DSM-5 FOR ASWB PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. What distinguishes Factitious Disorder from other disorders?

A. The symptoms are intentionally produced or feigned

B. The focus is on external incentives

C. It can only be diagnosed in children

D. It is always related to trauma

2. What characterizes Somatic Symptom and Related Disorders?

A. Exclusively psychiatric symptoms

B. Prominent somatic symptoms causing distress and impairment

C. The absence of any physical symptoms

D. Chronic fatigue without identifiable cause

3. Individuals diagnosed with panic disorder may experience feelings of:

A. Overwhelming sadness

B. Choking or chest pain

C. Chronic worry about social situations

D. Fear of separation

4. Which of the following is NOT considered a type of Neurocognitive Disorder?

A. Delirium

B. Major Neurocognitive Disorder

C. Mild Neurocognitive Disorder

D. Obsessive-Compulsive Disorder

5. Which disorder involves symptoms of altered motor or sensory function with no medical basis?

A. Factitious Disorder

B. Conversion Disorder

C. Illness Anxiety Disorder

D. Somatic Symptom Disorder

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6. What might signify that an individual has Fetishistic Disorder?

A. Consistent use of only explicit media in sexual contexts

B. Continual focus on aesthetic aspects of a partner

C. Reliance on specific nonliving objects for sexual arousal

D. Practicing sexual acts without any predetermined focus

7. What is a common feature of Intermittent Explosive Disorder?

A. Strategic planning before acting

B. Episodes that occur in response to minor provocations

C. Consistent feelings of joy and excitement

D. A gradual buildup of stress over time

8. Which of the following is INCLUDED in the types of Feeding Disorders?

A. Obsessive Compulsive Disorder

B. Panic Disorder

C. Rumination Disorder

D. Social Anxiety Disorder

9. Which developmental disorder might have onset during early childhood?

A. Obsessive-Compulsive Disorder

B. Autism Spectrum Disorder

C. Major Depressive Disorder

D. Generalized Anxiety Disorder

10. What is a common feature of both Anorexia Nervosa and Bulimia Nervosa?

A. Obsession with social interactions

B. Disturbance in perception of body image

C. Excessive exercise

D. Lack of interest in food

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Answers

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1. A
2. B
3. B
4. D
5. B
6. C
7. B
8. C
9. B
10. B

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Explanations

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1. What distinguishes Factitious Disorder from other disorders?

A. The symptoms are intentionally produced or feigned

B. The focus is on external incentives

C. It can only be diagnosed in children

D. It is always related to trauma

Factitious Disorder is characterized by the intentional production or feigning of physical or psychological symptoms. This means that individuals actively and deliberately engage in behavior that leads to the appearance of an illness, often to assume the role of a patient. This distinguishes Factitious Disorder from other similar disorders, such as malingering, where the motivation is typically to gain a specific external incentive, such as financial compensation or avoiding responsibilities. In Factitious Disorder, the primary motivation is not to achieve a tangible gain; rather, it revolves around the need to be seen as ill or to gain attention and sympathy from others, which is fundamentally different from disorders that involve genuine symptoms or external incentives. This deep-rooted need for affirmation and validation as a patient or suffering individual showcases a complex psychological dynamic unique to Factitious Disorder. Additionally, the disorder is not limited to a specific age group, as it can manifest in both adults and children, nor is it inherently tied to prior trauma, which means options regarding age limitations or trauma association do not apply. Therefore, the essence of Factitious Disorder lies in the conscious creation or exaggeration of illness symptoms without the primary motive of external rewards.

2. What characterizes Somatic Symptom and Related Disorders?

A. Exclusively psychiatric symptoms

B. Prominent somatic symptoms causing distress and impairment

C. The absence of any physical symptoms

D. Chronic fatigue without identifiable cause

Somatic Symptom and Related Disorders are primarily characterized by the presence of prominent somatic symptoms that cause significant distress and impairment in daily functioning. Individuals with these disorders experience physical complaints that may or may not have a clear medical explanation, but the impact of these symptoms on their emotional state and quality of life is profound. These disorders encompass a variety of presentations, including Somatic Symptom Disorder, Illness Anxiety Disorder, and Conversion Disorder, among others. The key feature is that the focus is on how these somatic symptoms lead to psychological distress and functional challenges, rather than solely being rooted in a psychiatric condition. This sets them apart from purely psychiatric disorders, where physical symptoms are not the primary focus. While options focusing on the absence of physical symptoms or chronic fatigue may touch on aspects related to somatic symptoms, they do not encompass the broader reality of the distress and functional impairment that defines the disorders in this category.

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3. Individuals diagnosed with panic disorder may experience feelings of:

A. Overwhelming sadness

B. Choking or chest pain

C. Chronic worry about social situations

D. Fear of separation

Individuals diagnosed with panic disorder often experience acute episodes known as panic attacks, which include a range of physical and psychological symptoms. Among these symptoms, feelings of choking or chest pain are particularly significant. During a panic attack, individuals may report sensations such as tightness in the chest, difficulty breathing, or a feeling of impending doom, which can mimic physical health issues like heart attacks. These symptoms can be very distressing and contribute to the anxiety about having future panic attacks. In contrast, the other choices do not align with the core experiences associated with panic disorder. Overwhelming sadness is more typical of mood disorders, chronic worry about social situations aligns with social anxiety disorder, and fear of separation is associated with separation anxiety disorder. Understanding these distinctions is crucial for accurate diagnosis and treatment planning in different anxiety-related disorders.

4. Which of the following is NOT considered a type of Neurocognitive Disorder?

A. Delirium

B. Major Neurocognitive Disorder

C. Mild Neurocognitive Disorder

D. Obsessive-Compulsive Disorder

Neurocognitive Disorders represent a category of cognitive impairments that primarily involve deficits in cognitive functioning, often associated with aging or disease processes affecting the brain. This category includes conditions such as Delirium, Major Neurocognitive Disorder (also known as dementia), and Mild Neurocognitive Disorder, all of which are characterized by varying degrees of cognitive decline impacting judgment, memory, and learning. Obsessive-Compulsive Disorder, on the other hand, is classified as an anxiety disorder rather than a neurocognitive disorder. It involves persistent, intrusive thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) performed in response to those thoughts. While OCD can certainly impact cognitive processes, it does not fit the definition of a disorder primarily characterized by cognitive decline or impairment. Therefore, it is correctly identified as not being a type of Neurocognitive Disorder. Understanding these distinctions is essential for grasping the broader categories within the DSM-5 framework, especially when preparing for assessments or clinical practice.

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5. Which disorder involves symptoms of altered motor or sensory function with no medical basis?

A. Factitious Disorder

B. Conversion Disorder

C. Illness Anxiety Disorder

D. Somatic Symptom Disorder

The disorder defined by symptoms of altered motor or sensory function that cannot be medically explained is Conversion Disorder. In this condition, individuals experience significant neurological symptoms such as weakness, paralysis, or sensory disturbances—such as loss of vision or numbness—that are inconsistent with any known medical condition. The hallmark of Conversion Disorder is that these symptoms are not intentionally produced or feigned, distinguishing them from certain other disorders where symptoms may be intentionally generated, like factitious disorder. The symptoms typically cause significant distress or impairment in social or occupational functioning. Conversion Disorder is often thought to occur as a psychological response to stress or trauma, where psychological conflicts manifest as physical symptoms. This mind-body interaction illustrates how a psychological issue can lead to real and observable physical symptoms without a biological cause. The other options currently provided involve different presentations of distress that are not categorized as alterations in neurological function without medical basis, making Conversion Disorder the correct choice.

6. What might signify that an individual has Fetishistic Disorder?

A. Consistent use of only explicit media in sexual contexts

B. Continual focus on aesthetic aspects of a partner

C. Reliance on specific nonliving objects for sexual arousal

D. Practicing sexual acts without any predetermined focus

Fetishistic Disorder is characterized by a strong sexual interest in nonliving objects or specific non-genital body parts, which are essential for sexual arousal and gratification. The key aspect of this disorder is that the individual experiences significant distress or impairment due to this focus, as the nonliving objects or specific parts become necessary for their sexual functioning. The choice that indicates reliance on specific nonliving objects for sexual arousal directly corresponds to the criteria established in the DSM-5 for Fetishistic Disorder. This condition is distinguished from more common sexual interests, as the arousal is not just a preference but rather a crucial element for the individual's sexual experiences. In summary, recognizing that the source of desire is fundamentally tied to specific objects or body parts highlights the distinction of Fetishistic Disorder and confirms why this answer aligns with the diagnostic criteria.

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7. What is a common feature of Intermittent Explosive Disorder?

A. Strategic planning before acting

B. Episodes that occur in response to minor provocations

C. Consistent feelings of joy and excitement

D. A gradual buildup of stress over time

Intermittent Explosive Disorder (IED) is characterized by recurrent episodes of impulsive aggression that are disproportionate to the circumstances prompting the outburst. A key feature of IED is that these aggressive episodes often occur in response to minor provocations, indicating an extreme sensitivity to irritation and frustration. This starkly contrasts with the typical emotional responses expected in most situations, where slight provocations would not normally elicit such intense anger or aggression. The significance of this characteristic in IED is that individuals may frequently find themselves reacting to trivial annoyances or minor setbacks with explosive anger. This impulsivity and lack of control over these aggressive behaviors are central to the diagnosis of IED. Thus, the connection between seemingly minor events and the intense outbursts is a hallmark symptom that helps differentiate IED from other disorders involving anger or aggression. In contrast, strategic planning prior to acting is inconsistent with the impulsive nature of IED. The disorder is marked by the spontaneity of aggressive outbursts rather than premeditation. Consistent feelings of joy and excitement are not characteristic of IED; rather, individuals may experience feelings of distress, irritability, or remorse following their outbursts. Finally, a gradual buildup of stress over time is not

8. Which of the following is INCLUDED in the types of Feeding Disorders?

A. Obsessive Compulsive Disorder

B. Panic Disorder

C. Rumination Disorder

D. Social Anxiety Disorder

Feeding disorders encompass a range of conditions that primarily involve difficulties with the consumption of food. Rumination Disorder is specifically classified under feeding disorders in the DSM-5. This disorder involves the repeated regurgitation of food, which may then be re-chewed, re-swallowed, or spit out, occurring repeatedly over a period of time. It is not the result of a medical condition and often requires behavioral interventions to address the underlying issues related to feeding. The other conditions mentioned, while they may influence eating behaviors indirectly, do not fall under the category of feeding disorders. Obsessive Compulsive Disorder and Panic Disorder may involve anxiety that could potentially affect eating habits, but they are classified as anxiety disorders. Social Anxiety Disorder pertains to the fear of social situations and is also categorized under anxiety disorders rather than feeding disorders. Therefore, Rumination Disorder is the only choice that fits the specific diagnostic criteria of feeding disorders, making it the correct answer.

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9. Which developmental disorder might have onset during early childhood?

A. Obsessive-Compulsive Disorder

B. Autism Spectrum Disorder

C. Major Depressive Disorder

D. Generalized Anxiety Disorder

Autism Spectrum Disorder (ASD) is recognized in the DSM-5 as having its onset during early childhood, typically before the age of three. Children diagnosed with ASD exhibit challenges in social communication and repetitive patterns of behavior, interests, or activities. These symptoms are often noticeable even in infancy and become increasingly observable as the child grows and develops, making early diagnosis crucial for intervention and support. In contrast, the other disorders listed tend to present later in development. Obsessive-Compulsive Disorder and Generalized Anxiety Disorder can develop during childhood but are more commonly recognized in later childhood or adolescence. Major Depressive Disorder can occur in children but also tends to manifest more clearly in later childhood or adulthood. Thus, Autism Spectrum Disorder stands out as the developmental disorder specifically linked to early childhood onset.

10. What is a common feature of both Anorexia Nervosa and Bulimia Nervosa?

A. Obsession with social interactions

B. Disturbance in perception of body image

C. Excessive exercise

D. Lack of interest in food

A common feature of both Anorexia Nervosa and Bulimia Nervosa is the disturbance in the perception of body image. Individuals with these eating disorders often experience a distorted view of their body size and shape, leading them to perceive themselves as overweight even when they may be underweight or at a normal weight. This distorted body image drives unhealthy eating behaviors and significant preoccupation with weight and shape. In Anorexia Nervosa, this distortion leads to severe restriction of food intake and an intense fear of gaining weight. Similarly, in Bulimia Nervosa, even though individuals may engage in binge eating episodes followed by compensatory behaviors (such as purging), they still struggle with a distorted body image that influences their eating patterns and self-esteem. Thus, the significant impact of body image distortion is a key characteristic that links both disorders when considering the psychological factors involved.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

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We wish you the very best on your exam journey. You've got this!

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