagement. (8) flexible. (9) neglect. (10) contrition (often called the honeymoon phase). 17.3: 1-T (slower new learning with intact daily functioning). 2-C (assess depression and suicide risk; depression is not typical aging, and self-neglect may call for protective services). 3-T (identity exploration, Marcia's moratorium). 4-C (bullying: protect the target and involve the school). 5-C (possible financial exploitation; follow state adult protective services law). 6-T (expected toddler autonomy). 7-C (possible school refusal; assess anxiety and plan a graded return). 8-T (Levinson's midlife transition; reappraising goals is expected, and nothing suggests distress or impairment).

Ch. 17 · 1

**Thomas and Chess: three  
temperament types**

Ch. 17 · 2

**Goodness of fit**

Ch. 17 · 3

**Baumrind's parenting styles**

Ch. 17 · 4

**Uninvolved (neglectful) parenting**

Ch. 17 · 5

**Marcia's identity statuses**

Ch. 17 · 6

**Foreclosure vs. achievement**

Ch. 17 · 7

**Bullying**

Ch. 17 · 8

**Responding to bullying**

Ch. 17 · 2

Outcomes depend on the match between a child's temperament and the environment's demands, not on temperament alone (Thomas & Chess, 1977).

Ch. 17 · 1

Easy (regular, positive, adaptable); difficult (irregular, intense, slow to adapt); slow-to-warm-up (wary at first, adapts with repeated exposure).

Ch. 17 · 4

Low warmth and low demands: little monitoring or support. Completes the warmth-by-demands grid.

Ch. 17 · 3

Authoritative (warm, firm, explained); authoritarian (firm, cold, "because I said so"); permissive (warm, few limits). A fourth, uninvolved, was added later.

Ch. 17 · 6

Both are committed. Only achievement followed real exploration. A confident young adult who adopted the family plan unquestioned is foreclosed.

Ch. 17 · 5

Achievement (explored, committed); moratorium (exploring, not committed); foreclosure (committed, never explored); diffusion (neither) (Marcia, 1966).

Ch. 17 · 8

Protect the target, meet with each student separately, and use whole-school prevention. No peer mediation; zero-tolerance suspension or expulsion should not be the standard policy.

Ch. 17 · 7

Repeated aggression with an imbalance of power (Olweus, 1993); it may be physical, verbal, relational, or electronic. Bully-victims tend to fare worst (Copeland et al., 2013).

Ch. 17 · 9

**School refusal vs. truancy**

Ch. 17 · 10

**Section 504 plan vs. IEP**

Ch. 17 · 11

**Levinson**

Ch. 17 · 12

**Social clock**

Ch. 17 · 13

**Fluid vs. crystallized intelligence**

Ch. 17 · 14

**Theories of aging**

Ch. 17 · 15

**Carter and McGoldrick's family life  
cycle**

Ch. 17 · 16

**Abuse across the lifespan**

Ch. 17 · 10

504 (Rehabilitation Act of 1973): accommodations, such as extra time. IEP (IDEA): specialized instruction for an eligible disability.

Ch. 17 · 9

Refusal: anxious, parents know; treat with graded return. Truancy: concealed from parents, not driven by anxiety.

Ch. 17 · 12

Neugarten: a culture's timetable for life events; being "off-time" can add stress (Neugarten et al., 1965).

Ch. 17 · 11

Adult life as eras separated by transitions; midlife transition around 40 to 45 (Levinson et al., 1978).

Ch. 17 · 14

Disengagement: older adults and society withdraw (Cumming & Henry, 1961). Activity: staying engaged predicts satisfaction. Continuity: people keep earlier patterns.

Ch. 17 · 13

Fluid (novel reasoning) declines with age; crystallized (knowledge, vocabulary) holds or grows (Horn & Cattell, 1967).

Ch. 17 · 16

Children: neglect is the most common type. Older adults: watch for financial exploitation. Domestic violence: Walker's cycle (tension, incident, loving contrition); no couples work while violence continues.

Ch. 17 · 15

Leaving home; the new couple; young children; adolescents (more flexible boundaries); launching (many exits and entries); later life (shifting generational roles).

## CHAPTER 18

# Career Development Theories

## Extra drills

### Drill 18.2 • Fill in the blank.

1. Parsons called the matching step between self-knowledge and occupational knowledge “\_\_\_\_\_ reasoning.”
2. Holland’s term for how clearly one type stands out in a profile is \_\_\_\_\_.
3. In TWA, the employer’s satisfaction with the worker is called \_\_\_\_\_.
4. Ginzberg’s first period, before about age 11, is the \_\_\_\_\_ period.
5. A 48-year-old retraining after a layoff is recycling. Super called this brief pass back through the stages a \_\_\_\_\_.
6. Gottfredson’s third stage, ages 9 to 13, is orientation to \_\_\_\_\_ valuation.
7. In Krumboltz’s theory, learning from the consequences of your own actions is \_\_\_\_\_ learning.
8. In SCCT, “What will happen if I do this?” is an \_\_\_\_\_ expectation.
9. Planned happenstance reframes indecision as \_\_\_\_\_.
10. Savickas’s four dimensions of career adaptability are concern, control, curiosity, and \_\_\_\_\_.

### Drill 18.3 • Which theory is the counselor using? Write the letter: **H** (Holland), **S** (Super), **G** (Gottfredson), **K** (Krumboltz or planned happenstance), **L** (SCCT), or **C** (career construction). Letters may repeat.

1. \_\_\_\_ The counselor asks which life roles, such as student, worker, and leisurite, matter most to the client right now.
2. \_\_\_\_ The counselor explores the associative learning experiences, such as watching an older brother work as an electrician, that drew the client toward the trade.
3. \_\_\_\_ The counselor compares a client’s Self-Directed Search code with the codes of jobs she is considering.
4. \_\_\_\_ The counselor asks a client to retell a favorite childhood story and a motto.
5. \_\_\_\_ The counselor explores why a 12-year-old has dropped every job he sees as “low status.”
6. \_\_\_\_ The counselor builds a client’s self-efficacy for statistics before she chooses a major.
7. \_\_\_\_ The counselor encourages a client to attend an industry event “just to see who you meet.”
8. \_\_\_\_ The counselor notes that a client’s top types, R and S, are opposites on the hexagon.

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## Answers to the Chapter 18 drills

**Drill answers.** 18.2: (1) true. (2) differentiation. (3) satisfactoriness. (4) fantasy. (5) minicycle. (6) social. (7) instrumental. (8) outcome. (9) open-mindedness (“openness” also counts; curiosity is one of the five skills, not the relabel). (10) confidence. 18.3: 1-S (role salience, Life-Career Rainbow). 2-K (associative learning). 3-H (congruence). 4-C (Career Construction Interview). 5-G (circumscription by social valuation). 6-L (self-efficacy). 7-K (planned happenstance: creating chance encounters). 8-H (low consistency).

Ch. 18 · 1

## **Five families of career theory**

Ch. 18 · 2

## **Parsons (1909)**

Ch. 18 · 3

## **RIASEC**

Ch. 18 · 4

## **Congruence vs. consistency**

Ch. 18 · 5

## **Differentiation vs. identity (Holland)**

Ch. 18 · 6

## **Theory of work adjustment**

Ch. 18 · 7

## **Ginzberg's periods**

Ch. 18 · 8

## **Super's five stages**

Ch. 18 · 2

Trait-and-factor: understand yourself, understand occupations, use true reasoning to match them. Planned and directed Boston's Vocation Bureau, which opened in 1908.

Ch. 18 · 1

Matching (fit): Parsons, Holland, TWA. Developmental (timeline): Ginzberg, Super, Gottfredson, Tiedeman. Needs: Roe. Learning: Krumboltz, SCCT. Narrative: Savickas.

Ch. 18 · 4

Congruence: person type fits environment type. Consistency: the person's top types are neighbors on the hexagon (RI consistent, RS not).

Ch. 18 · 3

Holland's six types: Realistic, Investigative, Artistic, Social, Enterprising, Conventional. Hexagon opposites: R-S, I-E, A-C.

Ch. 18 · 6

Dawis and Lofquist. Satisfaction (worker: rewards meet needs and values) + satisfactoriness (employer: abilities meet requirements) → tenure.

Ch. 18 · 5

Differentiation: one type clearly stands out; a flat profile is undifferentiated. Identity: clear, stable goals, interests, and talents.

Ch. 18 · 8

Growth (birth–14), exploration (15–24: crystallize, specify, implement), establishment (25–44), maintenance (45–64), disengagement, formerly decline (65+). Ages approximate.

Ch. 18 · 7

Fantasy (to about 11), tentative (11–17: interests, capacities, values, transition), realistic (17+: exploration, crystallization, specification). First “irreversible,” later lifelong.

Ch. 18 · 9

**Super: self-concept and recycling**

Ch. 18 · 10

**Life-Career Rainbow**

Ch. 18 · 11

**Gottfredson's circumscription**

Ch. 18 · 12

**Gottfredson's compromise**

Ch. 18 · 13

**Tiedeman and O'Hara; Roe**

Ch. 18 · 14

**Krumboltz's four factors**

Ch. 18 · 15

**Planned happenstance**

Ch. 18 · 16

**SCCT vs. career construction**

Ch. 18 · 10

Nine roles (child, student, leisurite, citizen, worker, spouse, homemaker, parent, pensioner) in four theaters (home, community, school, workplace). Role salience.

Ch. 18 · 9

Choice implements a developing self-concept (Super, 1953). Maxicycle: the five stages across life. Minicycle: recycling at a transition, such as a layoff at 50. Career maturity: readiness for stage tasks.

Ch. 18 · 12

In the original theory: give up interests first, prestige next, sex-type last. Compromise runs circumscription backward.

Ch. 18 · 11

Orientation to size and power (3–5), sex roles (6–8), social valuation (9–13), internal unique self (14+). Leaves a zone of acceptable alternatives.

Ch. 18 · 14

Genetic endowment and special abilities; environmental conditions and events; learning experiences (instrumental, associative); task-approach skills. Produce self-observation and world-view generalizations.

Ch. 18 · 13

Tiedeman and O'Hara: anticipation (exploration, crystallization, choice, clarification), implementation (induction, reformation, integration); ego identity. Roe: family climate → toward or not toward people.

Ch. 18 · 16

SCCT (Lent, Brown, Hackett, 1994): self-efficacy, outcome expectations, goals; supports and barriers. Savickas: life themes, role models, motto; adaptability's four Cs: concern, control, curiosity, confidence.

Ch. 18 · 15

Mitchell, Levin, and Krumboltz (1999): create and use chance events. Five skills: curiosity, persistence, flexibility, optimism, risk taking. Indecision = open-mindedness.

## CHAPTER 19

# Career Assessment, Information, and Counseling Practice

## Extra drills

### Drill 19.2 • Fill in the blank.

1. The Strong Interest Inventory descends from the Strong Vocational Interest \_\_\_\_\_ of 1927.
2. The SDS is self-administered, self-interpreted, and self-\_\_\_\_\_.
3. O\*NET replaced the *Dictionary of* \_\_\_\_\_.
4. The *Occupational Outlook Handbook* is published by the Bureau of \_\_\_\_\_.
5. In Jahoda's model, income is the \_\_\_\_\_ function of work; time structure is a \_\_\_\_\_ function.
6. ICD-11 classifies burnout as an \_\_\_\_\_ phenomenon, not a medical condition.
7. Under IDEA, transition services must be in the IEP in effect when the student turns \_\_\_\_\_.
8. Atchley's \_\_\_\_\_ theory says older adults adapt by preserving familiar activities and identity.
9. Card sorts were pioneered by Leona \_\_\_\_\_.
10. Chronic difficulty deciding across many areas of life is called \_\_\_\_\_.

### Drill 19.3 • First step: assess, inform, or explore? For each client, write **A** (assess mood and risk first), **I** (provide or point to occupational information), or **E** (explore interests, values, or results with the client).

1. \_\_\_\_ A laid-off welder says he has “nothing to get up for” and has stopped answering calls from family.
2. \_\_\_\_ A high school junior asks what electricians earn and whether jobs will be available.
3. \_\_\_\_ A college sophomore's Strong profile shows two high themes she has never considered.
4. \_\_\_\_ A retiree, cheerful in his first month, now says his family “would be better off” without him.
5. \_\_\_\_ A client asks what tasks and training a physical therapist assistant job involves.
6. \_\_\_\_ A client's card sort puts every helping occupation in the “would not choose” pile, and she wonders why.
7. \_\_\_\_ A client deep in credit card debt says he hasn't slept in a week and “can't see a way out.”
8. \_\_\_\_ A veteran wants to look up which civilian occupations match his military job.

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## Answers to the Chapter 19 drills

**Drill answers.** 19.2: (1) Blank. (2) scored. (3) Occupational Titles. (4) Labor Statistics. (5) manifest; latent. (6) occupational. (7) 16. (8) continuity. (9) Tyler. (10) indecisiveness (not *career indecision*, which is limited to career choice). 19.3: 1-A (hopelessness and withdrawal after job loss). 2-I (the OOH reports pay and outlook). 3-E (results are hypotheses to explore). 4-A (statements about being a burden call for suicide risk assessment). 5-I (O\*NET or the OOH). 6-E (her reasons are the data). 7-A (debt with hopelessness and insomnia). 8-I (O\*NET OnLine's Military Crosswalk Search links military occupation codes to civilian occupations).

Ch. 19 · 1

**Strong Interest Inventory**

Ch. 19 · 2

**Occupational Scales (Strong)**

Ch. 19 · 3

**Self-Directed Search (SDS)**

Ch. 19 · 4

**MBTI in career work**

Ch. 19 · 5

**Interest vs. aptitude vs. values**

Ch. 19 · 6

**ASVAB**

Ch. 19 · 7

**Card sort**

Ch. 19 · 8

**Career indecision vs. indecisiveness**

Ch. 19 · 2

Empirically keyed: compare the client's likes and dislikes with those of people satisfied in each occupation. Similarity, not ability.

Ch. 19 · 1

Interest inventory descended from the 1927 Strong Vocational Interest Blank. Reports General Occupational Themes (Holland), Basic Interest Scales, Occupational Scales, and Personal Style Scales.

Ch. 19 · 4

Four Jungian preference pairs, 16 types. Describes preferences and style, not ability or pathology; its publisher says it should not be used for hiring.

Ch. 19 · 3

Holland's self-administered, self-scored inventory. Yields a three-letter RIASEC code that the client matches to occupations. Named in the 2027 specifications.

Ch. 19 · 6

Multiple-aptitude battery used for military selection and, through a career exploration program, in high schools.

Ch. 19 · 5

Interest: would I like it? Aptitude: could I learn it? Values: would it matter to me? Only the client answers: should I choose it?

Ch. 19 · 8

Indecision: normal, developmental, career-specific; resolved by exploration.  
Indecisiveness: chronic difficulty deciding across life areas, often anxiety-linked; needs personal counseling.

Ch. 19 · 7

Informal, qualitative assessment pioneered by Leona Tyler (1961). Clients sort occupation or value cards into piles and explain why; useful when norms fit poorly.

Ch. 19 · 9

**Flat, low interest profile**

Ch. 19 · 10

**Using results (4K; 2B.10; 3A.5)**

Ch. 19 · 11

**O\*NET**

Ch. 19 · 12

**Occupational Outlook Handbook  
(OOH)**

Ch. 19 · 13

**Jahoda's latent deprivation model**

Ch. 19 · 14

**Burnout (ICD-11)**

Ch. 19 · 15

**Financial stress**

Ch. 19 · 16

**Transitions: IDEA and retirement**

Ch. 19 · 10

Results are hypotheses, not verdicts. Report them in terms the client understands (ACA Standard E.9.a), weigh with values and context, and let the client decide.

Ch. 19 · 9

No theme stands out. Explore low mood, worry, low self-efficacy, or limited experience before retesting or choosing the “highest” score.

Ch. 19 · 12

Bureau of Labor Statistics. Duties, work environment, education, pay, and job outlook (10-year projections); outlook and wage data updated annually.

Ch. 19 · 11

U.S. Department of Labor’s free online occupational database; replaced the *Dictionary of Occupational Titles*. Tasks, skills, wages, Job Zones, Interest Profiler (RIASEC).

Ch. 19 · 14

An occupational phenomenon, not a medical condition: exhaustion, cynicism or mental distance from the job, reduced professional efficacy. Applies only to work (WHO, 2019).

Ch. 19 · 13

Manifest function of work: income. Latent functions: time structure, social contact, shared purpose, status and identity, regular activity. Unemployment strips them all.

Ch. 19 · 16

IDEA: transition services and postsecondary goals in the IEP in effect at 16. Retirement: Atchley’s phases (honeymoon, disenchantment, reorientation, stability) and continuity theory (1989).

Ch. 19 · 15

Debt is associated with depression, problem drinking, and suicide (Richardson et al., 2013). Address shame and conflict, assess risk; refer investment, tax, and legal questions.

## CHAPTER 20

# Case Conceptualization and Treatment Plans

## Extra drills

### Drill 20.2 • Fill in the blank.

1. In Sperry and Sperry's model, the \_\_\_\_\_ formulation explains why problems persist.
2. Engel (1977) proposed the \_\_\_\_\_ model.
3. When prioritizing problems, \_\_\_\_\_ always comes first.
4. A broad outcome stated in the client's words is a \_\_\_\_\_.
5. "Counselor will teach assertiveness skills" is an \_\_\_\_\_.
6. In the 2027 specifications' spelling of SMART, the T stands for \_\_\_\_\_.
7. Cost, transportation, and child care are \_\_\_\_\_ barriers (the other two kinds are clinical and relational).
8. ACA Code of Ethics Standard \_\_\_\_\_ calls for counselors and clients to devise counseling plans jointly.
9. A behavioral plan teaches a \_\_\_\_\_ behavior that meets the same need as the problem behavior.
10. Assessing for \_\_\_\_\_ of treatment approaches is a task new to the 2027 NCE.

**Drill 20.3 • Sorting: ready, fix, or flag?** For each proposed plan item, write **S** (a SMART objective, ready to use), **F** (fix the wording: vague, not measurable, or unrealistic for any client), or **C** (contraindicated: well written, and it might suit another client, but wrong for this client now because of safety, a condition, or readiness).

1. \_\_\_\_ "Client will have no panic attacks within 1 week."
2. \_\_\_\_ For a client who still lives with the person who assaulted her: "Client will complete her trauma narrative by session 8."
3. \_\_\_\_ "Client will walk 20 minutes on at least 4 days a week, logged in an app, for the next 6 weeks."
4. \_\_\_\_ "Client will develop better coping skills."
5. \_\_\_\_ For a client with anorexia nervosa: "Client will lose 5 pounds by week 8."
6. \_\_\_\_ "Client will reduce her PHQ-9 score from 16 to below 10 by week 12."
7. \_\_\_\_ For a client who sees no problem with his drinking: "Client will attend three mutual-help meetings a week for the next 8 weeks."
8. \_\_\_\_ "Client will improve communication with her son."

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## Answers to the Chapter 20 drills

**Drill answers.** 20.2: (1) clinical. (2) biopsychosocial. (3) safety, or risk of harm (suicide, violence, abuse, or medical danger); crises and basic needs come next. (4) goal (or long-term goal). (5) intervention. (6) Timely (many other sources say time-bound). (7) practical (or logistical). (8) A.1.c. (9) replacement (alternative or functionally equivalent also fits). (10) contraindications. 20.3: 1-F (measurable but not attainable or realistic for any client). 2-C (well written, but ongoing danger rules out trauma processing now; safety and stabilization first). 3-S. 4-F (no behavior, number, or deadline). 5-C (weight-loss goals are contraindicated with an eating disorder). 6-S. 7-C (well written and realistic for a client ready to act, so not F; the problem is readiness: an action-stage task for a client not yet considering change is likely to fail now, so build motivation first, as with motivational interviewing). 8-F (name the behavior, how often, and by when).

Ch. 20 · 1

**Case conceptualization**

Ch. 20 · 2

**Sperry and Sperry's four components  
(2020)**

Ch. 20 · 3

**Biopsychosocial model (Engel, 1977)**

Ch. 20 · 4

**Prioritizing problems (3A.1)**

Ch. 20 · 5

**Parts of a treatment plan**

Ch. 20 · 6

**Goal vs. objective**

Ch. 20 · 7

**Objective vs. intervention**

Ch. 20 · 8

**SMART (2027 specifications)**

Ch. 20 · 2

Diagnostic formulation (what?), clinical formulation (why?), cultural formulation (through whose eyes?), treatment formulation (what now?).

Ch. 20 · 1

A working explanation of what is happening, why, how culture shapes it, and what will help. Links assessment and diagnosis to the plan; a revisable hypothesis.

Ch. 20 · 4

Fire, roof, rooms: safety → crises and basic needs → the client's priorities, weighed against the most impairing or maintaining problem.

Ch. 20 · 3

Biological, psychological, and social factors interact to produce health and illness. Named as required knowledge in the 2027 specifications.

Ch. 20 · 6

Goal: the broad destination, often in the client's words. Objective: a measurable mile marker the client does or achieves, with a deadline.

Ch. 20 · 5

Problem statements, long-term goals, objectives, interventions, modality (2I) and frequency, target dates, discharge criteria.

Ch. 20 · 8

Specific, Measurable, Attainable, Realistic, Timely. Other sources say achievable, relevant, or time-bound; the test is the same.

Ch. 20 · 7

Objective: what the client will do or achieve. Intervention: what the counselor will do. "Counselor will teach..." is always an intervention.

Ch. 20 · 9

**Spotting the best objective**

Ch. 20 · 10

**Three kinds of barriers**

Ch. 20 · 11

**Strengths (3A.4; Standard A.1.d)**

Ch. 20 · 12

**Assessment, culture, development  
(3A.5, 3A.6, 5A)**

Ch. 20 · 13

**Counseling plans (Standard A.1.c)**

Ch. 20 · 14

**When to revise the plan (3A.10)**

Ch. 20 · 15

**Contraindications (3A.8)**

Ch. 20 · 16

**Behavioral management plan (3A.11)**

Ch. 20 · 10

Practical (cost, transportation, child care, language): problem-solve. Clinical (substance use, medical, cognitive, crises): treat. Relational (alliance, culture, ambivalence): repair; MI.

Ch. 20 · 9

A behavior or score, a number, and a realistic deadline. Distractors: “feel better,” “improve,” “gain insight,” or an impossible time frame.

Ch. 20 · 12

Scores become baselines and targets. Goals fit the client’s values. Methods fit developmental level (play and caregiver coaching for young children).

Ch. 20 · 11

Past successes, skills, faith, family, community. With consent, enlist family, friends, or religious and community leaders as supports.

Ch. 20 · 14

Goal met, new problem, diagnosis changes, progress stalls, or the client asks. Revise with the client; document the date and reason.

Ch. 20 · 13

Devised jointly; reasonable promise of success; fit abilities, temperament, development, and circumstances; reviewed and revised regularly; respect freedom of choice.

Ch. 20 · 16

Define and baseline → functional assessment (antecedents, consequences) → replacement behavior → reinforce → same rules in every setting → track and revise.

Ch. 20 · 15

Safety now? Fit to condition? Fit to person? Examples: trauma processing amid danger; confrontational style in substance use; conjoint sessions amid fear of violence; weight-loss goals with an eating disorder.

## CHAPTER 21

# Levels of Care, Collaboration, Monitoring, and Termination

## Extra drills

### Drill 21.2 • Fill in the blank.

1. The guiding principle for placement is the \_\_\_\_\_ level of care.
2. *Addington v. Texas* (1979) requires at least \_\_\_\_\_ evidence for civil commitment.
3. When a client sees another mental health professional, the counselor requests a \_\_\_\_\_ (Standard A.3).
4. Wraparound's first principle is family \_\_\_\_\_.
5. Fortney et al. (2017) list feeding scores back to the provider \_\_\_\_\_ the context of the clinical encounter as an ineffective approach.
6. A counselor *may* terminate when in danger or when \_\_\_\_\_ go unpaid as agreed.
7. A discharge plan begins at \_\_\_\_\_.
8. A single slip is a \_\_\_\_\_; a return to the old pattern is a \_\_\_\_\_.

### Drill 21.3 • Sorting: up, down, or stay? For each client, write **U** (step up to a more intensive level), **D** (step down), or **S** (stay at the current level).

1. \_\_\_\_ An outpatient client now has a suicide plan, intent, and access to a firearm.
2. \_\_\_\_ A PHP client has been stable for three weeks, has a safe home, and has an outpatient counselor lined up.
3. \_\_\_\_ An outpatient client is improving; her PHQ-9 scores are falling steadily.
4. \_\_\_\_ An IOP client keeps drinking daily despite the program and two revisions of her plan, and she lives with people who use heavily.
5. \_\_\_\_ An inpatient client's mania has resolved, she is medically stable, and her family can support her at home.
6. \_\_\_\_ An outpatient client misses one session because her child is sick.

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## Answers to the Chapter 21 drills

**Drill answers.** 21.2: (1) least restrictive. (2) clear and convincing. (3) release (the Code's word; consent or authorization also fits). (4) voice and choice. (5) outside. (6) fees. (7) admission (or intake, the first session). (8) lapse; relapse. 21.3: 1-U (emergency evaluation). 2-D. 3-S. 4-U (IOP has not worked even after her plan was revised, and the home undermines recovery; consider residential care). 5-D (for example, to PHP or IOP). 6-S.

Ch. 21 · 1

**Level-of-care continuum**

Ch. 21 · 2

**IOP vs. PHP**

Ch. 21 · 3

**Civil commitment cases**

Ch. 21 · 4

**Referral as a process**

Ch. 21 · 5

**A.11.a vs. A.11.b**

Ch. 21 · 6

**Concurrent treatment (A.3)**

Ch. 21 · 7

**Interdisciplinary teams**

Ch. 21 · 8

**Wraparound's ten principles**

Ch. 21 · 2

IOP: a few hours on several days a week. PHP: most of the day, most weekdays. In both, the client sleeps at home.

Ch. 21 · 1

Outpatient → intensive outpatient (IOP) → partial hospitalization (PHP) → residential → inpatient. Choose the least restrictive level that is safe and allows progress; step up for risk, down as the client stabilizes.

Ch. 21 · 4

Explain why → offer specific options → obtain a release → send what the new provider needs → confirm the client connected. Keep communication open with both (A.11.d).

Ch. 21 · 3

*O'Connor v. Donaldson* (1975): no confining a nondangerous person who can live safely in freedom. *Addington v. Texas* (1979): at least clear and convincing evidence. *Olmstead v. L.C.* (1999): the ADA favors community-based care.

Ch. 21 · 6

The client sees another mental health professional: request a release to inform that professional and collaborate. Concurrent care is allowed.

Ch. 21 · 5

A.11.a: lacking competence, suggest referrals; if the client declines them, end the relationship. A.11.b: never refer solely because of personal values.

Ch. 21 · 8

Family voice and choice; team-based; natural supports; collaboration (one plan); community-based; culturally competent; individualized; strengths-based; unconditional (the 2004 list said persistence); outcome-based (Bruns et al., 2008).

Ch. 21 · 7

D.1.c: focus on the client and add the counseling perspective. B.3.b: tell the client about the team and what is shared. D.1.d: raise ethical concerns within the team first.

Ch. 21 · 9

**Measurement-based care**

Ch. 21 · 10

**Not on track**

Ch. 21 · 11

**Soliciting client feedback (4.12, new)**

Ch. 21 · 12

**Plan for disruption of service (3B.6, new)**

Ch. 21 · 13

**Must vs. may terminate (A.11.c)**

Ch. 21 · 14

**Premature termination**

Ch. 21 · 15

**Discharge vs. aftercare vs. follow-up**

Ch. 21 · 16

**Lapse vs. relapse**

Ch. 21 · 10

A client predicted to do poorly. Progress feedback helps these clients most (Lambert et al., 2018). Review the data together and revise the plan.

Ch. 21 · 9

Frequent brief measures, reviewed with the client, that drive decisions. One-time screening, infrequent measures, and feedback outside the session do not deliver the benefit (Fortney et al., 2017).

Ch. 21 · 12

Keeps each client's care going through an interruption: covering clinician, crisis resources (988), how clients will be contacted, a fallback option, and access to records.

Ch. 21 · 11

Ask about the process: Did you feel heard? Did we work on what mattered? Does the approach fit? Respond without defensiveness. Formative feedback shapes care; summative judges the result.

Ch. 21 · 14

The client stops coming: make reasonable outreach, send a closing letter inviting return and listing referrals, and document. Do not close silently or hold the slot indefinitely.

Ch. 21 · 13

Must: the client no longer needs help, is not likely to benefit, or is being harmed. May: the counselor is in danger, or fees go unpaid as agreed. Pretermination counseling and referrals when necessary.

Ch. 21 · 16

Lapse: a single slip. Relapse: a return to the old pattern. The abstinence violation effect turns one into the other (Marlatt & Gordon, 1985).

Ch. 21 · 15

Discharge plan: when and how the client leaves (starts at admission). Aftercare plan: support afterward. Follow-up: a planned check that the client connected and gains are holding.

## CHAPTER 22

# The Helping Relationship and Core Skills

## Extra drills

### Drill 22.2 • Fill in the blank.

1. Bordin's working alliance has three parts: goals, tasks, and \_\_\_\_\_.
2. In Lambert's estimates, the largest share of change comes from \_\_\_\_\_ factors.
3. Hill's three stages are exploration, \_\_\_\_\_, and action.
4. A response rated Level 3 on Carkhuff's scale is called \_\_\_\_\_.
5. Restating what happened, without naming emotion, is a \_\_\_\_\_.
6. Commenting on what is happening between counselor and client right now is \_\_\_\_\_.
7. Explaining how counseling works and each person's role is called role \_\_\_\_\_.
8. A client who becomes vague and overly agreeable may be showing a \_\_\_\_\_ rupture.

**Drill 22.3 • Rate the response.** Ruth, 41, says: "My mom moved in after her stroke. I love her, but I haven't had a minute to myself in months, and then I feel guilty for even thinking that." Rate each counselor response **S** (subtractive), **I** (interchangeable), or **A** (additive).

1. \_\_\_\_ "Lots of people care for their parents. You'll adjust."
2. \_\_\_\_ "You're worn out from caring for your mom with no time for yourself, and then you feel guilty for wanting some."
3. \_\_\_\_ "Have you looked into adult day programs?"
4. \_\_\_\_ "You're exhausted and guilty about it, and I wonder if part of you is grieving the mom you had before the stroke, and the life you had too."
5. \_\_\_\_ "Caregiving is hard."
6. \_\_\_\_ "You're drained from months of caregiving with no time to yourself, and guilty for wanting some."

## Answers to the Chapter 22 drills

**Drill answers.** 22.2: (1) bond. (2) extratherapeutic (client). (3) insight. (4) interchangeable (minimally facilitative). (5) paraphrase (Hill calls it a restatement). (6) immediacy. (7) induction (some studies say role preparation). (8) withdrawal. 22.3: 1-S (minimizes and reassures). 2-I (feeling and reason, nothing added). 3-S (jumps to advice before understanding). 4-A (names an implied loss, tentatively). 5-S (generic; misses her feelings). 6-I (the same feelings and reason in fewer words; shorter is not subtractive).

Ch. 22 · 1

**Common factors (Rosenzweig, 1936)**

Ch. 22 · 2

**Lambert's estimates (1992)**

Ch. 22 · 3

**Working alliance (Bordin, 1979)**

Ch. 22 · 4

**Stages of helping**

Ch. 22 · 5

**Role induction (4.9)**

Ch. 22 · 6

**SOLER (Egan)**

Ch. 22 · 7

**Open vs. closed questions**

Ch. 22 · 8

**Paraphrase vs. reflection of feeling**

Ch. 22 · 2

Extratherapeutic client factors about 40 percent; common factors (relationship) about 30; expectancy about 15; techniques about 15. Rough estimates, not a statistical result.

Ch. 22 · 1

Different therapies may work for shared reasons, such as catharsis, the therapist's personality, and a consistent rationale, more than their unique techniques.

Ch. 22 · 4

Hill: exploration, insight, action. Egan: what is going on, what do I want instead, how do I get there. Ivey: empathic relationship, story and strengths, goals, restory, action.

Ch. 22 · 3

Agreement on goals, agreement on tasks, and an emotional bond. Applies across theories; predicts outcome (Flückiger et al., 2018). 2027 crosswalk: 3A.9.

Ch. 22 · 6

Attending posture: face the client Squarely, Open posture, Lean toward, Eye contact, Relaxed. Adapt to culture.

Ch. 22 · 5

Orient the client: how counseling works, each person's role, likely length, what to expect. Reduces premature dropout (Swift et al., 2012).

Ch. 22 · 8

Paraphrase restates content (what happened). Reflection of feeling names the emotion (how it felt).

Ch. 22 · 7

Open questions invite elaboration ("could" is the most open); closed questions get specifics. "Why" questions tend to provoke defensiveness.

Ch. 22 · 9

**Reflection of meaning**

Ch. 22 · 10

**Summarizing**

Ch. 22 · 11

**Carkhuff's empathy scale (1969)**

Ch. 22 · 12

**Confrontation**

Ch. 22 · 13

**Immediacy vs. self-disclosure**

Ch. 22 · 14

**Broaching (Day-Vines et al., 2007)**

Ch. 22 · 15

**Soliciting feedback (4.12)**

Ch. 22 · 16

**Ruptures (Safran & Muran, 2000)**

Ch. 22 · 10

Ties several statements or themes together; used to open a session, mark a transition, or close.

Ch. 22 · 9

Names the value or significance beneath the client's words: why it matters.

Ch. 22 · 12

Supportively names a discrepancy: words vs. actions, two statements, or words vs. nonverbals. Needs an alliance first; Egan calls it challenging.

Ch. 22 · 11

Five levels. 1-2 subtractive; 3 interchangeable (minimally facilitative); 4-5 additive.

Ch. 22 · 14

Counselor initiates discussion of race, ethnicity, and culture. Continuum: avoidant, isolating, continuing/incongruent, integrated/congruent, infusing.

Ch. 22 · 13

Immediacy: what is happening between counselor and client right now. Self-disclosure: the counselor's own life, brief, for the client, then turn back.

Ch. 22 · 16

Withdrawal: client moves away (vague, deferential, topic shifts). Confrontation: client moves against (complaints, criticism). Repair: notice, name, invite, own, adjust (4.15).

Ch. 22 · 15

New in 2027. Ask every session (e.g., Session Rating Scale); respond nondefensively. Feedback helps most with clients not on track (Lambert & Shimokawa, 2011).

## CHAPTER 23

# Psychodynamic and Adlerian Approaches

## Extra drills

### Drill 23.2 • Fill in the blank.

1. The ego operates on the \_\_\_\_\_ principle.
2. The remembered story of a dream is its \_\_\_\_\_ content.
3. A deliberate decision to set a worry aside is \_\_\_\_\_.
4. Jung called the lifelong process of integrating conscious and unconscious, chiefly the task of life's second half, \_\_\_\_\_.
5. Winnicott's term for a blanket that soothes a toddler during separation is the \_\_\_\_\_ object.
6. Adler's yardstick of mental health is \_\_\_\_\_ interest.
7. Specific childhood memories used in Adlerian assessment are called early \_\_\_\_\_.
8. In Dreikurs's model, an adult who feels hurt by a child's behavior suggests the goal of \_\_\_\_\_.
9. The final phase of Adlerian counseling, turning insight into action, is \_\_\_\_\_.
10. Exposing the hidden payoff of a behavior so that it loses its appeal is called \_\_\_\_\_.

### Drill 23.3 • Sorting: Freudian, Jungian, or Adlerian? Write F, J, or A for each concept.

1. \_\_\_\_ Fictional finalism
2. \_\_\_\_ Persona and shadow
3. \_\_\_\_ Id, ego, and superego
4. \_\_\_\_ Birth order and family constellation
5. \_\_\_\_ Manifest and latent content
6. \_\_\_\_ Introversion and extraversion
7. \_\_\_\_ Inferiority feelings and striving for superiority
8. \_\_\_\_ Collective unconscious
9. \_\_\_\_ Free association
10. \_\_\_\_ Push-button technique

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## Answers to the Chapter 23 drills

**Drill answers.** 23.2: (1) reality. (2) manifest. (3) suppression. (4) individuation. (5) transitional. (6) social. (7) recollections (or memories). (8) revenge. (9) reorientation. (10) spitting in the client's soup. 23.3: 1-A. 2-J. 3-F. 4-A. 5-F. 6-J. 7-A. 8-J. 9-F. 10-A (an Adlerian technique, developed by the later Adlerian Harold Mosak rather than by Adler himself).

Ch. 23 · 1

**Id, ego, superego**

Ch. 23 · 2

**Freud's levels of mental life**

Ch. 23 · 3

**Freud's three anxieties**

Ch. 23 · 4

**Free association and dream analysis**

Ch. 23 · 5

**Resistance and working through**

Ch. 23 · 6

**Transference vs. countertransference**

Ch. 23 · 7

**Repression vs. suppression**

Ch. 23 · 8

**Projection vs. displacement**

Ch. 23 · 2

Conscious (aware now), preconscious (retrievable on demand), unconscious (largest; out of awareness, yet drives most behavior).

Ch. 23 · 1

Id: inborn drives, pleasure principle. Ego: mediator, reality principle. Superego: conscience (guilt) and ego ideal (pride).

Ch. 23 · 4

Free association: report every thought, uncensored. Dream analysis: the remembered manifest content is read for its hidden latent content.

Ch. 23 · 3

Reality: an outside threat. Neurotic: fear that id impulses will break through. Moral: fear of the superego's punishment.

Ch. 23 · 6

Transference: the client's feelings from earlier relationships redirected onto the counselor. Countertransference: the counselor's own reaction. Both occur in every approach.

Ch. 23 · 5

Resistance: anything that blocks unconscious material (lateness, silence, topic changes); explored, not fought. Working through: repeating insight until change holds.

Ch. 23 · 8

Projection: your feeling is seen in someone else ("He hates me"). Displacement: your feeling, aimed at a safer target (yelling at the dog).

Ch. 23 · 7

Repression: unconscious; material kept out of awareness. Suppression: a deliberate choice to set a worry aside; a mature defense (Vaillant).

Ch. 23 · 9

**Reaction formation, rationalization,  
intellectualization**

Ch. 23 · 10

**Teaching about defenses (5R, 4.11)**

Ch. 23 · 11

**Jung's archetypes**

Ch. 23 · 12

**Individuation and psychological  
types**

Ch. 23 · 13

**Object relations and self psychology**

Ch. 23 · 14

**Adler's core concepts**

Ch. 23 · 15

**Adlerian phases and techniques**

Ch. 23 · 16

**Dreikurs's goals of misbehavior**

Ch. 23 · 10

After trust exists; tentative (“I wonder if...”); normalizing; plain language; tied to the client’s goals. Never a label such as “You’re in denial.”

Ch. 23 · 9

Reaction formation: the opposite of the real impulse. Rationalization: plausible excuses. Intellectualization: analysis in place of feeling.

Ch. 23 · 12

Individuation: integrating conscious and unconscious, chiefly the task of life’s second half. Types: introversion, extraversion, and four functions; the basis of the MBTI.

Ch. 23 · 11

Persona (public mask), shadow (disowned side), anima and animus (contrasexual sides), self (wholeness). They live in the collective unconscious.

Ch. 23 · 14

Social interest (the yardstick of health); inferiority feelings and striving for superiority; style of life; fictional finalism; basic mistakes; life tasks of work, friendship, love.

Ch. 23 · 13

Klein: splitting. Winnicott: good-enough mother, transitional object, holding environment. Mahler: separation-individuation, rapprochement. Kohut: mirroring and a cohesive self.

Ch. 23 · 16

Attention (adult feels annoyed), power (angry), revenge (hurt), display of inadequacy (helpless). Natural consequences happen on their own; logical consequences are arranged and related.

Ch. 23 · 15

Relationship, assessment (early recollections, family constellation), insight, reorientation; encouragement throughout. Acting as if, spitting in the soup, catching oneself, push-button, the question.

## CHAPTER 24

# Humanistic, Existential, and Gestalt Approaches

## Extra drills

### Drill 24.2 • Fill in the blank.

1. Maslow called humanistic psychology the \_\_\_\_\_ force.
2. Standards a child must meet to feel valued are Rogers's \_\_\_\_\_.
3. Rogers's core conditions are congruence, unconditional positive regard, and accurate \_\_\_\_\_.
4. Rogers described his conditions as necessary and \_\_\_\_\_.
5. Frankl's approach, built on the will to meaning, is called \_\_\_\_\_.
6. Frankl's technique of asking a client to try to produce a feared symptom is \_\_\_\_\_.
7. Yalom's four ultimate concerns are death, freedom, isolation, and \_\_\_\_\_.
8. Gestalt counselors ask *what* and *how* rather than \_\_\_\_\_.
9. Unexpressed feelings from the past that intrude on the present are \_\_\_\_\_.
10. Biting your lip instead of telling someone you are angry is \_\_\_\_\_.

### Drill 24.3 • Sorting: which approach? Write **P** (person-centered), **E** (existential), or **G** (Gestalt) for each counselor statement.

1. \_\_\_\_ "You're angry, and underneath it you sound hurt."
2. \_\_\_\_ "Say that again, louder, and notice your fists."
3. \_\_\_\_ "Knowing your time is limited, what matters most to you now?"
4. \_\_\_\_ "Speak to your sister as if she were sitting in that chair."
5. \_\_\_\_ "It sounds like you're not sure you can trust your own judgment yet."
6. \_\_\_\_ "You keep saying you had no choice. What choices do you see now?"
7. \_\_\_\_ "Instead of 'I can't,' try 'I won't,' and see how that feels."
8. \_\_\_\_ To a client who dreads another sleepless night: "Tonight, try as hard as you can to stay awake."
9. \_\_\_\_ The counselor hears a shameful disclosure without judgment and stays with the client's feeling.

## Answers to the Chapter 24 drills

**Drill answers.** 24.2: (1) third. (2) conditions of worth. (3) empathic understanding (empathy). (4) sufficient. (5) logotherapy. (6) paradoxical intention (strategic therapists' version is prescribing the symptom, Chapter 28). (7) meaninglessness. (8) why. (9) unfinished business. (10) retroflexion. 24.3: 1-P. 2-G (exaggeration). 3-E. 4-G (empty chair). 5-P. 6-E (freedom and responsibility). 7-G (language experiment). 8-E (Frankl's paradoxical intention, a logotherapy technique that behavioral insomnia treatment later adopted). 9-P (unconditional positive regard).

Ch. 24 · 1

**Maslow's hierarchy**

Ch. 24 · 2

**Deficiency vs. growth needs**

Ch. 24 · 3

**Actualizing tendency**

Ch. 24 · 4

**Conditions of worth and  
incongruence**

Ch. 24 · 5

**Rogers's three phases**

Ch. 24 · 6

**Rogers's six conditions (1957)**

Ch. 24 · 7

**The core conditions**

Ch. 24 · 8

**The person-centered response**

Ch. 24 · 2

Deficiency needs motivate when they are lacking; growth needs drive self-actualization. Peak experiences: brief moments of awe and wholeness (Maslow, 1962).

Ch. 24 · 1

Physiological, safety, love and belonging, esteem, self-actualization. Lower needs must be partly met first; the order is not rigid. Maslow called humanistic psychology the “third force.”

Ch. 24 · 4

Conditional regard becomes conditions of worth, which split the self-concept from experience. The incongruence produces anxiety and defensiveness.

Ch. 24 · 3

Rogers: the inborn drive toward growth. The counselor provides conditions in which it can operate.

Ch. 24 · 6

Psychological contact; client incongruent and vulnerable; counselor congruent; unconditional positive regard; empathic understanding; client perceives the empathy and regard at least minimally. “Necessary and sufficient.”

Ch. 24 · 5

Nondirective (1940s), client-centered (1950s), person-centered (later, extended to groups, education, and conflict).

Ch. 24 · 8

Reflects the client’s feeling and meaning in the client’s frame, then stops. No advice, “why” questions, reassurance, or interpretation.

Ch. 24 · 7

Congruence (genuineness), unconditional positive regard, accurate empathic understanding. Regard means accepting the person, not approving every behavior.

Ch. 24 · 9

**Frankl and logotherapy**

Ch. 24 · 10

**Paradoxical intention vs. dereflection**

Ch. 24 · 11

**Rollo May**

Ch. 24 · 12

**Yalom's ultimate concerns**

Ch. 24 · 13

**Gestalt core ideas**

Ch. 24 · 14

**Contact disturbances**

Ch. 24 · 15

**Gestalt experiments**

Ch. 24 · 16

**Psychodrama and contraindications**

Ch. 24 · 10

Paradoxical intention: wish for or produce the feared symptom. Dereflection: turn attention from self-observation to people and purposes beyond the self.

Ch. 24 · 9

Will to meaning is the primary motive. Meaning comes through deeds, through love and experience, and through one's attitude toward unavoidable suffering. Existential vacuum: life without meaning.

Ch. 24 · 12

Death, freedom (with responsibility), isolation, meaninglessness. The goal is to face the anxiety they stir, not remove it.

Ch. 24 · 11

Normal anxiety fits the threat and can spur growth; neurotic anxiety is out of proportion and relies on repression. *Existence* (1958) brought existential thought to the U.S.

Ch. 24 · 14

Introjection (swallowing values whole), projection (disowned traits seen in others), retroflection (turned back on oneself), deflection (dodging), confluence (no self-other boundary).

Ch. 24 · 13

Fritz and Laura Perls, Paul Goodman; founding text by Perls, Hefferline, and Goodman (1951). Here and now; ask *what* and *how*, not *why*; figure and ground; unfinished business; holism; "I" statements.

Ch. 24 · 16

Psychodrama (Moreno): protagonist, director, auxiliary egos, stage. Confrontive experiments wait until a client in crisis, psychosis, or dissociation is stable (2027 task 3A.8).

Ch. 24 · 15

Empty chair; two-chair (top dog vs. underdog); exaggeration; reversal; dream work (speak as each element); language changes ("won't" instead of "can't"). Layers of neurosis: phony, phobic, impasse, implosive, explosive.

## CHAPTER 25

# Behavioral and Learning Approaches

## Extra drills

**Drill 25.2 • Sorting: reinforcement or punishment?** For each example, write **PR** (positive reinforcement), **NR** (negative reinforcement), **PP** (positive punishment), or **NP** (negative punishment).

1. \_\_\_\_ A student earns a sticker for each completed worksheet, and completion rises.
2. \_\_\_\_ A driver buckles up to stop the seat-belt chime, and buckling up becomes routine.
3. \_\_\_\_ A child loses 10 minutes of screen time for teasing, and teasing declines.
4. \_\_\_\_ A teen gets extra chores after lying, and lying declines.
5. \_\_\_\_ A client leaves a crowded store when panic starts, and leaving early becomes more frequent.
6. \_\_\_\_ A resident loses two tokens for cursing, and cursing declines.
7. \_\_\_\_ An employee gets a bonus for on-time reports, and on-time reports increase.
8. \_\_\_\_ A man takes a pain reliever when his back aches, and he reaches for it more often.

**Drill 25.3 • Fill in the blank.**

1. In classical conditioning, the response to the conditioned stimulus is called the \_\_\_\_\_ response.
2. The schedule behind slot machines is \_\_\_\_\_.
3. Wolpe's systematic desensitization rests on \_\_\_\_\_.
4. Bandura's strongest source of self-efficacy is \_\_\_\_\_.
5. Reinforcers are either primary (such as food) or \_\_\_\_\_ (conditioned, such as tokens).
6. "Finish your homework, then you can play outside" applies the \_\_\_\_\_ principle.
7. A brief surge in behavior after reinforcement stops is an \_\_\_\_\_.
8. A behavior plan begins by defining the behavior and measuring a \_\_\_\_\_.
9. A replacement behavior must serve the same \_\_\_\_\_ as the problem behavior.
10. Exposure and response prevention blocks the \_\_\_\_\_ during exposure.

## Answers to the Chapter 25 drills

**Drill answers.** 25.2: 1-PR, 2-NR, 3-NP, 4-PP, 5-NR (escape brings relief), 6-NP (response cost), 7-PR, 8-NR. 25.3: (1) conditioned. (2) variable ratio. (3) reciprocal inhibition (counterconditioning is the general process; the two blanks ask for Wolpe's term). (4) performance accomplishments (or mastery experiences). (5) secondary. (6) Premack. (7) extinction burst. (8) baseline. (9) function. (10) ritual (or compulsion, including mental neutralizing).

Ch. 25 · 1

**Classical conditioning (Pavlov)**

Ch. 25 · 2

**Extinction vs. spontaneous recovery**

Ch. 25 · 3

**Generalization vs. discrimination**

Ch. 25 · 4

**Little Albert and Peter**

Ch. 25 · 5

**Law of effect**

Ch. 25 · 6

**The operant 2 × 2**

Ch. 25 · 7

**Negative reinforcement trap**

Ch. 25 · 8

**Schedules of reinforcement**

Ch. 25 · 2

Extinction: the conditioned stimulus appears without the unconditioned stimulus, and the response fades. Spontaneous recovery: the extinguished response briefly returns after a rest.

Ch. 25 · 1

A neutral stimulus paired with an unconditioned stimulus (food) becomes a conditioned stimulus that triggers a conditioned response (salivation) by itself. The response is reflexive, not chosen.

Ch. 25 · 4

Watson and Rayner (1920) conditioned fear of a white rat in an 11-month-old by pairing it with a loud noise. Jones (1924) eased a boy's fear of a rabbit by bringing it closer while he ate.

Ch. 25 · 3

Generalization: similar stimuli trigger the response (Little Albert feared a rabbit and a fur coat). Discrimination: only the original stimulus does.

Ch. 25 · 6

Added + behavior up: positive reinforcement. Removed + up: negative reinforcement. Added + down: positive punishment. Removed + down: negative punishment.

Ch. 25 · 5

Thorndike: responses followed by satisfying outcomes become more likely to recur. Skinner built operant conditioning on it.

Ch. 25 · 8

Continuous: fastest learning and fastest extinction. Fixed ratio: pause after reward. Variable ratio: highest, most extinction-resistant rate. Fixed interval: scallop. Variable interval: steady, moderate rate.

Ch. 25 · 7

If the behavior increases, it is reinforcement, never punishment. Avoidance is negatively reinforced by relief, which is why exposure blocks escape.

Ch. 25 · 9

**Bandura's Bobo doll (1961)**

Ch. 25 · 10

**Observational learning processes**

Ch. 25 · 11

**Self-efficacy (Bandura, 1977)**

Ch. 25 · 12

**Reciprocal determinism**

Ch. 25 · 13

**Systematic desensitization  
vs. flooding**

Ch. 25 · 14

**Operant techniques**

Ch. 25 · 15

**Behavioral management plan**

Ch. 25 · 16

**Biofeedback**

Ch. 25 · 10

Attention, retention, reproduction, motivation. Vicarious reinforcement: seeing a model rewarded increases imitation.

Ch. 25 · 9

Children who watched an adult attack an inflatable doll copied the aggression without being reinforced: observational learning.

Ch. 25 · 12

Bandura: person, behavior, and environment influence one another.

Ch. 25 · 11

Belief in one's ability to perform a specific task. Sources: performance accomplishments (strongest), vicarious experience, verbal persuasion, physiological states.

Ch. 25 · 14

Token economy (secondary reinforcers traded for backup reinforcers); response cost; time-out; shaping; chaining; Premack principle; extinction and the extinction burst.

Ch. 25 · 13

Desensitization (Wolpe, 1958): relaxation paired with a hierarchy, lowest step first; reciprocal inhibition. Flooding: the most feared item first, without escape, until anxiety falls.

Ch. 25 · 16

Sensors show a body signal (muscle tension, skin temperature, heart rate variability, breathing, brain waves) in real time so the client learns to change it. Use only within your training and competence.

Ch. 25 · 15

Define the behavior observably; measure a baseline; record ABCs; hypothesize the function (get or escape); teach a replacement behavior with the same function; apply it consistently across settings.

## CHAPTER 26

# Cognitive-Behavioral and Third-Wave Approaches

## Extra drills

### Drill 26.2 • Fill in the blank.

1. In the ABC model, the \_\_\_\_\_ about an event, not the event itself, drives the consequence.
2. Ellis called rigid demands on oneself, others, and the world \_\_\_\_\_.
3. In Beck's model, "I am unlovable" is a \_\_\_\_\_ belief.
4. In Beck's cognitive therapy, the stance in which counselor and client work as co-investigators, treating a thought as a hypothesis to test, is called \_\_\_\_\_.
5. The three phases of stress inoculation training are conceptualization, skill acquisition and rehearsal, and \_\_\_\_\_ and follow-through.
6. DBT's biosocial theory pairs emotional vulnerability with an \_\_\_\_\_ environment.
7. In DBT's target hierarchy, \_\_\_\_\_ behavior comes first.
8. ACT's six processes aim to build psychological \_\_\_\_\_.
9. MBCT was designed for people with recurrent depression who are in \_\_\_\_\_.
10. CBT-SP's first session always produces a written \_\_\_\_\_.

### Drill 26.3 • Who would say it? Write **E** (Ellis, REBT), **B** (Beck, cognitive therapy), **M** (Meichenbaum), **D** (DBT), **A** (ACT), or **C** (MBCT).

1. \_\_\_\_ "Where is it written that you must be approved of by everyone?"
2. \_\_\_\_ "Let's write down the evidence for and against that thought, then plan a small experiment."
3. \_\_\_\_ "Notice the thought, thank your mind for it, and take the next step toward what you care about."
4. \_\_\_\_ "Let's practice the self-statements you'll use when your heart starts racing before the speech."
5. \_\_\_\_ "Before we talk about your week, let's look at your diary card and the urge to cut on Tuesday."
6. \_\_\_\_ "When you sense your mood starting to slide, take three minutes to come back to your breath."

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## Answers to the Chapter 26 drills

**Drill answers.** 26.2: (1) belief. (2) musturbation (also correct: demandingness). (3) core. (4) collaborative empiricism (the stance itself; behavioral experiments and Socratic questioning are tools used within it). (5) application. (6) invalidating. (7) life-threatening. (8) flexibility. (9) remission. (10) safety plan. 26.3: 1-E (disputing a “must”). 2-B (collaborative evidence testing). 3-A (defusion plus committed action). 4-M (coping self-statements in stress inoculation). 5-D (diary card; life-threatening behavior first). 6-C (three-minute breathing space to catch a depressive slide; DBT also teaches mindfulness, but this practice is MBCT’s).

Ch. 26 · 1

**First, second, and third waves**

Ch. 26 · 2

**REBT: ABC(DE)**

Ch. 26 · 3

**Irrational beliefs (Ellis)**

Ch. 26 · 4

**Healthy vs. unhealthy negative  
emotions; shame-attacking**

Ch. 26 · 5

**Beck's three levels of cognition**

Ch. 26 · 6

**Cognitive triad**

Ch. 26 · 7

**Beck's distortions**

Ch. 26 · 8

**Collaborative empiricism**

Ch. 26 · 2

Ellis. A, activating event; B, belief; C, consequence. Beliefs, not events, drive C. D, dispute the irrational belief; E, effective new philosophy.

Ch. 26 · 1

First: behavior therapy. Second: cognitive therapy, which changes the content of thoughts. Third: acceptance, mindfulness, and values, which change the relationship to thoughts (Hayes, 2004).

Ch. 26 · 4

REBT does not aim for no feeling: swap anxiety for concern, depression for sadness, guilt for remorse. Shame-attacking: do something harmlessly embarrassing to learn disapproval is bearable.

Ch. 26 · 3

Rigid musts and shoulds (“musturbation”), awfulizing, low frustration tolerance (“I can’t stand it”), and rating one’s whole self. Goal: unconditional self-acceptance.

Ch. 26 · 6

Beck: negative views of self, world, and future in depression.

Ch. 26 · 5

Automatic thoughts (situation-specific) → intermediate beliefs (rules, assumptions) → core beliefs, or schemas (global: “I am unlovable”).

Ch. 26 · 8

Beck’s stance: test a thought as a hypothesis together, using Socratic questioning, thought records, behavioral experiments, and activity scheduling. Beck runs the experiment; Ellis argues the case.

Ch. 26 · 7

All-or-nothing thinking, overgeneralization, selective abstraction, arbitrary inference, magnification and minimization, personalization.

Ch. 26 · 9

**Self-instructional training**

Ch. 26 · 10

**Stress inoculation training (SIT)**

Ch. 26 · 11

**DBT essentials**

Ch. 26 · 12

**DBT modules and targets**

Ch. 26 · 13

**ACT hexaflex**

Ch. 26 · 14

**MBCT vs. MBSR**

Ch. 26 · 15

**CBT-SP**

Ch. 26 · 16

**Teaching a skill (task 4.3)**

Ch. 26 · 10

Meichenbaum (1985): conceptualization → skill acquisition and rehearsal → application and follow-through, with graded real stressors.

Ch. 26 · 9

Meichenbaum and Goodman (1971): counselor models aloud → child follows spoken instructions → self-instructs aloud → whispers → silent self-talk.

Ch. 26 · 12

Accept: mindfulness, distress tolerance. Change: emotion regulation, interpersonal effectiveness. Targets: life-threatening → therapy-interfering → quality-of-life-interfering behavior.

Ch. 26 · 11

Linehan. Biosocial theory (vulnerability plus invalidating environment). Acceptance and change. Individual therapy, skills group, phone coaching, consultation team. Diary card; chain analysis.

Ch. 26 · 14

MBCT (Segal, Williams, Teasdale): eight-week group to prevent depressive relapse in remission; decentering. MBSR (Kabat-Zinn): stress and pain broadly.

Ch. 26 · 13

Acceptance, cognitive defusion, present moment, self-as-context, values, committed action → psychological flexibility. Problems: fusion and experiential avoidance. Judge by workability.

Ch. 26 · 16

Instruct → model → rehearse → feedback and coaching → homework → generalize. A handout alone is psychoeducation (task 4.11).

Ch. 26 · 15

Teens after an attempt (Stanley et al., 2009). Session 1: written safety plan and chain analysis. Then skills, family sessions, and a relapse prevention task (imagine the crisis, rehearse skills).

## CHAPTER 27

# Reality, Postmodern, and Brief Approaches

## Extra drills

**Drill 27.2 • Sorting: stage of change.** Write the stage for each statement: **PC** (precontemplation), **C** (contemplation), **P** (preparation), **A** (action), or **M** (maintenance).

1. \_\_\_\_ “I joined a gym yesterday and start Monday with a trainer.”
2. \_\_\_\_ “It’s been a year since my last cigarette, and I still avoid the smoke break.”
3. \_\_\_\_ “My doctor keeps nagging, but my blood pressure is fine.”
4. \_\_\_\_ “I know my spending is a problem, but shopping is the only fun I have.”
5. \_\_\_\_ “I haven’t had a drink in two months, not even at parties.”
6. \_\_\_\_ “I’m seriously thinking about cutting back on gaming in the next few months, but I’m not sure I can.”
7. \_\_\_\_ “I haven’t gambled in eight months, and I’m still going to meetings.”
8. \_\_\_\_ “My wife complains about my drinking, but she’s the one with the problem. I’m only here for her.”

**Drill 27.3 • Fill in the blank.**

1. Reality therapy was introduced by \_\_\_\_\_; the WDEP system was organized by \_\_\_\_\_.
2. In WDEP, the step that asks “Is it working?” is \_\_\_\_\_.
3. The SFBT question that imagines the problem solved overnight is the \_\_\_\_\_ question.
4. A client who wants someone else to change is, in SFBT terms, a \_\_\_\_\_.
5. Narrative therapists say the person is not the problem; the \_\_\_\_\_ is the problem.
6. A moment when the problem did not win is a \_\_\_\_\_ outcome.
7. The four MI skills abbreviated OARS are open questions, \_\_\_\_\_, reflections, and summaries.
8. In MI, statements defending the status quo are called \_\_\_\_\_ talk.
9. The counselor’s urge to fix or persuade is the \_\_\_\_\_ reflex.
10. The three MCO pillars are cultural humility, cultural \_\_\_\_\_, and cultural \_\_\_\_\_.

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## Answers to the Chapter 27 drills

**Drill answers.** 27.2: 1-P (joining is a preparatory step; the exercise itself has not started). 2-M. 3-PC. 4-C. 5-A (full abstinence, under 6 months). 6-C (intends to change within months, not within the next month, and is still ambivalent). 7-M (beyond 6 months). 8-PC (sees no problem with his drinking and attends only for his wife). 27.3: (1) William Glasser; Robert Wubbolding. (2) evaluation. (3) miracle. (4) complainant. (5) problem. (6) unique. (7) affirmations. (8) sustain. (9) righting or fixing (either is correct: “righting reflex” in the 2013 edition, renamed “fixing reflex” in the 2023 edition). (10) opportunities; comfort (either order).

Ch. 27 · 1

**Glasser's five basic needs**

Ch. 27 · 2

**Quality world**

Ch. 27 · 3

**Total behavior**

Ch. 27 · 4

**Reality therapy: what it ignores**

Ch. 27 · 5

**WDEP (Wubbolding)**

Ch. 27 · 6

**Reality therapy plans**

Ch. 27 · 7

**Social constructionism**

Ch. 27 · 8

**SFBT basics**

Ch. 27 · 2

A person's inner album of the people, things, and beliefs that best satisfy their needs. Wants in WDEP come from here.

Ch. 27 · 1

Survival, love and belonging, power, freedom, and fun. In choice theory, all behavior is a chosen attempt to meet them (Glasser, 1998).

Ch. 27 · 4

Little attention to the past, transference, the unconscious, or excuses. No criticism or punishment; the counselor never gives up.

Ch. 27 · 3

Acting, thinking, feeling, and physiology. We directly control acting and thinking; feeling and physiology follow. Hence "depressing," not "depressed."

Ch. 27 · 6

Simple, attainable, immediate, controlled by the client, and committed to. A failed plan is revised, not punished or excused.

Ch. 27 · 5

Wants, Doing and direction, Evaluation, Planning. Evaluation ("Is it getting you what you want?") is the heart of the method.

Ch. 27 · 8

de Shazer, Berg, and colleagues. Focus on solutions, not causes. If it works, do more of it; if not, do something different. Small changes grow.

Ch. 27 · 7

The postmodern premise that reality is built in language and relationships. The client is the expert; the counselor is a curious collaborator.

Ch. 27 · 9

**Miracle question**

Ch. 27 · 10

**Exception, scaling, coping questions**

Ch. 27 · 11

**Visitor, complainant, customer**

Ch. 27 · 12

**Narrative therapy**

Ch. 27 · 13

**Exception vs. unique outcome**

Ch. 27 · 14

**MI essentials**

Ch. 27 · 15

**Change talk vs. sustain talk  
vs. discord**

Ch. 27 · 16

**Stages of change**

Ch. 27 · 10

Exception: when is the problem absent or smaller (past)? Scaling: 0 to 10 today, and one point higher? Coping: how have you kept going?

Ch. 27 · 9

“If the problem vanished overnight, what would you notice first tomorrow?” Pictures the future and defines concrete goals (de Shazer, 1988).

Ch. 27 · 12

White and Epston (1990). Problem-saturated stories; externalizing; deconstruction; unique outcomes; re-authoring; therapeutic letters and certificates.

Ch. 27 · 11

SFBT readiness. Visitor: sees no problem. Complainant: wants someone else to change. Customer: ready to act.

Ch. 27 · 14

Miller and Rollnick. Resolve ambivalence. Spirit: collaboration, acceptance, compassion, evocation (empowerment in the 2023 edition). Processes (tasks in 2023): engaging, focusing, evoking, planning. OARS.

Ch. 27 · 13

SFBT exception builds behavior: do more of it. Narrative unique outcome builds identity: what does it say about who you are?

Ch. 27 · 16

Precontemplation (never), contemplation (maybe), preparation (soon), action (now, under 6 months), maintenance (still, beyond 6 months). Relapse is recycling.

Ch. 27 · 15

Change talk: DARN (desire, ability, reasons, need) and CAT (commitment, activation, taking steps). Sustain talk: for the status quo. Discord: relationship friction.

Ch. 27 · 17

**Multicultural orientation (MCO)**

A way of being, not a skill set (Owen et al., 2011; Davis et al., 2018). Pillars: cultural humility, cultural opportunities, cultural comfort (Davis et al., 2018).

## CHAPTER 28

# Couples and Family Counseling

## Extra drills

### Drill 28.2 • Fill in the blank.

1. Bowen's term for emotional reactivity and loss of self (one word, starting with *f*) is \_\_\_\_\_.
2. A diffuse boundary produces \_\_\_\_\_; a rigid boundary produces \_\_\_\_\_.
3. Having a family argue about chores in session so the counselor can watch is called \_\_\_\_\_.
4. Telling a client to deliberately do the symptom is \_\_\_\_\_ the symptom.
5. The MRI group held that a family's \_\_\_\_\_ keep the problem going.
6. Satir's healthy communication stance is \_\_\_\_\_.
7. The Gottman antidote to stonewalling is physiological \_\_\_\_\_.
8. In EFT, anger is often a reactive, \_\_\_\_\_ emotion covering a primary emotion such as fear.
9. In IFS, parts that react to pain with impulsive behavior are called \_\_\_\_\_.
10. Ongoing violence with fear or coercive control is a \_\_\_\_\_ to conjoint couples counseling.

### Drill 28.3 • Who is talking? Write the approach each counselor statement most likely comes from: **B** (Bowenian), **S** (structural), **ST** (strategic or MRI), **G** (Gottman), **E** (EFT), or **I** (IFS).

1. \_\_\_\_ "Mom, Dad, I'd like the two of you to decide right now what the bedtime will be, and Sam can wait outside the circle."
2. \_\_\_\_ "What did you try last time he refused school? And when that didn't work, what did you do next?"
3. \_\_\_\_ "Let's notice the eye-rolling. What would it sound like to tell him what you appreciate instead?"
4. \_\_\_\_ "When you go quiet and she follows you, what are you most afraid will happen?"
5. \_\_\_\_ "How did your grandparents handle conflict, and where do you see that pattern now?"
6. \_\_\_\_ "Can you ask the part of you that wants to drink what it's protecting you from?"
7. \_\_\_\_ "This week, I want you to have the argument on purpose, at exactly 7:00, for 10 minutes."
8. \_\_\_\_ "Rather than answering for your son, let him tell me himself."

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## Answers to the Chapter 28 drills

**Drill answers.** 28.2: (1) fusion. (2) enmeshment; disengagement. (3) enactment. (4) prescribing (a paradoxical directive; Frankl's related technique is paradoxical intention, Chapter 24). (5) attempted solutions. (6) congruent (leveling). (7) self-soothing. (8) secondary. (9) firefighters. (10) contraindication. 28.3: 1-S (enactment and boundary making). 2-ST (asking about attempted solutions, an MRI move). 3-G (contempt and its antidote). 4-E (attachment fear inside the cycle). 5-B (multigenerational transmission). 6-I (a firefighter part). 7-ST (paradoxical directive). 8-S (boundary making: blocking a parent who speaks for the child).

Ch. 28 · 1

**Systems vocabulary**

Ch. 28 · 2

**First- vs. second-order change**

Ch. 28 · 3

**Bowen's eight concepts**

Ch. 28 · 4

**Differentiation vs. fusion**

Ch. 28 · 5

**Triangles**

Ch. 28 · 6

**Emotional cutoff and the genogram**

Ch. 28 · 7

**Structural boundaries**

Ch. 28 · 8

**Structural techniques**

Ch. 28 · 2

First-order: behavior changes inside the same rules. Second-order: the rules change (Watzlawick et al., 1974; MRI).

Ch. 28 · 1

Homeostasis: the pull toward balance. Feedback: negative restores, positive amplifies. Circular causality: everyone is cause and effect. Identified patient: carries the symptom. Equifinality: many paths, same outcome.

Ch. 28 · 4

Differentiation: thinking separate from feeling; oneself while connected. Fusion: emotional reactivity and loss of self in the family system (Bowen).

Ch. 28 · 3

Differentiation of self, triangles, nuclear family emotional process, family projection process, multigenerational transmission process, emotional cutoff, sibling position, societal emotional process.

Ch. 28 · 6

Cutoff: distance or no contact to manage unresolved tension; the tension remains. Genogram: map of at least three generations, Bowen's assessment tool.

Ch. 28 · 5

A tense two-person relationship pulls in a third person, often a child, to lower anxiety. The Bowenian counselor stays detriangulated.

Ch. 28 · 8

Joining (tracking, mimesis), enactment, boundary making, unbalancing, reframing, family mapping.

Ch. 28 · 7

Diffuse: enmeshment. Rigid: disengagement. Clear: closeness with autonomy. Parents in charge (hierarchy). Cross-generational coalition: parent and child against the other parent (Minuchin).

Ch. 28 · 9

**Strategic therapy**

Ch. 28 · 10

**MRI and Milan**

Ch. 28 · 11

**Satir and Whitaker**

Ch. 28 · 12

**Four Horsemen and antidotes**

Ch. 28 · 13

**Gottman's numbers**

Ch. 28 · 14

**EFT**

Ch. 28 · 15

**IFS**

Ch. 28 · 16

**Safety and ethics in couples work**

Ch. 28 · 10

MRI: attempted solutions maintain the problem; interrupt them. Milan (Selvini Palazzoli et al.): hypothesizing, circular questioning, neutrality, positive connotation.

Ch. 28 · 9

Haley and Madanes: brief, problem-focused; symptoms serve a function and reflect hierarchy problems. Directives (straight or paradoxical), prescribing the symptom, ordeals, pretend techniques.

Ch. 28 · 12

Criticism: gentle start-up. Contempt: culture of appreciation. Defensiveness: take responsibility. Stonewalling: physiological self-soothing. Contempt is the strongest predictor of divorce.

Ch. 28 · 11

Satir: placating, blaming, super-reasonable (computing), irrelevant (distracting) vs. congruent leveling; family sculpting, family reconstruction. Whitaker: symbolic-experiential; use of self, absurdity, co-therapist.

Ch. 28 · 14

Johnson and Greenberg (1980s); attachment-based. The pursue-withdraw cycle is the enemy. Secondary emotions (anger) cover primary ones (fear). Stages: de-escalate, restructure interactions, consolidate.

Ch. 28 · 13

About 5 positive interactions for every negative one during conflict in stable couples. About 69% of conflicts are perpetual: manage them through dialogue, don't expect to solve them.

Ch. 28 · 16

Screen each person individually; fear or coercive control contraindicates conjoint work. Define the client (A.8) and secrets policy (B.4.b) before disclosures.

Ch. 28 · 15

Schwartz: the mind is a system of parts. Managers (proactive), firefighters (reactive), exiles (hurt). No bad parts. Goal: Self-leadership.

## CHAPTER 29

# Crisis Intervention and Trauma-Informed Care

## Extra drills

**Drill 29.2 • Sequence the models.** Number the steps in order.

*James and Gilliland's six-step model:* \_\_\_\_ make plans · \_\_\_\_ ensure client safety · \_\_\_\_ define the problem · \_\_\_\_ obtain commitment · \_\_\_\_ provide support · \_\_\_\_ examine alternatives

*Roberts's seven-stage model:* \_\_\_\_ follow up · \_\_\_\_ establish rapport · \_\_\_\_ generate alternatives · \_\_\_\_ assess lethality and needs · \_\_\_\_ deal with feelings · \_\_\_\_ form an action plan · \_\_\_\_ identify major problems

**Drill 29.3 • Sorting: helps or harms?** Write **H** (helps: consistent with crisis, disaster, postvention, or trauma-informed best practice) or **X** (harms or is not recommended).

1. \_\_\_\_ Requiring every employee who saw an accident to attend a single debriefing session
2. \_\_\_\_ Telling students about a classmate's suicide in homerooms, without describing the method
3. \_\_\_\_ Standing close to an agitated client and gripping his arm to steady him
4. \_\_\_\_ Offering a survivor water, a phone charger, and help locating her children
5. \_\_\_\_ Asking every new client to describe their worst trauma in detail at intake
6. \_\_\_\_ Building a safety plan with a client who chooses to stay with an abusive spouse
7. \_\_\_\_ Couples counseling while one spouse is threatening the other with a gun
8. \_\_\_\_ Explaining each step of an intake and asking permission before a blood-pressure check

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## Answers to the Chapter 29 drills

**Drill answers.** 29.2: Six-step: define the problem 1, ensure safety 2, provide support 3, examine alternatives 4, make plans 5, obtain commitment 6. Seven-stage: assess lethality and needs 1 (it overlaps with rapport but is numbered first), establish rapport 2, identify major problems 3, deal with feelings 4, generate alternatives 5, form an action plan 6, follow up 7. 29.3: 1-X (debriefing for all does not prevent PTSD). 2-H. 3-X (touch and crowding escalate). 4-H (PFA practical assistance and connection). 5-X (forced disclosure risks retraumatization). 6-H (respect choices; plan for safety where she is). 7-X. 8-H (transparency and choice).

Ch. 29 · 1

## **Crisis**

Ch. 29 · 2

## **Crisis vs. emergency**

Ch. 29 · 3

## **Lindemann (1944)**

Ch. 29 · 4

## **Caplan (1964)**

Ch. 29 · 5

## **Four types of crisis**

Ch. 29 · 6

## **Six-step model**

Ch. 29 · 7

## **Seven-stage model**

Ch. 29 · 8

## **Directiveness in crisis work**

Ch. 29 · 2

Emergency: life in danger right now (overdose in progress, weapon drawn); call emergency services first. Crisis: coping has failed but no one is in immediate danger; counseling begins.

Ch. 29 · 1

A temporary state in which usual coping fails to manage an event as the person perceives it. Time-limited; a turning point toward growth or decline; not a disorder.

Ch. 29 · 4

Crisis upsets equilibrium and is time-limited; intervention restores at least precrisis functioning. Three levels of prevention: primary (prevent), secondary (catch early), tertiary (limit impairment).

Ch. 29 · 3

Studied grief, notably among people bereaved by Boston's 1942 Cocoanut Grove nightclub fire; acute grief follows a predictable course that brief help can ease. A founding study of crisis theory.

Ch. 29 · 6

James and Gilliland (2017). Listening: define the problem, ensure safety, provide support. Acting: examine alternatives, make plans, obtain commitment. Assessment runs throughout.

Ch. 29 · 5

James and Gilliland (2017): developmental (expected transitions), situational (sudden events), existential (purpose and meaning), ecosystemic (disasters striking a community).

Ch. 29 · 8

Brief, active, present-focused. The counselor becomes more directive as the client's functioning drops (James & Gilliland, 2017).

Ch. 29 · 7

Roberts (2005): assess lethality and needs, establish rapport, identify problems, deal with feelings, generate alternatives, form an action plan, follow up.

Ch. 29 · 9

**Imminent suicide risk**

Ch. 29 · 10

**Involuntary commitment**

Ch. 29 · 11

**988 Suicide & Crisis Lifeline**

Ch. 29 · 12

**Verbal de-escalation**

Ch. 29 · 13

**Cycle of violence**

Ch. 29 · 14

**Domestic violence lethality**

Ch. 29 · 15

**Psychological first aid**

Ch. 29 · 16

**Postvention and trauma-informed  
care**

Ch. 29 · 10

Set by state law. Most states require mental illness plus danger to self or others; most also count grave disability (inability to meet basic needs).

Ch. 29 · 9

Do not leave the client alone. Arrange an emergency evaluation in the least restrictive safe setting; voluntary before involuntary. Never a no-suicide contract.

Ch. 29 · 12

Richmond et al. (2012): calm yourself; at least two arm's lengths, exits clear; one voice, brief sentences; ask about wants and feelings; agree where possible; set limits; offer choices; debrief afterward.

Ch. 29 · 11

Call, text, or chat. People do not have to be suicidal to contact it; veterans press 1 for the Veterans Crisis Line. Launched in 2022.

Ch. 29 · 14

Campbell et al. (2003): abuser's access to a gun, past threats with a weapon, and separation (especially from a controlling abuser) raise homicide risk. Safety plan; no couples counseling while violence continues.

Ch. 29 · 13

Walker (1979): tension building, acute battering incident, loving contrition ("honeymoon"), then renewed tension.

Ch. 29 · 16

Postvention (AFSP & SPRC, 2018): confirm facts; inform students in small groups, not by assembly or PA; no method details; screen; treat all deaths alike. Trauma-informed care (SAMHSA, 2014): realize, recognize, respond, resist retraumatization; six principles.

Ch. 29 · 15

Brymer et al. (2006), eight core actions: contact and engagement; safety and comfort; stabilization; information gathering; practical assistance; connection with social supports; information on coping; linkage with services. No debriefing for all.

## CHAPTER 30

# Group Foundations, Types, and Stages

## Extra drills

### Drill 30.2 • Fill in the blank.

1. The ASGW group type that teaches skills from a structured curriculum is the \_\_\_\_\_ group.
2. A group run by peers in recovery, with no professional leader, is a \_\_\_\_\_ group.
3. A \_\_\_\_\_ group keeps the same members from start to finish.
4. Standard A.9.a requires counselors to \_\_\_\_\_ prospective group members.
5. In a group, the leader explains that members' confidentiality cannot be \_\_\_\_\_.
6. The fifth stage of Tuckman's model, added by Tuckman and Jensen in 1977, is \_\_\_\_\_.
7. In Corey's model, members testing and challenging the leader signals the \_\_\_\_\_ stage.
8. Cohesion, risk-taking, and unprompted here-and-now feedback mark the \_\_\_\_\_ stage.

**Drill 30.3 • Sequence: put the moments in order.** Number these moments in a closed 12-week counseling group from 1 (earliest) to 6 (latest).

| Moment                                                       | Order |
|--------------------------------------------------------------|-------|
| Members review what they learned and say goodbye             | ----  |
| The leader interviews each candidate individually            | ----  |
| Two members argue, and one says the group is pointless       | ----  |
| Members talk politely and ask what they should share         | ----  |
| The leader holds a follow-up meeting and evaluates the group | ----  |
| Members give one another candid feedback without prompting   | ----  |

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## Answers to the Chapter 30 drills

**Drill answers.** 30.2: (1) psychoeducational. (2) self-help (also accept peer-support, mutual-help, or mutual-aid; a bare “support” is not enough, because many support groups have professional leaders). (3) closed. (4) screen. (5) guaranteed (or ensured, assured, promised). (6) adjourning. (7) transition. (8) working. 30.3: Leader interviews candidates (1, pre-group); polite talk (2, initial); argument (3, transition); candid feedback (4, working); review and goodbye (5, final); follow-up and evaluation (6, post-group). In table order: 5, 1, 3, 2, 6, 4.

Ch. 30 · 1

**Task/work group**

Ch. 30 · 2

**Psychoeducational group**

Ch. 30 · 3

**Counseling group**

Ch. 30 · 4

**Psychotherapy group**

Ch. 30 · 5

**Self-help vs. counselor-led**

Ch. 30 · 6

**Open vs. closed groups**

Ch. 30 · 7

**Homogeneous vs. heterogeneous**

Ch. 30 · 8

**Group size**

Ch. 30 · 2

Teaches skills and information to prevent problems: parenting, anger management, study skills. Structured curriculum; the leader sets the agenda.

Ch. 30 · 1

One of ASGW's four types (ASGW, 2000). Accomplishes a goal or product: committees, treatment teams. The focus is the work, not personal change. Verb: does.

Ch. 30 · 4

Remediates serious or long-standing problems; deeper and longer, and may reach past and unconscious material.

Ch. 30 · 3

Relatively well-functioning members work on present, conscious concerns and interpersonal growth, with a here-and-now focus.

Ch. 30 · 6

Closed: fixed membership after the start; faster cohesion. Open: members join as others leave; can run indefinitely, but repeated adjustment.

Ch. 30 · 5

Self-help and peer-support groups (twelve-step fellowships) are peer-led. Counselors refer to them; a counselor-led group is never a self-help group.

Ch. 30 · 8

Interactional adult groups: about 7 or 8 members, within roughly 5 to 10 (Yalom & Leszcz, 2020). Children's groups are smaller, with shorter sessions.

Ch. 30 · 7

Homogeneous: members share a concern; quick bonding and support. Heterogeneous: varied members; richer feedback that mirrors daily life.

Ch. 30 · 9

**ASGW best practice: three P's**

Ch. 30 · 10

**Screening and protection (A.9.a,  
A.9.b)**

Ch. 30 · 11

**Group informed consent**

Ch. 30 · 12

**Tuckman's stages**

Ch. 30 · 13

**Corey's stages**

Ch. 30 · 14

**Guests, rivals, family, alumni**

Ch. 30 · 15

**Transition stage: leader response**

Ch. 30 · 16

**Membership changes and endings**

Ch. 30 · 10

Screen for members whose goals fit, who will not impede the group, and who will not be harmed; usually an individual interview. Then protect members from trauma.

Ch. 30 · 9

Planning, performing, processing (2007 guidelines; Thomas & Pender, 2008). Planning includes needs assessment, goals, structure, recruitment, screening, and evaluation. The 2021 Guiding Principles keep the arc: pre-group planning, facilitation, evaluation (McCarthy et al., 2022).

Ch. 30 · 12

Forming, storming, norming, performing (1965); adjourning added by Tuckman and Jensen (1977).

Ch. 30 · 11

Purpose, format, leader qualifications, risks, confidentiality's parameters (B.4.a), including that members' confidentiality cannot be guaranteed, attendance and outside-contact policies, and the right to leave.

Ch. 30 · 14

Initial: polite guests. Transition: rivals testing the leader. Working: family that can be honest. Final: alumni carrying lessons home.

Ch. 30 · 13

Pre-group, initial, transition, working, final, post-group. Transition = storming; working = norming and performing.

Ch. 30 · 16

Newcomer: prepare individually; expect a brief return to trust issues. Leaver: invite them to tell the group. Ending: announce early; review, feedback, transfer, goodbye.

Ch. 30 · 15

Treat conflict and challenges as normal; engage them openly and without defensiveness; invite members to say their reactions in the group.

## CHAPTER 31

# Group Leadership, Therapeutic Factors, and Ethics

## Extra drills

### Drill 31.2 • Fill in the blank.

1. Yalom called \_\_\_\_\_ the group's counterpart to the therapeutic relationship.
2. Learning "I am not the only one" illustrates \_\_\_\_\_.
3. Over time, the group becomes a social \_\_\_\_\_ of members' lives outside it.
4. Commenting on how members are relating right now is process \_\_\_\_\_.
5. Lieberman, Yalom, and Miles found the best outcomes when caring and \_\_\_\_\_ were high.
6. In Benne and Sheats's scheme, the harmonizer is a building and \_\_\_\_\_ role.
7. Members casting one co-leader as good and the other as bad is called \_\_\_\_\_.
8. ACA Standard \_\_\_\_\_ requires reasonable precautions to protect group members from trauma.

### Drill 31.3 • Sorting: choose the leader's move. Write **L** (linking), **B** (blocking: stop harmful behavior), **C** (cutting off: redirect off-focus talk), **D** (drawing out), or **P** (process illumination).

1. \_\_\_\_ Two members are mocking a third member's weight.
2. \_\_\_\_ Both Ana and Theo have described feeling like a burden to their adult children.
3. \_\_\_\_ Ravi has talked for 15 minutes about his commute; others are checking the clock.
4. \_\_\_\_ A member who rarely speaks leans forward as others discuss loneliness.
5. \_\_\_\_ Every time conflict starts, the group changes the subject to safer topics.
6. \_\_\_\_ Members begin asking one person a rapid series of probing questions about her divorce.
7. \_\_\_\_ Mei's fear of being judged echoes what Carlos said last week.
8. \_\_\_\_ The group has fallen silent each time the leader asks about the upcoming final session.

---

## Answers to the Chapter 31 drills

**Drill answers.** 31.2: (1) group cohesiveness. (2) universality. (3) microcosm. (4) illumination (or commentary). (5) meaning attribution. (6) maintenance. (7) splitting. (8) A.9.b. 31.3: 1-B. 2-L. 3-C (off-focus talk that uses up the time calls for cutting off; some texts list storytelling under blocking, but this drill keeps B for harmful behavior; then invite others in). 4-D (an invitation, not a demand). 5-P (name the pattern and explore it). 6-B (interrogation pressures disclosure). 7-L. 8-P (the whole group falls silent, so comment on the pattern and what it may mean as the group nears its end; drawing out targets one quiet member).

Ch. 31 · 1

**Yalom's 11 therapeutic factors**

Ch. 31 · 2

**Universality, cohesiveness, hope,  
altruism**

Ch. 31 · 3

**Corrective recapitulation of the  
primary family group**

Ch. 31 · 4

**Interpersonal learning and the social  
microcosm**

Ch. 31 · 5

**Cohesiveness and catharsis**

Ch. 31 · 6

**Here-and-now and process  
illumination**

Ch. 31 · 7

**Linking vs. blocking**

Ch. 31 · 8

**Cutting off vs. drawing out**

Ch. 31 · 2

“Me too” (the problem is shared) = universality. “We” (I belong) = cohesiveness. “She made it” = hope. “I gave” = altruism.

Ch. 31 · 1

Instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, socializing techniques, imitative behavior, interpersonal learning, cohesiveness, catharsis, existential factors (Yalom & Leszcz, 2020).

Ch. 31 · 4

Over time, members act in the group as they do outside it. Feedback shows them their impact, and they try new behavior.

Ch. 31 · 3

Family-of-origin patterns replay with leaders (parent figures) and members (siblings) and are recognized and reworked.

Ch. 31 · 6

Two steps: members interact in the present; the leader then helps them examine what just happened. Storytelling is turned toward feelings in the room.

Ch. 31 · 5

Cohesiveness is the group's counterpart to the therapeutic relationship and a precondition for the other factors. Catharsis helps when paired with understanding, not on its own.

Ch. 31 · 8

Cutting off respectfully interrupts rambling or a member using up the time. Drawing out invites a quiet member to participate, without pressure.

Ch. 31 · 7

Linking connects members' words, feelings, and themes, building universality and member-to-member talk. Blocking stops harmful behavior (scapegoating, gossip, pressured disclosure) and protects everyone involved.

Ch. 31 · 9

**Effective feedback**

Ch. 31 · 10

**Lewin's leadership climates (1939)**

Ch. 31 · 11

**Four leader functions (1973)**

Ch. 31 · 12

**Co-leadership**

Ch. 31 · 13

**Benne and Sheats's member roles  
(1948)**

Ch. 31 · 14

**Problem behaviors**

Ch. 31 · 15

**Outside contact and subgroups**

Ch. 31 · 16

**Group ethics: ACA and ASGW**

Ch. 31 · 10

Authoritarian (autocratic), democratic, laissez-faire. Exam default: democratic, shared leadership; laissez-faire leaves members adrift (Lewin et al., 1939).

Ch. 31 · 9

Specific, behavioral (not about character), timely, and owned by the speaker ("I felt brushed aside"). The leader models giving and receiving it.

Ch. 31 · 12

Benefits: two perspectives, a modeled working relationship, coverage, support. Risks: competition, unresolved conflict, splitting (one leader cast as good, the other bad). Plan, debrief, use supervision.

Ch. 31 · 11

Emotional stimulation, caring, meaning attribution, executive function. Best outcomes: caring and meaning attribution high; stimulation and executive function moderate (Lieberman et al., 1973).

Ch. 31 · 14

Monopolizing: cut off, link, explore. Scapegoating: block at once, protect, explore. Rescuing or advice-giving: redirect to one's own experience. Silence: invite, never demand. Rule: protect, then explore.

Ch. 31 · 13

Task roles move the work (initiator, information seeker). Building and maintenance roles sustain relationships (encourager, harmonizer, gatekeeper). Individual roles serve one member at the group's expense (aggressor, blocker, dominator).

Ch. 31 · 16

ACA (2014): A.9.a screening, A.9.b protecting members from trauma, B.4.a explaining confidentiality's importance and parameters. ASGW: planning, performing, processing (2007); 2021 Guiding Principles; at least 10 hours as a group member in training.

Ch. 31 · 15

Leaders explain in advance what outside contact can mean. Secrecy is the danger, so meaningful outside contact is brought into the group, not banned or ignored.

## CHAPTER 32

# Core Conditions and the Counselor as a Person

## Extra drills

### Drill 32.2 • Fill in the blank.

1. Rogers (1957) called his conditions necessary and \_\_\_\_\_.
2. For the conditions to work, the client must \_\_\_\_\_ the counselor's empathy and regard.
3. Empathy feels with the client; sympathy feels \_\_\_\_\_ the client.
4. Overidentification loses the "\_\_\_\_\_" quality of empathy.
5. On Carkhuff's scale, level 3 responses are called \_\_\_\_\_.
6. Unconditional positive regard means no conditions of \_\_\_\_\_.
7. Standard A.11.b bars referral based solely on the counselor's personally held \_\_\_\_\_, attitudes, beliefs, and behaviors.
8. A client who suddenly agrees with everything after a challenge may be showing a \_\_\_\_\_ rupture.

**Drill 32.3 • Rate the response.** A client says, "My mom keeps calling me lazy for living at home, but I'm working two jobs to pay off loans." Write **S** (subtractive), **I** (interchangeable), or **A** (additive) for each counselor response.

1. \_\_\_\_ "Have you thought about moving out?"
2. \_\_\_\_ "You're frustrated that she calls you lazy when you're working this hard."
3. \_\_\_\_ "Maybe what stings most is wanting her to see how hard you're trying."
4. \_\_\_\_ "I'm sure she doesn't really mean it."
5. \_\_\_\_ "Why does her opinion matter so much?"
6. \_\_\_\_ "It's maddening to be called lazy while you're stretched this thin."
7. \_\_\_\_ "It sounds like you may be wondering whether you'll ever earn her respect."
8. \_\_\_\_ "Lots of young adults live at home these days."

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## Answers to the Chapter 32 drills

**Drill answers.** 32.2: (1) sufficient. (2) perceive (or experience). (3) for. (4) as if. (5) interchangeable (or minimally facilitative). (6) worth. (7) values. (8) withdrawal. 32.3: 1-S (advice). 2-I. 3-A (names an implied wish). 4-S (reassurance that dismisses the client's experience). 5-S ("why" question). 6-I (surface feeling and situation, nothing added; "maddening" restates her frustration, while an additive response would name a deeper feeling, such as hurt). 7-A (names an implied fear). 8-S (minimizes).

Ch. 32 · 1

**Rogers's six conditions (1957)**

Ch. 32 · 2

**“Necessary and sufficient”**

Ch. 32 · 3

**Empathy and outcome**

Ch. 32 · 4

**Congruence vs. genuineness**

Ch. 32 · 5

**What congruence is not**

Ch. 32 · 6

**Empathy, sympathy,  
overidentification**

Ch. 32 · 7

**Attunement vs. responding (6G, 6H)**

Ch. 32 · 8

**Carkhuff's scale (1969)**

Ch. 32 · 2

Rogers's claim for his conditions (1957). Many now see them as necessary but not sufficient: groundwork, not the whole treatment.

Ch. 32 · 1

Psychological contact; a client in a state of incongruence (vulnerable or anxious); a congruent counselor; unconditional positive regard; empathic understanding; and the client perceiving the empathy and regard.

Ch. 32 · 4

Congruence: inner experience, awareness, and expression match. Genuineness: how that looks from outside, a real person rather than a façade. Rogers used the terms interchangeably.

Ch. 32 · 3

A meta-analysis found empathy a moderately strong predictor of outcome ( $r = .28$ ), holding across theoretical orientations (Elliott et al., 2018).

Ch. 32 · 6

Empathy feels with the client. Sympathy feels for the client. Overidentification feels as the client, losing the "as if."

Ch. 32 · 5

Saying everything you feel. The congruent counselor admits reactions when asked and voices them briefly, only when that serves the client.

Ch. 32 · 8

Levels 1–2 subtractive (miss, minimize, redirect); level 3 interchangeable (minimum helpful level); levels 4–5 additive (name what is implied).

Ch. 32 · 7

Empathic attunement senses what the client feels, moment to moment, voice and body included. Empathic responding communicates that understanding.

Ch. 32 · 9

**Additive empathy: timing**

Ch. 32 · 10

**The most empathic exam option**

Ch. 32 · 11

**Unconditional positive regard**

Ch. 32 · 12

**Non-judgmental stance (A.4.b, A.11.b)**

Ch. 32 · 13

**Alliance rupture**

Ch. 32 · 14

**Confrontation vs. withdrawal  
ruptures**

Ch. 32 · 15

**Conflict tolerance (6F; 2027 task 4.15)**

Ch. 32 · 16

**The counselor as a person (6A; 1B.11)**

Ch. 32 · 10

Names the feeling and its meaning, tentatively, and stops. Reassurance, advice, “why” questions, and imposed interpretations are subtractive.

Ch. 32 · 9

Use it once trust exists. Offered too early, naming what the client has not said feels like mind reading.

Ch. 32 · 12

Avoid imposing personal values; never refer solely over a values difference. Not value-free: safety and ethics still apply.

Ch. 32 · 11

Acceptance of the client as a person with no conditions of worth; also called prizing. Not approval: you can prize a client and still challenge harmful behavior.

Ch. 32 · 14

Confrontation: the client moves against the counselor (complaints, anger). Withdrawal: the client moves away (vague answers, sudden compliance, topic shifts).

Ch. 32 · 13

A strain over goals, tasks, or the bond. Repair is moderately linked to better outcomes (Eubanks et al., 2018).

Ch. 32 · 16

Core conditions are ways of being. Self-awareness lets you notice a reaction, bracket it in session, and examine it later in supervision.

Ch. 32 · 15

Stay steady and nondefensive under criticism: name the strain, invite more, own your part, adjust. Explaining, defending, or referring are distractors.

## CHAPTER 33

# Multicultural and Social Justice Counseling

## Extra drills

### Drill 33.2 • Fill in the blank.

1. The MSJCC added the counseling \_\_\_\_\_ domain and the competency of \_\_\_\_\_.
2. Pedersen (1991) called multiculturalism counseling's \_\_\_\_\_ force.
3. In Sue's model, the dominant U.S. worldview is \_\_\_\_\_.
4. In Berry's model, keeping one's heritage culture while taking part in the new one is the strategy of \_\_\_\_\_.
5. "Where are you really from?" is the type of microaggression called a \_\_\_\_\_.
6. Among the three levels of racism, policies that produce unequal outcomes regardless of intent illustrate \_\_\_\_\_ racism.
7. Raising race and culture with a client, early and throughout, is called \_\_\_\_\_.
8. The MCO pillars are cultural humility, cultural \_\_\_\_\_, and cultural \_\_\_\_\_.
9. Standard \_\_\_\_\_ requires client consent before advocating for an identifiable client.
10. In the 2018 Advocacy Competencies, "public information" became \_\_\_\_\_.

### Drill 33.3 • Sorting: which advocacy domain? Write **CE** (client/student empowerment), **CA** (client/student advocacy), **CC** (community collaboration), **SA** (systems advocacy), **AC** (collective action), or **SP** (social/political advocacy).

1. \_\_\_\_ A counselor role-plays with a teen how to ask a teacher for an accommodation.
2. \_\_\_\_ With consent, a counselor calls a housing office to challenge a client's denied application.
3. \_\_\_\_ A counselor offers group-facilitation skills to a neighborhood association that is leading its own effort to make a local park safer.
4. \_\_\_\_ A counselor chairs an agency committee that adds evening intake hours for shift workers.
5. \_\_\_\_ A counselor helps a coalition of parents prepare their own testimony to the state legislature and a public-awareness campaign they have chosen to run.
6. \_\_\_\_ A counselor writes an op-ed urging the legislature to fund more school counselors.

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## Answers to the Chapter 33 drills

**Drill answers.** 33.2: (1) relationship; action. (2) fourth. (3) internal control, internal responsibility (IC-IR). (4) integration. (5) microinvalidation. (6) institutional. (7) broaching. (8) opportunities; comfort (either order). (9) A.7.b. (10) collective action. 33.3: 1-CE (acting with one client). 2-CA (acting on behalf of one client, with consent). 3-CC (a local, community-level issue; the community leads and the counselor is an ally. Collective action also draws on group facilitation, so scale decides: a neighborhood park is not a public-arena issue). 4-SA (changing an organization's practice on behalf of a client group). 5-AC (public arena, acting with a group that chose its own campaign; the parents, not the counselor, testify to the legislature). 6-SP (public arena, the counselor speaking alone on behalf of client populations; the 2018 competencies place a counselor's own media advocacy here).

Ch. 33 · 1

**Multicultural Counseling  
Competencies (1992)**

Ch. 33 · 2

**MSJCC (2015)**

Ch. 33 · 3

**MSJCC quadrants and levels**

Ch. 33 · 4

**Fourth and fifth forces**

Ch. 33 · 5

**Sue's worldview model (1978)**

Ch. 33 · 6

**Collectivism and high-context  
communication**

Ch. 33 · 7

**Etic vs. emic**

Ch. 33 · 8

**Berry's acculturation strategies**

Ch. 33 · 2

Four domains: counselor self-awareness, client worldview, the counseling relationship, counseling and advocacy interventions. AKSA: attitudes and beliefs, knowledge, skills, and **action** (new). Endorsed by AMCD and ACA in 2015 (Ratts et al., 2016).

Ch. 33 · 1

Sue, Arredondo, and McDavis. Three areas: awareness of one's own assumptions, values, and biases; understanding the client's worldview; culturally appropriate interventions. Each has beliefs and attitudes, knowledge, and skills.

Ch. 33 · 4

Multiculturalism: the fourth force, with culture defined broadly so all counseling is multicultural (Pedersen, 1991). Social justice: the fifth force (Ratts, 2009).

Ch. 33 · 3

Counselor and client each hold privileged or marginalized statuses (four combinations). Intervention levels: intrapersonal, interpersonal, institutional, community, public policy, international and global.

Ch. 33 · 6

Consulting family before deciding may be collectivist, not enmeshed. High-context (Hall, 1976): meaning in relationship and nonverbal cues. Low-context: meaning stated explicitly. Indirectness is not evasiveness.

Ch. 33 · 5

Locus of control × locus of responsibility. IC-IR: dominant U.S. view. EC-IR: self-blame. EC-ER: powerless before an unfair system. IC-ER: "I could succeed if the system were fair."

Ch. 33 · 8

Keep heritage + join new culture = integration (generally the best adjustment). New only = assimilation. Heritage only = separation. Neither = marginalization (generally the poorest) (Berry, 1997).

Ch. 33 · 7

Etic: the same concepts applied to every culture. Emic: each culture understood on its own terms. Unexamined etic assumptions underlie cultural encapsulation.

Ch. 33 · 9

**Acculturative stress and the  
acculturation gap**

Ch. 33 · 10

**Levels of racism**

Ch. 33 · 11

**Privilege, intersectionality,  
internalized oppression**

Ch. 33 · 12

**Microaggressions (Sue et al., 2007)**

Ch. 33 · 13

**Broaching (Day-Vines et al., 2007)**

Ch. 33 · 14

**Multicultural orientation (MCO)**

Ch. 33 · 15

**ACA Advocacy Competencies (2003;  
updated 2018)**

Ch. 33 · 16

**Advocacy and the ACA Code (2014)**

Ch. 33 · 10

Individual: a person's beliefs and acts.  
 Institutional: policies producing unequal outcomes regardless of intent. Cultural: one group's values and products treated as the standard.

Ch. 33 · 9

Strain of adapting: language, discrimination, lost support, changed roles. Children often acculturate faster than parents, a gap linked to family conflict. DSM-5-TR Z code: acculturation difficulty.

Ch. 33 · 12

Microassault: deliberate attack (a slur).  
 Microinsult: demeans heritage or identity (a surprised "You're so articulate").  
 Microinvalidation: denies experience ("I don't see color"; "Where are you really from?"; "Anyone can make it if they work hard").

Ch. 33 · 11

Privilege: unearned, often invisible advantage (McIntosh, 1989). Intersectionality: overlapping identities create distinct experiences (Crenshaw, 1989). Internalized oppression: accepting the dominant culture's negative messages about one's group.

Ch. 33 · 14

Three pillars: cultural humility, cultural opportunities, cultural comfort (Davis et al., 2018). A way of being with clients rather than a set of techniques. Named in the 2027 NCE specifications.

Ch. 33 · 13

The counselor initiates, early and ongoing.  
 Continuum: avoidant, isolating, continuing/incongruent, integrated/congruent, infusing.

Ch. 33 · 16

Preamble: promoting social justice is a core value. A.7.a: advocate at individual, group, institutional, and societal levels when appropriate. A.7.b: get consent before advocating for an identifiable client.

Ch. 33 · 15

Acting with: client/student empowerment, community collaboration, collective action (formerly public information). Acting on behalf of: client/student advocacy, systems advocacy, social/political advocacy (Toporek & Daniels, 2018).

## CHAPTER 34

# Identity Development and Diverse Populations

## Extra drills

### Drill 34.2 • Fill in the blank.

1. The first stage of Cross's model is \_\_\_\_\_.
2. In the R/CID model, rejecting the dominant culture and endorsing one's own marks the \_\_\_\_\_ stage.
3. The Helms status in which a White person retreats into blaming people of color is \_\_\_\_\_.
4. Phinney's middle stage is ethnic identity \_\_\_\_\_.
5. The final stage of Cass's model is identity \_\_\_\_\_.
6. Meyer calls expected rejection and concealment \_\_\_\_\_ stressors.
7. The disability model that asks "What is in the way?" is the \_\_\_\_\_ model.
8. DSM-5-TR code \_\_\_\_\_ records a moral, religious, or spiritual problem.

### Drill 34.3 • Sorting: whose stage is it? Write the model for each stage: **C** (Cross), **R** (R/CID), **H** (Helms's

White model), **P** (Phinney), **Po** (Poston), **Ca** (Cass), or **D** (Downing and Roush). One stage belongs to two models.

1. \_\_\_\_ Pseudo-independence
2. \_\_\_\_ Revelation
3. \_\_\_\_ Enmeshment/denial
4. \_\_\_\_ Dissonance
5. \_\_\_\_ Immersion-emersion
6. \_\_\_\_ Comparison
7. \_\_\_\_ Introspection
8. \_\_\_\_ Embeddedness-emanation
9. \_\_\_\_ Unexamined
10. \_\_\_\_ Internalization-commitment

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## Answers to the Chapter 34 drills

**Drill answers.** 34.2: (1) pre-encounter. (2) resistance and immersion. (3) reintegration. (4) search (moratorium is also correct; Phinney, 1989, coded this stage as moratorium). (5) synthesis. (6) proximal. (7) social (or minority). (8) Z65.8 (the September 2025 DSM-5-TR update added “moral”; older printings title it “religious or spiritual problem”). 34.3: 1-H. 2-D. 3-Po. 4-R (Helms’s separate People of Color model also has a dissonance status, which is why H is limited to her White model). 5-C and H (both models use immersion-emersion; R/CID’s version is resistance and immersion). 6-Ca. 7-R. 8-D. 9-P. 10-C.

Ch. 34 · 1

**Cross's nigrescence model**

Ch. 34 · 2

**R/CID model**

Ch. 34 · 3

**Helms's White racial identity model**

Ch. 34 · 4

**Phinney (1989)**

Ch. 34 · 5

**Poston (1990)**

Ch. 34 · 6

**The four-beat arc**

Ch. 34 · 7

**Identity stage and the counseling  
relationship**

Ch. 34 · 8

**Four dimensions of sex and gender**

Ch. 34 · 2

Conformity → dissonance → resistance and immersion → introspection → integrative awareness. Applies to any person of color; grew from the 1979 Minority Identity Development model (Sue et al., 2022).

Ch. 34 · 1

Pre-encounter (race not salient) → encounter (an event makes race unavoidable) → immersion-emersion → internalization → internalization-commitment. First published 1971; revised in Cross (1991).

Ch. 34 · 4

Unexamined → search → achieved ethnic identity. Parallels Marcia's statuses (diffusion or foreclosure, moratorium, achievement). Applies across ethnic minority groups.

Ch. 34 · 3

Contact → disintegration → reintegration → pseudo-independence → immersion-emersion → autonomy (Helms, 1990). Reintegration retreats into blaming people of color; pseudo-independence accepts others intellectually but not emotionally.

Ch. 34 · 6

Most racial identity models run unaware → jolted → immersed → integrated. Learn each model's first stage: pre-encounter (Cross), conformity (R/CID), contact (Helms), unexamined (Phinney), personal identity (Poston).

Ch. 34 · 5

Personal identity → choice of group categorization → enmeshment/denial → appreciation → integration. Pressure to "pick a side" is stage 2; guilt and confusion follow.

Ch. 34 · 8

Sex assigned at birth, gender identity, gender expression, sexual orientation; each independent of the others. Gender dysphoria diagnoses distress, not identity.

Ch. 34 · 7

Conformity: may prefer a White counselor. Resistance and immersion: may distrust one. Broach the difference and explore needs; do not defend, argue, or refer at once.

Ch. 34 · 9

**Cass (1979)**

Ch. 34 · 10

**Downing and Roush (1985)**

Ch. 34 · 11

**Minority stress (Meyer, 2003)**

Ch. 34 · 12

**Values conflicts with a client's  
identity**

Ch. 34 · 13

**Models of disability**

Ch. 34 · 14

**ASERVIC competencies**

Ch. 34 · 15

**Z65.8 vs. Z60.3**

Ch. 34 · 16

**Age, class, immigration, and  
interpreters**

Ch. 34 · 10

Feminist identity development: passive acceptance → revelation → embeddedness-emanation → synthesis → active commitment.

Ch. 34 · 9

Confusion → comparison → tolerance → acceptance → pride → synthesis. Pride: immersion in the community and anger at heterosexism. Synthesis: orientation is one part of a whole self.

Ch. 34 · 12

Avoid imposing values and seek training (A.4.b) or consultation (C.2.e); do not refer based solely on personal values (A.11.b). The ACA opposes conversion therapy.

Ch. 34 · 11

Stigma, not orientation, explains elevated risk. Distal stressors: discrimination, violence. Proximal stressors: expected rejection, concealment, internalized homophobia.

Ch. 34 · 14

Fourteen competencies in six areas: culture and worldview, counselor self-awareness, human and spiritual development, communication, assessment, diagnosis and treatment (Cashwell & Watts, 2010). Explore faith in the client's terms.

Ch. 34 · 13

Moral: whose fault? Medical: what is broken? Social (minority): what is in the way? (Olkin, 1999). Follow the client's person-first or identity-first preference; accommodate (task 6.14).

Ch. 34 · 16

Ageism (Butler, 1969). Classism: fees, hours, transportation. Refugees and asylum seekers fled persecution; undocumented clients may fear exposure. Qualified interpreter, not the client's child (A.2.c; task 5.7).

Ch. 34 · 15

Z65.8: moral, religious, or spiritual problem (renamed 2025). Z60.3: acculturation difficulty. Both are DSM-5-TR codes for a focus of clinical attention, not mental disorders (APA, 2022, 2025).

# Extended Glossary: Chapters 1–9

These terms from Chapters 1–9 are taught in the book but did not make the printed glossary, which keeps the essential terms for each chapter. (For Chapters 10–34, every glossary term written for those chapters is already in the printed glossary.) Definitions are written for this book. A source in parentheses points to the standard reference for the term; the full entry is in that chapter's References.

## Chapter 1: Professional Identity and the Ethical Core

### ACA Code of Ethics

The American Counseling Association's ethical standards for professional counselors, organized in nine sections (A–I); the current version was adopted in 2014 (ACA, 2014).

### American Counseling Association (ACA)

The largest professional association for counselors; founded in 1952 as APGA, renamed AACD in 1983 and ACA in 1992.

### Aspirational ethics

Striving toward the profession's highest ideals and the client's best interest, beyond what the rules require. Contrast with mandatory ethics.

### Burnout

Physical and emotional exhaustion from chronic work stress, often with cynicism and reduced effectiveness.

### CACREP

The Council for Accreditation of Counseling and Related Educational Programs, established in 1981; accredits master's and doctoral counseling programs.

### Claims-made policy

Liability insurance that covers claims filed while the policy is in force; dropping it may require tail coverage for past work.

### Expert witness

A witness who offers professional opinions to a court based on specialized knowledge. Contrast with fact witness.

### Fact witness

A witness who testifies only about what they directly observed or did, without offering expert opinion.

### Impairment

A decline in a counselor's functioning, from physical, mental, or emotional problems, significant enough to affect client care; requires the counselor to seek help and limit practice as needed (ACA, 2014, Standard C.2.g).

### Mandatory ethics

Compliance with the minimum required ethical standards. Contrast with aspirational ethics.

### Mental hygiene movement

An early twentieth-century reform movement for humane treatment, prevention, and early intervention in mental illness, launched by Clifford Beers (1908).

### National Board for Certified Counselors (NBCC)

The national certification body for counselors, established in 1982; awards the NCC and develops the NCE and NCMHCE.

### National Certified Counselor (NCC)

NBCC's general-practice national certification for counselors; voluntary and maintained through continuing education.

### National Defense Education Act (NDEA)

A 1958 federal law, passed after Sputnik, that among other things funded the training of school counselors.

### Occurrence-based policy

Liability insurance that covers incidents occurring during the policy period, regardless of when the claim is filed.

### Paternalism

Overriding a competent person's choices for what the helper believes is their own good; beneficence pushed too far.

### Practice act

A licensure law that restricts the activity of a profession to licensed people. Contrast with title act.

**Principle ethics**

An approach that asks what the counselor should do, applying principles and rules to a specific dilemma. Contrast with virtue ethics.

**Professional will**

A counselor's plan for transferring clients and records, with a designated colleague or custodian, in case of incapacitation, death, retirement, or closing a practice (ACA, 2014, Standard C.2.h).

**Scope of practice**

The activities a state's law permits a licensed professional to perform.

**Social constructivism model**

Cottone's (2001) model in which ethical decisions are made between people through negotiating, consensualizing, and, if needed, arbitrating.

**Standard of care**

What a reasonable, prudent counselor with similar training would do in similar circumstances; the benchmark for judging negligence.

**Title act**

A licensure law that protects the use of a professional title without restricting the activity itself. Contrast with practice act.

**Virtue ethics**

An approach that asks who the counselor should be, focusing on character traits such as prudence, integrity, respectfulness, and benevolence (Meara et al., 1996).

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## **Chapter 2: Confidentiality, Informed Consent, and Records**

**42 CFR Part 2**

Federal regulations protecting the records of federally assisted substance use disorder treatment programs; historically stricter than HIPAA on consent and redisclosure, and aligned more closely with HIPAA by a 2024 rule (Confidentiality of Substance Use Disorder Patient Records, 2025).

**Capacity**

The ability to make a specific decision: expressing a choice, understanding the information, appreciating how it applies to oneself, and reasoning about options (Appelbaum & Grisso, 1988).

**Competence (legal)**

A legal status determined by a court. Adults are presumed competent unless a court rules otherwise and appoints a guardian.

**Court order**

A directive issued by a judge that can compel disclosure of confidential or privileged information. Contrast with subpoena.

**HITECH Act**

A 2009 federal law that strengthened HIPAA with breach notification requirements, higher penalties, and direct liability for business associates, and promoted electronic health records.

**Mandated client**

A client required by a court, agency, employer, or school to attend counseling; still entitled to informed consent about what will be reported and the consequences of refusing (ACA, 2014, Standard A.2.e).

**Minimum necessary**

The principle of disclosing only the information essential to the purpose of a disclosure (ACA, 2014, Standard B.2.e).

**Notice of Privacy Practices**

The document a HIPAA covered entity gives clients describing how their health information may be used and disclosed and what rights they have.

**Professional disclosure statement**

A written document describing the counselor's credentials, approach, fees, confidentiality limits, and complaint procedures; required by law in some states.

**Records custodian**

A person designated to take responsibility for client records if a counselor dies, becomes incapacitated, or closes a practice (ACA, 2014, Standard C.2.h).

**Release of information**

A client's written authorization specifying what information may be disclosed, to whom, for what purpose, and until when; called an authorization under HIPAA.

**Secrets policy**

In couples or family counseling, the agreed rule for handling information one member shares privately: no secrets, limited secrets, or secrets kept.

**Sole-possession records**

A school counselor's personal notes, used only as a memory aid and not shared, which are excluded from FERPA's definition of education records.

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## **Chapter 3: Boundaries, Supervision, Consultation, and Counselor Self-Awareness**

**Bracketing**

Noticing one's own values, reactions, and assumptions and setting them aside so they do not steer the session; the 2027 NCE specification pairs it with reflexivity (NBCC, 2026).

**Compassion fatigue**

Reduced capacity for empathy and trauma-like stress reactions that result from caring for people who are suffering; often used as a synonym for secondary traumatic stress (Figley, 1995).

**Consultee-centered case consultation**

Caplan's type of consultation that addresses the consultee's lack of knowledge, skill, confidence, or objectivity in handling a particular case (Caplan, 1970).

**Extending counseling boundaries**

A potentially beneficial interaction beyond conventional counseling limits, such as attending a client's ceremony; requires weighing risks and benefits, documenting the rationale beforehand when feasible, and attempting to remedy any unintentional harm (ACA, 2014, Standards A.6.b–A.6.c).

**Pretermination counseling**

Preparing a client for the end of services by reviewing progress, discussing feelings about ending, and offering referrals when needed (ACA, 2014, Standard A.11.c).

**Process consultation**

The consultation model most associated with Schein, in which the consultant helps the consultee understand and act on events in its own system so it can solve current and future problems (Schein, 1978).

**Supervision contract**

A written agreement that sets out the goals, logistics, roles, evaluation methods, confidentiality limits, emergency procedures, and due process for supervision.

**Theme interference**

Caplan's term for a consultee's loss of objectivity because a case touches an unresolved personal theme (Caplan, 1970).

**Transference**

A client's redirection of feelings and expectations from earlier important relationships onto the counselor.

**Vicarious trauma**

A lasting change in a counselor's beliefs (cognitive schemas) about self, others, and the world, such as beliefs about safety and trust, resulting from cumulative exposure to clients' traumatic material (McCann & Pearlman, 1990).

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## **Chapter 4: Practice Management: Documentation, Billing, Telemental Health, and Technology**

**BIRP note**

A progress-note format organized as Behavior, Intervention, Response, and Plan: what the client presented, what the counselor did, how the client responded, and what comes next.

**CAQH (Provider Data Portal)**

The Council for Affordable Quality Healthcare (renamed DataSpring, powered by CAQH, in 2026) and its online database, long called ProView, where providers store credentialing information that many insurers review before admitting them to a network; profiles are re-attested every 120 days (DataSpring, 2026).

**Credentialing (paneling)**

An insurer's review of a counselor's license, education, liability coverage, and history before contracting with the counselor as an in-network provider.

**Effective communication**

The ADA requirement that a public accommodation provide auxiliary aids, such as a qualified sign language interpreter, so a person with a communication disability can take part in services, at no charge to the client (Americans with Disabilities Act of 1990).

**Electronic health record (EHR)**

A digital client record designed to be shared across providers and settings; often used interchangeably with EMR, which strictly refers to a chart kept within one practice.

**Emergency preparedness plan**

A practice-level plan for responding to incidents such as fires, storms, outages, cyberattacks, or pandemics, covering records backup, client notification, alternate sites or telehealth, and crisis resources.

**Late entry**

A progress note written after the usual time, dated when it is written and labeled as referring to an earlier session, so the record stays honest.

**Privilege to practice**

Under the Counseling Compact, authorization to practice in a remote member state based on the counselor's home-state license, rather than a separate full license; it is lost if the home license becomes encumbered (Counseling Compact Commission, n.d.).

## Chapter 5: The Intake, Risk Assessment, and Mental Status

### 988 Suicide & Crisis Lifeline

The national three-digit number for suicidal and mental health crises in the United States, reachable by call, text, or chat; it took over from the 10-digit National Suicide Prevention Lifeline number on July 16, 2022, though the old number still connects (SAMHSA, 2022).

### Adverse childhood experiences (ACEs)

Potentially traumatic childhood events such as abuse, neglect, and household challenges. The ACE score counts categories of exposure; more categories are linked with greater adult health risk (Felitti et al., 1998), but the score does not diagnose.

### ASQ (Ask Suicide-Screening Questions)

Four yes/no suicide screening questions built for medical settings; any yes leads to an acuity question about current thoughts of suicide (Horowitz et al., 2012; NIMH, n.d.).

### AUDIT (Alcohol Use Disorders Identification Test)

A 10-item World Health Organization alcohol screen covering hazardous use, dependence symptoms, and harmful use; a total of 8 or more suggests hazardous or harmful drinking (Babor et al., 2001).

### Collateral information

Information about a client gathered from others, such as family, prior providers, schools, clergy, or legal services, with the client's written release.

### CRAFFT

A substance use screen for adolescents ages 12 to 21 whose six yes/no questions are keyed to Car, Relax, Alone, Forget, Friends/Family, and Trouble; two or more yes answers call for further assessment (Knight et al., 1999).

### C-SSRS (Columbia–Suicide Severity Rating Scale)

A structured set of questions rating the severity of suicidal ideation and suicidal behavior (Posner et al., 2011); its brief screener can be asked by people without mental health training.

### DAST-10

A 10-item yes/no short form of the Drug Abuse Screening Test that screens for use of drugs other than alcohol (Skinner, 1982).

### Delusion

A fixed false belief held despite clear contrary evidence; recorded under thought content in the mental status examination.

### Four Ps

A case formulation framework that sorts the history into predisposing (why this person), precipitating (why now), perpetuating (why it continues), and

protective (what helps) factors (Macneil et al., 2012).

### Genogram

A diagram of at least three generations of a family showing structure, relationship patterns such as closeness, conflict, and cutoff, and recurring issues (McGoldrick et al., 2020).

### Lethal means counseling

A collaborative conversation that reduces a person's access to a method of suicide during a period of risk, for example by storing firearms away from home or locking up medications.

### SBIRT

Screening, Brief Intervention, and Referral to Treatment: a public health model that screens everyone for substance use, offers brief intervention for risky use, and refers those likely to have a disorder.

## Chapter 6: Diagnosis: DSM-5-TR and ICD

### Ataque de nervios

A cultural syndrome described among people of Latin American descent: an episode of intense emotional upset, such as crying, shouting, or trembling, that often follows a family crisis (APA, 2022).

### Comorbidity

The presence of two or more diagnoses at once. DSM-5-TR allows it when criteria for each are met, with exceptions such as DMDD and oppositional defiant disorder (APA, 2022).

### Cultural concepts of distress

The DSM-5-TR umbrella for culturally shaped ways of experiencing, expressing, and explaining suffering: cultural syndromes, idioms of distress, and cultural explanations (APA, 2022).

### Cultural explanation

A client's or community's account of what causes a problem, such as *susto*, illness blamed on a frightening event; also called a perceived cause or explanatory model (APA, 2022).

### Cultural idiom of distress

A shared way of voicing suffering within a cultural group, such as *nervios*, that may not match any single DSM disorder (APA, 2022).

### Cultural syndrome

A cluster of symptoms that a cultural community recognizes as a coherent condition, such as *ataque de nervios* or *taijin kyofusho* (APA, 2022).

### ICD-11

The WHO's 11th revision of the *International Classification of Diseases*, in effect since January 1, 2022. It uses diagnostic requirements rather than

strict symptom counts and is not yet used on U.S. claims (Medical Data Code Sets, 2025; WHO, n.d., 2024).

#### **Mental disorder (DSM definition)**

A clinically significant disturbance in thinking, emotion regulation, or behavior reflecting an underlying dysfunction, usually with distress or impairment. Expectable responses to loss are excluded (APA, 2022).

#### **Multiaxial system**

The five-axis recording format introduced in DSM-III (1980) and dropped in DSM-5 (2013).

#### **Principal diagnosis**

The condition chiefly responsible for an admission (inpatient) or, as the reason for visit, for outpatient services; listed first (APA, 2022).

#### **Taijin kyofusho**

A cultural syndrome described in Japan: fear that one's gaze, blushing, appearance, or odor will offend or discomfort others (APA, 2022).

#### **WHODAS 2.0**

The World Health Organization Disability Assessment Schedule, offered in DSM-5 and DSM-5-TR as a measure of functioning after the Global Assessment of Functioning was dropped (APA, 2022).

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## **Chapter 7: Measurement Foundations**

### **Alternate-forms reliability**

Consistency estimated by correlating scores on two equivalent versions of a test; it controls for memory of specific items. Also called parallel-forms or equivalence reliability.

### **Ceiling effect**

Scores bunching at the top of a scale because the test is too easy, which hides differences among high scorers and skews the distribution negatively. Its opposite, the floor effect, occurs when a test is too hard.

### **Coefficient alpha**

An internal-consistency estimate that works for items scored on more than two points, such as rating scales; for right/wrong items it equals KR-20. Often called Cronbach's alpha (Cronbach, 1951).

### **Cohen's kappa**

A statistic for agreement between two raters on categorical judgments that corrects for the agreement expected by chance (Cohen, 1960).

### **Concurrent validity**

Criterion-related validity evidence in which test scores are compared with a criterion measured at about the same time, such as a diagnostic interview

given in the same visit.

### **Convergent and discriminant validity**

Construct evidence showing that a test correlates strongly with measures of the same construct (convergent) and weakly with measures of unrelated constructs (discriminant) (Campbell & Fiske, 1959).

### **Differential item functioning**

A pattern in which test takers of equal ability from different groups have different chances of answering an item correctly; a statistical flag for possible item bias (AERA et al., 2014).

### **Face validity**

Whether a test appears, to the people taking it, to measure what it claims; it can affect cooperation but is not technical evidence of validity.

### **Grade-equivalent score**

A developmental score reporting the grade level whose typical student earns a given raw score; often misread as the grade level of skills a student has mastered.

### **Inter-rater reliability**

The consistency of scores or judgments across different raters scoring the same responses; also called interscorer reliability.

### **Ipsative score**

A score that compares a person's traits or preferences with their own other traits or preferences rather than with a norm group, as in many forced-choice inventories.

### **Item discrimination index**

The proportion of a high-scoring group answering an item correctly minus the proportion of a low-scoring group doing so (*D*), from  $-1$  to  $+1$ ; a negative value signals a flawed item.

### **Norm-referenced score**

A score interpreted by comparing a person's performance with that of a reference (norm) group, such as a percentile rank or a standard score.

### **Reliable change index**

A statistic that divides a client's pre-to-post change by the standard error of the difference; values beyond  $\pm 1.96$  suggest change larger than measurement error alone (Jacobson & Truax, 1991).

### **Sensitivity and specificity**

For a screening test with a cut score, sensitivity is the proportion of people with the condition whom the test correctly flags; specificity is the proportion without it whom the test correctly clears.

### **Test bias**

Systematic error that makes test scores mean something different for members of a particular group, in measurement or in prediction; group average dif-

ferences alone do not establish it (AERA et al., 2014).

## Chapter 8: Tests and Instruments

### Beck Anxiety Inventory (BAI)

A 21-item self-report scale (total 0–63) that rates anxiety symptoms over the past week, most of them physical, and was built to separate anxiety from depression (Beck et al., 1988; Beck & Steer, 1993).

### Culture-fair test

An ability test that limits language and culturally specific content, such as Raven's Progressive Matrices. It reduces cultural loading but is never culture-free.

### Formal observation

Observation that follows a set protocol, such as a behavior rating scale, a recording method, or a structured interview.

### GAD-7

The Generalized Anxiety Disorder-7, a free seven-item self-report screen (total 0–21) covering the past two weeks; scores of 5, 10, and 15 mark mild, moderate, and severe anxiety (Spitzer et al., 2006).

### Informal observation

Unstructured observation of a client's behavior, appearance, affect, and body language, used to form hypotheses that are checked against other data.

### NEO PI-3

The NEO Personality Inventory-3, which measures the five-factor (Big Five) model of personality: neuroticism, extraversion, openness, agreeableness, and conscientiousness, plus 30 facets.

### Objective personality test

A personality measure with fixed response options, such as true/false, scored the same way for every test taker against norms.

### PCL-5

The PTSD Checklist for DSM-5, a free 20-item self-report measure (total 0–80) of PTSD symptoms over the past month, used to screen and track change (National Center for PTSD, n.d.).

### Power test

A test with items of increasing difficulty and generous time, so the score reflects how hard a problem the person can solve.

### Qualification levels

Publisher categories (commonly A, B, and C) that set the education and training a buyer needs to purchase a test. Meeting a level does not by itself establish competence to use the test (Pearson Assessments, n.d.).

### Ratio IQ

The early intelligence score calculated as mental age divided by chronological age, times 100; replaced by the deviation IQ.

### Speed test

A test of many easy items under a strict time limit, so the score reflects how quickly the person works.

### Validity scales

Scales within an inventory such as the MMPI-3 that detect inconsistent responding, overreporting, and underreporting, and so show whether the rest of the profile can be interpreted.

## Chapter 9: Research, Statistics, and Program Evaluation

### Alpha (level of significance)

The probability of a Type I error that a researcher agrees to accept, set before data collection, usually .05 or .01.

### Clinical significance

Change large enough to matter in a client's life, judged by whether it exceeds measurement error and brings the client into the range of a nonclinical population (Jacobson & Truax, 1991).

### Evidence-based practice

Clinical decision-making that integrates the best available research with clinical expertise and the client's characteristics, culture, and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006).

### External validity

The degree to which a study's results generalize to other people, settings, and times.

### Grounded theory

A qualitative tradition that builds a theory from the data through constant comparison and staged coding (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

### Independent variable

The variable a researcher manipulates or uses to form groups; its effect is measured on the dependent variable, the study's outcome.

### Institutional review board (IRB)

A committee that reviews proposed research with human participants to protect their rights and welfare under federal rules (Protection of Human Subjects, 2025).

### Needs assessment

The first step of program evaluation: identifying the gap between the services that exist and those a population needs.

**Phenomenology**

A qualitative tradition that describes the lived experience of a phenomenon through in-depth interviews, with the researcher bracketing personal assumptions.

**p-value**

The probability of obtaining results at least as extreme as those observed if the null hypothesis were true; a value below alpha is statistically significant.

**Quasi-experimental design**

A design that manipulates an independent variable but uses intact groups rather than random assignment, so causal conclusions are tentative.

**Single-case design**

A design that measures one client (or a few) repeatedly across baseline (A) and treatment (B) phases, as in AB, ABAB (reversal), and multiple-baseline designs.

**Trustworthiness**

The qualitative counterpart of reliability and validity, made up of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).