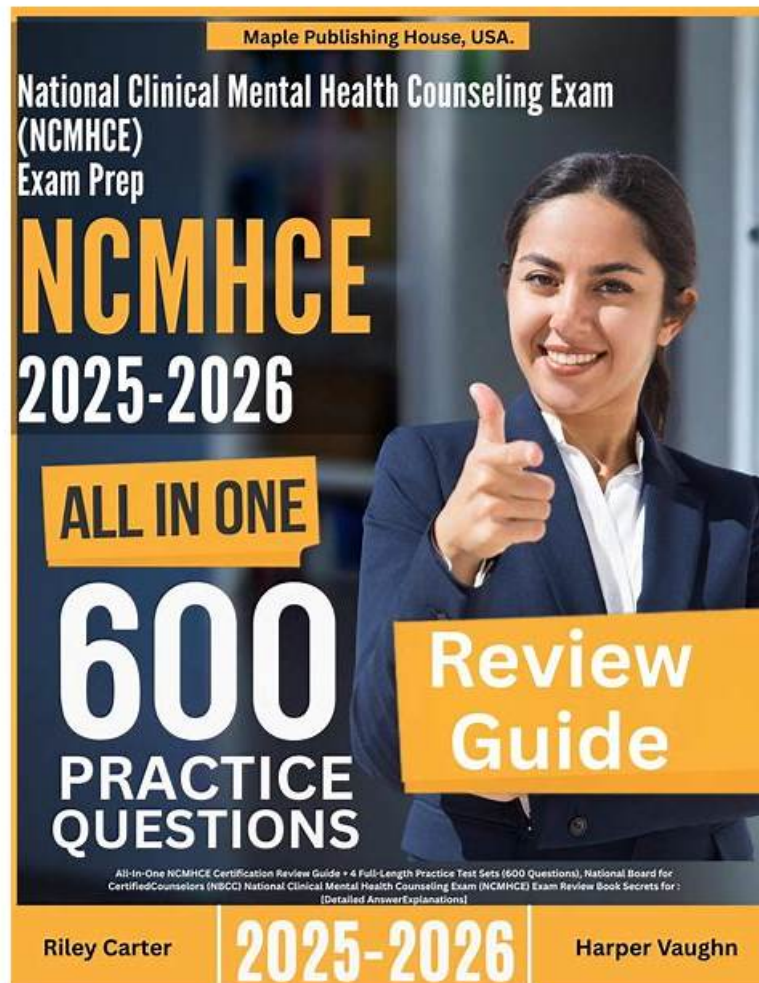


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## NBCC National Counselor Examination Sample Questions (Q72-Q77):

### NEW QUESTION # 72

What is a primary component of Minuchin's structural family therapy?

- A. Catharsis and interpersonal feedback
- **B. Homeostatic systems**
- C. Therapeutic spontaneity
- D. Conflict resolution

**Answer: B**

Explanation:

Within Counseling and Helping Relationships, CACREP includes knowledge of systemic and family counseling theories, including structural family therapy developed by Salvador Minuchin.

\* Structural family therapy views the family as a system that seeks homeostasis, meaning it tends to maintain its existing patterns and organization, even when those patterns are dysfunctional. A core idea is that the family structure (subsystems, boundaries, hierarchies, alignments) maintains symptoms to preserve this homeostatic balance. Interventions aim at restructuring these patterns so that healthier, more flexible functioning can emerge. Thus, the concept of homeostatic systems (A) is central to this model.

\* Catharsis and interpersonal feedback (B) are more characteristic of group counseling models (for example, Yalom's therapeutic factors), not uniquely structural family therapy.

\* Therapeutic spontaneity (C) is more closely associated with experiential family therapists such as Carl Whitaker, who emphasized creativity and spontaneity.

\* Conflict resolution (D) can occur in many counseling approaches but is not the defining core construct of Minuchin's structural model; the key focus is on family structure and systemic homeostasis.

Therefore, among the options provided, homeostatic systems (A) is the primary component most directly tied to structural family therapy.

### NEW QUESTION # 73

In using self-report devices as criterion measures, which of the following may be problematic?

- A. Type I error
- **B. Social desirability responding**
- C. Homogeneity of variance
- D. Halo effect

**Answer: B**

Explanation:

In the Assessment and Testing core area, CACREP highlights the importance of understanding test limitations, response biases, and sources of error in measurement-especially when using self-report instruments.

A major concern with self-report is social desirability responding, where individuals intentionally or unintentionally answer in ways that:

\* Present themselves in a more favorable light

\* Conform to perceived expectations or norms

\* Minimize or hide behaviors or attitudes that might be viewed negatively This bias can seriously affect the accuracy of self-report measures when they are used as criterion measures (standards against which other instruments are validated).

\* Homogeneity of variance (A) is a statistical assumption, not a specific self-report response bias.

\* Halo effect (B) is more commonly associated with rater bias (e.g., supervisor ratings), not with standardized self-report questionnaires.

\* Type I error (C) is a statistical concept (rejecting a true null hypothesis), again not a specific behavioral response style in self-report.

Thus, the most relevant and problematic issue when using self-report as a criterion measure is D. Social desirability responding.

### NEW QUESTION # 74

An observer's subjective description that provides a narrative of a client's behavior in a given situation or event is

- A. a checklist.
- **B. an anecdotal report.**

- C. a rating scale.
- D. a cumulative folder.

**Answer: B**

Explanation:

In the Assessment and Testing core area, counselors are required to understand different types of observational and documentation methods used to gather data about client behavior:

\* An anecdotal report (or anecdotal record) is a narrative, descriptive account of a specific incident or event, written in the observer's own words. It is inherently subjective and focuses on describing what the client did or said in a particular context. This matches the stem exactly, so Option D is correct.

\* A rating scale (Option A) involves assigning numerical or descriptive ratings (e.g., "never," "sometimes," "often") to specific behaviors or traits; it is not a narrative description.

\* A checklist (Option B) is a list of behaviors or characteristics where the observer simply marks whether each behavior was observed; it is not a written narrative.

\* A cumulative folder (Option C) is a collection of records and documents (e.g., grades, test scores, reports) that summarize a student's or client's history over time; it is not a single narrative observation.

Thus, the term that best fits a subjective, narrative description of behavior in a specific situation is anecdotal report (D).

### NEW QUESTION # 75

Using a psychodynamic approach, how can you relate reported symptoms to the best treatment process?

- A. By utilizing the DSM-5-TR to associate symptoms with disorders.
- B. By researching the optimal interventions for the treatment process.
- C. By examining the client's attachment to symptoms and the therapeutic alliance.
- D. By including a reinforcement learning model in the treatment process.

**Answer: C**

Explanation:

Within a psychodynamic framework, the counselor's clinical work emphasizes the meaning and function of symptoms, the client's unconscious conflicts, and the relational patterns that are re-enacted in the counseling relationship. Treatment planning in this approach relies heavily on understanding how the client is attached to their symptoms (e.g., how symptoms may protect against painful feelings or maintain familiar relational roles) and on using the therapeutic alliance as the primary vehicle for change.

Option D reflects this: examining the client's attachment to symptoms and the quality of the therapeutic alliance is consistent with psychodynamic treatment planning, where the counselor links symptoms to deeper emotional and relational processes and uses insight and the counseling relationship to facilitate change.

\* A focuses on diagnostic classification using the DSM-5-TR, which is important for diagnosis but not specific to a psychodynamic understanding or treatment planning process.

\* B refers to "reinforcement learning," a behavioral concept not central to psychodynamic work.

\* C describes a general evidence-based stance but does not capture the distinct psychodynamic emphasis on symptom meaning and the therapeutic relationship.

This aligns with the NBCC Counselor Work Behavior Areas expectation that counselors integrate theoretical orientation into conceptualization and treatment planning, using the counseling relationship and client insight as core components of psychodynamic treatment.

### NEW QUESTION # 76

A client comes to you for counseling because they identify with a gender that is not typically associated with their sex at birth. This could be diagnosed as gender dysphoria. A counselor would only make this diagnosis if

- A. The client exhibited a strong dislike for their anatomy.
- B. The client showed a desire for the secondary sexual characteristics of another gender.
- C. The client was considering surgical reassignment.
- D. There was clinically significant distress.

**Answer: D**

Explanation:

In the Assessment and Testing core area, CACREP requires that counselors understand:

- \* The use of diagnostic classification systems (such as DSM),
- \* The difference between identity or behavior and a mental disorder, and
- \* The central role of distress or impairment in making a diagnosis.

For gender dysphoria, diagnostic criteria emphasize that:

- \* A person may experience incongruence between their experienced/expressed gender and assigned sex,
- \* However, this incongruence alone is not sufficient for a mental health diagnosis,
- \* A diagnosis is appropriate only when the experience is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Evaluating the options:

- \* A. Considering surgical reassignment - Not required for diagnosis. Many individuals with gender dysphoria may never seek surgery.
  - \* B. Strong dislike for their anatomy - This can be one feature, but by itself does not justify a diagnosis without associated distress or impairment.
  - \* C. Desire for secondary sexual characteristics of another gender - Again, this can be part of the experience but is not sufficient alone to meet diagnostic criteria.
  - \* D. There was clinically significant distress. - This is the essential condition across DSM diagnoses: the symptoms must cause clinically significant distress or impairment. Without that, a formal diagnosis of gender dysphoria should not be made.
- Therefore, the counselor would only diagnose gender dysphoria if D (there was clinically significant distress) is present.

## NEW QUESTION # 77

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