SOCIAL WORK ASWB®
BACHELORS EXAM GUIDE

A COMPREHENSIVE STUDY GUIDE FOR SUCCESS

DAWN APGAR

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

Bachelors

The Social Work ASWB® Bachelors Exam Guide: A Comprehensive Guide for Success

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

Masters

The Social Work ASWB® Masters Exam Guide: A Comprehensive Guide for Success

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

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Dawn Apgar, PhD, LSW, ACSW, has helped thousands of social workers across the country pass the examinations associated with all levels of licensure. In recent years, she has consulted in numerous states to assist with establishing licensure test preparation programs, including training the instructors.

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

Social Work ASWB[®] Bachelors Exam Guide

A Comprehensive Study Guide for Success

Dawn Apgar, PhD, LSW, ACSW

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Preface

Congratulations on getting to this point in your social work career. The decision to become licensed is significant, and passing the licensing examination demonstrates that you have the basic knowledge necessary to safely practice. Social workers are employed in all kinds of settings including hospitals, correctional facilities, mental health and addictions agencies, government offices, and private practices. It is essential that those served have some assurance that these practitioners are competent to provide the services that they are charged with delivering.

Regulation through certification and licensure helps to assure that social workers will interact in an ethical and safe manner, and there is oversight to address actions that are not consistent with this standard.

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

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

1. Increase your knowledge of the Association of Social Work Boards (ASWB®) examination, including testing conditions and scoring

2. Provide valuable test-taking strategies that will assist in developing a good study plan and in analyzing question wording in order to select the correct answer

3. Summarize content areas that may be included on the examination as per the Knowledge, Skills, and Abilities (KSA) statements published by ASWB, which are used by test developers to formulate actual questions

4. Supply sample questions that can be used to simulate an actual examination experience

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

Individuals who are studying for the social work licensing examination have a primary concern and request. They are worried that they do not know important

information about the tests that will prove to be a barrier to passing, and they want a "place" to go that will have all the necessary materials in a single location. They want to focus their efforts on studying for the exam—not hunting around for what needs to be studied!

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

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

About the Examination

Generally, when social workers are getting ready to take the ASWB® tests, they are anxious not only about knowing the content, but also about the examinations themselves. They have many questions about the number of questions that will be asked and the number of correct answers required to pass. Becoming familiar with the examination basics will assist in making you more comfortable with the examination conditions and structure, thereby reducing your anxiety about the unknown.

10 THINGS THAT YOU SHOULD KNOW ABOUT THE ASWB EXAMINATIONS

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

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

3. You **do not want to leave any questions blank**; answer all 170 questions in the 4 hours.

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4 ABOUT THE EXAMINATION

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

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

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

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

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

9. Social workers always want to know how many questions of the 150 scored items they will need to answer correctly to pass the exam. Although this sounds like an easy question, it is not! Not all questions on the ASWB examinations are the same level of difficulty as determined by the pilot process, so individuals who are asked to answer harder questions that have been randomly selected from the test bank will need to answer fewer questions correctly than those who were lucky enough to have easier questions randomly assigned. This method ensures that the examination is fair for all those who are taking it, regardless of which questions were chosen. **The number of questions that you have to get correct *generally* varies from 93 to 106 of the 150 scored items**. You will find out how many needed to be answered correctly only after you are finished with your examination and it is immediately scored electronically. When you examine your unofficial test results, which are provided in a printout prior to leaving the testing center, you will be able to gauge the difficulty of your examination. If you needed to get closer to 93 correct, you had a harder combination of questions, and if you needed to get 106 or above correct, you had an easier combination.

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

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

Test-Taking Strategies

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

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

As both of these strategy types are keys to success on the examinations, they are outlined here.

10 ESSENTIAL STRATEGIES FOR STUDY SUCCESS

Tip 1

This is an examination to assess knowledge of social work content, so you will need to make sure that you can describe an overview of the key concepts and terms related to each of the KSAs. You will know if you are ready to take the examinations when

you are able to briefly explain these areas to someone who does not have any prior knowledge of them. The difference between passing and not passing the examinations almost always is a result of gaps in knowledge, not application of test-taking strategies, so you need to make sure that the bulk of your studying is aimed at filling in knowledge gaps or refreshing information already learned.

Tip 2

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

Tip 3

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

Tip 4

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

1. Although it makes individuals feel better when they get an answer correct on a sample test, getting an answer correct is not a valid indicator

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of really knowing the content in the KSA for which the question was developed. Studying from the KSAs and the topics within them will ensure that you are able to answer any question, not just the one that is in a sample test.

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

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

Tip 5

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

1. *After* you are done studying the content and think you are ready to take the ASWB examination, select a 4-hour period where you can create a quiet environment without interruptions.

2. Answer the questions as you would on the actual examination—using the strategies and having to pick *one* answer, even if you are not completely sure that it is correct.

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

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

Tip 6

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

Tip 7

There is always a time lag between the generation of new social work content and when it appears on the ASWB examinations. It takes time to write and pretest questions on new material. For example, when the Health Insurance Portability and Accountability Act (HIPAA) of 1996 was passed, there were several years before questions related to this law were asked. Although the *DSM-5* was published in 2013, ASWB announced that it would not be included on examinations until July 2015. This lag is good and bad. The good news is that you do not have to know the "latest and greatest" in all content areas. It is hard to keep completely up to date in a profession that is changing so rapidly. Now for the bad news! For many, especially if they are working in a particular specialty area, some of the content or answers may appear to be dated. This is often the case in the area of psychopharmacology, because new medications are being approved and used rapidly. Remember the time lapse in your studying, and do not rely on breaking news or even practices in your own agency as information sources.

Tip 8

As you think about what is important to learn or remember when you are reviewing this guide, you should recognize that social workers who have attended social work programs at different schools, as well as courses within a program taught by various instructors, have passed the examinations. Thus, although there is always information to add to a KSA related to experience or depth of knowledge, there are "core" elements included in any overview or lecture on the topic, regardless of school or professor. These elements are the ones that have to be learned and remembered because they are the basis of the knowledge being tested. In addition, there are also "core" or essential areas that contain information that is seen as critical to competent practice. Can you imagine a social worker leaving an undergraduate or graduate program without reviewing the signs of child abuse and neglect and his or her duty as a mandatory reporter? Of course not! This is a "core" topic that

often is the basis of examination questions. The list of these areas is not fixed, but includes confidentiality, assessment of danger to self and others, cultural competence, and so on. You should ask yourself when studying, "Is this something that every social worker needs to know, regardless of setting or specialization?" If so, it may be essential to include it in your review of a topic because it is likely to be included on the examination.

Tip 9

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

Tip 10

Often, social workers are focused on using the clinical and other jargon that they learned in their MSW programs; however, they may be unable to explain what these concepts mean in plain and understandable terms. For example, when asked what should happen when meeting with a client for the first time, social workers often use phrases such as "You need to build rapport," "It is essential that you start where a client is," or "Social workers should show empathy as to what a client is going through." Though all true, these statements give little insight into *any* real actions that a social worker should take in this first meeting. What should a social worker do to "build rapport"? How would a client know if a social worker was being "empathetic"? What would a social worker be doing or saying? Having to explain the KSAs to someone who knows little about social work practice and will ask you *lots* of questions about the content area can be a far better strategy than studying with a social work colleague who will not challenge you when you use jargon or technical terms without having to explain the basics.

20 TIPS YOU NEED TO USE TO ANSWER QUESTIONS CORRECTLY

Tip 1

This is an examination of your knowledge of social work content. Often, what we learn in the classroom and how we might act in practice based upon practice wisdom

Dealing With Test Anxiety

Perhaps one of the biggest issues that social workers have to address when preparing for and actually taking the examinations is anxiety. Although not designed to be an exhaustive resource on how to address test anxiety, this guide would be incomplete if it did not provide some guidance to social workers to assist with anxiety during this stressful time in their professional development.

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

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

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

1. *Make a Study Plan and Work the Plan*
   A great way to instill confidence is being able to walk into the testing center having prepared the way that you set out to do. A study plan will help you break the material into smaller manageable segments and avoid last minute cramming.

2. *Don't Forget the Basics*
   You need to make sure that you don't neglect your biological, emotional, and social needs leading up to and on the day of the examination. Get plenty of rest, build in relaxation time to your study plan, and eat well to give you energy during this exhausting process.

3. *Familiarize Yourself With the Test Environment*
   Before the day of the examination, drive to the testing center so you know how to get there. Arrive early so you are not rushed. Take your time reviewing the tutorial on the computer before you start the examination.

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

5. *Put the Examination Into Perspective*
   Rarely do people get the score that they want the first time taking any standardized test. Taking the SATs or GREs more than once is the rule rather than the exception. Social workers often attach too much meaning to whether or not they pass the examination the first or second time. They walk into the testing center feeling their entire career rests on the results. This is not true. There are many outstanding social workers who have had to take the test multiple times. Remember that you will be able to retake the examination if you do not pass—this is not your only chance. Not passing is not in any way reflective of your ability to practice social work. You *will* eventually pass, whether it is this time or another, so don't let the test define you. Avoid thinking in "all or nothing" terms.

6. *Expect Setbacks*
   The road to licensure is not different than other journeys in life and not usually without unexpected delays or even disappointments. It is important to see these as typical parts of the process and not ends in themselves. Try to figure out why these setbacks in studying or passing are occurring and how you can use this information as feedback for making improvements. You did not get a social work degree without some disappointments and challenges. Studying for and passing the examination will also not be easy, but you will be successful if you keep focused and learn from challenges encountered.

7. *Reward Yourself*
   You don't have to wait until you pass in order to celebrate. Build some enjoyment into the test-taking experience by creating little incentives or rewards along the way. Go out to dinner after having studied for 4 hours on a Saturday afternoon. Get up early and study before work so you can enjoy a movie when you get home. Improving your attitude about the test-taking experience can actually help you study more and improve your performance on the examination.

8. *Acknowledge and Address the Anxiety*
   Ignoring the anxiety that accompanies this process will not help. It is impossible to completely eliminate it through any of the techniques mentioned. However, you do need to assess whether it is manageable and can be addressed by some of these suggestions or if it is interfering so significantly with the learning process that you are "blanking out" or having problems in other areas of your life because of its presence. If this is the case, you may need more intensive anxiety reduction interventions. Repeatedly studying the content over and over will not reduce your anxiety. Although most people can develop their own strategies for anxiety management, others need outside help. Usually, individuals who need the assistance of others are those who have experienced debilitating anxiety in other areas of life prior to taking the examinations. No matter what the severity—anxiety management is a critical part of every study plan!

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Models of Human Growth and Development

TYPICAL AND ATYPICAL PHYSICAL GROWTH AND DEVELOPMENT

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

TYPICAL AND ATYPICAL COGNITIVE GROWTH

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

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

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Stage	Age	Characteristics
1. Sensorimotor	0–2 years	a. Retains image of objects b. Develops primitive logic in manipulating objects c. Begins intentional actions d. Play is imitative e. Signals meaning—infant invests meaning in event (i.e., babysitter arriving means mother is leaving) f. Symbol meaning (language) begins in last part of stage
2. Preoperational	2–7 years	a. Progress from concrete to abstract thinking b. Can comprehend past, present, future c. Night terrors d. Acquires words and symbols e. Magical thinking f. Thinking is not generalized g. Thinking is concrete, irreversible, egocentric h. Cannot see another point of view i. Thinking is centered on one detail or event Imaginary friends often emerge during this stage and may last into elementary school. Although children do interact with them, most know that their friends are not real and only pretend they are real. Thus, having an imaginary friend in childhood does *not* indicate the presence of a disorder. It is a normal part of development and social workers should normalize behavior with parents who are distressed about this activity during this developmental stage.
3. Concrete Operations	7–11 years	a. Beginnings of abstract thought b. Plays games with *rules* c. Cause and effect relationship understood d. Logical implications are understood e. Thinking *is* independent of experience f. Thinking is reversible g. Rules of logic are developed
4. Formal Operations	11 through maturity	a. Higher level of abstraction b. Planning for future c. Thinks hypothetically d. Assumes adult roles and responsibilities

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

TYPICAL AND ATYPICAL SOCIAL GROWTH AND DEVELOPMENT

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

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

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

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

TYPICAL AND ATYPICAL EMOTIONAL GROWTH AND DEVELOPMENT

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

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

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

TYPICAL AND ATYPICAL SEXUAL GROWTH AND DEVELOPMENT

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

Sexuality in infants and toddlers—Children are sexual even before birth. Males can have erections while still in the uterus, and some boys are born with an erection. Infants touch and rub their genitals because it provides pleasure. Little boys and girls can experience orgasm from masturbation, although boys will not ejaculate until puberty. By about age 2, children know their own gender. They are aware of differences in the genitals of males and females and in how males and females urinate.

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

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

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

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

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

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Some group dating occurs at this age. Preadolescents may attend parties that have guests of both genders, and they may dance and play kissing games. By age 12 or 13, some young adolescents may pair off and begin dating and/or "making out." Young women are usually older when they begin voluntary sexual intercourse. However, many very young teens do practice sexual behaviors other than vaginal intercourse, such as petting to orgasm and oral intercourse.

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

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

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

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

SPIRITUAL GROWTH AND DEVELOPMENT

There are many models that attempt to explain spiritual growth and development. Many of them describe this development along a continuum as follows, with some individuals changing during their life course and others remaining at the same point.

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

Behavior is chaotic, disordered, and reckless. Individuals tend to defy and disobey, and are extremely egoistic. They lack empathy for others. Very young children

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can be at this stage. Adults who do not move beyond this point in the continuum may engage in criminal activity because they cannot obey rules.

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

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

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

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

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

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

Basic principles of all models move from the "egocentric," which are associated particularly with childhood, to "conformist," and eventually to "integration" or "universal."

CHILD BEHAVIOR AND DEVELOPMENT

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

Infants and Toddlers (Age 0–3)

Healthy Growth and Development

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

Key Health Care Issues

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

Examples of age-specific care for infants and toddlers:

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

Young Children (Age 4–6)

Healthy Growth and Development

- *Physical*—grows at a slower rate; improving motor skills; dresses self, toilet trained
- *Mental*—begins to use symbols; improving memory; vivid imagination, fears; likes stories
- *Social–Emotional*—identifies with parent(s); becomes more independent; sensitive to others' feelings

Key Health Care Issues

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

Examples of age-specific care for young children:

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

Older Children (Age 7–12)

Healthy Growth and Development

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

Key Health Care Issues

- *Communication*—help child to feel competent, useful
- *Health*—keep immunizations/checkups on schedule; give information on alcohol, tobacco, other drugs, sexuality
- *Safety*—promote safety habits (playground safety, resolving conflicts peacefully, etc.)

Examples of age-specific care for older children:

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

ADOLESCENT BEHAVIOR AND DEVELOPMENT

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

Healthy Growth and Development

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

Key Health Care Issues

- *Communication*—provide acceptance, privacy; build teamwork, respect
- *Health*—encourage regular checkups; promote sexual responsibility; advise against substance abuse; update immunizations
- *Safety*—discourage risk-taking (promote safe driving, violence prevention, etc.)

Examples of age-specific care for adolescents:

- Treat more as an adult than child—avoid authoritarian approaches
- Show respect—be considerate of how treatment may affect relationships

- Guide teen in making positive lifestyle choices (i.e., correct misinformation from teen's peers)
- Encourage open communication between parent(s), teen, and peers

YOUNG ADULT BEHAVIOR AND DEVELOPMENT

The development of adults ages 21 through 39 years old focuses on family, career, and community involvement.

Healthy Growth and Development

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

Key Health Care Issues

- *Communication*—be supportive and honest; respect personal values
- *Health*—encourage regular checkups; promote healthy lifestyle (proper nutrition, exercise, weight, etc.); inform about health risks (heart disease, cancer, etc.); update immunizations
- *Safety*—provide information on hazards at home, work

Examples of age-specific care for young adults:

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

MIDDLE ADULT BEHAVIOR AND DEVELOPMENT

The development of adults ages 40 through 64 years old focuses on recognizing abilities and contributions while planning for older adulthood.

Healthy Growth and Development

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

Key Health Care Issues

- *Communication*—keep a hopeful attitude; focus on strengths, not limitations
- *Health*—encourage regular checkups and preventive exams; address age-related changes; monitor health risks; update immunizations
- *Safety*—address age-related changes (effects on sense, reflexes, etc.)

Examples of age-specific care for middle adults:

- Address worries about future—encourage talking about feelings, plans, and so on
- Recognize the person's physical, mental, and social abilities/contributions
- Help with plans for a healthy active retirement

OLDER ADULT BEHAVIOR AND DEVELOPMENT

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

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

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

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

The development of adults ages 65 through 79 focuses on social activities, physical health maintenance, and promoting independence.

Healthy Growth and Development

- *Physical*—ages gradually; natural decline in some physical abilities, senses
- *Mental*—continues to be an active learner, thinker; memory skills may start to decline

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- *Social–Emotional*—takes on new roles (grandparent, widow or widower, etc.); balances independence, dependence; reviews life

Key Health Care Issues

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

Examples of age-specific care for adults ages 65 to 79 years:

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

The development of adults ages 80 and older focuses on health issues, encouraging independence, and planning for care needs.

Healthy Growth and Development

- *Physical*—Continues to decline in physical abilities; at increasing risk for chronic illness, major health problems
- *Mental*—Continues to learn; memory skills and/or speed of learning may decline; confusion often signals illness or medication problem
- *Social–Emotional*—Accepts end of life and personal losses; lives as independently as possible

Key Health Care Issues

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

Examples of age-specific care for adults ages 80 and older:

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

THE IMPACT OF PHYSICAL, MENTAL, AND COGNITIVE IMPAIRMENT ON HUMAN DEVELOPMENT

The impacts of disabilities on human development are extremely varied depending upon the manifestations of the disability and when it occurs during the life course. Some disabilities are short-term, whereas others are lifelong. Critical to mitigating the negative impacts is the development of coping skills that strengthen a client's ability to deal with his or her limitations. Support (formal and informal) is also critical.

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

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

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

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

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

In addition to the biopsychosocial domains of human development, spirituality must also be considered as it relates to well-being. There is often a perceived spiritual basis of many physical and psychological symptoms. Thus, individuals may consult

a religious or spiritual adviser instead of or in addition to seeking help from a social worker. In fact, the use of spiritual healers in the non-Western world is so widespread that it is the backbone of many rural health care systems.

Given the central role of spirituality in all cultures, it will certainly have an impact on client functioning in some manner. In a clinical sense, client beliefs about themselves and their worlds are the "spirits" that comprise their personal realities and inform their feelings and actions. Including spirituality when gaining a better understanding of client problems and developing interventions to address them completes the holistic approach required by the ecological perspective of social work.

ATTACHMENT AND BONDING

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

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

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

These theories are, however, criticized because there are cultural influences that may impact on attachment and the ways in which children interact with caregivers. Much of Bowlby and others' work has not fully considered these differences.

John Bowlby also discussed typical stages of attachment that included stranger and separation anxieties.

Stranger anxiety, manifested by crying when an unfamiliar person tries to hold or closely approach a child, usually begins between 5 and 9 months, intensifies at about a year, and usually stops by approximately age 2.

Separation anxiety typically begins at about 6 to 8 months, peaks in intensity between 14 and 18 months, and generally resolves by approximately 24 to 36 months. It is characterized by being upset and anxious when a caregiver is out of sight or leaves the room.

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The onset and intensity of stranger and separation anxieties vary with each child, but these are typical developmental processes related to attachment and bonding, as opposed to Separation Anxiety Disorder, which occurs later in childhood, is characterized by excessive worrying about being away from a caregiver, and is not typical for the age at which it occurs.

BASIC HUMAN NEEDS

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

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

Deficiency Needs

- Physiological
- Safety
- Social
- Esteem

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

Growth Needs

- Self-actualization

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

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

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

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

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

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

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

Self-actualization Needs: There is a need to be oneself, to act consistently with whom one is. *Self-actualization is an ongoing process.* It involves developing potential, becoming, and being what one is capable of being. It makes possible true objectivity—dealing with the world as it is, rather than as one needs it to be. You are free to really do what you want to do. There are moments when everything is right (peak experience); a glimmer of what it is like to be complete. One is in a position to find one's true calling (i.e., being an artist, writer, musician). Only 1% of the population consistently operates at this level.
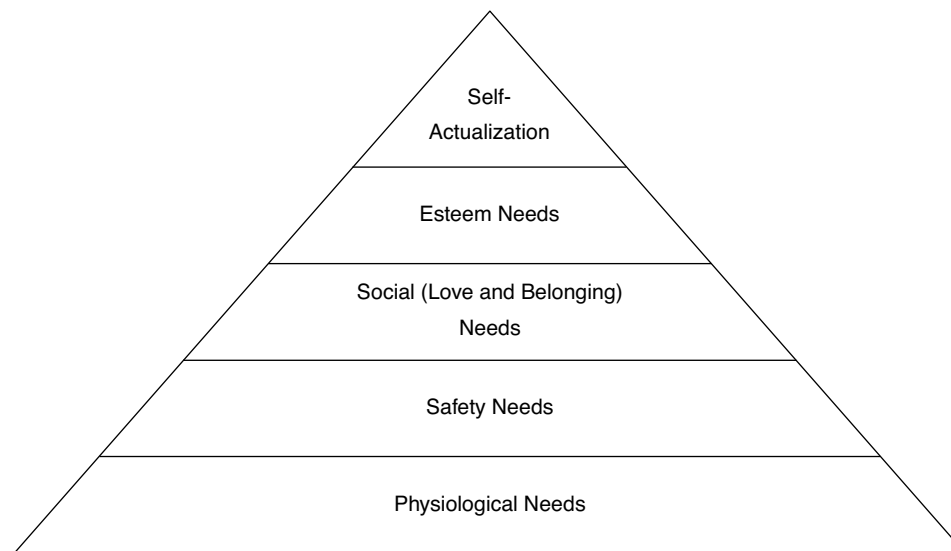
On the examination, Maslow's hierarchy of needs is often not explicitly asked about, but it can be applied when asked about the order of prioritizing problems or issues with a client. A client with an acute medical problem should focus on getting a medical evaluation first; a victim of domestic violence should prioritize medical and safety issues; and a refugee must initially meet basic survival needs (shelter, food, income, clothing, etc.) before working on fulfilling higher level needs.