WILIAM & MARY

Counseling Center
Internship in Health Service Psychology

Manual

2024-2025

WILLIAM & MARY
CHARTERED 1693

Counseling Center
McLeod Tyler Wellness Center
Post Office Box 8795
240 Gooch Drive, 2nd Floor
Williamsburg, VA 23187-8795

Phone Number 757-221-3620
Fax Number 757-221-2254

Counseling Center Front Office Information

The front desk personnel consist of the Executive Secretary / Office Manager and the Administrative & Program Specialist. The front desk will help you with administrative tasks. Please also feel free to ask them for assistance with getting acclimated to office, technology issues, university procedures and administrative tasks you may have.

Building and Office Access (Key Policy)

All Counseling Center staff are issued a Staff ID and keys for access to building, hall office door and interior office door. To obtain your Staff ID, follow the instructions at: https://www.wm.edu/offices/auxiliary/tribecardservices/newcard/fac-staff/index.php.

After obtaining your Staff ID, please consult with front desk personnel to get access to the building card readers.

Assigned keys are to be used ONLY by Counseling Center Staff. DO NOT allow anyone unaffiliated with the Counseling Center to use your keys. Spare office keys are housed in a security envelope in the front office. Consult with front desk personnel if you need a spare key.

Keys to College property may be duplicated only by the College locksmith. Keys will only be issued to provide access to areas and property necessary to accomplish assigned work of Counseling Center employees. All keys are returned and logged in upon separation from the College.

Weather policy

To sign up for the College's emergency notification system you will need to log into the Banner on the W&M homepage and provide the necessary contact information. This will provide you updates on any College emergencies, closures, delayed openings, etc.
Please don't hesitate to see the Training Director or the Office Manger if you have any questions or concerns. The policy regarding university operations in the event of serious inclement weather conditions can be found here:
http://www.wm.edu/about/administration/provost/forfacstaff/weather/

Campus Emergencies

The College of William & Mary is committed to providing a safe and secure environment for its students, faculty, employees and visitors to learn, teach, work and enjoy our beautiful campus and all it offers. In pursuit of that goal the College takes a comprehensive approach to protecting the College community and preparing for any emergency.

To obtain the necessary information start by keeping your emergency contact information updated in Banner so that the Emergency Management Team (EMT) can contact you through the mass notification system. (Landline phone, cell phone, text messages and e-mail). You may also check the university's mail website, www.wm.edu, the W&M News Facebook page (http://media.wm.edu/content/wm/emergency/siren.wav) and W&M News Twitter page (https://twitter.com/WMNews)

The Building Emergency Coordinator Program involves building occupants in emergency planning and response and addresses the unique needs of specific buildings. Building Emergency Coordinators are the conduit for the information flow between the Emergency Management Team and the occupants of the facility. Members of the College community should familiarize themselves with the responsibilities of building coordinators and identify the coordinators for the buildings they use most.

McLeod Tyler Wellness Center:	Lindsey Heck	lheck@wm.edu

Fire Drills

All fire drills at the College will be announced and preplanned.
If a fire alarm sounds and you have not been notified prior to the alarm that it is a drill, take immediate action, evacuate the building and protect yourself.

IF THERE'S A FIRE

FOLLOW C.A.R.E. PROCEDURES

Close doors

Alert others

Report the fire- call 911

Evacuate the building

Try to rescue others ONLY if you can do so safely.

Move away from the building at least 50 feet away, out of the way of the fire department.

Don’t go back into the building until the fire department says it is safe to do so.

Emergency Alarms

The College has a number of ways to communicate to the campus community during an emergency situation and it's important that you take an active role in staying informed.

The College has three emergency sirens that are stationed on top of the Integrated Science Center, the School of Education building and the Law School. The sirens are 120-decibels. That's loud – about the same as a jet engine flying.

Hear it for yourself – get to know this sound (http://media.wm.edu/content/wm/emergency/siren.wav). When you hear the siren, it means two things – **seek shelter and seek information**.

WILLIAM & MARY
CHARTERED 1693

UNDERGRADUATE ACADEMIC CALENDAR 2024-2025

2024	**Fall Semester**	
August TBD	Orientation	
August 28	Classes begin	(Wednesday)
September 2	Labor Day	(Monday)
October 10-13	Fall Break	(Thursday-Sunday)
November 5	Election Day	(Tuesday)
November 27-December 1	Thanksgiving holiday	(Wednesday-Sunday)
December 6	Last day of classes	(Friday)
December 7-8	Reading period	(Saturday-Sunday)
December 9-13	Exams	(Monday-Friday)
December 14-15	Reading period	(Saturday-Sunday)
December 16-17	Exams	(Monday-Tuesday)

2025	**Spring Semester**	
January TBD	Orientation	
January 22	Classes begin	(Wednesday)
March 8-16	Spring Break	(Saturday-Sunday)
May 2	Last day of classes	(Friday)
May 3-4	Reading period	(Saturday-Sunday)
May 5-9	Exams	(Monday-Friday)
May 10-11	Reading period	(Saturday-Sunday)
May 12-13	Exams	(Monday-Tuesday)
May 15-17	Commencement	(Thursday-Saturday)

	Summer Session	
May 27-June 27	Session I	(Tuesday-Friday)
June 30-August 1	Session II	(Monday-Friday)

Commonwealth of Virginia
2024 Pay and Holiday Calendar

State Holidays

January 1
New Year's Day
January 15
Martin Luther King, Jr. Day
February 19
George Washington Day
May 27
Memorial Day
June 19
Juneteenth
July 4
Independence Day
September 2
Labor Day
October 14
Columbus Day & Yorktown Victory Day
November 5
Election Day
November 11
Veterans Day
November 27
4 hours additional holiday time
November 28
Thanksgiving
November 29
Day After Thanksgiving
December 24
8 hours additional holiday time
December 25
Christmas

Please note: In some agencies, the holiday and payday schedule may vary from what is shown here. If you have questions, see your agency human resources officer.

Denotes Payday ☐

Denotes Holiday ◯

Denotes Additional Time Off 8 hrs 4 hrs

Denotes Payday on Holiday or Time Off

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January

S	M	T	W	T	F	S
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7	8	9	10	11	12	13
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November

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December

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29	30	31				

COMMONWEALTH *of* VIRGINIA

Department of Human Resource Management

SARA REDDING WILSON
DIRECTOR

101 N. 14TH STREET
JAMES MONROE BUILDING, 12TH FLOOR
RICHMOND, VIRGINIA 23219
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Dear Employee:

This *Employee Handbook* has been designed to serve as a quick reference for many issues relating to your employment with the Commonwealth of Virginia. **It is not a contract, nor is it an invitation to contract.**

In order to remain current, the *Handbook* treats most topics briefly and provides links to the Department of Human Resource Management's *Policies and Procedures Manual* and other sources of information. This *Manual* is updated as official policies change. The *Policies and Procedures Manual* is the authority in case of a disparity between the *Manual* and the *Employee Handbook.*

It is important for you to be familiar with the information in this *Handbook*. Please review it carefully. If you need to refer to the *Handbook* in the future, remember that the most recent version will be available on the DHRM Web site, where the links can also be used. In addition, your agency Human Resources office can provide assistance with questions relating to your employment.

Please sign below to indicate that you have seen and read this *Handbook*, and give the signed page to your agency Human Resource office. This page will be kept in your file.

We hope you will enjoy a rewarding career with the Commonwealth.

Department of Human Resource Management

Signature: ____

Printed name: ____

Agency: ____________________________________ Date: ______________

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NOTICE

This handbook contains general information about your employment with the Commonwealth and outlines policies and procedures that affect your daily work. It does not include specific provisions of the policies and procedures, nor does it create any employee rights or benefits. **The handbook is not a contract, nor is it an invitation to contract. Nothing in this handbook is intended to create or imply any contract rights.**

Discrimination on the basis of race, sex, color, national origin, religion, age, or political affiliation, or against otherwise qualified persons with disabilities is prohibited in all aspects of employment with the Commonwealth of Virginia.

INTRODUCTION TO EMPLOYEE HANDBOOK

Whether you are new to the Commonwealth of Virginia or are a continuing employee, this Employee Handbook is written to help you develop a satisfying career in service to Virginia by outlining the basic elements of the employment relationship between you and the Commonwealth.

This Handbook is designed for you as a classified employee of the Commonwealth. (Classified employees are salaried employees whose positions are subject to the Virginia Personnel Act.) The Employee Handbook contains basic information related to your employment and refers you to Department of Human Resource Management policies for specific details. These policies are found at the Web Site of the Department of Human Resource Management (DHRM), www.dhrm.virginia.gov. Supervisors, managers, and Human Resource staff will also find information here that is useful to their work with employees.

This handbook does not include all information that may apply specifically to your agency because of the flexibility that agencies have to tailor policies to meet their management needs. Other specific information is available from your supervisor or your Human Resource office.

The official policies of the Department of Human Resource Management, some of which are discussed in this handbook, are revised frequently as the need arises. If any statements in this handbook differ from policy as contained in the *Policies and Procedures Manual*, the *Manual* governs.

QUICK REFERENCE TO KEY WEBSITES

http://www.dhrm.virginia.gov/	Department of Human Resource Management (DHRM) home page
http://www.dhrm.virginia.gov/hrpolicy/policy.html	Human Resource Policy
http://www.dhrm.virginia.gov/employeebenefits.html	Employee Benefits
http://www.dhrm.virginia.gov/compensation.html	Employee Compensation
http://www.dhrm.virginia.gov/programs.html	Employee Programs
http://www.dhrm.virginia.gov/employeerelations.html	Employee Relations
http://www.dhrm.virginia.gov/employmentandcareers.html	Employment and Careers
https://secure.doa.virginia.gov/payline//	Department of Accounts Payline
http://www.edr.virginia.gov/index.htm	Department of Employment Dispute Resolution
http://www.varetire.org/	Virginia Retirement System
http://www.gwr.com	Great West Retirement

GENERAL CONDITIONS OF EMPLOYMENT

A. Hours Of Work – *See Policy 1.25, Hours of Work, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

A full-time classified employee works a schedule of 40 hours per week ("F" status) or 32 to 39 hours per week ("Q' status). Classified employees working a schedule of 20-31 hours per week are part-time ("P" status). There is no classified employment for a schedule of less than 20 hours per week.

For most jobs, an unpaid lunch break of 30 to 60 minutes (45 minutes is typical) is required. Your supervisor will schedule this for you. In addition, agencies may provide two 15-minute breaks, one morning and one afternoon, which are part of the paid day. These breaks are optional and may not be used to cover missed time or to extend the lunch period.

The standard workday is 8 hours. Unless otherwise indicated, official statements including policy and handbook references to "workday" mean an 8-hour period. If you work an alternate schedule, remember that official statements generally assume 8-hour days.

1. Some agencies have established flexible work hours to better meet their business needs. Normally, administrative offices must ensure adequate coverage during core business hours. In most cases, flexible schedules maintain a 40-hour workweek. Ask your supervisor if one of these schedules applies to you or is an option available to you.

2. Your agency may permit alternate work schedules in some cases. An example of an alternate schedule is four 10-hour days per week. Based on its business needs, an agency or work unit may decide not to permit alternate schedules, or may decide to discontinue them at any time.

   Most *non-exempt* employees (those covered by the Fair Labor Standards Act) may work only those schedules that maintain a 40-hour workweek. For certain employees in law enforcement and health care delivery, the Fair Labor Standards Act (FLSA) permits arrangements, such as 28-day cycles, which do not require a 40-hour workweek. In these cases, the calculation of overtime is based on the alternative work cycle.

   With agency approval, *exempt* employees (those not covered by the FLSA) may work a two-week schedule that results in 80 work hours in two weeks.

B. Attendance – *See Policy 1.60, Standards of Conduct, and Policy 1.25, Hours of Work, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

You are expected to report to work in accordance with the work schedule assigned by your supervisor, and you are responsible for letting your supervisor know as soon as possible if you expect to be late or absent. Ask your supervisor about your agency's procedure for reporting absences. Failure to notify your supervisor appropriately may result in disciplinary action including termination.

C. Hiring Requirements – *See Policy 2.10, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Employees hired into certain positions must complete a Statement of Personal Economic Interests as required by the Code of Virginia (§ 2.2-3100). Your Human Resource office will know whether you need to complete this statement.

All employees must meet certain conditions of employment. Additionally, agencies may require a background check which could include pre-employment tests and/or drug tests.

Certain state jobs are designated by agencies as "sensitive" according to the definition in the Code of Virginia, §2.2-1201.1. Final candidates for these positions are subject to a fingerprint-based background check, including current employees who apply for a sensitive position.

D. Information About Your Paycheck

1. Standard pay periods for classified employees are the 10th through 24th of a month and the 25th through the 9th of a month. Most classified employees are paid twice a month, on the 1st and 16th following the end of the pay period. When paydays fall on weekends or holidays, paychecks normally are distributed and direct deposits normally are made the last workday before the regular pay date. Ask your supervisor about your agency pay schedule. New state employees generally are required to participate in direct deposit.

2. Tax liens and garnishments are honored as directed by state and federal law. An employee will be charged a fee for processing certain garnishments. See the Commonwealth Accounting Policies and Procedures (CAPP) Manual http://www.doa.state.va.us/procedures/AdminServices/capp/summary.htmTopic 50405.

E. Probationary Period – *See Policy 1.45, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Classified state employees serve a probationary period of one year from their employment or re-employment date. This is a trial period during which the agency and employee learn whether the employee is suited for the job. This time may be extended if the employee experiences absence(s) of more than 14 consecutive days and for certain other reasons. Except to make up for the employee's absence, the probationary period may not be extended for more than six additional months. If you are selected for a

position that requires certification following completion of a prescribed training program, you must complete a new probationary period.

The state's grievance procedure is not available to probationary employees. However, if you believe you have been discriminated against in any condition of employment based on race, color, religion, national origin, sex, age, disability, or political affiliation, you may file a discrimination complaint through your agency's human resource department, with the Office of Equal Employment Services section of DHRM, or with the federal Equal Employment Opportunity Commission, http://www.dhrm.virginia.gov/employeerelations.html.

During your probationary period and throughout your employment with the Commonwealth, you should consult your agency Human Resource office for assistance with workplace issues of all kinds. This office can provide guidance and referral to other resources as needed.

F. Overtime – *See Policy 3.15, Overtime Leave, and Policy 1.25, Hours of Work, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Some positions involve occasional or periodic overtime work; employees must work overtime as required by their supervisors. Employees are designated as covered by the federal Fair Labor Standards Act ("non-exempt") or not covered ("exempt"). Agencies determine the exempt or non-exempt status of each employee using FLSA guidelines and based on the type of work done. For non-exempt employees, payment of overtime hours worked must comply with the Act.

Non-exempt employees are normally paid overtime at time and one-half their regular rate for hours worked over 40 during a workweek. Agencies may elect to grant overtime leave instead of overtime pay. In this case, the employee must be notified in advance. Overtime leave hours do not expire, and there is a maximum number of overtime leave hours an employee may accrue. Thus, an employee must take paid time off to avoid exceeding his or her agency limit. Employees receive pay for accrued overtime hours when leaving state service and at certain other times specified in policy.

Exempt employees typically are not compensated for working overtime. However, in unusual circumstances, agencies may choose to provide straight-time compensatory leave or pay.

G. Office Closings – *See Policy 1.35, Emergency Closings, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

When weather conditions or an emergency situation forces late openings, early closings, or full-day closings of state agencies, classified employees may be paid for these periods. Decisions regarding such closings are made by the following authorities:

- For administrative agencies in the city of Richmond and in Chesterfield, Henrico, and Hanover counties – the Governor;

- For state colleges and universities – the college or university president; and
- For state operations or branch offices of administrative agencies outside of Richmond – the responsible agency head or appropriate facility or operations director.

Closing decisions normally are announced on local radio and television stations.

Be sure you know the radio or television stations that will announce closings in your area. Closing announcements also appear on the DHRM web site, http://www.dhrm.virginia.gov/. You are responsible for knowing this information and for acting accordingly.

Certain personnel may be "designated" by their agencies as being required to work during authorized closings. They may earn compensatory leave or pay for hours worked during periods of closing.

H. Telecommuting – *See Policy 1.61 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Agencies may designate certain positions and certain employees for telecommuting (teleworking). This practice enables employees to conduct some of their work from their homes or from another site other than the central workplace.

State agencies are encouraged to develop telecommuting and alternative work schedule arrangements where high standards of employee performance and service delivery can be maintained.

I. Outside Employment – *See Policy 1.60, Standards of Conduct,* at http://www.dhrm.virginia.gov/hrpolicy/policy.html.

As a state employee, your obligation to your state job is considered to be your primary duty. An employee must receive approval from his or her agency *before* taking on an additional job, including self-employment. An employee who already has other employment when he or she enters state service or moves from one agency to another must inform the hiring manager and seek approval to continue the other employment. An employee may be disciplined for outside employment that occurs during work hours or that is deemed to affect work performance.

J. Alcohol And Other Drugs – *See Policy 1.05 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

The Commonwealth intends to maintain a workplace free from the adverse effects of alcohol and other drugs. Employees are forbidden to use these substances at the workplace or to come to the workplace while under the influence of these substances. In addition, employees are expected to notify their supervisors if they are convicted of violating any criminal drug law, either within or outside the work place, or if they are convicted of violating any alcohol beverage control law or law that governs driving while

intoxicated, based on conduct occurring in the workplace. Violation of policies related to these matters can result in serious disciplinary action including termination.

Because of the nature of the work, some agencies require drug testing before a final employment offer is made. Some positions may also require ongoing random drug testing and/or as-needed drug or alcohol testing.

K. Safety And Security In The Workplace – *See Policies 1.80, Workplace Violence, and 2.30, Workplace Harassment, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

As an employer, the Commonwealth of Virginia makes every effort to ensure a safe and healthy workplace for its employees as well as for customers, patients, business colleagues, and visitors. Harassment (sexual or other), threats of violence, and violent acts will not be tolerated in the state workplace. Policy 1.80 provides guidance regarding the kinds of actions which will not be tolerated in the workplace, and describes the responsibility of state agencies to take certain measures to promote safety and security in the work environment. Violation of policies related to these matters can result in serious disciplinary action including termination.

All state employees are covered by the Virginia Workers' Compensation Act. In addition, the Workers' Compensation section of the Department of Human Resource Management offers services such as training and consultation in workplace safety and loss control.

You should consult your Human Resource office if you have concerns in this area. Incidents of workplace violence should be reported immediately through appropriate channels in your agency.

L. Layoff And Severance – *See Policies 1.30, Layoff; 1.57, Severance Benefits; and 1.65 Temporary Work Force Reduction, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Business needs, including economic constraints, may require an agency to re-configure or reduce its workforce. Policy 1.30 (Layoff), Policy 1.57 (Severance Benefits), and Policy 1.65 (Temporary Work Force Reduction) outline procedures for agencies to follow and rights of employees in these situations.

Employees may be identified for layoff using a number of factors, including business needs, job functions, and employees' length of continuous state service. Severance benefits are based on salary and length of continuous state service and may sometimes be used by eligible employees for enhanced retirement. Restricted employees (those paid from non-continuing sources of funds) and part-time employees should check these policies and consult their Human Resource offices to find out whether they are eligible for layoff and/or severance benefits.

Your agency may experience variations in work flow which make temporary staff reductions advisable. Policy 1.65, Temporary Work Force Reduction, explains how

agencies should implement these short-term reductions and defines the rights of employees during such actions.

M. Statement of Public Accountability

State agencies are public institutions supported by the Commonwealth of Virginia, a public employer committed to serving the interests of the taxpayers and accountable to them for the effective use of public funds. Therefore, it is the policy of the Commonwealth that employees are not paid for time that they do not work, unless they use leave time, such as annual leave or sick leave, accrued under human resource policies. You will be placed on Leave Without Pay, and your paycheck for that pay period will be reduced, if you are absent from work for personal reasons or because of illness or injury, even for periods of less than one day, if you do not use accrued leave because (1) you do not request use of accrued leave or your request is denied, (2) your accrued leave has been exhausted, or (3) you request leave without pay.

If your position is exempt from the overtime provisions of the Fair Labor Standards Act (FLSA), there will be no deductions from your compensation for periods of absence from work of less than one day, except for the reasons and circumstances specifically described in the preceding paragraph or for infractions of safety rules of major significance.

COMPENSATION

See Policy 3.05, at http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Your total compensation includes both your salary and the state's benefits package. In addition to salary, classified employees are eligible to receive several kinds of paid time off, group health insurance (with a state contribution to the premiums for full-time employees), state-supported membership in the Virginia Retirement System, life insurance, short- and long-term disability coverage (for VSDP participants) and others. Many of these benefits are explained in this Handbook, and the Benefits Administrator in your agency's Human Resource office can give you detailed information.

Classified positions are assigned to approximately 300 roles (titles) within about 60 career groups and seven occupational families. Each role is assigned to one of nine pay bands. Both the employee and the job are assessed for pay purposes using specified factors. Various pay practices are used to establish your original salary and to guide the movement of your salary during your career. Agencies retain some latitude to develop their own salary administration plans within the broad framework set by DHRM policies.

The state does not guarantee any specific pay increases or any certain timetable for pay increases. Funds to support employee pay increases may be provided and earmarked by the Governor or the legislature, or may be identified by the agencies within their own budgets. The legislature and Governor may provide for general pay increases in some years. These typically are linked to the employee's satisfactory job performance.

In addition to Policy 3.05, the Human Resource Management Manual provides information about compensation practices. You may refer to this manual at http://www.dhrm.virginia.gov/resources/manuals.html.

PERFORMANCE MANAGEMENT AND EVALUATION

See Policy 1.40, Performance Planning and Evaluation, and Policy 1.45, Probationary Period, at http://www.dhrm.virginia.gov/hrpolicy/policy.html

It is important for you to clearly understand what you will be expected to do in your job. One way to get this information is through the Employee Work Profile (EWP), a description of the work you will be assigned to do and the level of performance you are expected to achieve. You will receive an EWP shortly after you begin work, and it will be reviewed annually thereafter. The EWP may be revised as needed.

The EWP may also include a Development Plan that describes specific steps you should take to improve job-related competencies (behaviors, knowledge, and skills) during the coming performance evaluation period.

During an employee's probationary period, the supervisor prepares reports on the new employee's progress. After probation, employees receive an annual performance review. You may also receive ongoing feedback concerning your performance during the performance cycle.

Along with pay practices mentioned in Policy 3.05, your performance rating may affect your salary increases.

BENEFITS AND PROGRAMS

A. Insurance Coverage and Income Replacement Programs

1. Group Life Insurance – *See the VRS web site at* www.varetire.org.

   All classified state employees are enrolled in the group life insurance plan administered by the Virginia Retirement System (VRS) at no cost to the employee. This plan provides life insurance and accidental death and dismemberment insurance during your employment.

   The amount of your life insurance coverage for death from natural causes is your annual salary rounded to the next highest thousand, then doubled. The benefit for accidental death is double the natural death benefit.

   Through a plan also administered by VRS, active insured employees may purchase optional life insurance for themselves, their spouses, and their minor children. Premiums are paid through payroll deduction. In some cases, some coverage may be continued into retirement. Your agency's Benefits Administrator can provide additional information on Optional Life Insurance.

2. Health Benefits – *See* http://www.dhrm.virginia.gov/employeebenefits.html.

   When an employee is hired, he or she has a specified length of time to decide whether to enroll in the State Health Benefits Program or to waive coverage. Your agency Benefits Administrator will let you know about important deadlines. The state's program, administered by the Department of Human Resource Management, includes medical, behavioral health, dental, and prescription drug coverage. An employee may choose membership for employee only, membership for employee and one dependent or family membership for the employee and two or more dependents. The employee's portion of the premium is paid by payroll deduction. The state contributes a monthly amount toward the cost of this benefit for employees in full-time status (F or Q). Part-time classified employees (P status) may participate in the State Health Benefits Program but do not receive a state contribution to their premium costs.

3. Employee Assistance Program

   The Employee Assistance Program (EAP) offers help to employees and their family members who need counseling and treatment referrals for alcohol and substance abuse problems and for various personal difficulties including legal, financial, and relationship concerns. The employee or family member may seek these services directly, or a supervisor may encourage an employee to use EAP resources because of employment issues that may be adversely affecting work performance. All services are provided under strict guidelines of confidentiality.

EAP services are available for all state employees enrolled in the Commonwealth's health care plan and their covered family members. For additional information, ask your agency Benefits Administrator or your insurance carrier for contact information.

4. Virginia Sickness and Disability Program (VSDP) – *See Policy 4.57, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   All classified employees hired on or after January 1, 1999, are enrolled in VSDP; many employees already working at that time have made the choice to join the program. The chief purpose of this program is to provide income replacement to employees when they are unable to work because of short-term (up to 125 workdays) or long-term illness or disability. The program also provides:

   - return-to-work services,
   - paid sick leave time of up to 80 hours per year, based on months of state service, to be used for the employee's own short occasions of sickness/injury or for personal doctor visits,
   - paid leave time of up to 40 hours per year for other family and personal reasons, and
   - a long-term care component.

   Eligible employees may use up to 33% of their available sick leave balance for absences for family illness or disability that are covered by the Family and Medical Leave Act (FMLA).

   Details about VSDP are available in the VSDP Handbook and under Benefits at http://www.dhrm.virginia.gov/compandbenefits.html.

5. Long-Term Care Insurance

   The Commonwealth of Virginia offers long-term care insurance to eligible state employees, retirees, and certain family members under a contract awarded to a third-party vendor. Long-term care typically provides assistance when necessary to accomplish normal activities of daily living, such as eating, dressing, and getting in and out of bed. This is an optional benefit which you may choose to purchase through payroll deduction.

6. Workers' Compensation – *See Policies 4.60, Workers' Compensation, and 4.57, Virginia Sickness and Disability Program Leave, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   If you incur a work-related injury or illness, you may be eligible for benefits under the Workers' Compensation Act. In addition, the Commonwealth provides employees covered by the Virginia Personnel Act benefits to replace lost income and to compensate for certain permanent losses to the body. Workers'

Compensation benefits include a return-to-work program to help employees resume productive activity. Procedures and benefits may vary depending on whether you are in the Traditional Sick Leave program or in the Virginia Sickness and Disability Program (VSDP). Your agency Human Resource office can provide more detailed information.

It is important to report a work-related injury as soon as possible. Your Human Resource office can help you with this process.

B. Time-Off Benefits, Paid and Unpaid

The Commonwealth provides paid leave time to employees for a variety of reasons. The various types of leave are outlined below. Refer to the specific policy for more detailed information. In general, all leave must be scheduled in advance and approved by your supervisor. Ask your supervisor about your agency policies and procedures for scheduling, taking, and reporting leave.

1. Annual Leave – *See Policy 4.10 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   Annual Leave is earned (accrued) at the end of each completed pay period, at a rate set according to your total amount of state salaried service; new full-time employees start by accruing four hours per pay period. Classified employees who work less than 100% but at least 50% accrue at a rate proportionate to the percentage worked.

   You can carry accrued annual leave hours forward from one leave year to the next up to the carryover limits, which are also based on state service. When you separate from state service or experience certain other status changes, you will receive payment for unused annual leave, up to established payout limits. Annual Leave is available for personal uses such as vacation. Ask your supervisor for approval to use this leave ahead of time.

2. Sick Leave – *See Policy 4.55 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   Traditional Sick Leave is not available to employees hired on January 1, 1999, or later. Traditional Sick Leave is granted at the rate of five hours per completed pay period regardless of length of service. Payout limits and other provisions are explained in Policy 4.55.

   Eligible employees may use up to 33% of their available sick leave balance for absences for family illness or disability that are covered by FMLA.

3. VSDP Leave – *See Policy 4.57 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

VSDP Family and Personal Leave and VSDP Sick Leave amounts are granted to participants in the Virginia Sickness and Disability Program upon hire and at the beginning of the leave year, January 10. Hours remaining from the previous year do not carry over. Length of state service (shown in months) determines the amount of these types of leave. The VSDP Employee Manual at http://www.varetire.org/Members/BenefitPlans/Disability.html provides further information.

4. Leave Sharing – *See Policy 4.35 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   Employees may donate annual leave hours they have accrued to help other employees who are eligible to receive the leave and who are experiencing Leave Without Pay. Employees covered by the Traditional Sick Leave policy may request to receive Leave Sharing donations when they are in a Leave Without Pay status because of their own personal illness or injury or because of the illness or injury of a family member for which the employee is using Family and Medical Leave (FMLA). Employees covered by the Virginia Sickness and Disability Program may request to receive Leave Sharing donations when they are in a Leave Without Pay status because of a *family member's* illness or injury for which the employee is using Family and Medical Leave. The agency continues to make its contribution to the health care premium for the time covered by FMLA leave.

   If you want to donate leave or request to use donated leave, you should consult your agency Human Resource office.

5. Family and Medical Leave Act – *See Policy 4.20* at http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   The Commonwealth complies with the federal Family and Medical Leave Act (FMLA) in providing leave with or without pay to eligible employees for situations defined in that Act. State policies and procedures apply to many situations covered by FMLA. Because FMLA is a designation rather than a separate type of leave, an employee may also use other kinds of leave while in FMLA leave status. An eligible employee on FMLA leave continues to receive the state contribution to health insurance, and FMLA provides reemployment rights to employees under certain conditions. Employees may use up to 33% of their traditional sick leave or available VSDP sick leave to cover absences for family illness or disability covered by FMLA.

6. Compensatory and Overtime Leave – *See Policies 3.10 and 3.15 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

Some employees may be eligible to earn paid leave for work performed overtime or during non-scheduled work times. The Fair Labor Standards Act (FLSA) governs application of these leave types for employees covered by the Act (non-exempt).

7. Civil and Work Related Leave – *See Policy 4.05 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   The Commonwealth grants employees paid time off for certain reasons related to court proceedings (including jury duty); for some kinds of service to official state councils, boards, etc; for some activities related to employee relations processes; and reasonable time to interview for state positions. Eligibility criteria and specific conditions are explained in Policy 4.05.

8. School Assistance and Volunteer Services Leave – *See Policy 4.40 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   As an employer, the Commonwealth supports employees' responsibilities to their children and communities. This policy permits agencies to grant employees up to 16 hours of time off with pay per leave calendar year to provide volunteer services through eligible non-profit organizations within or outside their communities. Such service may be provided as a member of a service organization or through authorized school assistance. Read the policy to learn how this leave type may apply to you.

9. Military Leave – *See Policy 4.50 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

   Employees who are members of the Commonwealth's militia (including National Guard) are granted paid military leave while providing military service when called forth by the Governor. Employees who serve in the National Guard, Naval Militia, or in a branch of the military reserve are entitled to as much as 15 days of paid military leave for federally funded training or active duty per federal fiscal year. Employees called for more than 15 days of active federal duty in a federal fiscal year may use accrued leave balances in order to remain on the state payroll. Employees who exhaust their leave balances or who choose not to use them for military duty may be placed on Military Leave Without Pay.

   In compliance with federal requirements, employees are guaranteed reinstatement to their original position or a comparable position for up to five years of cumulative military service, with certain exemptions to the five-year cap. If you are a member of the National Guard or a military reserve unit, you may want to review your benefits under the Uniformed Services Employment and Reemployment Act (USERRA). Some state benefits continue for all or part of a term of military leave, as detailed in Policy 4.50.

10. Emergency/Disaster Leave – *See Policy 4.17 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

    Employees with specific, needed skills may receive up to 80 hours of paid leave to give requested assistance in officially-declared disaster areas, typically in cases of large-scale flood, fire, ice storm, or a similarly destructive natural event. To qualify for this leave, the services provided must not be within the regular job duties of the called employees. In addition, employees who are the *victims* of major disastrous events, such as destruction of their primary residence, are sometimes eligible for paid leave under this policy. Employees called to provide emergency service through active duty in the military or National Guard are covered by the Military Leave policy, #4.50.

11. Educational Leave and Educational Assistance – *See Policy 4.15 and Policy 5.10 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

    Employees may be allowed leave time to take courses related to their work. This may be with full, partial, or no pay, and/or tuition payment. Financial assistance for costs related to such courses is sometimes available from the employee's agency. Educational Assistance Agreements often include work obligations. Agencies develop the details of their own policies in this area, so consult with your agency Human Resource office and see your agency's policies for further explanation of these programs.

12. Leave to Donate Bone Marrow or Organs – *See Policy 4.37 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

    Employees may use up to 30 workdays in a calendar year to donate their bone marrow or an organ and to recover from the procedure.

13. Leave Without Pay – *See Policy 4.45 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

    In certain situations, you may ask for or need to be placed in a Leave Without Pay (LWOP) status. This status preserves some benefits of employment and permits reinstatement of other benefits if you return to paid status. LWOP does not separate you from state service, and many benefits are not affected, especially if the period of LWOP is not long. In order to avoid unintentional LWOP, you should learn to manage your paid leave carefully. Employee-initiated LWOP must be approved by your agency.

    Leave Without Pay may be Unconditional (reinstatement to the pre-leave position is guaranteed) or Conditional (reinstatement will occur only if the pre-leave position remains available).

C. **Holidays** – *See Policy 4.25 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

As mandated by state law, the following days are generally observed as paid holidays for state employees:

New Year's Day (January 1)
Lee-Jackson Day (Friday before the third Monday in January)
Martin Luther King Day (third Monday in January)
George Washington Day (third Monday in February)
Memorial Day (last Monday in May)
Independence Day (July 4)
Labor Day (first Monday in September)
Columbus Day and Yorktown Victory Day (second Monday in October)
Veterans Day (November 11)
Thanksgiving Day (fourth Thursday in November)
The day after Thanksgiving Day
Christmas Day (December 25)

The Governor or the President of the United States may designate additional holiday time.

When a holiday falls on Saturday, it will be observed on the preceding Friday; when a holiday falls on Sunday, it will be observed on the next Monday. If a holiday falls on an employee's scheduled day off, other than a weekend, the employee will be granted up to 8 hours of compensatory leave. If an employee is required to work on a holiday, the employee may be eligible for pay plus compensatory leave.

Some agencies observe a different holiday schedule, but the number of paid holidays is the same for all agencies. Regardless of the schedule worked, full-time (F) classified employees receive 8 hours of Holiday Leave for a full-day state holiday. If you work an alternate work schedule, talk with your supervisor or Human Resource office about holiday leave. Holiday leave is prorated for classified employees who work less than a 40-hour schedule ("Q" and "P" status employees).

D. **Employee Service and Recognition Programs**

Employee Service and Recognition Programs – *See Policy 1.10, Service Recognition, and Policy 1.20, Employee Recognition Programs, at* http://www.dhrm.virginia.gov/hrpolicy/policy.html.

If you make State employment your career, you may receive periodic Service Awards for your years of service. Policy 1.10, Service Recognition, describes the general state policy. Some agencies have developed their own Service Awards program. Your Human Resource office will have information about your agency's program.

Policy 1.20 directs agencies to develop programs to recognize employees for their contributions to agency objectives and to state government, and outlines requirements for the program. A Handbook following the policy contains detailed information to help agencies develop programs that suit their objectives and culture. Awards to employees may include money, non-monetary items, or paid leave time. Ask your supervisor or Human Resource office about your agency's program.

E. Employee Suggestion Program

Employee Suggestion Program – *See* http://esp.dhrm.virginia.gov/.

The Employee Suggestion Program (ESP) was created to recognize and reward employees for ideas that improve the efficiency or effectiveness of the Commonwealth. If you make a suggestion through ESP that saves time, money, or resources, or will improve productivity or safety, and that is outside of your ability to implement in the normal course of your job, you may be eligible for an award. If your suggestion is adopted, you may receive a certificate and either cash or paid leave time. The ESP Procedures Manual and Suggestion Evaluation Form can be found following Policy 1.21 on the Web. Forms and additional information are available at http://esp.dhrm.virginia.gov/. Your Agency ESP Coordinator can give you more information about this program.

F. Savings Programs

1. The Flexible Benefits Program is subject to regulations established by the Internal Revenue Service (IRS). You will find more detailed information from your agency Benefits Administrator and at the Health Benefits web site at http://www.dhrm.virginia.gov/employeebenefits.html.

   a. Premium Conversion
   This feature reduces your net cost because you pay your portion of your health benefit premium with pre-tax salary.

   b. Medical and Dependent Reimbursement Accounts
   Employees are eligible to enroll in the medical and/or dependent care reimbursement program, which allows payment of certain out-of-pocket expenses with pre-tax dollars. Talk with your agency Benefits Administrator about eligibility requirements.

2. Deferred Compensation Plan (DCP) – See http://www.varetire.org/Members/BenefitPlans/DefComp.html.

   Through this program, you may direct a portion of your salary into an investment program by payroll deduction ***before*** state and federal taxes are applied. Typically, employees choose to receive the deferred income after retirement when they are likely to be in a lower tax bracket. A third-party administrator (TPA) manages the program, including the investments, and will help you select from a

variety of investment options. Further information is available from this TPA and from the Virginia Retirement System, which administers the program. Your Benefits Administrator will be able to provide phone numbers for reaching them.

The Commonwealth supports employee participation in this plan by offering a Cash Match Program. Deferred Comp participants who sign up for Cash Match will receive a contribution to their accounts each pay period of an amount equal to one-half of the employee's own contribution, up to an established maximum. The maximum matching amount is set by the legislature.

G. Wellness Program

CommonHealth is the state's wellness program for employees, families, and retirees offering a range of health-related activities and resources at participating agencies. Information about CommonHealth is available on the Web at http://www.commonhealthva.com.

H. Work/Life Programs – *See* http://www.dhrm.virginia.gov/worklife/worklifetoc.html.

Work/Life Programs are designed to improve balance between work and personal life. The state offers a number of Work/Life programs to state employees. These services and programs may vary by agency. Contact your Human Resource office for additional information.

I. Retirement Benefits

Retirement Program - *See* www.varetire.org.

Classified employees are covered by the state's defined-benefit retirement program. Upon retirement, the Virginia Retirement System (VRS) provides monthly retirement benefits for eligible, qualifying employees, who may choose among a variety of retirement options. In addition, VRS administers other programs, including short-term and long-term disability programs (through the Virginia Sickness and Disability Program), life insurance, and deferred compensation. For more information, contact your Benefits Administrator or VRS.

EQUAL EMPLOYMENT OPPORTUNITY (EEO)

See Policies 2.05, Equal Employment Opportunity, 2.10, Hiring, and 2.30, Workplace Harassment at http://www.dhrm.virginia.gov/hrpolicy/policy.html

A. The Commonwealth is committed to providing **equal employment opportunity** for all employees and job applicants regardless of their race, color, religion, sex, age, national origin, disability, and political affiliation. Employment discrimination based upon these traits is unlawful under both state and federal law. Equal opportunity extends to all aspects of employment including hiring, transfers, promotions, training, termination, working conditions, compensation, benefits, and other terms and conditions of employment. The Commonwealth complies with federal and state equal employment opportunity laws and strives to keep the workplace free from all forms of unlawful discrimination, including harassment and retaliation.

B. **Harassment** is any unwelcome verbal, written, or physical conduct that either denigrates or shows hostility or aversion towards a person on the basis of race, color, national origin, age, religion, disability, marital status, or pregnancy that (1) has the purpose or effect of creating an intimidating, hostile, or offensive working environment; (2) has the purpose or effect of unreasonably interfering with an employee's work performance; or (3) affects an employee's employment opportunities or compensation.

C. **Retaliation** is any overt or covert act of reprisal, interference, restraint, penalty, discrimination, intimidation, or harassment against one or more individuals for exercising their rights (or supporting others for exercising their rights) under the Commonwealth's EEO policies.

D. **Violations and Enforcement**

Unlawful discrimination in any form is a serious offense that will not be tolerated in state employment. The Department of Human Resource Management's *Policies and Procedures Manual* sets forth the relevant policies of the Commonwealth. If you believe you are a victim of unlawful discrimination, several avenues of redress are available to you, including processes within your agency, the grievance procedure, and the state and federal discrimination complaint processes.

Supervisors or employees found to have engaged in unlawful discriminatory conduct are subject to disciplinary action, including termination.

DHRM's Office of Equal Employment Services (OEES) is responsible for enforcing policies concerning equal employment opportunity. This office investigates and resolves complaints of unlawful employment discrimination. If you wish to submit a complaint or allegation, you may obtain the needed forms from your agency's Human Resource office, by contacting the OEES, or from the DHRM web site. Employees may also file complaints under the Grievance Procedure or directly with the federal Equal Employment Opportunity Commission.

DISCIPLINARY PROCESS

See Policy 1.60, Standards of Conduct at http://www.dhrm.virginia.gov/hrpolicy/policy.html

Policy 1.60, Standards of Conduct, provides guidance to employees and supervisors by outlining (1) standards of appropriate conduct; (2) behavior that is unacceptable; and (3) corrective actions that agencies may take to address behavior and employment problems. The standards apply to full-time and part-time classified and non-probationary employees (generally, those covered by the Personnel Act). In addition, agencies may refer to the Standards of Conduct in evaluating the behavior of employees not covered by the Personnel Act. The Standards of Conduct also explain procedures for imposing suspensions either during investigation of employee behavior or as part of the discipline.

The Standards of Conduct policy addresses workplace conduct or behavior and outlines a three-tier system based on the seriousness of the behavior and the corresponding agency response. While discipline or even termination may be required, the goal of the Commonwealth is always for the employee to be a constructive, contributing member of the work force. Therefore, ***progressive discipline*** is recommended, so that minor and/or first offenses generally receive such corrective actions as counseling or low-level disciplinary action. Major and/or repeated offenses generally should result in more severe consequences, including an official Written Notice and, in the most serious cases, termination. The policy explains the importance of ***due process*** and how it is applied, especially when suspension, termination, disciplinary demotion, or disciplinary transfer may result. Due process gives the employee an opportunity to respond to the allegations before discipline is imposed.

Note that although Policy 1.60 describes a variety of actions that may be addressed through the disciplinary process, the list of actions in the policy is not all-inclusive. Listed actions are intended as examples of the levels of severity of possible infractions. Supervisors and managers should become familiar with the Standards of Conduct, and should review them carefully when applying any disciplinary action. Policy 1.60, Standards of Conduct, can be found in its entirety in DHRM's on-line policy manual at http://www.dhrm.virginia.gov/hrpolicy/policy.html.

As with all workplace issues, you should refer to your Human Resource office if you have questions or concerns about the Standards of Conduct, or about specific situations.

Non-probationary employees may challenge disciplinary actions through the Employee Grievance Procedure, which is administered by the Department of Employment Dispute Resolution (DEDR). Detailed information on these procedures is available from DEDR.

EMPLOYEE RELATIONS ISSUES

The Department of Employment Dispute Resolution (EDR) is available to advise employees on work-related problems, use of the grievance procedure, and mediation. It also assists employees and managers in exploring options for resolving work-related conflicts. See http://www.edr.virginia.gov/.

As a classified employee, you will have access to the State Grievance Procedure after you have completed your Probationary Period. This procedure allows you to bring your concerns to the attention of upper management. For example, you may believe that a policy was misapplied, or there may be a dispute between you and a co-worker or supervisor.

Before seeking dispute resolution through the Grievance Procedure, you may choose the less formal alternative of mediation. The Commonwealth Mediation Program for state employees is a voluntary process whereby trained mediators work with the parties in strict confidentiality to resolve work-related conflicts. You may learn if your agency utilizes this program by calling your Human Resource staff or DEDR.

Policy 4.05, Civil and Work-Related Leave provides for employees to use a reasonable amount of work time to pursue these remedies. Resolution step meetings, grievance hearings, and meetings with DEDR counselors may generally be charged to Civil and Work-Related Leave.

MISCELLANEOUS TOPICS

A. Commonwealth of Virginia Campaign

The Commonwealth of Virginia Campaign is the voluntary employee charitable giving program that raises funds for numerous non-profit health and humanitarian organizations throughout the state, the nation, and the world. Contributions are tax deductible and can be made in lump sum or by payroll deduction. Each agency has a CVC Coordinator who can provide further information. This is the only charitable giving program authorized by the Commonwealth to operate within the state workplace.

B. Electronic mail, computer, and telephone use

Many jobs provide access to computer equipment and the Internet so that employees can perform their work tasks. Policy #1.75, Use of Internet and Electronic Communications Systems, expresses the general guidelines for use of these systems and provides for agencies to adopt more specific guidelines that may be suitable to their needs. In general, the equipment and systems should be used for business purposes. Personal use should be limited to minor occasions. Users should expect their system use to be monitored. Certain specified Internet uses, such as transmitting obscene, discriminatory, or fraudulent material, are strictly forbidden at all times.

Telephone use should follow a similar pattern. The telephone is provided so that employees can conduct state business. Personal use should be limited and does not include long distance calls. Lengthy or frequent personal phone calls may constitute an abuse of work time and may result in disciplinary action under the Standards of Conduct.

C. Gifts, Gratuities, and Rewards

As a state employee, you are in a position of public trust. Therefore, you may not accept gifts, gratuities, favors, or rewards for any services you perform in connection with state employment other than from the agency where you work. Likewise, it is unlawful for employees to solicit, offer, or accept money or any thing of value in exchange for appointment or selection to a position at a higher salary, or for special privilege with any state agency. Violation of this policy will be handled through the Standards of Conduct.

D. Intellectual Properties

While employed by the state, many employees work on projects or develop materials that also have worth outside of state government. The Code of Virginia (§ 2.2-2822) and policies developed by institutions of higher education also address these matters. You may obtain information and guidance related to intellectual property from your agency Human Resource staff.

E. Nepotism

The Code of Virginia (§ 2.2-3106) prohibits (as a conflict of interests) supervision by an employee of a member of his or her immediate family. Immediate family includes the spouse and any other person residing in the same household as the employee who is a dependent of the employee or of whom the employee is a dependent. (See the Conflict of Interests Act in the Code of Virginia, § 2.2-3100 and following.)

F. Personal Appearance

As an employee of the Commonwealth, you should come to work dressed and groomed appropriately for your working conditions. Your agency may apply more specific requirements for dress and grooming based on their business needs.

G. Political Activity

State employees may not campaign for themselves or for anyone else during work hours, nor can they use state equipment or resources for political activities. Further, no employee is to be rewarded or discriminated against in any way for participating or not participating in political activities outside of the workday and work place. Before beginning any political activity, you should determine whether such activity violates the Virginia Conflict of Interests Act.

The political activities of employees in state agencies that are funded in whole or in part by federal loans or grants are subject to the conditions of the Hatch Act, a federal law limiting political activities of government employees. (http://www.osc.gov/hatchact.htm) If you are in a position that receives any federal funds, you may not:

1. stand as a candidate for any public or political party elective office in a partisan election (one in which any candidate runs as representative of a political party whose presidential candidate received electoral votes in the preceding presidential election);

2. directly or indirectly coerce, attempt to coerce, command, or advise a state or local officer or employee to pay, lend, or contribute anything of value for political purposes; or

3. use official authority or influence to interfere with, or to influence, the results of an election or nomination for office.

H. Privacy of Records – *See Policy 6.05 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html

Your personnel record, maintained by your employing agency, is the property of the Commonwealth.

The Virginia Freedom of Information Act (FOIA) provides that an employee may have access to information contained in his or her personnel records with the exception of reference letters and mental and medical records when the treating physician has

indicated that a review of such records might be injurious to the employee's health. The contents of an employee's personnel file may be disclosed to third parties only as provided in the Virginia Freedom of Information Act, the Privacy Protection Act, and Policy 6.05, Personnel Records Disclosure.

If you apply for credit of any kind that will require a credit check or other investigation, you may give written authorization to the Human Resource office to release the needed information.

I. Smoking

The Commonwealth of Virginia promotes a productive and cooperative working environment. No special rights are granted to smokers or nonsmokers. Employees must strive to assure that any personal habits do not interfere with the effective production of work, and must adhere to regular break times.

Smoking is banned in offices occupied and/or operated by executive branch agencies and institutions, including institutions of higher education. Please ask your Human Resource office for information regarding guidelines for smoking outside on state-owned property,

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As an employee of the Commonwealth, you should come to work dressed and groomed appropriately for your working conditions. Your agency may apply more specific requirements for dress and grooming based on their business needs.

G. Political Activity

State employees may not campaign for themselves or for anyone else during work hours, nor can they use state equipment or resources for political activities. Further, no employee is to be rewarded or discriminated against in any way for participating or not participating in political activities outside of the workday and work place. Before beginning any political activity, you should determine whether such activity violates the Virginia Conflict of Interests Act.

The political activities of employees in state agencies that are funded in whole or in part by federal loans or grants are subject to the conditions of the Hatch Act, a federal law limiting political activities of government employees. (http://www.osc.gov/hatchact.htm) If you are in a position that receives any federal funds, you may not:

1. stand as a candidate for any public or political party elective office in a partisan election (one in which any candidate runs as representative of a political party whose presidential candidate received electoral votes in the preceding presidential election);

2. directly or indirectly coerce, attempt to coerce, command, or advise a state or local officer or employee to pay, lend, or contribute anything of value for political purposes; or

3. use official authority or influence to interfere with, or to influence, the results of an election or nomination for office.

H. Privacy of Records – *See Policy 6.05 at* http://www.dhrm.virginia.gov/hrpolicy/policy.html

Your personnel record, maintained by your employing agency, is the property of the Commonwealth.

The Virginia Freedom of Information Act (FOIA) provides that an employee may have access to information contained in his or her personnel records with the exception of reference letters and mental and medical records when the treating physician has

indicated that a review of such records might be injurious to the employee's health. The contents of an employee's personnel file may be disclosed to third parties only as provided in the Virginia Freedom of Information Act, the Privacy Protection Act, and Policy 6.05, Personnel Records Disclosure.

If you apply for credit of any kind that will require a credit check or other investigation, you may give written authorization to the Human Resource office to release the needed information.

I. Smoking

The Commonwealth of Virginia promotes a productive and cooperative working environment. No special rights are granted to smokers or nonsmokers. Employees must strive to assure that any personal habits do not interfere with the effective production of work, and must adhere to regular break times.

Smoking is banned in offices occupied and/or operated by executive branch agencies and institutions, including institutions of higher education. Please ask your Human Resource office for information regarding guidelines for smoking outside on state-owned property,

Type of Employee:

Pay Period Reporting for:

Month Pay Period Year

Name:

Banner ID:

Position #

Department:

Banner Orgn:

Phone Number

Dates-> **Earned or Used:**																
Total Hours																

Original Time sheet never submitted because

Correction to original submission (copy attached)

Other Reason:

I hereby certify that this report correctly reflects all time worked by me for the pay period indicated.

Signature: **Approved By:** **Date:**

The College of William & Mary & The Division of Student Affairs

William & Mary Division of Student Affairs Strategic Plan 2022-2027

Vision:

William & Mary transcends the boundaries between research and teaching, teaching and learning, learning and living. People come to William & Mary wanting to understand and change the world – and together we do.

Mission:

A preeminent, public research university, grounded in the liberal arts and sciences since 1693, William & Mary is a vibrant and inclusive community. Through close mentoring and collaboration, we inspire lifelong learning, generate new knowledge, and expand understanding. We cultivate creative thinkers, principled leaders, and compassionate global citizens equipped for lives of meaning and distinction. William & Mary convenes great minds and hearts to meet the most pressing needs of our time.

Statement of Values:

Accomplishing our mission requires that the entire community work together as stewards of the core values that infuse our collective effort:

> **Belonging.**
>
> We create a welcoming and caring community that embraces diverse people and perspectives.
>
> **Curiosity.**
>
> We foster an open academic environment that champions intellectual agility and inspires creativity in the discovery, preservation, application, and advancement of knowledge.
>
> **Excellence.**
>
> We aim for the extraordinary, recognizing that personal growth and meaningful accomplishment require bold and innovative aspirations, courageous risk-taking, and focused effort.
>
> **Flourishing.**

We create conditions that ensure William & Mary will thrive for all time coming, and we empower those who live, learn, and work here to make choices toward a healthy and fulfilling life.

Integrity.

We are honorable, equitable, trustworthy, and committed to the highest ethical standards in all that we do.

Respect.

We treat one another with mutual respect, recognizing and upholding each person's inherent dignity and worth.

Service.

We engage with individuals and communities both near and far, devoting our knowledge, skills, and time to serving the greater good.

William & Mary is a community that fosters deep human connection. We reflect on the lessons of history to meet the challenges of a rapidly changing world. We engage diverse perspectives and seek wisdom in bridging differences. Together, we are unceasing in our efforts to make a meaningful difference in our communities, the state, the nation, and the world.

Approved by the W&M Board of Visitors on November 22, 2019.

For more information on the strategic plan of the university visit:
https://www.wm.edu/about/administration/vision-mission-values/

College of William & Mary
Statement on Diversity

William & Mary is a community that shares values of belonging, curiosity, excellence, flourishing, integrity, respect and service. We support the right to free expression of a range of ideas and work to create an educational environment that draws on diverse backgrounds and perspectives to foster mutual respect, collaboration, critical thinking and meaningful relationships. We affirm the vital role of the university in recognizing and fostering equity, inclusion and belonging related to social identities and positions that have been excluded or marginalized in our community, including differences such as ability, class, country of origin, gender identity and expression, language, race and ethnicity, religion, sexuality, and other cultural or political affiliations.

For William & Mary to fulfill its educational mission and become a place that is itself diverse, equitable and inclusive, we must acknowledge the uncomfortable truths of our history and consider the ways in which historical patterns of exploitation and exclusion may continue to shape our university.

We take seriously our obligation to speak up when we see bias, whether it be in our classrooms, workspaces or the university community at large. We embrace our shared responsibility to create change where we fall short of our goals. William & Mary strives to be a place where people of all backgrounds are able to learn and grow, and where each individual takes responsibility for upholding the dignity of all members of the community.

- Approved by the W&M Board of Visitors, February 2022

Division of Student Affairs
Vision, Mission, Values, & Objectives

Vision

Creating an engaging learning environment where community is strengthened and individuals flourish.

Mission

Through student-centered programs, policies, and services, the Division of Student Affairs supports the academic enterprise and our students by preparing them to learn, engage, and grow with integrity, wellness, and purpose.

Values

We create a welcoming and caring community that embraces diverse people and perspectives.

We foster an open academic environment that champions intellectual agility and inspires creativity in the discovery, preservation, application, and advancement of knowledge.

We aim for the extraordinary, recognizing that personal growth and meaningful accomplishment require bold and innovative aspirations, courageous risk-taking, and focused effort.

We create conditions that ensure William & Mary will thrive for all time coming, and we empower those who live, learn, and work here to make choices toward a healthy and fulfilling life.

We are honorable, equitable, trustworthy, and committed to the highest ethical standards in all that we do.

We treat one another with mutual respect recognizing and upholding each person's inherent dignity and worth.

We engage with individuals and communities both near and far devoting our knowledge, skills, and time to serving the greater good.

Goals

We will cultivate a welcoming, affirming environment where all members feel connected within the university community, embrace diverse people and perspectives, and express their authentic selves.

- Objective A:
  - Develop authentic connections between and amongst students, Student Affairs staff, and other members of the university community
- Objective B:
  - Create environments where all members can freely develop and thrive
- Objective C:

- Support the lifelong practice of cultural humility

We will plan and execute clear communication that advances our mission and educates, informs, and inspires the W&M community.

- Objective A:
  - Effectively communicate information across the division, university, and community through increased collaboration and technology integration
- Objective B:
  - Ensure all communication reflects our ethic of care with sensitivity to impact
- Objective C:
  - Increase the understanding of the work in Student Affairs

We will counteract inequality and injustice thereby affirming the inherent dignity and wellbeing of all in our community.

- Objective A:
  - Take an equity centered approach to openly address the impacts of power and privilege on individuals and communities at William & Mary
- Objective B:
  - Integrate restorative practices into our work
- Objective C:
  - Create a community where uncomfortable meaningful dialogue is valued and practiced

We will advance experiential and applied learning opportunities that promote whole-person development

- Objective A:
  - Amplify and enhance student leadership outcomes
- Objective B:
  - Leverage campus engagement experiences for whole-person development
- Objective C:
  - Implement credentialing opportunities for co-curricular development
- Objective D:
  - Create opportunities for students to learn and practice the skills of democracy and civic engagement

We will identify data-informed needs and cultivate opportunities and partnerships to pursue the resources necessary to accomplish our mission.

- Objective A:
  - Assess and evaluate departmental budget and programmatic goals to identify critical needs
- Objective B:
  - Develop support based upon each departments budget and fundraising goals
- Objective C:

    - Boldly embrace the story of the impact Student Affairs has across campus to advance funding
- Objective D:
    - Recruit and retain diverse and talented staff as our most valuable resource

We will Create a healthy environment that empowers those who live, learn, and work here to flourish.

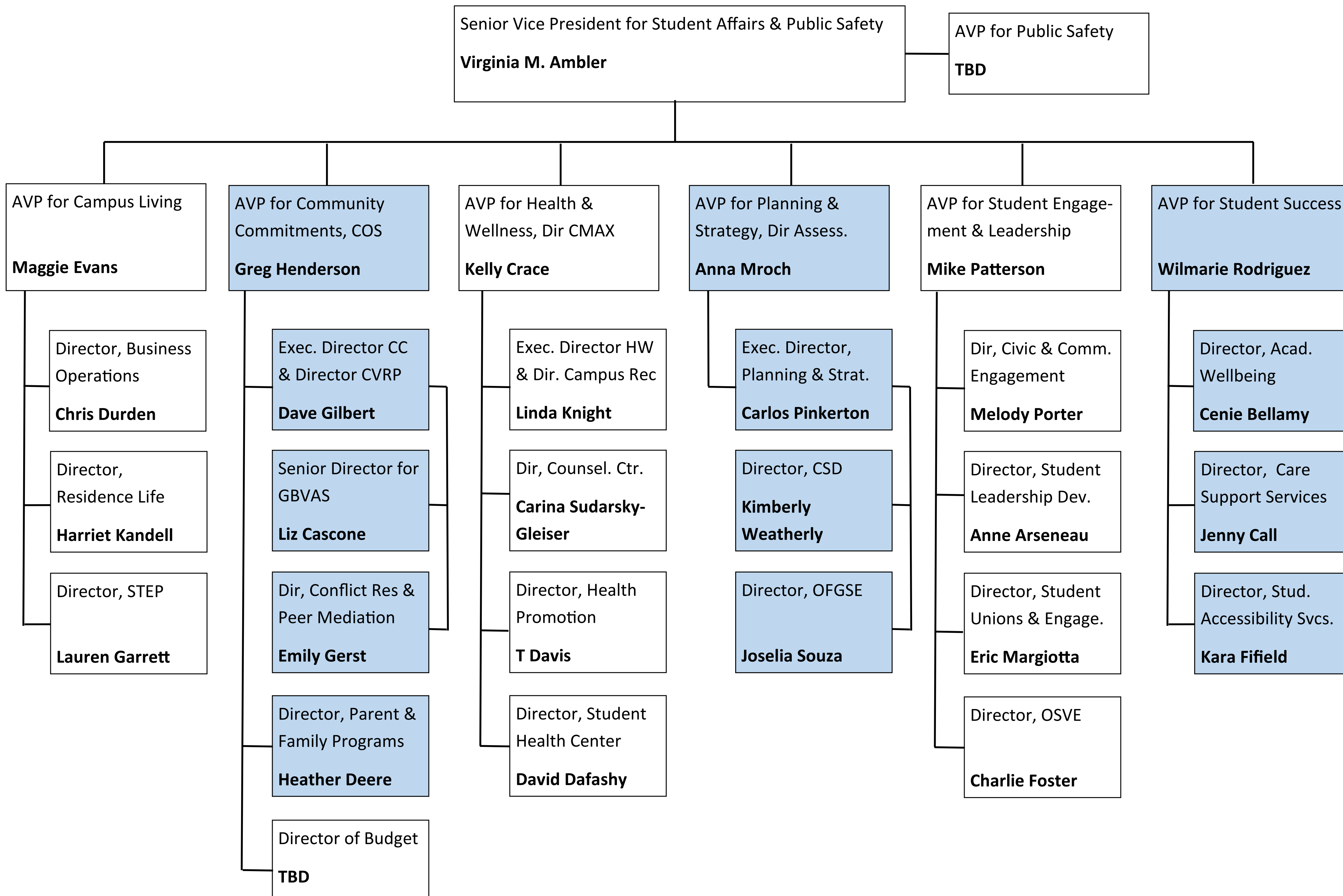
- Objective A:
    - Reinforce the paradigm of integrative wellness at the individual and community levels
- Objective B:
    - Develop relevant and inclusive wellness programs that meet the pressing needs of our students
- Objective C:
    - Support a work culture that prioritizes wellbeing

Student Affairs Diversity Statement

The Division of Student Affairs strives to ensure a safe, affirming, and nurturing environment for William and Mary students and staff. Inherent in this mission is a belief that a strong community is built upon, and enriched by, both commonalities and differences. Division members recognize and celebrate the fact that William and Mary students, staff, and faculty are diverse—varying in age, physical abilities and cognitive talents, socioeconomic status, political viewpoints, religious/spiritual and/or philosophical beliefs, and sexual, gender, and racial/ethnic identities. We actively demonstrate our commitment to the success of all community members through our programs, policies, and services. We foster a welcoming environment based upon open and considerate dialogue, mutual understanding, and respect for individual differences.

William & Mary

Division of Student Affairs



6/25/2024

WMCC Internship Policies & Procedures

Case Documentation & Clinical Records

Clinical Records (Electronic) Include:

- New Client paperwork, including consent forms
- Consent for Supervision & Recording forms, where relevant
- Session notes
- All other correspondence (I.e., e-mail and/or phone communication, etc.)
- Releases of Information, where applicable
- Referral forms, where applicable (e.g., referred to MHSC for off-campus services, referred to SHC for medication evaluation, referred to group, etc.)
- Terminations

Documentation Timeline Expectations:
**Business days denote days in the office.*

Appointment Type	Timeline
Initial Consultations	2 business days
Individual, Couples, Group sessions	2 business days (*group addendums complete 2 business days after note is distributed)
Urgent/Crisis sessions	1 business day
Terminations	30 days after last seen with no future scheduled appointments

** These expectations are approximations and have occasional flexibility. Sustained inability to meet the proposed documentation timelines may result in remedial actions. Importantly, any safety/risk information should always be documented before the end of the day for any session type**

Supervisors are expected to review and provide revisions on notes within 2 business days of original receipt of the note, after which supervisees have 2 business days to integrate supervisor edits.

Additional Procedures:

- Trainees should forward notes in Titanium to supervisors unsigned until supervisors provide guidance otherwise.
- Interns sign notes on Line 2 in Titanium. Practicum Students sign on Line 1.
- Trainees never deactivate clients from their “My Clients” list. This step should always be completed by supervisors.

Telehealth Procedures:

Conducting Initial consultations via Zoom:

1. Send the Zoom initial consultation welcome email (see example below) via encrypted email at the beginning of the hour-long initial consultation appointment

2. Monitor paperwork completion in Titanium - Open - Approve Incoming Data

3. Confirm a match in our system and/or address any mismatches in the existing file (not the new, incoming data). Typical sources of mismatches are (a) inconsistent formatting of student ID number; (b) inclusion or exclusion of middle name or middle initial; or (c) incorrect or mismatched birthdays. When in doubt, call the front desk staff or senior staff for help before processing

4. Once matched, process the paperwork by selecting the checkbox next to the client's name and clicking "Process Selected"

5. Access the new "Client Data" in the client's file and take 5-10 minutes to review the paperwork for any relevant information

6. Create the Zoom appointment and email the client the Zoom link

7. Begin initial consultation by reviewing:

a. Limits of confidentiality

b. "Consent to Supervision, Observation, and Recording of Counseling Sessions" form; ask the client to complete it and then start video-recording in Zoom

c. Purpose of the initial consultation

d. Client's physical address during the initial consultation; confirm it is correct in the file

e. Client's alternative contact information; confirm it is correct in the file

f. Client's emergency contact information; confirm it is correct in the file

8. Conduct initial consultation in the remaining time (~20-30 minutes)

9. Schedule extended initial consultation in Titanium and in Zoom, and send Zoom invitation email prior to ending the session

10. Write initial consultation note with attached, signed consent form and submit to supervisor

11. Discuss disposition in supervision meeting

12. Confirm disposition with client in extended initial consultation

Zoom Initial consultation Email Example *Check with Supervisor Before Using*:

Dear [CLIENT NAME],

I'm looking forward to connecting with you for our telemental health initial consultation appointment! During the initial consultation, we will discuss whether the counseling center services, including telemental health services, are the very best way to your needs and create a plan for next steps.

Before we can begin our meeting, please visit the URL below and select "Telemental Health – New Client" to complete our full set of paperwork. It's important that you read, complete, and sign this paperwork in order to: (1) provide important information about yourself; (2) learn about the benefits and limitations of mental health/telemental health services; (2) verify an emergency contact near your physical location during appointments; and (3) provide a secondary method of contacting you should there be a technological failure before or during an appointment.
https://wmcounseling.titaniumhwc.com/Hwc

Our paperwork typically takes 15-20 minutes to complete and then we will spend the remainder of the appointment discussing your goals and concerns. Please note that we cannot proceed with the initial consultation appointment before the full set of paperwork is completed by you. Once you have submitted your completed paperwork, I will review it and then email you a unique Zoom link and password so that we can begin the video-conferencing portion of your appointment. It's important that you safeguard this information to ensure the privacy and confidentiality of your work. If you have any questions, would like to discuss the paperwork before signing it, and/or do not receive the email with the Zoom link within 15 minutes of submitting your paperwork, please call me directly at (757) 221-3620 during the scheduled time of our initial consultation.

Also note that it is important that you are physically located in Virginia during all appointments, as this is the only state where counseling center clinicians are licensed to provide services. If you are not located in Virginia (or do not expect to be) during an appointment, please let your clinician know as soon as possible to reschedule.

The counseling center is currently using HIPAA-compliant Zoom Healthcare video-conferencing software to protect your confidentiality. However, there are a few items to be aware of prior to engaging in telemental health services.

Please ensure that you have the following equipment/technology:

· Tablet, laptop, or desktop computer (a smartphone would be a last resort)

· Access to high-speed internet

· Built-in or external camera

· Built-in or external microphone

· Headphones or speakers

Here are some tips for you engaging in telemental health services:

· Try to log-in 5-10 minutes before appointments to certify that everything is working properly and take time to troubleshoot any technical issues. Should you need assistance, it may be helpful to consult with W&M IT.

· Make certain that you have access to good bandwidth. Poor bandwidth may weaken our connection and create difficulties for us communicating via Zoom.

· Choose a place and time that guarantees your privacy during appointments. This will help ensure confidentiality and reduce the likelihood of being overheard. If this does not feel possible, we can brainstorm about options.

· I encourage you to use headphones, if possible (I probably will, too). This can help us ensure that we have a confidential conversation and minimize distractions for both of us.

· It’s very important that we can see each other as clearly as possible, so confirm that your image is sharp and bright, you have a diffuse light source in front of you (not above or behind) to avoid shadows on your face, your lens is at eye level, and your face is centered in the camera view.

· If there is a technological failure that prevents us from using Zoom, ensure that your phone is nearby and will accept incoming calls from a potentially unfamiliar or unidentified number.

· If you are unable to connect or get disconnected during an appointment, please try to connect again. If problems continue, please call me directly at (757) 221-3626.

· Use of email should be limited to general questions and other non-sensitive information (e.g., scheduling). Sensitive or therapeutic topics should be discussed during Zoom appointments or by phone.

What you can expect from me during Zoom appointments:

· I will verify your physical location at the beginning of an appointment.

· I may ask to briefly be shown the space you're in during the appointment to ensure your privacy and that other individuals are not present without your consent.

· I will use the alternative method that you've provided in the paperwork for contacting you if we experience a technological failure.

· I will determine whether telemental health services are the very best way to address your concerns and make alternative recommendations, if necessary.

If you experience a mental health emergency or other crisis while you are an enrolled W&M student, please use the following crisis services:

· W&M Counseling Center crisis services: 757-221-3620 (24 hours)

· National Suicide Prevention Hotline: 800-273-8255 (24 hours) · Crisis text line: text HOME to 741741 (24 hours; https://www.crisistextline.org/)

· Call 911 or go to your nearest emergency room

Please let me know if you have any questions or concerns. I'm looking forward to meeting you soon!

Conducting Individual Counseling Sessions via Zoom:

1. The morning of the session, send out the session Zoom link via encrypted e-mail. (E-mails can be scheduled to send later, so consider prepping the day before, particularly if you have an 8am telehealth appointment)
2. Begin the session once the client appears in the Waiting Room
3. Confirm client's physical address and that they are in a private/confidential space
4. Proceed with individual session
5. At end of session, be sure to schedule client for their next appointment

   * If you need to administer the CCAPS during a session, put the link for CCAPS in the Zoom chat. Instruct that you and the client will turn off your cameras to allow them privacy as they complete the questionnaire. Instruct the client to turn on their camera once complete, indicating they are ready for you to process the paperwork. Go to Titanium - Open - Approve Incoming Data. Confirm a match in our system and/or address any mismatches in the existing file (not the new, incoming data). Typical sources of mismatches are (a) inconsistent formatting of

student ID number; (b) inclusion or exclusion of middle name or middle initial; or (c) incorrect or mismatched birthdays. When in doubt, call the front desk staff or senior staff for help before processing. Once processed, review CCAPS results. When prepared, turn your camera back on and provide feedback of CCAPS results to client.

Evaluations:

Evaluations are submitted on forms via Google Drive. Except for evaluations of presentations and seminars, evaluations are reviewed in person by the trainee and supervisor. Each member of the supervision dyad will come prepared with an evaluation of the other. Supervisors provide their evaluation of a trainee before a trainee shares their evaluation of the supervisor to reduce concerns of retaliation. Trainees should discuss with their supervisors the timelines for evaluation to ensure both parties are prepared.

How to Complete & Print Evaluations:

1) Ensure you are signed into Google workspace (https://my.wm.edu/ --click on the "G Workspace" icon)
2) Go to: https://drive.google.com/drive/folders/129oF9VenKyxAT8zPui1i4m47Nd6xlyzH?usp=sharing
3) Click on the Evaluation to be completed
4) Complete the evaluation (be sure to type in your e-mail address XXX@wm.edu at the top of the form)
5) At the bottom of the form, be sure to select "Send me a copy of my responses." before submitting. This will ensure that you will have a backup copy of the form to print in case Front Desk Staff is unable to format the evaluation by the date the supervisory dyad has selected to share evaluations.
6) Once submitted, contact Front Desk staff with the number of the evaluation for formatting (e.g. 8—Eval of Intern by Group Supervisor).
7) Once formatted, Front Desk staff will print a copy, place the printed evaluation in the writer's mailbox, then notify the writer that the copy is in their mailbox.
8) Review evaluation with supervisor/trainee, if relevant. Should any changes be made to the evaluation (quantitative or qualitative), you must inform Front Desk staff of the changes so the data is accurate in our records.
9) Once all parties agree on the evaluation, sign the document, if relevant (e.g., no signature required on presentation evaluations, seminars, etc.).
10) Interns should immediately scan and upload the evaluation to their Electronic Portfolio.

Checking Out of the Center

1) Please schedule a final meeting to discuss your internship experience with the Training Director

2) Complete the End of Internship Self-Assessment, Seminar Evaluations, Evaluation of the Internship Experience, and Evaluation of the Training Director

3) You are to scan all documents listed on **the End of Year Checklist** to leave **a complete portfolio** at the Center. This portfolio should be stored electronically on G→Interns→AY (your cohort year)→Your Name→New Folder Titled Electronic Portfolio. The **evaluations** scanned need to be the ones that were **signed** by you and your supervisor. Please do not include copies of unsigned evaluations. That would be a serious problem for us during our next accreditation visit. The End of Year Checklist should be reviewed and signed by you, your individual supervisor, and the Training Director before Internship is considered complete. The signed copy should be uploaded as the last document in your electronic portfolio.

4) Closing Cases: Please make sure that all client files have been closed and removed from your client list by your supervisor. By the end of the internship, there should be no cases in your client list.

5) Documentation of Supervision: Please provide all documentation of your supervision of the practicum student to the Training Director.

6) Digital Recordings: Please make sure that you have deleted all digital recordings of your individual and group work

7) Cleaning and Packing: Please make sure that you clean your office so that you leave it in the way as you found it (to the best of your ability)

8) Keys: Please return your key to the building to the Front Desk Staff on your last day in the office

9) University Clearance: There is an HR clearance process as you separate from the university. I have already initiated this process. Things that most often apply to interns are returning any outstanding library books and returning your parking pass. They will contact you if there are any other outstanding items for your attention.

10) Leave: Please remember that you will still need to submit leave in Banner for any leave taken until the end of your contract, even if you are no longer coming into the office. (Pay periods may not yet be open on Banner to submit time before the last day in office).

EMERGENCY PROCEDURES FOR CLINICIANS IN THEIR OFFICES

General Office Safety Guidelines:

1. Leave office door unlocked.

2. Attempt to arrange office furniture that provides the clinician seating without any barrier between the clinician and the door.

3. Attempt to end sessions on time. Notify the front desk if you are in session and running over.

4. Do not schedule individual or group sessions over the noon hour or after 5:00 PM.

5. During the academic year, if you do schedule sessions over the noon hour, notify the IC counselor for back-up.

6. If you are feeling unsafe, the first priority is to leave your office. In such a case, the best way to help your client will be by seeking consultation. At a minimum, you may choose to stay with the client but open the office door in order to have access to help and for help to have access to you. In some cases, it may be appropriate to request that another staff member join you in the session.

Procedures for calling Campus Police if a clinician is unable to leave her/his office with a potentially dangerous client:

1. All offices and group rooms have a panic button. Hold the button down for approximately three seconds.

2. Kamco security services will immediately call WMPD and dispatch them to the location the panic button was pressed. If you accidentally press your panic button, call Kamco at 757-220-4300 to report that it was a false alarm.

3. After Kamco has dispatched the WMPD, they will call the front-desk to inform them that WMPD has been dispatched. The Front Desk staff will be able to note the location of the event on the security alarm panels and Kamco can provide this information.

6. Once Campus Police have been called, the front desk staff will:

    a. Clear the reception area.
    b. Notify the Director who will assist in clearing the office.

c. Director and available staff will clear other staff members and clients from offices.

7. Campus Police will:

a. Send two officers.
b. Approach door of office.

**** If clinician is unable to reach panic button they should make an effort to alert someone there is a problem (e.g. knock phone off the hook, break something, or create a loud disturbance).

The College of William & Mary Counseling Center

COMMON SENSE GUIDELINES

The following guidelines have been established through the years given experiences we have had at the Center. This document is intended to make our expectations explicit from the start of internship.

General Counseling Center Issues:

- Trainees are to comply with the Center's hours of operation. The Center is typically open from 8am-5pm. Lunch is observed as a Center from 12-1pm.
- It is expected that, like the rest of the staff, interns will be flexible with their schedules to meet the needs of the community while doing outreach and when there is special need to attend to an emergency. Evening and weekend hours may occasionally be necessary for outreach purposes and/or to respond to crises.
- If you are seeking to take vacation/leave (i.e., being away from the office when the office open for business), please discuss this request with relevant supervisors/the Training Director before making travel plans such as booking flights.
- To help with communication at the Center, it is expected that trainees will read email at the very least twice (morning and afternoon) during the workday. Please reply to all emails that are asking for your response or input.
- Professional attire is expected while at work. Our clinical staff strives to balance appearing warm and approachable while maintaining a professional image. We all attempt to do so, respecting our individuality, taste, and cultural traditions while being mindful of the emotional vulnerability of clients, the intimacy that characterizes therapeutic encounters, and the potential for sexualization of the therapy hour/therapist. Please refrain from wearing attire that shows midriff, undergarments, and significant amounts of upper thighs. While sandals may regularly be worn by staff, please refrain from wearing flip-flops to work.
- In order to maintain a comfortable and clean break area, it is encouraged that we all clean any area or appliance we use. Cleaning as soon as something spills is easier than cleaning after it has dried out. Please inform us if there are any cleaning supplies that are needed.
- The front office is the admin staff's only office space. Please be respectful of their privacy and personal space while in this area. Please also wait until there are no clients at the window if you need to ask them something. They are skilled at multi-tasking but it may become confusing when their attention is called in different directions.
- There are times when you will need to use College equipment for educational purposes (dissertation, contact with graduate program or committee members, etc.). Please take into consideration when others may need the equipment to print or fax for Counseling Center business purposes.

Clinical Issues:

- As a professional in the field, we do not operate out of convenience. It is expected that interns will prioritize client care and have integrity in their work at all times. Always operate in the interest of your client. Do the right thing. When there is a question, ask—please!
- We aspire to uphold the highest ethical standards in our work and expect integrity in the work of our trainees. This holds true in clinical documentation. Please ensure your documentation accurately summarizes what occurred in sessions. Examples include but are not limited to: Documenting anything that was not explicitly discussed in session (such as past and present suicidal risk assessment of ideation, plan, intent, and/or attempts). If you are going to quote a client, please ensure this quote is accurate and not your language (if unsure, find a different way to document it!). Please do not exclude clinically relevant information. Etc.
- Consult! Consult! Consult! Most supervisors do not like surprises—keep us in the loop!
- At times, you may have questions and opinions about Center operations. You are welcome to be curious and engage in professional dialogue around such issues. We value feedback and regularly adjust our procedures; however, we ask that you give us the benefit of the doubt and trust our wisdom as you enter this new system. There is usually a solid rationale or historical context for why we do things the way we do.
- Confidential information (clients' files, case notes, reports, assessment measures, etc.) is to be kept at the Counseling Center. It is illegal to take information out of the Counseling Center. Remember that the Ethics Code emphasizes the obligation to protect confidential information.
- For security reasons, all documentation of clinical services is to be done using TITANIUM. Word documents are not protected in the same way Titanium is protected.
- Zoom HealthCare is the Center's HIPAA-compliant virtual platform. Any telemental health services should occur via this platform. Please ensure that you are logged into and using your Zoom HealthCare account when interacting with clients. Additionally, any recordings of telemental health sessions should only be saved to the Center's secure drives (V-video), and should be saved immediately following sessions.
- At the end of the day, please make sure any clinical information is locked in your desk, and that your office door is locked and closed. This ensures confidentiality is maintained.
- Assessment instruments are not to leave the Counseling Center (unless they are public assessment measures such as the LVI). Remember that the Ethics Code addresses the need to maintain the integrity and security of test materials and the confidentiality of test data.
- All signed consent forms for supervision/digital recording as well as consent to release information are to be scanned and kept in clients' clinical files. Hard copies should be shredded only after they are properly scanned to the right file.
- A new consent form for supervision is to be completed if there is a change of supervisor for that client between semesters. Informed consent regarding

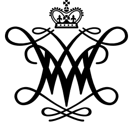
supervision requires that clients are not only informed that a trainee is under supervision but also the name(s) of the supervisors.

- All supervision notes with your practicum student(s) are to stay at the Counseling Center upon your departure. Return these to your supervisor of supervision when you have completed the practicum student's final evaluation.
- All faxes are to be sent with a cover page that indicates that the information is coming from the Counseling Center. Information fax is to be scanned into the client's file (even if the same information is already in the file as a note) to indicate that in fact the information was faxed to the office/person intended to be faxed to. It is good practice to include the confirmation from the fax machine. Feel free to create a personal fax cover page for any personal faxes.
- It is possible to open two windows with Titanium. This is for instance useful when you are typing a termination report and you want to look at client's file for any given reason.

Training:

- Be aware that APA/licensure standards are not always aligned with your classification as a state employee. For example, should you take all the leave available to a state employee, you may risk not obtaining the required hours for APA/licensure standards. It is the Intern's responsibility to balance these various roles and expectations.
- Seminars have readings that will add to the time at the office. The time spent reading counts towards the required 2000 internship hours and should be recorded in the log. Also count any readings done in preparation for work with certain clients, to learn about certain clinical issues, etc.
- Interns are expected to be truthful in the recording of hours. Hours logs should be kept on the G- drive and updated weekly to allow for random audits by supervisors.
- While clinical load is typically lower during the summer, interns are still expected to see clients during this time. This is true even if they have already met their required number of hours.
- Test all equipment (e.g. digital camera) before your first session. Let Training Director or Director know immediately if you experience any technical malfunctions.
- Please keep in mind that the staff at the Counseling Center is committed to training and to the professional and clinical development of interns. Feedback is provided with the intent of promoting growth. It is the hope of the staff that interns would recognize that the aim of the corrective feedback they will offer during the year is to create possibilities and stimulate growth. Similarly, the staff at the Counseling Center appreciates constructive feedback from interns. We are interested in learning if there are ways in which we can better address your training needs.
- Given our commitment to training and if believed to be helpful, different staff members may watch videos of or discuss your work. This may result in additional understanding of a case or ideas on how to proceed. Similarly, it may be helpful for a multiple number of reasons, for a staff member, in addition to the supervisor of supervision, to watch tape of or discuss your supervision with the practicum student.

- Peer supervision is an important component for professional growth. As such it is expected that you would complete evaluations of each other's presentations when those are requested and provide ongoing support for the work of other trainees.



WILLIAM & MARY
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Counseling Center
McLeod Tyler Wellness Center
Post Office Box 8795
240 Gooch Drive, Second Floor
Williamsburg, VA 23187-8795

Phone Number 757-221-3620
Fax Number 757-221-3615

I, ____________________________, understand that as an employee in the William & Mary Counseling Center:

- I will be working with sensitive and confidential information.
- I will follow the policies and procedures of the WMCC Training Program and The College of William & Mary
- I will follow the Ethics Code of my profession and all laws regarding confidentiality and the practice of my profession as indicated in the *Code of Virginia* and the Regulations Governing the Rule of Psychology, Counseling, or Social Work
- I am jeopardizing my employment and potentially subjecting the University to litigation for violation of the Family Educational Rights and Privacy Act if I break the confidentiality of this office and that I may be subject to dismissal from my position if I have violated any of the above.

_____ Check here if you have read, understood, had the opportunity to ask questions, and agree with the policies and procedures of the training program outlined in this Training Manual.

________________________________ Date ______________________

Trainee Signature (sign)

____

Trainee Name (print)

WMCC Mission Statement

The William and Mary Counseling Center is the sole mental health unit on campus with the primary responsibility of providing a range of mental health services to students, and related support to the campus community. Our role is congruent with the mission of the College of William and Mary, and the Division of Student Affairs, which is to prepare students to learn, lead and live with integrity and purpose. In so doing, the Counseling Center seeks to provide services that allow students to achieve their personal and educational goals. These services include the provision of mental health practices intended to reduce psychological distress, treat clinical conditions, and enhance well-being and personal growth. Our interdisciplinary team facilitates primary education and prevention activities, provides support to students experiencing normal developmental issues associated with the transition from adolescence to early adulthood, provides support for emerging, acute, and chronic clinical concerns and responds to individual student and campus-wide immediate crises. Based on clinical assessment of an individual student's needs, we make evidence-based recommendations drawing from the resources available on campus, in the local area, and in the student's home community when necessary. The Counseling Center actively demonstrates commitment to diversity in its broadest form and serves as an advocate for social justice in the college community and beyond. Through our multi-level training program, we dedicate ourselves to instilling these practices and values in future professionals.

William and Mary Counseling Center

Scope of Services

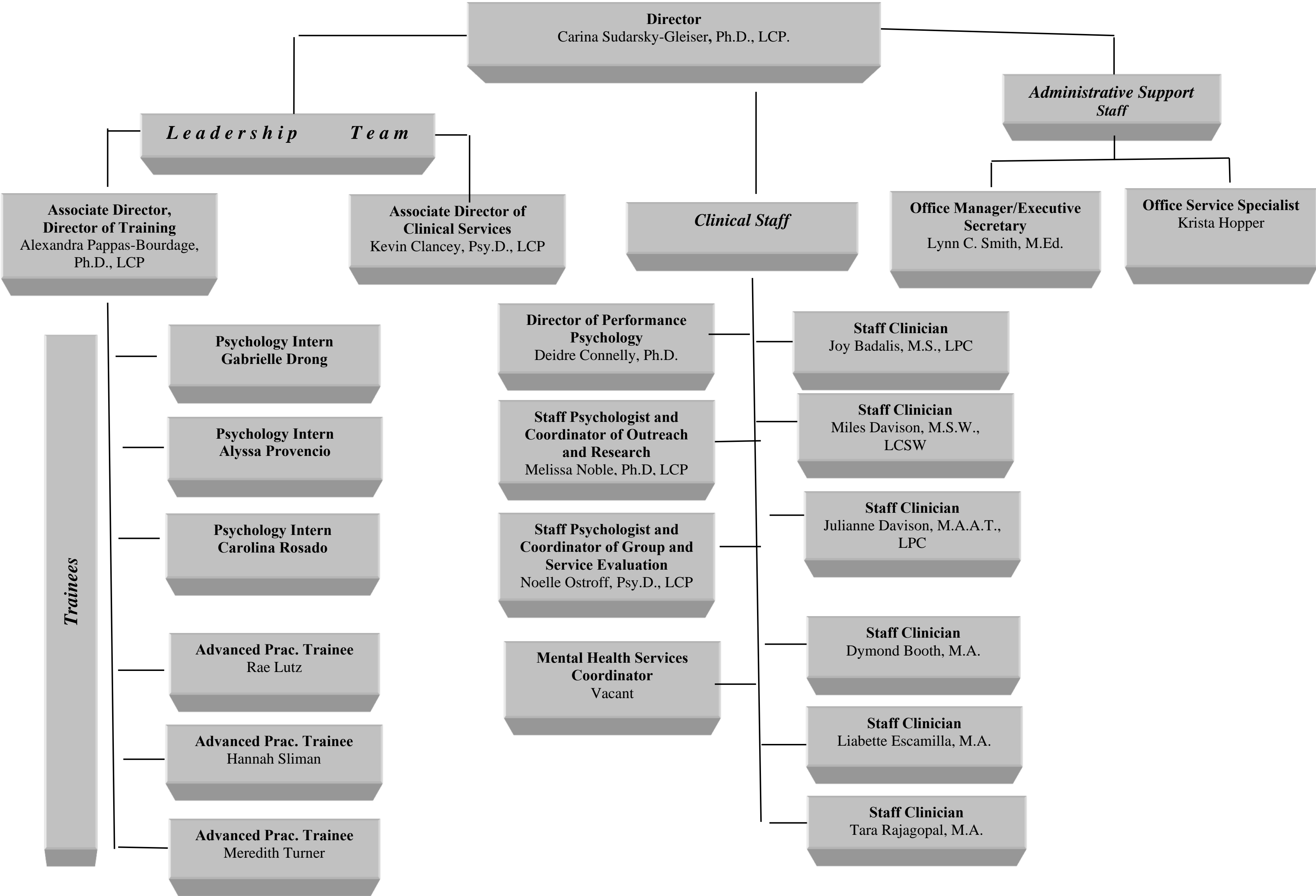
The Counseling Center is designed to provide short-term, time-limited counseling, in order to offer services to as many students as possible. In keeping with the mission of the Division, the Counseling Center strives to provide brief treatment to facilitate adjustment, improve functioning, achieve resolution of problems, and to relieve acute symptoms as soon as possible to support academic progress.

Students whose presenting issues suggest the need for longer long-term services, can meet with the Mental Health Services Coordinator for assistance with a referral to a private mental health care provider in the community or may search for a professional through our **online database**. Counseling Center services will not be an appropriate substitute for long-term, intensive psychological services. Some common examples that may be more suited to an outside referral include but are not limited to:

- concerns that may require weekly appointments
- issues which may require a specific type of therapy not practiced by staff
- issues that tend to worsen in short-term counseling
- history of weekly or long-term treatment prior to college or interest/preference for this type of services
-

In the event a client presents to WMCC who is outside of the typical scope of services, but there is lack of access to services external to WMCC, providers should request to review the case with the clinical committee to determine if an exception to the scope of services at WMCC is appropriate.

William & Mary Counseling Center
Organizational Chart
2024-2025



Counseling Center
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Phone Number 757-221-3620
Fax Number 757-221-2254

Building and Office Access

All Counseling Center staff are issued keys and Staff IDs for access to building, hall office door and interior office door. Staff are also provided a desk/file drawer keys. Spare office keys are housed in a security envelope in front office.

- Keys to College property may be duplicated ***only*** by the College locksmith.
- Keys will only be issued to provide access to areas and property necessary to accomplish assigned work of Counseling Center employees.
- All keys are returned to WMCC front desk staff and logged in upon separation from the College.
- Instructions for Staff IDs can be found at the following link: https://www.wm.edu/offices/auxiliary/tribecardservices/newcard/index.php

Office keys and Staff ID are to be used ONLY by Counseling Center Staff. DO NOT allow anyone not affiliated with the Counseling Center to use your keys or ID.

Internship Duration

Per APPIC, the Internship occurs over a 12-month period. Extensions to the Internship year beyond the original contract dates are unavailable unless there is a university-approved accommodation that would result in need for an extension or a genuine extenuating circumstance. In case of the latter, the Center will review the circumstance on an individual basis to decide on the appropriateness of an extension. Insufficient overall and direct service hours at the end of the 12-month period may be grounds for failure of the Internship.

Leave Accrual

Interns accrue 8 hours of annual personal paid time off (24 days over the course of the year). Interns also additionally receive sick leave, per university policies. The university indicates that "*Sick leave may be used if you are sick or injured, or for medical appointments. Your supervisor may request the proof of any illness requiring the use of sick leave.*" In addition to annual and sick leave, employees receive 13 paid holidays per year. The university Holiday calendar can be found at: https://www.wm.edu/about/administration/provost/resources/holidays/index.php.

Interns should be aware that it may be necessary to use time outside of the office to accrue the 2,000 overall hours required by APA for successful completion of Internship. Work related to psychological practice (e.g., reading psychological research, working on dissertation, presenting at a conference, etc.) outside of the office can be recorded towards the 2,000 overall hours required for Internship.

Additional information on the university's employee leave policy can be found here: https://www.wm.edu/offices/uhr/benefits/leave/12month-facultyleave/index.php

For any additional questions, please contact university Human Resources.

Requesting Leave:

Trainees must get prior approval from their individual supervisor and the Training Director to take annual leave. Trainees must make arrangements for any of their responsibilities affected while away from the office including, but not limited to 1) exchanging Team Days, 2) rescheduling any supervision sessions that will be missed (own supervision and/or provision to an Advanced Practicum Student), 3) consulting with your supervisor regarding any clinical issues/clients of concern, and/or 4) informing seminar leaders if you will be absent for a meeting, 5) rescheduling any clients, etc.

Trainees request leave via the following steps:

1. Go to your personal calendar in Outlook.
2. Select the date starting your leave and double click to create a "New Event"

3. Once the “New Event” window pops up, add the following information:
    a. **Add a Title:** “Vacation”
    b. **Invite attendees:** Enter and select “CAL-WMCCTraineeLeave”, Training Director, AND individual supervisor
    c. **Start Time**: First day and time of leave (if relevant, you may click the “All day” option)
    d. **End Time**: Last day and time of leave (if relevant, you may click the “All day” option)
    e. **Location:** Leave blank
    f. **Narrative Box:** Please detail relevant arrangements you have made for any clinical and training (e.g., Exchange of Team Days, rescheduled supervision meetings, seminars affected, etc.).

4. At the top of the New Event window, select the “Send” button. You will receive a notice if the request has been approved and the appointment will be placed on the Outlook calendar to ensure appropriate coverage for the office.

Leave requests may be denied for reasons including, but not limited to: 1) the trainee is requesting more time off than available in their Leave Balance denoted in Banner, 2) the trainee is requesting an amount time off that could disrupt continuity of care to clients and/or hours accrual (i.e., typically more than 1 consecutive week off during semesters, or 2 consecutive weeks off in the summer), and/or 3) several other trainees and/or staff have already gotten approved time off on the dates requested, thus resulting in disruption to office coverage.

To view your current Leave Balance in Banner, visit: https://prod.banner.wm.edu/EmployeeSelfService/ssb/hrDashboard#/leaveBalanceDetailByEmployee

Recording Leave Taken:

Interns are classified as exempt employees, and therefore, only record leave when taken. Leave is recorded by submitting timesheets through the Banner system. Interns record the hours of leave taken on the appropriate days of the timesheet. Trainees are required to independently monitor the university pay period schedule to submit timesheets by the appropriate deadlines.

Should you miss a timesheet submission deadline, a Manual Timesheet must be completed and submitted to the Training Director as soon as possible. Manual Timesheets can be found in Section A of this training manual or at: https://www.wm.edu/offices/financialoperations/payroll/timesheetsandcorrections/index.php

Inaccurate documentation of leave taken and/or misrepresentation of leave taken (i.e., pre-planning sick days), may be grounds for disciplinary action.

End of Internship

Interns are required to reserve 5 days (40 hours) of **annual leave** for the last 5 business days of Internship to allow for transition from Internship. Interns must complete all end of year tasks by the end of their last working day of Internship. Not doing so jeopardizes successful completion of the Internship. Interns may choose to use up to 10 days (80 hours) of annual leave at the end of the Internship. Requests for more than 10 consecutive days off for the end of Internship may be denied, as this may present a continuity of care concern for clients. Should the entire cohort wish to reserve more than the required 5 days of leave for the end of Internship, please inform the Training Director as soon as possible, so the end of Internship celebration can be scheduled accordingly.

Remote Work

Any clinical work provided by trainees, including tele-mental health services, is done so on-site at the agency. Trainees are not eligible for remote work/work-from home or remote access of Titanium software unless they have a university-approved accommodation. Information and procedures on employee accommodations can be found at: https://www.wm.edu/offices/compliance/policies/employee_reasonable_accommodation/index.php

Telesupervision

Telesupervision is defined by the Commission on Accreditation (CoA) as *"supervision of psychological services through a synchronous audio and video format where the supervisor is not in the same physical facility as the trainee"* (CoA C-13 D. Telesupervision; CoA C-15 I. Telesupervision). The CoA defines In-Person supervision as *"supervision of psychological services where the supervisor is physically in the same room as the trainee."*

Any clinical work provided by trainees, including tele-mental health services, is done so on-site at the agency. All supervision at WMCC is provided by licensed permanent staff members on-site. WMCC values the unique benefits of in-person supervision, including but not limited to, opportunities to observe and process nonverbal and affective cues and establish professional relationships. It is the general expectation that all supervision provided at WMCC occur in-person; however, WMCC recognizes that there may be an occasional need for telesupervision. Telesupervision may be considered in cases of temporary extenuating circumstances, based on supervisor discretion. Any long-term need for telesupervision requires a university-approved accommodation. Information and procedures on employee accommodations can be found at: https://www.wm.edu/offices/compliance/policies/employee_reasonable_accommodation/index.php. The Training Director should be consulted in cases where telesupervision is being considered.

In the event that telesupervision has been approved, it may not account for more than 50% of the two weekly hours of individual supervision and may not account for more than 50% of the overall supervision hours at the training site.

Any telesupervision conducted should occur on a HIPAA-compliant platform and both parties should be in a confidential space.

Hours of Operation & Lunch

Typical business hours at the Center are 8am-5pm. Any deviation in hours of operation will be communicated to interns. Interns are expected to be present at the office during operating hours. The Center observes lunch from 12-1pm. Interns are discouraged from scheduling clients over the lunch hour, as staff may not be available to provide back up in case of an urgent need. Trainees must always have a permanent staff member available for backup when meeting with clients. Occasionally on Team Days, an urgent issue may arise over the lunch hour. Interns should coordinate with their Teammate to determine how the urgent need will be addressed.

There is reasonable flexibility considered in this policy (i.e., arriving a few minutes late, leaving a few minutes early), so long as there is no neglect of clinical and/or training responsibilities, and/or any negative impact to client care. Abuse of this flexibility may be cause for adjusted expectations and/or disciplinary action.

Team Days:

Interns are assigned to a Team Day with a permanent staff member during the Fall and Spring Semesters. Team Day assignments are made by the Clinical Director and Training Director. Interns can submit Team Day preferences, though preferences are considered secondary to system/Center needs. Interns will be assigned a new Team Day as the semesters change, following the same procedures noted previously.

When on Team Day, staff are responsible for coverage with their teammate during the entire business day (8:00am-5:00pm). Any time away from the office (e.g., stepping out to get lunch, going for a brief walk on campus, running late to the office, etc.) on a Team Day should be coordinated among the teammates. Informing Front Desk staff is also advised in these cases. Even when temporarily out of the office on a Team Day, staff should keep their cellphones nearby to monitor if there is an urgent need.

No appointments other than Initial Consultations should be scheduled on Team Days, as to ensure staff are available for urgent appointments and consultations. The number of Initial Consultation appointments on each staff member's Team Day is determined by the Director, Clinical Director, and when relevant, the Training Director. Any other meeting scheduled on a Team Day should have prior coordination and approval with one's teammate. Such occurrences should be rare. Even when coordinated by the Team, it is possible that a meeting scheduled on a Team Day could be interrupted due to a clinical need. Any participants in such a meeting should be informed of the possibility for interruption.

If you plan to request annual leave on a Team Day, you must work to find coverage for your Team Day. This typically takes the form of "exchanging" Team Days with another staff member. Which days are exchanged should be clearly denoted on Titanium. Due to clinical demand, it is advised to request coverage for Team Days as far in advance as possible. Similarly, if you are planning leave or need uninterrupted time for part of a Team Day (e.g., medical appointments, providing an outreach, attending an event on campus, etc.), the same coverage expectations apply.

Occasionally, an urgent issue may arise at the end of the day and those on Team Day may be required to stay late at the office. Please plan accordingly.

On-Call:

WMCC uses a center-provided cellphone for on-call concerns. Interns provide one week of on-call/after hours coverage during each semester and one week during the summer. On-call coverage typically begins at 4pm on a Friday and extends until 8am the following Friday. Interns are asked to provide their availability for on-call coverage at the start of the semester. On-call coverage is determined primarily by availability and

Center needs; preferences are considered secondarily. Interns' individual supervisors serve as back up during on-call coverage. Interns are expected to consult with their supervisors for any calls received during their on-call weeks. Interns also receive an on-call folder with various resources.

The on-call clinician is required to reserve the 4pm hour on their schedule for any urgent appointments for each day that they are on-call, as these issues are more likely to extend after hours. Should an urgent appointment extend beyond business hours, a staff member on Team Day will remain in the office to provide support for the on-call clinician. It is the on-call clinician's responsibility to find coverage if there is a conflict with any 4pm or after-hours coverage requirements. If exchanging a 4pm coverage hour with a staff member, please clearly denote this on Titanium. Any coverage changes after hours should have prior approval from the intern's supervisor and the Clinical Director, as this requires notification to campus partners.

While on-call, Interns should always remain close to the on-call phone. Known reception issues should be communicated to the intern's individual supervisor to explore solutions. Documentation, particularly for issues of safety/risk, should occur as soon as possible once the intern has access to Titanium.

W&M Counseling Center

Internship Training

WILLIAM & MARY

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PHILOSOPHY OF TRAINING

The training program at the WMCC embraces the responsibility of providing supportive, comprehensive doctoral-level internship training in a counseling center setting. Our training program is consistent with the overall mission of the WMCC, providing quality and culturally sensitive professional services to students facing developmental and clinical issues that could interfere with the fulfillment of their educational and personal goals.

Developmental-Experiential-Mentorship Based Training

The WMCC internship program is based on a Developmental-Experiential-and mentorship philosophy of training. The internship builds on the foundation of knowledge and skills acquired through the diverse experiences of graduate coursework, research, practica and other applied activities. The center considers the internship a capstone to a doctoral training in health service psychology. We strive to facilitate the integration of research, knowledge, and skills and the consolidation of a professional identity as a psychologist. As such, our mission is to provide a training environment that facilitates the transition from graduate student to culturally sensitive, clinically skilled and ethically sound psychologist.

Integration of Research/Scholarly Work and Practice

An important component of the WMCC philosophy of training is the belief in the need to integrate scholarly knowledge, research findings, and critical thinking into clinical practice and clinical decision making. We encourage the consumption and implementation of scholarly research across roles within the agency.

Mentoring, Modeling, and Supervision

Trainees are supervised by senior staff members who model the highest ethical, legal, and professional standards of the profession and provide a safe and supportive environment that would foster interns' learning and development. It is in this type of environment that interns could effectively develop conceptual, methodological, therapeutic, and case management skills while engaging in a self-exploration process that would be conducive to personal and professional growth.

In addition to the intense clinical supervision interns receive, they also participate in formal training activities that are structured to promote a theoretical and clinical foundation in health service psychology. The structured training activities include an orientation program, training seminars, case conferences, and group supervision.

Mentoring and an “open door policy” are highly valued at the center. Interns are encouraged to utilize and consult with all professional staff regardless of supervision assignments.

PROFESSION-WIDE COMPETENCIES

The field of health service psychology demands a flexible and integrated repertoire of skills and competencies. The Standards of Accreditation in Health Service Psychology define nine Profession-Wide Competencies that serve as the basis for evaluation throughout the internship program. The Profession-Wide Competencies are as follows:

PROFESSION-WIDE COMPETENCIES	
I.	RESEARCH
II.	ETHICAL AND LEGAL STANDARDS
III.	INDIVIDUAL AND CULTURAL DIVERSITY
IV.	PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS
V.	COMMUNICATION AND INTERPERSONAL SKILLS
VI.	ASSESSMENT
VII.	INTERVENTION A. Individual Therapy B. Crisis Intervention C. Group Therapy D. Outreach Programming
VIII.	SUPERVISION
IX.	CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS

I. RESEARCH

Interns are presented with multiple opportunities to consume research to inform their clinical practice during the training year. Interns will regularly read research articles for seminars, supervision, and are expected to integrate research in presentations. In addition, interns are expected to present their personal research (e.g., dissertation) to their peers and the staff at the Center. Interns will be expected to demonstrate knowledge, skill, and competence to critically evaluate research and apply research findings in the different professional roles assumed during the internship year.

II. ETHICAL BEHAVIOR AND LEGAL STANDARDS

An overarching goal of the WMCC is to instill a commitment to ethical practice. Interns will have opportunity to discuss ethical issues in the different didactic seminars offered during the year, as well as in group supervision meetings (e.g., case conference, group therapy supervision, etc.), and in supervision. Interns will be expected to behave according to the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (2002) and demonstrate knowledge regarding the rules, regulations and standards governing health service psychology. In addition, interns are to familiarize themselves with the Virginia Law regarding the ethical practice of psychology. Interns will be expected to recognize ethical dilemmas and apply ethical decision-making processes competently. In addition, interns are expected to follow the Counseling Center policies and procedures, maintain an appropriate professional role with clients, develop appropriate interaction with staff and trainees, and maintain accurate documentation records.

III. INDIVIDUAL AND CULTURAL DIVERSITY

Interns participate in didactic and experiential training regarding multicultural competence. Sensitivity to issues of power and privilege as well as social justice issues are central to the mission of the Counseling Center and the Training program. As such, interns are to demonstrate ability to engage in self-reflection about the way in which their own personal/cultural history affects how they understand and interact with people different from themselves, including peers, colleagues, supervisees, supervisors, other staff/professionals, and those seeking services. Interns are expected to demonstrate cultural sensitivity and competence in service delivery with clients, groups, and organizations from diverse cultural backgrounds and other forms of individual difference. Multicultural competence is defined according to APA Guidelines (see Training Manual, VII. ETHICS & LAWS).

IV. PROFESSIONAL VALUES, ATTITUDES AND BEHAVIORS

A significant goal of the internship is to instill a commitment to professionalism, integrity, self-reflection, and lifelong learning. The internship attempts to foster the development of interns' reflective practice and self-assessment so that they can recognize the boundaries of their competencies, demonstrate ability to monitor their own professional behavior, and recognize strengths and areas of growth. Similarly, the internship offers opportunities for interns to consolidate their professional identity. It is anticipated that interns will gain a sense of competence, confidence, and autonomy in the practice of health service psychology. As the year progresses, it is expected that interns will respond professionally in increasingly complex situations with a greater degree of independence. As such, interns are to demonstrate ability to effectively use supervision, being receptive feedback and new ideas as well as open to looking at own issues that may impact professional behavior.

V. COMMUNICATION AND INTERPERSONAL SKILLS

Appropriate communication and interpersonal skills are essential for positive interactions and effective work with others. Communication and interpersonal skills are the foundations for many of the other vital competencies in the field of health service psychology. It is expected that Interns will demonstrate understanding of professional language and concepts, and produce and comprehend oral, nonverbal, and written communication. Interns are to demonstrate the ability to maintain effective relationships with a wide range of individuals including clients, peers, colleagues, supervisees, supervisors, and other staff/professionals, being sensitive to individual and cultural differences as well as to issues of power and privilege. Interns are expected to utilize and develop appropriate interpersonal skills, appropriately managing emotional reactions while interacting with others, particularly when engaged in difficult communication.

VI. ASSESSMENT

Interns participate in didactic and experiential assessment training as well as in weekly supervision to assure competent assessment practices. They will have ample opportunity to engage in initial assessments and clinical interviews with clients seeking services. Interns are expected to accurately assess clients' psychological needs, write comprehensive conceptualizations, and make appropriate treatment recommendations such as the need for individual or group therapy, psychiatric referral, or other interventions including referrals to other professionals or community services. Interns are also expected to be able to make clinical decisions about the selection and utilization of psychological tests in their clinical practice; they are to demonstrate ability to accurately interpret data from assessment instruments. Interns will demonstrate sensitivity to the context of the client's culture when selecting, implementing, and interpreting test results. Interns will be able to demonstrate ability to use assessment data to inform their clinical interventions.

VII. INTERVENTION

A. Individual Psychotherapy:

Interns demonstrate the ability to offer individual psychotherapy to college students with a variety of presenting concerns and identities during the internship year. Interns will receive didactic and experiential training as well as weekly supervision to assure competent service delivery. Interns are expected to appropriately apply therapeutic knowledge, multicultural guidelines, and evidenced-based treatments in clinical work. It is expected that interns demonstrate the ability to gather data, establish therapeutic rapport, develop accurate diagnostic impressions, and appropriately conceptualize cases, with consideration of client diversity variables. Interns will demonstrate effective timing and flexibility in therapeutic interventions. Interns are expected to timely and accurately document their clinical interventions with clients.

B. Crisis Intervention:

Interns receive didactic and experiential training as well as ongoing supervision and consultation regarding crisis intervention skills. During working hours or through after-hours on-call duties (with a back-up supervisor), interns will be able to provide crisis intervention for clients experiencing acute personal distress or symptomatology. Interns are to be aware of best practices and evidence-based strategies related to crisis intervention. Interns will appropriately consult when assessing and responding to crisis situations. Interns are expected to appropriately assess the magnitude of the crisis situation, the clients' needs, and to implement appropriate interventions to reduce distress. Interns are expected to demonstrate ability to evaluate clients' safety regarding risk of danger to self and/or others and mobilize resources accordingly. Interns will also maintain timely and accurate documentation records.

C. Group Psychotherapy:

Interns receive didactic and experiential training in group therapy intervention. They work with a group co-leader from the earlier stages of group referral, pre-group screenings and group formation, through the working and termination stages of group. Interns are expected to demonstrate ability to facilitate process-oriented therapy groups and/or theme/population-oriented groups. They are to be able to collaborate with co-leaders and accurately document the clinical interventions with groups.

D. Outreach Programming:

Interns are presented with multiple opportunities to engage in outreach programming. Interns are expected to be able to design and implement psycho-educational presentations and workshops for audiences within the campus community. Interns are expected to demonstrate the ability to develop programming based on current research, with sensitivity to different cultural variables, and based on the needs of the target audience. Interns will exhibit competency in their presentation skills. Interns receive didactic and experiential training in crisis management; it is expected that interns will be able to respond to critical incidents or crisis debriefing outreach events if there are situations of this caliber during their internship year.

VIII. SUPERVISION

Interns provide supervision for doctoral level practicum students. Interns receive didactic and experiential training in supervision. Interns are expected to model ethical practice, provide a safe environment for practicum students to discuss their cases, and demonstrate ability to assist supervisees with conceptualization and treatment planning. As supervisors, interns provide feedback and help supervisees develop self-reflective skills, encouraging identification of strengths as well as areas of growth. Interns are to apply the criteria for evaluation in a fair and developmentally appropriate manner.

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

Interns are expected to gain knowledge and skills regarding consultation. Interns receive didactic and experiential training as well as supervision regarding consultation with the multidisciplinary staff of the Center, faculty, staff, parents, Student Affairs professionals, and any other members of the university. Interns will be expected to exhibit ability to use their assessment and clinical judgment as they consult with others. Similarly, interns are expected to demonstrate knowledge and respect for the roles and perspectives of other professions and apply this knowledge in interprofessional/interdisciplinary consultation with individuals, groups and/or systems.

Clinical & Training Requirements

Special Interest Areas/Concentrations:

The training program seeks to offer training experiences and mentorship tailored to interns' specific interests where possible. Opportunities for additional training and mentorship may include, but are not limited to:

- Group Therapy
- Outreach
- Suicide Prevention Coalition
- Multicultural Consultation
- UCC Leadership/Student Affairs
- Program Evaluation
- Specific Clinical Populations

Interns are encouraged to express if they would like to pursue additional training opportunities to the Training Director. The program's Training Committee would meet to determine if offering additional training experiences are feasible. The program does not guarantee that additional training/mentorship in a specific area will be available each year. Special interest areas do not take priority over standard requirements of the internship. There is no consequence to an Intern's standing with the program if they do not express a desire to pursue additional training opportunities beyond the standard requirements of the internship.

Hours[1]:

1. **Direct Service Hours:** Interns must accrue a minimum of 500 direct service hours over the course of the internship for successful completion of the program.[2]
2. **Overall Internship Hours:** Interns must accrue a minimum of 2,000 overall hours over the course of the internship for successful completion of the program.

Individual, Couples, & Group Therapy:

1. **Individual/Couples Therapy**: Schedule individual/couples for <u>an average</u> of 16 clinical hours/week. [3,4,5]

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[1] Interns use an hour log provided by the program to record their hours.

[2] Direct service hours include interactions with clients or supervisees while serving in a clinical role (i.e., individual, couples, group, crisis, and/or consultation sessions, outreach events, and provision of supervision).

2. **Group Therapy**: Co-facilitate one therapy group with a senior staff member during the Fall and Spring semesters.

3. **Initial Consultations**: Schedule three initial consultations per week on Team Day, weekly throughout the Fall and Spring semesters.[6]

4. **Intakes:** Schedule three intake appointments/week in the Fall and Spring semesters.[7]

5. **Urgent/Crisis & Consultation Appointments:** In collaboration with one's teammate, urgent/crisis and consultation appointments are distributed throughout the day.[8,9]
6. **On call**: Provide at least one week of on-call/after-hours coverage per semester and one week of on-call/after-hours coverage during the summer.

Outreach:

1. **Orientation:** Observe or co-facilitate at least two outreach programs during the W&M students' orientation.
    a. If the RA Suicide Risk Reduction/Campus Connect Training is conducted during orientation, Interns are required to co-facilitate this program in addition to the two other orientation outreach programs.

2. **Screening Programs:** Participate in at least one screening program during the internship year, if offered.

3. **Mental Health Mondays (MHM):** Facilitate at least 1 MHM program per semester.[10]

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[3] To complete the 500 direct service hours required for completion of the internship, interns may need to have more than the estimated clinical hours per week scheduled during some weeks of the semester.

[4] At the beginning of semesters, interns may have less than the estimated clinical hours scheduled.

[5] If an intern is pursuing additional group therapy experience (i.e., co-leading more than one group during a semester), adjustments are made to the individual/couples therapy hours expectations (See Weekly Activity Summary for details).

[6] During the initial weeks of the fall semester, interns will schedule more initial consultations, as determined by the Training Director and Clinical Director, to assist in building their caseloads.

[7] The number of Intakes expected per week may vary if an intern is engaging in additional group therapy experience (see Weekly Activity Summary for details).

[8] Distribution of appointments between teammates may not be equal, due to the unpredictable nature of such appointments.

[9] Interns as well as senior staff members may be called to help with crisis, initial consultations, or consultation appointments on non-team days if the team for that day is managing excessive clinical need.

[10] Interns can participate in more than 1 MHM program per semester, however, this will not take the place of the Didactic/Interactive outreach requirements detailed in Outreach item #4.

4. **Didactic/Interactive Presentations**: Facilitate a minimum of three didactic/interactive outreach presentations per semester (minimum of six didactic outreach programs over the course of the internship year).[11,12]

5. **Campus Connect:** Facilitate at least one Campus Connect suicide prevention training per semester, if offered. During the Spring semester, Interns will assist in training practicum students in the program and co-facilitate the program with a practicum student, if offered.

Assessment [13]:

1. **CCAPS-62:** Interns administer and interpret the CCAPS-62 at initial consultation, urgent appointments, and every three sessions of individual therapy.

2. **Clinical Interviewing:** Interns regularly engage in assessment via clinical interviews during initial consultations, urgent/crisis appointments, and intakes.

3. **Case Presentations:** Interns complete one case presentation during the Fall and Spring semesters.[14] Case presentations occur during weekly Case Conference meetings attended by all staff (see *Supervision* below for details on Case Conference). Case Presentation requirements are described below:
    a. Complete a short write up of the case (no more than 3 pages single-spaced)[15] including:
        i. Demographics
        ii. Relevant Background/History
        iii. Medical History

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[11] Interns must produce an original program for at least one didactic/interactive presentation over the course of the year and be observed by a licensed staff member to complete the evaluation of Intern's outreach skills.

[12] Programs can be in response to requests received by the Counseling Center or based on own interest. If self-initiated, it would be important to take into account the academic calendar and students' schedules to increase the likelihood of getting an audience.

[13] Interns who are interested in acquiring additional assessment experience may integrate use of more assessment instruments and/or request more assessment referrals and supervision. Consultation should occur with the intern's supervisor before administering any additional assessment beyond the CCAPS-62.

[14] The intention is for Case Presentations to generate feedback that will benefit you and your client. Therefore, the Training Director will determine dates by which Case Presentations must be completed each semester in efforts allow for integration of feedback before the semester ends.

[15] The case presentation write up should be printed and distributed to staff members at least **24 hours** prior to the presentation.

iv. Presenting Concerns
v. Assessment data (instruments, rationale, results)
vi. Diagnosis
vii. Treatment Summary
viii. Theoretical Approach & Conceptualization
ix. Relevant Research/Literature (include citations)
x. Discussion Questions
xi. References

b. During the presentation, provide a summary of the case/write-up for no more than 10-15 minutes
c. Show a video clip illustrating your work approximately 10 minutes in length

Supervision:

1. **Individual Supervision**: Interns receive two-hours per week of clinical supervision for individual cases, initial consultations/intakes, on-call and crises.

2. **Provision of Supervision:** Interns provide 2 hours per week of individual supervision to a practicum student in the Spring semester. Based on the number of practicum students being trained each year, interns will supervise the equivalent of at least half a caseload of a practicum student during the Spring semester. Interns will meet with their practicum supervisee for 2 hours per week

3. **Supervision of Supervision**: During the Spring semester, interns receive 1 hour of supervision of supervision per week (in additional to individual supervision) overseeing their supervision of a practicum student.

4. **Group Therapy Supervision:** Interns receive 1.5 hours per week of group therapy supervision. One hour of group therapy supervision occurs during weekly meetings attended by all staff members facilitating groups. This meeting will include regular discussion of group progress and informal presentations (including showing video recordings) of group therapy. The remaining 0.5 hours per week of supervision occurs during a meeting with the intern's group co-leader to discuss and process issues relevant to your specific group.[16]

5. **Case Conference (1-2hr/week)**. This meeting is considered supervision in a group format, attended by all staff members. Trainees take turns showing clips of sessions and discussing clinical issues in order to hear different perspectives and

[16] Interns may receive additional weekly group therapy supervision if participating in multiple therapy groups.

receive feedback from those in attendance. Peer input is valued and encouraged. Practicum students also bring cases to these meetings and interns are able to provide input as a way to demonstrate their consultation, conceptualization, and clinical skills.[17]

6. **Supervision Logs:** Interns maintain a weekly supervision log for individual supervision and supervision of supervision caseloads, presenting concerns, any safety/risk concerns, and supervision discussions.[18]

Seminars:

1. **Integrated Seminar:** Interns meet for two hours per week during the Fall semester for this seminar covering various topics. More details provided in seminar syllabus.

2. **Diversity Seminar:** Interns meet for one hour biweekly (once every other week) throughout the Fall and Spring semesters for this seminar focused on issues of identity, diversity, and social justice. More details provided in seminar syllabus.

3. **Supervision Seminar**: Interns meet for one hour biweekly (once every other week) throughout the Fall and Spring semesters for this seminar focused on supervision.[19] More details provided in seminar syllabus.

Meetings:

1. **Staff Meetings**: Attend and participate in "All Staff" meetings scheduled throughout the Fall and Spring semesters, typically one hour per month.

2. **Meetings with Training Director:** Attend and participate in meetings with the Training Director, scheduled 0.5-1.0 hour per month during the Fall semester

[17] The Training Director typically coordinates a rotation with trainees to share clinical work in this meeting. If a trainee is unexpectedly unable to present on a scheduled day, a different person will need to present that day.

[18] Supervision logs are to remain at the Center with the Training Director after the completion of the Internship. Please do not shred any supervision logs.

[19] The seminar focused on supervision theories/approaches during the Fall, as interns prepare to supervise a practicum student. In the Spring, seminar takes the form of a group consultation format to discuss supervision issues. Interns also present on their supervision work with a practicum student in the Spring seminar.

(alternating group-individual meetings), 0.5-1.0 hour per month (alternating group-individual meetings) during the Spring semester, and as needed/as requested during the summer. The purpose of these meetings is to address potential questions or concerns and/or provide feedback about the training program to the Training Director.[20]

3. **Student Affair Meetings:** Interns attend all Student Affairs meetings, typically two hours per month, including semester "Kickoffs" and end of semester celebrations.[21]

Research[22]:

1. **Research Presentation**: Interns present on personal research to Counseling Center staff. This presentation can be scheduled at any time during the training year.[23]

Teaching:

1. **Practicum Seminar Teaching Presentation**: Interns present on a topic of their choice during the practicum seminar (fall or spring semester).[24]

Summer Project:

1. **Summer Project**: Interns will complete a summer project of their choosing. Examples include creating psychoeducational brochures, completing a program evaluation using internal data, developing resource guides, developing training resources, improvements to counseling center website, projects identified as Counseling Center needs, etc.[25]

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[20] Interns are always welcome to request an individual meeting with the Training Director outside of these regular meetings.

[21] Any absence from a Student Affairs gathering should have prior approval from the Training Director and the intern's individual supervisor.

[22] It is expected that interns will apply scholarly work and research findings in all activities and roles assumed during the internship year.

[23] Interns who decide to present during the academic year (vs. summer) should schedule early in the semester to increase the likelihood for staff availability.

[24] Interns should consult with practicum seminar co-leader(s) and the Training Director before finalizing a presentation topic and to coordinate scheduling.

[25] Interns should seek approval of their summer project idea with their primary supervisor(s) and the Training Director before moving forward.

Evaluations[26]**:**

1. **Self-Assessments**: Completed at the start and end of internship.

2. **Individual Supervisor(s) Evaluations**: The "Evaluation of Psychology Interns by Supervisors" is used for this purpose. Interns receive evaluations from individual supervisors on a quarterly basis over the internship year: 1st quarter (approximately October), 2nd quarter (approximately January), 3rd quarter (approximately April), and end of internship/4th quarter (July).

3. **Group Supervisor(s) Evaluations:** Interns receive evaluations from group supervisor(s) at mid-group and end-group.

4. **Supervisor of Supervision Evaluations:** Interns receive an evaluation of their supervisory skills by their Supervisor of Supervision in the Spring at mid-semester and end-semester.

5. **Evaluations of Intern Performance in Seminar**[27]**:**
    a. **Diversity Seminar:** Evaluations of performance provided at mid-seminar (end Fall) and end-of-seminar (end Spring).
    b. **Supervision Seminar:** Evaluations of performance will be provided at mid-seminar (end Fall) and end-of seminar (end Spring).

6. **Case Presentation Evaluations**: Staff members and trainees in attendance during interns' case presentations (Fall and Spring) complete a case presentation evaluation.

7. **Supervision Presentation Evaluation**: The coordinator(s) of the Supervision Seminar and all interns in attendance during presentation complete a supervision presentation evaluation (Spring semester).

8. **Outreach Presentation Evaluation**: Licensed staff member(s) observes and completes the outreach presentation evaluation.[28]

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[26] All evaluations can be found in the Training Manual, *V. EVALUATIONS.* Interns are encouraged to familiarize themselves with the program's Minimum Level of Achievement (MLA) and all evaluations.
[27] There is no performance evaluation for Integrated Seminar.
[28] This evaluation may occur at any time over the course of the internship; however, interns are asked to be proactive when requesting observation by a staff member.

9. **Teaching Presentation Evaluation**: Licensed staff member(s) observes and completes the teaching presentation evaluation (Fall or Spring semester).

10. **Research Presentation Evaluation:** Staff members and trainees in attendance during the intern's research presentation complete the research presentation evaluation.

11. **Intern Evaluations of Supervisors**: Interns complete an evaluation of supervision to share with supervisors (individual, group, supervision of supervision) whenever receiving an evaluation of themselves, except for presentation evaluations.[29]

12. **Intern Evaluation of Supervisee(s)**: Interns complete evaluations of their practicum supervisee at mid- and end-semester, in collaboration with their Supervisor of Supervision. Practicum students typically have evaluation forms specific to their graduate program.

13. **Supervisee Evaluation of Intern Supervisor**: Practicum provide evaluations of the intern in their role of supervisor using evaluation of supervision form**.**[30]

14. **Intern Evaluation of Seminar:** Interns provide evaluations of seminar at the end of the seminar.

15. **Intern Evaluation of Training Director:** Interns complete an evaluation of the Training Director at the end of internship.

16. **Evaluation of Internship Experience:** Interns complete an evaluation of the internship experience at the end of internship.

17. **Evaluations from Academic Programs**: Interns are responsible for informing the Training Director and submitting all required forms to the doctoral program if their academic program requires specific forms to be completed. Interns are to provide copies of these evaluation forms to the Training Director and supervisor(s).

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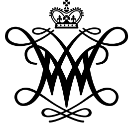
[29] Interns should share their evaluation of supervision *after* receiving the supervisor's evaluation to eliminate any concerns of retaliation.

[30] As is the case for interns, Practicum Students provide their evaluation of the Intern supervisor *after* receiving the evaluation of themselves to eliminate concerns of retaliation.

Electronic Portfolio:

All training records are included in an Electronic Portfolio to remain indefinitely in a restricted file with the Center. Interns use the "End of the Year Checklist" (*Training Manual, V. Evaluations, 22. End of Year Checklist)* to determine that all required documents are in the Electronic Portfolio. The Intern, individual supervisor, and Training Director must sign off on this document before the internship is considered complete.



WILLIAM & MARY
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Williamsburg, VA 23187-8795

Phone Number 757-221-3620
Fax Number 757-221-3615

I ________________________________ have read, understood, and agree with the Clinical and Training Requirements of the internship outlined above (including footnotes). I had the opportunity to discuss these requirements with the Training Director and have questions answered. I understand that it is my responsibility to ensure I meet all the clinical and training requirements for successful completion of the training program.

_______________________________ Date ______________________

Psychology Intern (sign)

____

Psychology Intern (print)

Weekly Activity Summary

Hours denoted are an *approximation* of average time per week per category	Fall	Fall (w/ 2 groups)	Spring	Spring (w/ 2 groups)	Summer	Summer (w/ group)
Clinical Service						
Individual/Couples Therapy	16	14	14	13	10	9
Group Therapy	1.5	3	1.5	3	0	1.5
Initial Consultations	1.5	1.5	1.5	1.5	1	1
Intake	3	3	3	2	1.5	1.5
Assessment	Varied	Varied	Varied	Varied	Varied	Varied
Crisis	1	1	1.5	1.5	1	1
Consultation & Outreach	Varied	Varied	Varied	Varied	Varied	Varied
Supervision of Practicum Students	0	0	2	2-2.5	0	0
On-Call Response	Varied	Varied	Varied	Varied	Varied	Varied
Subtotal:	**23**	**22.5**	**23.5**	**23-23.5**	**13.5**	**14**
Supervision, Seminar, Research						
Individual Supervision	2	2	2	2	2	2
Group Therapy Supervision	1.5	2	1.5	2-2.5	0	1
Integrative Seminar	2	2	0	0	0	0
Supervision Seminar	0.5	0.5	0.5	0.5	0	0
Diversity Seminar	0.5	0.5	0.5	0.5	0	0
Case Conference	1	1	1	1	2	2
Networking/Professional Development Meetings	Varied	Varied	Varied	Varied	0	0
Prep for Seminars/Readings	1	1	1	1	0	0
Research/Prep for Research Presentation/Program Evaluation/Professional Development	Varied	Varied	Varied	Varied	12	12
Subtotal:	**8.5**	**9**	**6.5**	**7-7.5**	**16**	**17**
Administrative						
Staff Meeting	0.25	0.25	0.25	0.25	0	0
Documentation/Paperwork	6	6	6	6	5	5
Supervision Prep (Self & Practicum Student)	1	1	2	2	1	1
Phone Calls/Email	Varied	Varied	Varied	Varied	Varied	Varied

Meetings with Training Director	0.25	0.25	0.25	0.25	As needed	As needed
SA Meetings	0.5	0.5	0.5	0.5	0	0
Subtotal:	**8**	**8**	**9**	**9**	**6**	**6**
Other						
Intern Bonding	.25	.25	.25	.25	0	0
Summer Project	0	0	0	0	3	3
Subtotal:	**0.25**	**0.25**	**0.25**	**0.25**	**3**	**3**
TOTAL HOURS/WEEK	**39.75**	**39.75**	**39.25-40.25**	**41-42.5**	**38.5**	**40**

INTERN SEMINARS COORDINATORS

SEMINAR	COORDINATOR(S)	FORMAT	FREQUENCY
INTEGRATIVE SEMINAR	Joy Badalis, LPC Julianne Davison, LPC Dymond Booth, M.A.	Different Presenters/ Readings +Discussion	1 hr, 2x/week-Fall semester
DIVERSITY SEMINAR	Carina Sudarsky Gleiser, Ph.D. Kevin Clancey, Psy. D.	Readings + Discussion	1 hr every other week- Fall & Spring semesters
SUPERVISION SEMINAR	Melissa Noble, Ph.D. Ali Pappas-Bourdage, Ph.D.	Readings+ Discussion + Case Presentation	1 hr every other week-Fall & Spring semesters *Seminar leaders my change in Spring per Supervision of Supervision assignments

Intern: ______________________ Supervisor(s): ______________________

Fall Overall Total: 0.00 Clinical/Direct Service Hours: 0.00

		8/1	8/5	8/12	8/19	8/26	9/2	9/9	9/16	9/23	9/30	10/7	10/14	10/21	10/28
ACTIVITY	T	W1	W2	W3	W4	W5	W6	W7	W8	W9	W10	W11	W12	W13	W14
Clinical/Direct Service															
Individual/Couples	0.00														
Consultation	0.00														
Group Therapy	0.00														
PGI	0.00														
Initial Consults	0.00														
Intakes	0.00														
Immediate crisis	0.00														
Assessment: face to face	0.00														
Outreach: face to face	0.00														
On-Call Contact	0.00														
Supervision & Seminars															
Individual Supervision	0.00														
Group Therapy Sup	0.00														
Case Conference	0.00														
Integrative Seminar	0.00														
Sup Seminar-BW1	0.00														
Diversity Seminar-BW-1	0.00														
Outreach & Consultation	0.00														
Teaching	0.00														
Admin, Case Mgt & Prep	0.00														
Assessment Prep	0.00														
Outreach Prep	0.00														
Supervision Prep	0.00														
Case Prep: sup, pres, etc.	0.00														
Admin: e-mail, checking vm	0.00														
Case Mgt/Paperwork	0.00														
Meetings	0.00														
Orientation	0.00														
Staff Meeting	0.00														

Student Affair Meetings	0.00														
Networking	0.00														
Staff Development	0.00														
Meeting w/Training Director	0.00														
Prof Dev: job rel, conf	0.00														
Dissertation/Research	0.00														
Intern Support Meeting	0.00														
Other	0.00														
Sick Time	0.00														
Vacation	0.00														
Weekly Total Hours		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Overall Total Hours	0.00														

REQUIREMENTS CHECKLIST

Case Presentation ______________________ ________

Outreach Requirements

____ Orientation 1: ______________________

____ Orientation 2: ______________________

____ Screening Program: ______________________

____ Didactic/Interactive Presentation 1:

____ Didactic/Interactive Presentation 2:

____ Didactic/Interactive Presentation 3:

Outreach Notes:

Outreach must be direct contact with an audience. Screening contact does count, but only the time actually spent with the person you are screening. After the screening outreach, estimate your total time of face to face contact. Outreach prep is any research, planning and organizing you do.

Other

Client Demographics **# of clients**

Formal Case Presentation Requirements

African-American / Black / African Origin	________
Asian-American / Asian Origin / Pacific Islander	________
Latino / a / x / Hispanic	________
American Indian / Alaska Native / Aboriginal Canadian	________
European Origin / White	________
Biracial / Multiracial	________
No Race Provided	________
Heterosexual	________
Gay	________
Lesbian	________
Bisexual	________
Asexual	________
Queer	________
Demisexual	________
Other / Questioning	________
Male	________
Female	________
Transgender	________
Non-binary	________
Genderqueer	________
Questioning Gender	________
Physical / Orthopedic Disability	________
Blind / Visually Impaired	________
Deaf / Hard of Hearing	________
Learning / Cognitive Disability	________
Developmental Disability	________

11/4	11/11	11/18	11/25	12/2	12/9	12/16	12/23
W15	**W16**	**W17**	**W18**	**W19**	**W20**	**W21**	**W22**

0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Intern: ______________________ Supervisor(s): ______

Spring Overall Total: **0.00**

Clinica

ACTIVITY	T	W1	W2	W3	W4	W5	W6	W7	W8	W9
		12/30	1/6	1/13	1/20	1/27	2/3	2/10	2/17	2/24
Clinical/Direct Service										
Individual/Couples	0.00									
Consultation	0.00									
Group Therapy	0.00									
PGI	0.00									
Initial Consults	0.00									
Intakes	0.00									
Supe with Prac Student	0.00									
Immediate crisis	0.00									
Assessment: face to face	0.00									
Outreach: face to face	0.00									
On-Call Contact	0.00									
Supervision & Seminars										
Individual Supervision	0.00									
Group Therapy Sup	0.00									
Case Conference	0.00									
Supe of Supe	0.00									
Sup Seminar/SOS-BW1	0.00									
Diversity Seminar: BW-1	0.00									
Outreach & Consultation	0.00									
Teaching	0.00									
Admin, Case Mgt & Prep										
Assessment Prep	0.00									
Outreach Prep	0.00									
Supervision Prep	0.00									
Case Prep: sup, pres, etc.	0.00									
Admin: e-mail, checking vm	0.00									
Case Mgt/Paperwork	0.00									
Meetings										
Orientation	0.00									
Staff Meeting	0.00									
Student Affair Meetings	0.00									
Networking	0.00									
Staff Development	0.00									
Meeting w/Training Director	0.00									
Prof Dev: job rel, conf	0.00									
Dissertation/Research	0.00									
Intern Support Meeting	0.00									
Other	0.00									
Professional / Sick Time	0.00									
Vacation	0.00									

Weekly Total Hours		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Overall Total Hours	0.00									

REQUIREMENTS CHECKLIST

Case Presentation ______________________________

Outreach Requirements

____ Didactic/Interactive Presentation 1: ______________________

____ Didactic/Interactive Presentation 2: ______________________

____ Didactic/Interactive Presentation 3: ______________________

Client Demographics	# of clients
African-American / Black / African Origin	________
Asian-American / Asian Origin / Pacific Islander	________
Latino / a / x / Hispanic	________
American Indian / Alaska Native / Aboriginal Canadian	________
European Origin / White	________
Biracial / Multiracial	________
No Race Provided	________
Heterosexual	________
Gay	________
Lesbian	________
Bisexual	________
Asexual	________
Queer	________
Demisexual	________
Other / Questioning	________
Male	________
Female	________
Transgender	________
Non-binary	________
Genderqueer	________
Questioning Gender	________
Physical / Orthopedic Disability	________
Blind / Visually Impaired	________
Deaf / Hard of Hearing	________
Learning / Cognitive Disability	________
Developmental Disability	________

al/Direct Service Hours: 0.00

Total Clinical/Direct Service Hours: 0.00

3/3	3/10	3/17	3/24	3/31	4/7	4/14	4/21	4/28	5/5	5/12	5/19	5/26
W10	W11	W12	W13	W14	W15	W16	W17	W18	W19	W20	W21	W22

0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Internship Overall Total 0.00

Intern: Supervisor(s):

Summer Overall Total: 0.00 | Clinical/Direct Hours: 0.00 | Direct Service Overall: 0.00 | Overall Internship Total: 0.00

ACTIVITY	T	W1 6/2	W2 6/9	W3 6/16	W4 6/23	W5 6/30	W6 7/7	W7 7/14	W8 7/21	W9 7/28
Clinical/Direct Service										
Individual/Couples	0.00									
Group Therapy	0.00									
Initial Consults	0.00									
Intakes	0.00									
Immediate Crisis	0.00									
Assessment: face to face	0.00									
Sup w/Prac Student	0.00									
Outreach: face to face	0.00									
On-Call Contact	0.00									
Supervision & Seminars										
Individual Supervision	0.00									
Group Therapy Sup	0.00									
Case Conference	0.00									
Sup of Sup	0.00									
Sup Seminar/SOS	0.00									
Diversity Seminar	0.00									
Outreach & Consultation	0.00									
Teaching	0.00									
Admin, Case Mgt & Prep										
Assessment Prep-V	0.00									
Outreach Prep-V	0.00									
Supervision Prep-1	0.00									
Case Prep: sup, pres, research	0.00									
Admin: e-mail, checking vm	0.00									
Case Mgt/Paperwork	0.00									
Meetings										
Orientation	0.00									
Staff Meeting	0.00									
Student Affair Meetings	0.00									
Networking	0.00									
Staff Development	0.00									
Meeting w/Training Director	0.00									
Prof Dev: job rel, conf	0.00									
Dissertation/Research	0.00									
Intern Support	0.00									
Other	0.00									
Sick Time	0.00									
Vacation	0.00									
Weekly Total Hours	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Overall Total Hours	0.00									

Manual Hours Check

Fall Direct Service Total:

Fall Overall Total:

Spring Direct Service Total:

Spring Overall Total:

# of Clients

Cumulative Totals

African-American/Black/African Origin		
Asian-American/Asian Origin/Pacific Islander		
Latino/a/Hispanic		
American Indian/Alaska Native/Aboriginal Canadian		
European Origin/White		
Biracial/Multiracial		
Heterosexual		
Gay		
Lesbian		
Bisexual		
Male		
Female		
Transgendered		
Physical/Orthopedic Disaability		
Blind/Visually Impaired		
Deaf/Hard of Hearing		
Learning/Cognitive Disability		
Developmental Disability		
Other: Questioning		
Other: Asexual		
Other: Middle Eastern		

Supervision

Supervision of Supervision Contract
Semester XXX

This document is intended to outline the expectations and parameters of supervision, assist in supervisee professional development, and provide clarity in supervisor responsibilities in accordance with the APA Ethical Principles of Psychologists and Code of Conduct and the Virginia Board of Psychology.

This contract between ______________________________ (supervisor) and ______________________________ (supervisee) at the William & Mary Counseling Center, signed on __________ (date), serves to verify supervision and establish its parameters.

Context of Supervision

A. Supervision will occur in a competency-based and developmentally appropriate framework
B. 1 hour of group supervision biweekly (supervision of supervision)
C. Review of videotapes will be a part of the supervision process
D. Supervision will consist of multiple modalities including review of tapes of your supervision, progress notes and feedback given to your supervisee, triad supervision, instruction, modeling, discussion, and mutual problem-solving

Evaluation

A. Competency-based and developmentally appropriate feedback will be provided to the supervisee
B. A formal mid-semester evaluation and formal final evaluation will be conducted and provided to the supervisee
C. Evaluation forms are available on the G: Drive in respective program training manuals
D. The supervisee will formally evaluate the supervisor at the mid-point and end of the semester

Duties and Responsibilities of Supervisor

A. Upholds and adheres to the APA Ethical Principles of Psychologists and Code of Conduct, the policies and procedures of the William and Mary Counseling Center and College of William and Mary, and Virginia Board of Psychology
B. Attends all supervision meetings in a private/confidential space and/or platform
C. Oversees and monitors all aspects of client case conceptualization and treatment planning
D. Reschedules all missed supervision meetings to ensure supervisee receives the agreed upon hours of supervision (see Context of Supervision—B, above). The supervisor will work with the Training Director to develop a plan in the event of an issue that prevents a supervisor from making up meetings.
E. Prepares for supervision meetings and reviews video tapes outside of sessions
F. Challenges and problem solves with supervisee
G. Provides interventions and directives for clients at risk
H. Identifies and builds upon the supervisee's strengths
I. Supervision may include exploration of belief structures, worldview, values, culture, transference, countertransference, and parallel process
J. Ensures a high level of professionalism in all interactions

K. Identifies and addresses strains or ruptures in the supervisory relationship
L. Establishes informed consent for all aspects of supervision
M. Helps supervisee to attain training goals and tasks
N. Reviews and signs all supervisee case notes according to Center's documentation policy timeframes.
O. Clearly distinguishes and maintains the line between supervision and therapy
P. Avoids dual relationships which could compromise the objectivity of the relationship to the supervisee
Q. Ensures understanding of all aspects of the supervisory process in this document and the underlying legal and ethical standards from the onset of supervision
R. Assumes legal liability for all clinical activities of the practicum trainee for the duration of this contract
S. If the supervisee does not meet criteria for successful completion, the supervisee will be informed at the first indication of this, and supportive and remedial steps will be implemented to assist the supervisee.

Duties and Responsibilities of the Supervisee

A. Upholds and adheres to the APA Ethical Principles of Psychologists and Code of Conduct, the policies and procedures of the William and Mary Counseling Center and College of William and Mary, and Virginia Board of Psychology
B. Attends all supervision meetings in a private/confidential space and/or platform
C. Prepares for supervision and provides weekly updates to a client log for supervision meetings
D. Identifies training goals and tasks to achieve in supervision
E. Identifies strengths and areas of future development
F. Understands the liability (direct and vicarious) of the supervisor with respect to supervisee's practice and behavior
G. Ensures clients and practicum student are aware of their status as a supervisee, and the name of the licensed clinical supervisor
H. All supervision sessions with practicum trainee should be recorded and only with pre-approval from agency/licensed supervisor can recording be waived.
I. Discloses errors, concerns, and clinical issues to the supervisor as they arise, including those that occur for the practicum trainee.
J. Consults with the supervisor or other agency clinical staff member in all cases of emergency or significant risk concerns for practicum trainee
K. Conducts all supervision sessions with the practicum trainee using a HIPAA compliant platform and/or setting
L. Communicates with supervisor, or other appropriate staff as necessary, if they are going to be out of the office
M. Will reschedule any missed supervision session with their practicum trainee
N. Monitors and tracks their supervisee's caseload and communicates to the licensed supervisor any concerns.
O. No information should be withheld from the licensed supervisor regarding supervision of the practicum trainee

Procedural Aspects of Supervision

A. Information which relates to the client is strictly confidential in supervision, the supervisor will treat supervisee disclosures with discretion
B. There are limits of confidentiality for supervisee disclosures. These include ethical and legal violations, indication of harm to self and others, and/or reported abuse or neglect of a vulnerable population (e.g. a minor or elderly individual).
C. If the supervisor or the supervisee must cancel or miss a supervision session, the supervisor and supervisee will communicate to determine a plan for rescheduling.
D. The supervisee will contact the supervisor at XXXX or on-call counselor during business hours at (757) 221-3620 should an urgent matter arise.

This contract may be revised at the request of supervisee or supervisor. Revisions will be made only with consent of supervisee and approval of supervisor. A copy of this signed contract will be provided to both the supervisor, supervisee, and Training Director.

We, ______________________ (supervisee) and ____________________ (supervisor), will follow the directives laid out in this supervision contract and conduct ourselves in keeping with the APA Ethical Principles and Code of Conduct, Virginia Board of Psychology, state and federal laws, and site-specific procedures.

_________________ ___________________
(Supervisor) Date

__________________________________ __________________________________
(Supervisee) Date

This contract is in effect from ________________________ (date) through ________________________ (date).

Group Therapy Supervision Contract
Semester XXX

This document is intended to outline the expectations and parameters of group therapy supervision, assist in supervisee professional development, and provide clarity in supervisor responsibilities in accordance with the APA Ethical Principles of Psychologists and Code of Conduct and the Virginia Board of Psychology.

This contract between ______________________________ (supervisor) and ______________________________ (supervisee) at the William & Mary Counseling Center, signed on _______________ (date), serves to verify supervision and establish its parameters.

Context of Supervision

A. Supervision will occur in a competency-based and developmentally appropriate framework for 0.5 hr/group
B. Supervision will consist of multiple modalities including review of tapes, progress notes, instruction, modeling, discussion, and mutual problem-solving
C. Treatment notes will be completed for all clinical contact with group members will be an important aspect of supervision. Risk and safety will be documented before the end of the business day for all types of notes. A first draft of all notes will be sent to the supervisor according to agency documentation policies.

Evaluation

A. Competency-based and developmentally appropriate feedback will be provided to the supervisee
B. A formal mid-semester evaluation and formal final evaluation will be provided by both supervisor and supervisee (Evaluation forms are available on the G: Drive in the program training manual).

Duties and Responsibilities of Supervisor

A. Upholds and adheres to the APA Ethical Principles of Psychologists and Code of Conduct, the policies and procedures of the William and Mary Counseling Center and College of William and Mary, and Virginia Board of Psychology
B. Attends all supervision meetings in a private/confidential space and/or platform
C. Oversees and monitors all aspects of group conceptualization and treatment planning
D. Reschedules all missed supervision meetings to ensure supervisee receives the necessary supervision hours. The supervisor will work with the Training Director to develop a plan in the event of an issue that prevents a supervisor from making up meetings.
E. Provides regular feedback to supervisee to assist in their development as a group leader
F. Provides a space for exploration of clinical interventions, supervisee's strengths and areas for growth, diversity factors, potential countertransference and personal factors, the supervisory relationship, etc., in the interest of the clinical work.
G. Establishes informed consent for all aspects of supervision
H. Helps supervisee to attain training goals and tasks
I. Reviews and signs all supervisee case notes according to Center's documentation policy timeframes.

J. Clearly distinguishes and maintains the line between supervision and therapy
K. Avoids dual relationships which could compromise the objectivity of the relationship to the supervisee
L. Ensures understanding of all aspects of the supervisory process in this document and the underlying legal and ethical standards from the onset of supervision
M. Assumes full responsibility for the clinical activities of the supervisee for the duration of this contract
N. If the supervisee does not meet criteria for successful completion, the supervisee will be informed at the first indication of this, and supportive and remedial steps will be implemented to assist the supervisee.

Duties and Responsibilities of the Supervisee

A. Upholds and adheres to the APA Ethical Principles of Psychologists and Code of Conduct, the policies and procedures of the William and Mary Counseling Center and College of William and Mary, and Virginia Board of Psychology
B. Attends all supervision meetings in a private/confidential space and/or platform
C. Prepares for supervision and identifies training goals, tasks to achieve in supervision.
D. Understands the liability (direct and vicarious) of the supervisor with respect to supervisee's practice and behavior
E. Identifies to clients his/her status as a supervisee and name of the clinical supervisor
F. Receives client permission prior to recording any sessions and receives an agency supervisors' approval prior to conducting any sessions without recording.
G. Discloses errors, concerns, and clinical issues to the supervisor as they arise
H. Limits all email communication with clients to non-sensitive information (e.g. scheduling appointments)
I. Documents all communications and meetings with clients according to aforementioned timelines and disposes of all confidential materials in an appropriate manner
J. Consults with the supervisor or other agency clinical staff member in all cases of emergency or significant risk concerns
K. Conducts all telemental health appointments in HIPAA compliant platforms and/or settings, and only provides treatment to clients located in jurisdictions where the supervisor is licensed to practice.
L. Verifies the client's physical location before starting any telemental health appointment
M. Communicates with supervisor, or other appropriate staff as necessary, if they are going to be out of the office
N. Makes appropriate arrangements for clients if canceling appointments due to absence and makes up any missed supervision meetings.
O. Ensures that all email correspondence with clients includes the following signature disclaimer:

> *E-mail is not a confidential form of communication and confidentiality cannot be guaranteed. Further, we cannot guarantee that e-mail messages will be read regularly or within a given time period. Therefore, we recommend that all clients communicate with us by phone. This is especially important in the case of an emergency situation. For W&M crisis services after hours and weekends call (757) 221-3620. To access crisis services unaffiliated with W&M, call the National*

Suicide Hotline at 1-800-273-8255 or text HOME to 741741 (text "STEVE" for a culturally trained clinician). For a life-threatening emergency, call 911 right away. If you are not the intended recipient of this message, please destroy this message and notify the sender immediately.

Procedural Aspects of Supervision

A. Information which relates to the client is strictly confidential in supervision, the supervisor will treat supervisee disclosures with discretion
B. There are limits of confidentiality for supervisee disclosures. These include ethical and legal violations, indication of harm to self and others, and/or reported abuse or neglect of a vulnerable population (e.g. a minor or elderly individual).
C. If the supervisor or the supervisee must cancel or miss a supervision session, the supervisor and supervisee will communicate to determine a plan for rescheduling.
D. The supervisee will contact the supervisor at XXXX or on-call counselor during business hours at (757) 221-3620 should an urgent matter arise.

This contract may be revised at the request of supervisee or supervisor. Revisions will be made only with consent of supervisee and approval of supervisor. A copy of this signed contract will be provided to both the supervisor and supervisee.

We, _______________________ (supervisee) and _____________________ (supervisor), will follow the directives laid out in this supervision contract and conduct ourselves in keeping with the APA Ethical Principles and Code of Conduct, Virginia Board of Psychology, state and federal laws, and site-specific procedures.

____________________________________ ____________________________________

(Supervisor) Date

____________________________________ ____________________________________

(Supervisee) Date

This contract is in effect from _________________________ (date) through _________________________ (date).

The College Of WILLIAM&MARY

Counseling Center
240 Gooch Drive
Williamsburg, VA 23185
757/221-3620, Fax 757/221-3615

Consent to Supervision, Observation, and Recording of Counseling Sessions

In order to provide you with the best possible care, counselors-in-training are assigned supervisors with whom they must consult regarding their cases and are required to record their sessions using a digital camera. They review these video recordings with their supervisors and, on rare occasions, with other Counseling Center staff for the purpose of supervision and consultation regarding the services you receive.

It is our strict policy that recordings are viewed only at the Counseling Center. Digital video files are typically deleted within 60 days. Occasionally, video files may be stored longer for supervision purposes. No recordings are stored permanently.

Video files are protected in accordance with confidentiality laws. They are saved in encrypted format and stored in password-protected computers accessible to Counseling Center staff only. You have the right to refuse recording and may withdraw your consent at any time. However, this may result in your case being transferred to another clinician.

I understand that:

- The purpose of recording is to ensure the quality of services I receive, and for training, supervision, and consultation purposes.
- I may request that recordings be stopped at any time during the sessions.
- All recordings will be viewed and safeguarded appropriately within the Counseling Center.
- I may discuss or clarify these issues with my counselor at any time.

Counselor's Licensed Supervisor is: ____________

____ Yes, I give my consent to recording of my counseling sessions with _________________
(Counselor's Name/Title)

____ No, I do not give my consent to recording of my sessions.

This release expires in 12 months unless another date is specified:_______________________

___________________________________ ___________
Client Signature Date

____
Name (Print)

The College Of WILLIAM&MARY

Counseling Center
240 Gooch Drive
P.O. Box 8795
Williamsburg, VA 23185
757/221-3620, Fax 757/221-3615

Consent to Supervision of Supervision and Recording of Supervision Sessions

As you were previously informed about the WMCC Advanced practicum during the interview and orientation processes, in order to provide you with the best possible supervisory experience, psychology interns are assigned supervisors with whom they must consult about their supervision of the practicum student they are working with. Recording of supervision sessions using a digital camera is used for this purpose. Licensed supervisors review these video recordings with the psychology intern they are supervising and, once a semester, with the group of their peers and the coordinators of the Supervision Seminar when they present a report of their supervisory experience. The purpose of all supervision of supervision is to offer you, the practicum student, the supervisory experience that would most adequately fit your training needs.

It is our strict policy that recordings are deleted regularly. Video files are protected in accordance with confidentiality laws. They are saved in encrypted format and stored in password-protected computers accessible to Counseling Center staff only.

I understand that:

- The purpose of recording is to ensure the quality of supervision I receive, and for training, supervision, and consultation purposes.
- All recordings will be viewed and safeguarded appropriately within the Counseling Center.
- I may discuss or clarify these issues with my supervisor or with the Coordinator of Practicum at any time.

The Supervisor in charge of the Psychology Intern's Supervision of the Practicum Student is:

____.____________

____ Yes, I give my consent to recording of my Supervision sessions with ___________________________
(Intern's name/title)

____ No, I do not give my consent to recording of my sessions (In this case, the practicum student would need to be transferred to another practicum site)

This release expires in 12 months unless another date is specified:___________________

___________________________________ ___________________
Practicum Student Signature Date

____
Name (Print)

Supervision Log & Discussion

Supervisee_________________ Supervisor___________________ Date____________________

Supervisee Training Goals:	General Supervision Discussion and Feedback

Client Initials & Demographics	# of Sessions	Last session date	Presenting Issue	Treatment Goals/Disposition Treatment Plan	Safety concerns
Date of last Sup Discussion	Supervision Discussion:				
Client Initials & Demographics	# of Sessions	Last session date	Presenting Issue	Treatment Goals/Disposition Treatment Plan	Safety concerns
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Supervision Log & Discussion

Supervisee__________________ Supervisor____________________ Date_____________________

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Supervision Log & Discussion

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Supervisee Training Goals:	General Supervision Discussion and Feedback

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Supervision Log & Discussion

Supervisee__________________ Supervisor____________________ Date_____________________

TRAINING NEEDS, SUPERVISORS, GROUPS

Name: ____________________________________ Date: _______________

Please list the areas of strength you have identified at this point in your professional development and the training goals you have for this semester:

Please describe, based on your knowledge/understanding of their work/clinical/supervisory approach, what you believe you can learn from *ALL* of the available individual supervisors and how this learning connects with your training needs and goals:

Please describe, based on your knowledge/understanding of the different groups and the co-leaders' therapeutic style/approach, what you believe you can learn from your experience in each of them. Please address how your training needs/goals regarding group therapy would be achieved in *ALL* of the available groups:

Evaluations:

Evaluations are submitted on forms via Google Drive. Except for evaluations of presentations and seminars, evaluations are reviewed in person by the trainee and supervisor. Each member of the supervision dyad will come prepared with an evaluation of the other. Supervisors provide their evaluation of a trainee before a trainee shares their evaluation of the supervisor to reduce concerns of retaliation. Trainees should discuss with their supervisors the timelines for evaluation to ensure both parties are prepared.

How to Complete & Print Evaluations:

1) Ensure you are signed into Google workspace (https://my.wm.edu/ --click on the "G Workspace" icon)
2) Go to: https://drive.google.com/drive/folders/129oF9VenKyxAT8zPui1i4m47Nd6xlyzH?usp=sharing
3) Click on the Evaluation to be completed
4) Complete the evaluation (be sure to type in your e-mail address XXX@wm.edu at the top of the form)
5) At the bottom of the form, be sure to select "Send me a copy of my responses." before submitting. This will ensure that you will have a backup copy of the form to print in case Front Desk Staff is unable to format the evaluation by the date the supervisory dyad has selected to share evaluations.
6) Once submitted, contact Front Desk staff with the number of the evaluation for formatting (e.g. 8—Eval of Intern by Group Supervisor).
7) Once formatted, Front Desk staff will print a copy, place the printed evaluation in the writer's mailbox, then notify the writer that the copy is in their mailbox.
8) Review evaluation with supervisor/trainee, if relevant. Should any changes be made to the evaluation (quantitative or qualitative), you must inform Front Desk staff of the changes so the data is accurate in our records.
9) Once all parties agree on the evaluation, sign the document, if relevant (e.g., no signature required on presentation evaluations, seminars, etc.).
10) Interns should immediately scan and upload the evaluation to their Electronic Portfolio.

Individual Supervision Contract

This document is intended to outline the expectations and parameters of supervision, assist in supervisee professional development, and provide clarity in supervisor responsibilities in accordance with the APA Ethical Principles of Psychologists and Code of Conduct and the Virginia Board of Psychology.

This contract between ______________ (supervisee) and ______________ (supervisor) at the William & Mary Counseling Center, signed on ______________, serves to verify supervision, and establish its parameters.

Context of Supervision

A. Supervision will occur in a competency-based and developmentally appropriate framework
B. 2 hours of individual supervision weekly
C. Review of videotapes will be a part of the supervision process
D. Treatment notes will be completed for all clinical contact with clients and will be an important aspect of supervision. Risk and safety will be documented before the end of the business day for all types of notes. A draft of all notes will be sent to the supervisor within 1 week of the date of session.
E. Supervision will consist of multiple modalities including review of tapes, progress notes, instruction, modeling, discussion, and mutual problem-solving

Evaluation

A. Competency-based and developmentally appropriate feedback will be provided to the supervisee
B. A formal final evaluation will be conducted and provided to the supervisee
C. Evaluation forms are available on the G: Drive and in the Training Manual
D. The supervisee will formally evaluate the supervisor at the designated evaluation times

Duties and Responsibilities of Supervisor

A. Upholds and adheres to the APA Ethical Principles of Psychologists and Code of Conduct, the policies and procedures of the William and Mary Counseling Center and College of William and Mary, and Virginia Board of Psychology
B. Attends all supervision meetings in a private/confidential space and/or platform
C. Oversees and monitors all aspects of client case conceptualization and treatment planning
D. Reschedules all missed supervision meetings to ensure supervisee receives 2-hrs/week individual supervision. Supervisors will work with the Training Director to develop a plan in the event of an issue that prevents a supervisor from making up meetings.
E. Prepares for supervision meetings and reviews video tapes outside of sessions
F. Challenges and problem solves with supervisee
G. Provides interventions and directives for clients at risk
H. Identifies and builds upon the supervisee's strengths
I. Introduces and models use of personal factors including belief structures, worldview, values, culture, transference, countertransference, and parallel process
J. Ensures a high level of professionalism in all interactions
K. Identifies and addresses strains or ruptures in the supervisory relationship

L. Establishes informed consent for all aspects of supervision
M. Helps supervisee to attain training goals and tasks
N. Reviews and signs all supervisee case notes according to Center's documentation policy timeframes.
O. Clearly distinguishes and maintains the line between supervision and therapy
P. Avoids dual relationships which could compromise the objectivity of the relationship to the supervisee
Q. Ensures understanding of all aspects of the supervisory process in this document and the underlying legal and ethical standards from the onset of supervision
R. Assumes full responsibility for the clinical activities of the supervisee for the duration of this contract
S. If the supervisee does not meet criteria for successful completion, the supervisee will be informed at the first indication of this, and supportive and remedial steps will be implemented to assist the supervisee.

Duties and Responsibilities of the Supervisee

A. Upholds and adheres to the APA Ethical Principles of Psychologists and Code of Conduct, the policies and procedures of the William and Mary Counseling Center and College of William and Mary, and Virginia Board of Psychology
B. Attends all supervision meetings in a private/confidential space and/or platform
C. Prepares for supervision and provides weekly updates to a client log for supervision meetings
D. Identifies training goals and tasks to achieve in supervision
E. Identifies strengths and areas of future development
F. Understands the liability (direct and vicarious) of the supervisor with respect to supervisee's practice and behavior
G. Identifies to clients his/her status as a supervisee and name of the clinical supervisor
H. Receives client permission prior to recording any sessions and receives an agency supervisors' approval prior to conducting any sessions without recording.
I. Discloses errors, concerns, and clinical issues to the supervisor as they arise
J. Limits all email communication with clients to non-sensitive information (e.g. scheduling appointments)
K. Documents all communications and meetings with clients according to aforementioned timelines and disposes of all confidential materials in an appropriate manner
L. Consults with the supervisor or other agency clinical staff member in all cases of emergency or significant risk concerns
M. Conducts all telemental health appointments in HIPAA compliant platforms and/or settings, and only provides treatment to clients located in jurisdictions where the supervisor is licensed to practice.
N. Verifies the client's physical location before starting any telemental health appointment
O. Communicates with supervisor, or other appropriate staff as necessary, if they are going to be out of the office
P. Makes appropriate arrangements for clients if canceling appointments due to absence and makes up any missed supervision meetings.
Q. Ensures that all email correspondence with clients includes a signature disclaimer:

Example:
E-mail is not a confidential form of communication and confidentiality cannot be guaranteed. Further, we cannot guarantee that e-mail messages will be read regularly or within a given time period. Therefore, we recommend that all clients communicate with us by phone. This is especially important in the case of an emergency situation. For W&M crisis services after hours and weekends call (757) 221-3620. To access crisis services unaffiliated with W&M, call the National Suicide Hotline at 1-800-273-8255 or text HOME to 741741 (text "STEVE" for a culturally trained clinician). For a life-threatening emergency, call 911 right away. If you are not the intended recipient of this message, please destroy this message and notify the sender immediately.

R. Monitors and tracks their caseload and hours logs to ensure they are meeting hours expectations. The supervisee communicates to the supervisor should concerns about hours arise.

Procedural Aspects of Supervision

A. Information which relates to the client is strictly confidential in supervision, the supervisor will treat supervisee disclosures with discretion
B. There are limits of confidentiality for supervisee disclosures. These include ethical and legal violations, indication of harm to self and others, and/or reported abuse or neglect of a vulnerable population (e.g. a minor or elderly individual).
C. If the supervisor or the supervisee must cancel or miss a supervision session, the supervisor and supervisee will communicate to determine a plan for rescheduling.
D. The supervisee will contact the supervisor at ______________ or on-call counselor during business hours at (757) 221-3620 should an urgent matter arise.

This contract may be revised at the request of supervisee or supervisor. Revisions will be made only with consent of supervisee and approval of supervisor. A copy of this signed contract will be provided to both the supervisor and supervisee.

We, ______________ (supervisee) and ______________ (supervisor), will follow the directives laid out in this supervision contract and conduct ourselves in keeping with the APA Ethical Principles and Code of Conduct, Virginia Board of Psychology, state and federal laws, and site-specific procedures.

________________________________ ___________________________
(Supervisor) Date

___________________________________ ____________________________
(Supervisee) Date

This contract is in effect from ______________ through ______________.

Evaluation Forms

INTERN PERFORMANCE IN SEMINAR

Intern ________________________________
Seminar ________________________________
Date ___________________________________
Evaluator(s) _____________________________

The goal of this evaluation form is to stimulate feedback regarding the intern performance in the seminar. As such, the assessment should be reflective of the expected developmental progress at the time of the evaluation. Using the scale below, evaluate the different aspects of the intern's work as well as the overall performance in the seminar.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

Evaluation of Intern Clinical Case Presentation

College of William & Mary Counseling Center

Intern: ____

Date ___________

Evaluated by: ____

The goal of this evaluation is provide feedback related to the interns' professional functioning as a Health Service Provider in the context of a college mental health agency. This evaluation is typically completed upon observing the intern's formal presentation of their work with a current individual client.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

I. RESEARCH	1. Demonstrates flexibility in therapeutic techniques, including the ability to use and adapt evidence-based approaches, based on assessment data, treatment goals, diversity and contextual variables, and evaluation of intervention effectiveness ______ 2. Demonstrates ability to use evidence based methodology to conduct suicide risk assessment ______
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to ethical and legal concerns _____
III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Demonstrates ability to integrate issues of identity into their case conceptualization, treatment planning, and interventions ______ 2. Demonstrates sensitivity of how self and client are shaped by individual and cultural diversity and the cultural context and sub-cultures in which they function ______ 3. Demonstrates sensitivity to issues of power and privilege as they interact with client ______
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Demonstrates integrity and a professional demeanor in the interaction with the client ______ 2. Demonstrates concern for the client's welfare ______ 3. Demonstrates ability to monitor their reactions and behaviors ______ 4. Demonstrates receptiveness to feedback ______
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Provides clear, succinct, and comprehensive written case presentation report __________ 2. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding the therapeutic work__________ 3. Demonstrates ability to present the case taking in consideration the allotted schedule, allowing time for questions and feedback __________ 4. Demonstrates effective use of technology and/or visual aids to provide understanding of the work being presented __________
VI. ASSESSMENT	1. Demonstrates understanding of human behavior within its context (e.g., family, social, societal and cultural). ____ 2. Demonstrates ability to select, use and interpret assessment data being sensitive to clients' cultural identity(ies) ______

	3. Demonstrates ability to collect relevant data using multiple sources and methods appropriate to the goals and questions of the assessment ______ 4. Demonstrates ability to accurately interpret assessment data according to professional standards and guidelines _____ 5. Demonstrates the ability to apply the knowledge of functional and dysfunctional behaviors including context to the assessment and/or diagnostic process.______ 6. Demonstrates ability to make appropriate diagnostic impressions based on assessment data ________ 7. Demonstrates current knowledge of diagnostic classification systems, functional and dysfunctional behaviors, including consideration of client strengths and psychopathology._____ 8. Demonstrates ability to use assessment data to inform case conceptualization, intervention, and recommendations______
VII. INTERVENTION	1. Demonstrates appropriate level of rapport with client _________ 2. Demonstrates ability to gather data and to facilitate exploration _____ 3. Demonstrates ability to integrate data into meaningful conceptualizations ______ 4. Demonstrates ability to conceptualize according to an identified theoretical orientation ______ 5. Demonstrates ability to formulate treatment strategies that integrate theory, current evidence-based information, assessment findings, diversity and contextual variables ______ 6. Appropriately utilizes complementary approaches/services based on client need and diversity/cultural/contextual variables ______ 7. Demonstrates use of self as a therapeutic tool in treatment planning and intervention _______ 8. Helps client identify and understand appropriate goal for therapeutic work _______ 9. Demonstrates ability to handle theirs and their client's affect ______ 10. Demonstrates effective timing of interventions ______ 11. Demonstrates ability to expand own skills in order to benefit the client ______
IX. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Demonstrates willingness to consult with other professionals to provide the most effective treatment for the client ______

Overall Average Rating ________________

COMMENTS including particular strengths and areas for further growth:

Evaluation of Intern Supervision Presentation

College of William & Mary Counseling Center

Intern: ____

Date ___________

Evaluated by: ____

The goal of this evaluation is to provide feedback related to the interns' presentation of their work in supervision of a practicum student. This presentation is typically conducted in Supervision of Supervision Seminar. The focus of this evaluation should be the intern's demonstration of their ability to a) provide an effective environment and intervention(s) according to the practicum student's developmental skill, training goals, and necessary areas of support b) monitor the quality of the professional services offered by this trainee.

Please rate trainee using the following 5-point scale.

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

I. RESEARCH	1. Demonstrates ability to evaluate and apply supervision research in the supervision of practicum student ______
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates ability to manage ethical and/or legal issues relevant to supervisory work ____
III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Demonstrates cultural sensitivity in the supervisory relationship with their supervisees ______ 2. Demonstrates sensitivity to issues of power and privilege as they interact with supervisee ______
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Demonstrates integrity, commitment, and a professional demeanor in the supervisory role ______ 2. Demonstrates ability to monitor their reactions and behaviors as a supervisor ______ 3. Demonstrates receptiveness to feedback ______
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Provides clear, succinct, and comprehensive written presentation report __________ 2. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding the supervisory work__________ 3. Demonstrates ability to present taking in consideration the allotted schedule, allowing time for questions and feedback __________ 4. Demonstrates effective use of technology and/or visual aids to provide understanding of the work being presented __________
VI. SUPERVISION	1. Demonstrates ability to establish and maintain a safe and supportive supervisory relationship ______ 2. Demonstrates respect and offers support for their supervisee ______ 3. Assists trainee in identifying appropriate goal for supervision ________ 4. Demonstrates appropriate use of role as supervisor and supervisory task(s) ______ 5. Appropriately selects and utilizes a theoretical model of supervision ______ 6. Demonstrates clarity and theoretical soundness related to conceptualization of supervision work _____ 7. Supports trainee's use of self as a therapeutic tool _____ 8. Demonstrates awareness of self and utilizes this awareness to support trainee development ______ 9. Demonstrates ability to monitor their supervisee professional functioning and quality of services provided ______

	10. Demonstrates ability to take risks that allow supervisory skills to develop ________
IX. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Demonstrates willingness to consult with other professionals to provide the most effective supervision ______

Overall Rating ________________

COMMENTS including particular strengths and areas for further development:

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Evaluation of Intern Outreach Presentation

William and Mary Counseling Center
College of William and Mary

Intern: ____

Observer: ____

Presentation Title: ____

Date of Presentation: ________________________ Location: ________________________

Audience/# of Participants ____

The goal of this evaluation is primarily that of stimulating feedback regarding the perceived status and progress of the intern being evaluated. As such, the ratings should be reflective of the expected developmental progress at the time of the evaluation; at the beginning of the year, interns are evaluated according to what the profession describes as "readiness to enter internship" and at the end of year based on the competencies expected for "entry level practice." Given this framework, interns could make progress on any given aim/competency and receive the same score on two different evaluation periods considering what is developmentally expected at that point in the internship year. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee's training, progress, and how skills can be acquired or improved.

A score of 1 or 2 on any given item should be accompanied by specific data or description in the narrative/comment section addressing why the intern is receiving such rating for that competency.

Passing Criteria: An average score of 4 is required on each of the overall nine professional competencies and a minimum score of 3 on any given item within each competency area by the last evaluation of the competency area during the internship.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability

to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

I. RESEARCH	1. Demonstrates thorough literature review ____ 2. Demonstrates ability to include up to date research information about the content area ____
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to ethical and legal concerns as relevant____
III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Presents in a manner that is inclusive and/or affirming of issues of diversity ____
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Demonstrates integrity and a professional demeanor during the presentation ______ 2. Demonstrates knowledge about the content area 3. Demonstrates receptiveness to feedback ______
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Demonstrated consideration of needs of the target audience (academic calendar, student's schedules, etc.) ______ 2. Developed an appropriate outline for the time allotted 3. Developed a marketing plan for this presentation if necessary/indicated ______ 4. Demonstrated consideration of logistics (room size, AV needs, etc.) ______ 5. Provided an introduction to the program ______ 6. Facilitator was knowledgeable about the content area ______ 7. Material was presented in a clear, understandable manner ______ 8. Transitions between topics were managed in a smooth manner ______ 9. Engaged the audience in an effective manner (e.g. used interactive strategies, activities from different modalities) ______ 10. Facilitator was responsive to the needs of the audience throughout the presentation (e.g. answered questions effectively, handled disruptive participants) ______ 11. Demonstrated effective use of time allotted, including enough time for questions ______ 12. Handouts/worksheets given to the participants were useful 13. Provided a closing summary of the program ______ 14. Provided accurate information about the Counseling Center services or other campus resources ______
VI. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Consulted with in house staff, university and community members to assess programming needs ______ 2. Demonstrates willingness to consult with other professionals to present the most accurate information ______

Overall Average Rating ________________

COMMENTS including particular strengths and areas for further growth:

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EVALUATION OF TEACHING IN SEMINAR

Intern:_________________________ Evaluator: _________________________Date: ___________

Presentation Title: ____

The goal of this evaluation form is primarily that of stimulating feedback regarding the perceived status and progress of the intern being rated in regards to teaching/presentation skills. As such, the ratings should be reflective of the expected developmental progress at the time of the evaluation. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee's training, progress, and the means by which skills can be acquired or improved.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

You are asked to evaluate the intern's teaching skills considering the following area.

I. RESEARCH	1. Demonstrates thorough literature review ____ 2. Demonstrates ability to include up to date research information about the content area ____
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to ethical and legal concerns as relevant____
III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Presents in a manner that is inclusive and/or affirming of issues of diversity ____
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Demonstrates integrity and a professional demeanor during the presentation ______ 2. Demonstrates knowledge about the content area ______ 3. Demonstrates receptiveness to feedback ______
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Demonstrates consideration of needs of the target audience. ______ 2. Integrates the necessary information for a clear understanding of the topic__________ 3. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding content area__________ 4. Demonstrates ability to respond to the needs of the audience throughout the presentation and engages the audience in an effective manner _______ 5. Demonstrates ability to present the information taking in consideration the allotted schedule, allowing time for questions and feedback __________ 6. Demonstrates effective use of technology, handouts, and/or visual aids __________
VI. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Demonstrates willingness to consult with other professionals to present the most accurate information ______

Overall Rating ________________

COMMENTS including particular strengths and areas for further growth:

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Evaluation of Intern Research Presentation

College of William & Mary Counseling Center

Intern: ____

Date ____________

Evaluated by: ____

The goal of this evaluation is provide feedback related to the interns' professional functioning as a consumer, contributor, and disseminator of research and evidence base of the field of psychology. This evaluation is typically completed upon observance of the intern's formal presentation of original research or a selected topic under review by them.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

I. RESEARCH	1. Demonstrates theoretical rationale for their selected research question or review approach _____ 2. Demonstrates a thorough understanding of the existing evidence base and literature in their area of focus ________ 3. Demonstrates appropriate use of research design and methodology _________ 4. Identifies appropriate directions for future research based on current findings or status of evidence base _______
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to legal and ethical issues related to the conduct of research _______
III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Demonstrates knowledge, skills, and competence to attend to issues of diversity and contextual variables in the design, methodology, and discussion of research findings ________
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Strives to promote accuracy/Demonstrates integrity regarding the science of psychology ______ 2. Demonstrates awareness of their professional and scientific responsibility to society and the communities potentially impacted by the research study _____ 3. Demonstrates receptiveness to feedback ______
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding the study__________ 2. Communicates research findings with clarity while identifying any relevant limitations to conclusions and implications of practical use of findings ________ 3. Demonstrates ability to present the study taking in consideration the allotted schedule, allowing time for questions and feedback __________ 4. Demonstrates effective use of technology and/or visual aids to provide understanding of the research being presented __________

Overall Average Rating ________________

COMMENTS including particular strengths and areas for further development:

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EVALUATION OF SUPERVISION

Name of Supervisor: ____

Name of Supervisee: ______________________________________

Period Covered: _____________________ to ________________________

Rating Scale: 1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

1. ____ Concrete feedback was provided.
2. ____ Feedback and evaluation were based on adequate observation of my counseling.
3. ____ Alternative ways to handle specific client situations were provided.
4. ____ Adequate time was allocated for supervision.
5. ____ My supervisor was prompt for supervision sessions.
6. ____ Questions and suggestions regarding clients were helpful in conceptualizing cases and developing treatment plans.
7. ____ Treatment models were discussed that were different from my supervisor's.
8. ____ I was provided with helpful suggestions when at an impasse with a client.
9. ____ Concern was shown for me as a person.
10. ____ I was provided feedback about personal behaviors and characteristics that might aid or interfere with my effectiveness.
11. ____ I was treated with respect.
12. ____ Disagreements with my supervisor were supported and discussed openly.
13. ____ My feelings of inadequacy generated by cases were explored.
14. ____ The interaction between my supervisor and me was used as a medium for understanding my work with clients.
15. ____ My supervisor acknowledged his/her limitations.
16. ____ Assistance was given in identifying my personal strengths which increased my confidence as a helping professional.
17. ____ My supervisor was available to give help outside of our regular supervision time.

18. ____ My ideas and concerns were respected.

19. ____ Personal goals were established and periodically renegotiated with my supervisor.

20. ____ Assistance was given in understanding the implications of counseling approaches I used.

21. ____ Discussion of problems I encountered in the training setting was facilitated by my supervisor.

22. ____ Supervision emphasized verbal and nonverbal behavior of my clients and myself.

23. ____ Supervision helped me define and maintain ethical behavior in counseling and case management.

24. ____ Supervision focused on both content (e.g. client concerns, counseling interventions) and affect (e.g. client's and therapist's emotional reactions).

25. ____ Assistance was given in identifying important case data for planning goals and strategies with my clients.

26. ____ Resource information was provided when I requested it.

27. ____ Supervision helped me develop increased skill in critiquing and gaining insight from my counseling tapes.

28. ____ The criteria for evaluation was explained clearly by my supervisor.

29. ____ The criteria for evaluation was applied fairly in evaluating my counseling performance.

30. ____ Supervisor attended to individual and cultural diversity issues of clients.

31. ____ Supervision attended to my individual and cultural diversity as it relates to clinical work.

32. ____ Overall rating of the supervision experience.

Other comments:

_________________________   ____________________

Supervisor   Date

_________________________   ____________________

Supervisee   Date

Seminar Evaluation
(SEMINAR- e.g. supervision seminar, assessment seminar, etc)
College of William and Mary Counseling Center
Pre-doctoral Internship

Title: ____
Presenter(s): _______________________________________
Date: ______________

Please use the scale below to answer the following questions.

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
5	4	3	2	1

___1. The topic was relevant to my training and thoroughly covered.

___2. The presentation was congruent with the objectives of the clinical/professional issues seminar.

___3. There was enough time allotted to answer questions.

___4. The presenter(s) was/were knowledgeable.

___5. The presenter(s) spoke in a clear and understandable manner.

___6. The presentation was organized in a logical sequence.

___7. The handouts/audio-visual aids were helpful.

___8. This presentation has improved my understanding of the topic.

___9. I have a better understanding of how I can use what I learned in my counseling center work.

___10.The presentation included information based on current literature, theory and/or research.

The most helpful part of the program was:

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The least helpful part of the program was:

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Suggestions:

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Self-Assessment: End of Internship

William and Mary Counseling Center
College of William and Mary

Intern: ____ Date:___________

Please use this evaluation form to assess your skill in the following aims and competencies. The goal of this self-assessment is to help you engage in self-reflection, appreciate your growth during the internship year, and contemplate your strengths and areas of further growth.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

I. RESEARCH
Demonstrates knowledge, skills, and competence in Research

Rating: _________

1. Demonstrates knowledge, skills, and competence to critically evaluate research according to methods, procedures, practices, and attention to diversity and contextual variables ________
2. Demonstrates knowledge, skills, and competence to use existing knowledge in clinical practice and other professional activities, taking into consideration issues of diversity ______
3. Demonstrates ability to locate, appraise, and assimilate evidence from scientific studies on college mental health and local clinical data (trends in mental health issues in college populations, results from research comparing W&M students health related issues/needs to those of students in other universities, etc.)______
4. Appropriately utilizes scholarly work and applies scientific knowledge in the different roles assumed at the agency ______
5. Appropriately disseminates research information in presentations (case presentation, supervision presentation, research presentation), outreach events, seminars, consultation, teaching in practicum student seminar, etc.

Summary Comments:

II. ETHICAL AND LEGAL STANDARDS
Demonstrates knowledge, skills, and competence in Ethical and Legal Standards

Rating: _________

1. Demonstrates ability to monitor their behavior to conduct themselves following the APA Ethical Principles and Code of Conduct as well as APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change of the American Psychological Association ______
2. Demonstrates knowledge and ability to follow the Virginia Law regarding the ethical practice of Psychologists________

3. Demonstrates knowledge regarding the relevant laws, regulations, rules, policies, standards and guidelines governing health service psychology ______
4. Understands and follows the Center's policies and procedures ______
5. Recognized ethical dilemmas and apply ethical decision-making processes ______
6. Appropriately seeks consultation when ethical or legal issues require resolution
7. Behaves in an ethical manner in all professional activities ______
8. Maintains accurate documentation records ______

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY

Demonstrates knowledge, skills, and competence as it relates to addressing diversity in all professional activities

Rating: _________

1. Incorporates theoretical and research knowledge on multiculturalism ______
2. Demonstrates sensitivity of how self and others are shaped by individual and cultural diversity and the cultural context and sub-cultures in which people function.
3. Integrates knowledge of self and others as cultural beings across professional roles and functions ______
4. Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases affect how they understand and interact with people different from themselves ___
5. Demonstrates awareness of own and others' multiple identities and the intersection of these identities ______
6. Demonstrates sensitivity to issues of power and privilege as they interact with others ______
7. Demonstrates an understanding of the manner in which people of diverse cultures and belief systems perceive mental health issues and interventions ______
8. Understands oppression and discrimination in society and other environments including university settings, and understands how these environments are microcosms for the larger society___________________

Summary Comments:

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS (Sections A-B)

Demonstrates the development of a professional identity congruent with Health Service Psychology

Rating: _________

A: Behaves in ways that reflect the values and attitudes of Health Service psychology.

Rating: _________

1. Demonstrates integrity, accountability, a professional demeanor, eagerness/readiness to learn, and concern for others, across the different roles assumed at the agency ______
2. Engages in self-reflection regarding personal and professional functioning ______
3. Demonstrates ability to monitor their reactions and behaviors ______
4. Demonstrates ability to recognize areas of strength and areas of growth ______
5. Seeks the means to ameliorate the impact of potential problems on the delivery of services, including engagement in activities to maintain and improve performance, well-being, and professional effectiveness ______
6. Uses diverse resources for professional development including staff resources (supervision and consultation), workshops, conferences, and/or professional organizations ______
7. Responds professionally in increasingly complex situations with a greater degree of independence as the internship year progresses ______

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _________

1. Demonstrates effective preparation for supervision ______
2. Demonstrates receptiveness to new ideas and approaches ______
3. Actively seeks and demonstrates openness to/in supervision _____
4. Demonstrates receptiveness to feedback about counseling deficits/strengths _____
5. Demonstrates effective use of what is learned in future sessions ______

6. Demonstrates openness to looking at own issues ______
7. Demonstrates awareness of multicultural issues within the supervisory relationship ______
8. Demonstrates ability to seek supervisory help resulting from a self-perceived need ______

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _________

1. Develops and maintains effective relationships with a wide range of individuals including colleagues, peers, supervisors, supervisees, other staff/professionals, parents, communities, organizations, and those receiving professional services, ______
2. Produces and comprehends oral, nonverbal, and written communications, demonstrating knowledge and understanding of professional language and concepts ______
3. Demonstrates effective communication and interpersonal skills, understanding the impact of their interpersonal and communication practices ______
4. Demonstrates effective communication and interpersonal skills being sensitive to issues of power and privilege ______
5. Demonstrates ability to manage difficult communication well ______
6. Appropriately manages emotional reactions while communicating/interacting with others _____

Summary Comments:

VI. ASSESSMENT

Demonstrates competence in conducting intake and objective assessment consistent with the scope of Health Service Psychology.

Rating: _________

1. Demonstrates ability to conduct initial assessments, write comprehensive intake reports, and make appropriate treatment recommendations and referrals based on client's clinical needs, diversity characteristics, and contextual variables ______
2. Considers the biological, cognitive, behavioral, developmental, and sociocultural components of health and illness in initial and other assessments ______
3. Demonstrates ability to appropriately select assessment instruments and interpret test results based on clients' clinical needs and diversity characteristics ______
4. Demonstrates ability to collect relevant data using multiple sources and methods appropriate to the goals and questions of the assessment ______

5. Demonstrates ability to accurately interpret assessment data according to professional standards and guidelines ______
6. Demonstrates ability to use assessment data to inform case conceptualization, intervention, and recommendations ______
7. Demonstrates ability to use assessment instruments and interpret assessment data being sensitive to clients' cultural identity(ies) ______
8. Demonstrates ability to integrate assessment data into comprehensive, culturally sensitive reports ______
9. Accurately, effectively, timely, and sensitively communicates (orally and/or in writing) the results and implications of the assessment ______

Summary Comments:

VII. INTERVENTION (Sections A-D)
Demonstrates knowledge and skill in implementing interventions for prevention and treatment consistent with the scope of Health Service Psychology. The level of intervention includes those directed at an individual, a group, an organization, a community, or other systems level

Overall Rating: _________

A: Demonstrates ability to provide effective services to a wide range of individual clients with diverse presenting concerns

Rating: _________

1. Demonstrates ability to establish and maintain an effective therapeutic relationship with diverse clients presenting with different type of concerns. ______
2. Demonstrates ability to gather data and to facilitate exploration ______
3. Demonstrates ability to integrate data into meaningful conceptualizations ______
4. Demonstrates ability to conceptualize using different theoretical orientations ______
5. Demonstrates ability to formulate treatment strategies that integrate theory, current scientific literature, assessment findings, diversity and contextual variables ______
6. Demonstrates sensitivity, awareness, and skills regarding diversity issues in clinical work ______
7. Demonstrates ability to integrate diversity issues into their case conceptualization, treatment planning, and interventions ______
8. Appropriately utilizes complementary approaches/services based on client need and diversity/cultural/contextual variables ______
9. Utilizes multicultural guidelines to inform all aspects of the intervention process ______
10. Demonstrates ability to handle theirs and their client's affect ______
11. Demonstrates ability to use the self as a therapeutic tool ______
12. Demonstrates effective timing of interventions with their individual clients ______
13. Demonstrates ability to use Empirically-Validated treatments ______

14. Demonstrates flexibility in therapeutic techniques, including the ability to adapt evidence-based approaches, based on assessment data, treatment goals, diversity and contextual variables, and evaluation of intervention effectiveness ______
15. Demonstrates ability to accurately diagnose clients ______
16. Demonstrates ability to handle termination issues ______
17. Maintains accurate documentation records ______

Summary Comments:

B:	**Demonstrates ability to assess <u>crisis</u> situations and provide effective interventions** Rating _________

1. Demonstrates ability to assess the intensity/magnitude of clients' crisis situation ______
2. Demonstrates ability to thoroughly assess suicidality; this assessment is informed by the scientific literature in regards to safety assessment ______
3. Demonstrates ability to use appropriate interventions in crisis situations according to best practices and the scientific literature ______
4. Demonstrates ability to adapt intervention strategies evaluating effectiveness, issues of diversity, and contextual variables ______
5. Demonstrates ability to handle their affect in response to the client's affect or the nature of the crisis presented ______
6. Demonstrates ability to appropriately consult while assessing and responding to crises ______
7. Maintains accurate documentation records ______

Summary Comments:

C:	**Demonstrates knowledge and skill in <u>group</u> therapy work** Rating: _________

1. Demonstrates ability to refer appropriate clients to groups _____
2. Demonstrates effective use of pre-group interviews _____
3. Builds rapport and cohesion in group work _____
4. Demonstrates ability to integrate data into meaningful conceptualizations for group members and for the group as a whole _____

5. Demonstrates ability to integrate theory and practice of group work ______
6. Demonstrates effective timing of interventions according to the group stage _____
7. Demonstrates ability to integrate diversity issues into their conceptualization, treatment planning, and interventions in group ______
8. Demonstrates ability to formulate treatment strategies based on group dynamics ______
9. Implements interventions informed by current group therapy scientific literature/ evidence-based treatment______
10. Demonstrates collaboration and effective communication with group co-leader _____
11. Demonstrates receptiveness to feedback about group counseling skills and ability to implement feedback and new ideas into group therapy practice _____
12. Demonstrates ability to handle their own and the group's affect ______
13. Maintains accurate documentation records ______
14. Demonstrates ability to handle termination issues of group work ______

Summary Comments:

D: Demonstrates ability to plan and conduct outreach programs that are culturally and developmentally appropriate

Rating: __________

1. Demonstrates consideration of needs of the target audience ______
2. Demonstrates ability to engage the audience in an effective manner ______
3. Demonstrates knowledge about the content area ______
4. Demonstrates ability to include up to date research information about the content area ______
5. Demonstrates sensitivity, awareness, and skills regarding diversity in their provision of outreach services ______
6. Presents in a manner that is inclusive and/or affirming of issues of diversity ______
7. Demonstrates flexibility including the ability to adapt the presentation in response to the needs of the audience ______

Summary Comments:

VIII. CLINICAL SUPERVISION

Demonstrates ability to establish a supervisory relationship that has the purpose of enhancing the professional functioning of a practicum student and monitoring the quality of the professional services offered by this trainee

Rating: _________

1. Demonstrates knowledge of supervision models and practices ______
2. Applies knowledge scientific/scholarly work in the supervision of a practicum trainee ______
3. Demonstrates commitment to supervision ______
4. Demonstrates ability to establish and maintain a safe and supportive supervisory relationship ______
5. Demonstrates respect and offers support for their supervisee ______
6. Demonstrates ability to monitor their supervisee professional functioning and quality of services provided ______
7. Demonstrates ability to offer ongoing/formative feedback and suggestions about their supervisees' clinical work ______
8. Assists with case conceptualizations ______
9. Demonstrates ability to provide effective formative and summative feedback through mid and end of semester evaluations of their supervisees' professional functioning ______
10. Demonstrates cultural sensitivity in the supervisory relationship with their supervisees ______

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _________

1. Demonstrates knowledge and respect for the roles and perspectives of other professions ______
2. Applies knowledge about other professions in consultation with other health care professionals, inter-professional groups, and/or systems ______
3. Appropriately consults with peers/other trainees and senior staff ______
4. Demonstrates ability to effectively communicate and consult with parents/family members while respecting client's confidentiality/scope of signed releases of information ______
5. Demonstrates sensitivity, awareness, and skills regarding diversity in their provision of consultation services ______

COLLEGE OF WILLIAM & MARY COUNSELING CENTER
INTERN EVALUATION OF THE TRAINING DIRECTOR

Please rate the following statements using the scale below:

5 = Excellent – training director performed above and beyond expectations.
4 = Very Good
3 = Average – training director performed at an adequate and expected level.
2 = Below Average
1 = Unacceptable – training director performed insufficiently
NA

The Training Director

1.	Was responsive to the needs of the intern group.	1	2	3	4	5
2.	Was available/approachable	1	2	3	4	5
3.	Was supportive/encouraging	1	2	3	4	5
4.	Was responsive to my needs.	1	2	3	4	5
5.	Established a trusting environment	1	2	3	4	5
6.	Was clear in communicating expectations and responsibilities of interns.	1	2	3	4	5
7.	Presented materials in a timely fashion.	1	2	3	4	5
8.	Is knowledgeable about clinical issues	1	2	3	4	5
9.	Is knowledgeable about training issues	1	2	3	4	5
10.	Is respectful of diversity/ individual differences	1	2	3	4	5
11.	Was skilled in dealing with conflicts and disagreements within the intern cohort.	1	2	3	4	5
12.	Was skilled in offering me constructive feedback.	1	2	3	4	5
13.	Was flexible and open to feedback.	1	2	3	4	5
14.	Effectively advocated for trainees/training needs	1	2	3	4	5

15. Allowed time address immediate concerns or personal issues.	1	2	3	4	5
16. Was effective as a liaison to other staff in the agency.	1	2	3	4	5
17. Appropriately supported my autonomy.	1	2	3	4	5
18. Was able to appropriately confront	1	2	3	4	5
19. Kept interns apprised of changes within the agency and the university.	1	2	3	4	5
20. Supported me in my professional development.	1	2	3	4	5
21. Was an effective professional mentor.	1	2	3	4	5

Comments

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Minimum Level of Achievement & Passing Criteria

Per the Commission on Accreditation (CoA) Implementing Regulation C-8 I. Profession-Wide Competencies, programs are required to establish a Minimum Level of Achievement (MLA by which Interns are considered ready for entry level practice in the field/meet passing criteria of the internship. As such, evaluations associated with profession-wide competencies use the following definition and rating scales to determine if an Intern has met the MLA:

MLA/Passing Criteria: An average score of 4 is required on each of the overall nine professional competencies and a minimum score of 3 on any given item within each competency area by the last evaluation of the competency area during the internship.

Rating Scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

Ratings on evaluations are reflective of the expected developmental progress at the time of the evaluation. For example, at the beginning of the year, interns are evaluated according to what the profession describes as “readiness to enter internship” and at the end of year based on the competencies expected for “entry level practice.” Given this framework, interns could make progress on any given aim/competency and receive the same score on two different evaluation periods considering what is developmentally expected at that point in the internship year. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee’s training, progress, and how skills can be acquired or improved.

A score of 1 or 2 on any given item should be accompanied by specific data or description in the narrative/comment section addressing why the intern is receiving such rating for that competency.

COLLEGE OF WILLIAM & MARY COUNSELING CENTER
INTERN EVALUATION OF INTERNSHIP EXPERIENCE

Date______________________

We would like your feedback on your internship experience. Please review the main goals and objectives of the internship as described below and provide your feedback on A. the degree to which the training opportunity was available, B. the degree you felt the objectives (under each goal) were met for you, C. your comments about the strengths and limitations of the programs and staff relating to each objective under each goal. Please consider the specific competencies under each objective in your rating. Please feel free to use the space for comments to add specific feedback.

Note: Your comments will be used by the CC staff to evaluate the training program. They may be used in agency reports as well as in the self-study for APA accreditation.

Please use the following scale for your rating:

5=excellent
4=good
3=adequate
2=poor
1=unsatisfactory

GOALS OF THE INTERNSHIP

I. RESEARCH

1. Demonstrates knowledge, skills, and competence to critically evaluate research according to methods, procedures, practices, and attention to diversity and contextual variables
2. Demonstrates knowledge, skills, and competence to use existing knowledge in clinical practice and other professional activities, taking into consideration issues of diversity
3. Demonstrates ability to locate, appraise, and assimilate scientific evidence on college mental health and local clinical data (trends in mental health issues in college populations, results from research comparing W&M students health related issues/needs to those of students in other universities, etc.)

4. Appropriately utilizes scholarly work and applies existing evidence in the different roles assumed at the agency
5. Appropriately disseminates research information in presentations (case presentation, supervision presentation, research presentation), outreach events, seminars, consultation, teaching in practicum student seminar, etc.

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

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B. The degree objective was met for you 5 4 3 2 1

Comments:

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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

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II. ETHICAL AND LEGAL STANDARDS
Demonstrates knowledge, skills, and competence in Ethical and Legal Standards

1. Demonstrates ability to monitor their behavior to conduct themselves following the APA Ethical Principles and Code of Conduct as well as APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change of the American Psychological Association
2. Demonstrates knowledge and ability to follow the Virginia Law regarding the ethical practice of Psychologists
3. Demonstrates knowledge regarding the relevant laws, regulations, rules, policies, standards and guidelines governing health service psychology
4. Understands and follows the Center's policies and procedures
5. Recognized ethical dilemmas and apply ethical decision-making processes
6. Appropriately seeks consultation when ethical or legal issues require resolution
7. Behaves in an ethical manner in all professional activities
8. Maintains accurate documentation records

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

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B. The degree objective was met for you 5 4 3 2 1

Comments:

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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY
Demonstrates knowledge, skills, and competence as it relates to addressing diversity in all professional activities

1. Incorporates theoretical and research knowledge on multiculturalism
2. Demonstrates sensitivity of how self and others are shaped by individual and cultural diversity and the cultural context and sub-cultures in which people function.
3. Integrates knowledge of self and others as cultural beings across professional roles and functions
4. Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases affect how they understand and interact with people different from themselves
5. Demonstrates awareness of own and others' multiple identities and the intersection of these identities
6. Demonstrates sensitivity to issues of power and privilege as they interact with others
7. Demonstrates an understanding of the manner in which people of diverse cultures and belief systems perceive mental health issues and interventions
8. Understands oppression and discrimination in society and other environments including university settings, and understands how these environments are microcosms for the larger society

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

B. The degree objective was met for you 5 4 3 2 1

Comments:

C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS (Sections A-B)
Demonstrates the development of a professional identity congruent with Health Service Psychology

A: Behaves in ways that reflect the values and attitudes of Health Service psychology.

1. Demonstrates integrity, accountability, a professional demeanor, eagerness/readiness to learn, and concern for others, across the different roles assumed at the agency
2. Engages in self-reflection regarding personal and professional functioning
3. Demonstrates ability to monitor their reactions and behaviors
4. Demonstrates ability to recognize areas of strength and areas of growth
5. Seeks the means to ameliorate the impact of potential problems on the delivery of services, including engagement in activities to maintain and improve performance, well-being, and professional effectiveness
6. Uses diverse resources for professional development including staff resources (supervision and consultation), workshops, conferences, and/or professional organizations
7. Responds professionally in increasingly complex situations with a greater degree of independence as the internship year progresses

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

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B. The degree objective was met for you 5 4 3 2 1

Comments:

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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

B: Demonstrates ability to <u>effectively use supervision</u>

1. Demonstrates effective preparation for supervision
2. Demonstrates receptiveness to new ideas and approaches
3. Actively seeks and demonstrates openness to/in supervision
4. Demonstrates receptiveness to feedback about professional deficits/strengths
5. Demonstrates effective use of what is learned in future sessions
6. Demonstrates openness to looking at own issues
7. Demonstrates awareness of multicultural issues within the supervisory relationship
8. Demonstrates ability to seek supervisory help resulting from a self-perceived need

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

B. The degree objective was met for you 5 4 3 2 1

Comments:

C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

1. Develops and maintains effective relationships with a wide range of individuals including colleagues, peers, supervisors, supervisees, other staff/professionals, parents, communities, organizations, and those receiving professional services,
2. Produces and comprehends oral, nonverbal, and written communications, demonstrating knowledge and understanding of professional language and concepts
3. Demonstrates effective communication and interpersonal skills, understanding the impact of their interpersonal and communication practices
4. Demonstrates effective communication and interpersonal skills being sensitive to issues of power and privilege

5. Demonstrates ability to manage difficult communication well
6. Appropriately manages emotional reactions while communicating/interacting with others

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

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B. The degree objective was met for you 5 4 3 2 1

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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

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VI. ASSESSMENT
Demonstrates competence in conducting intake and objective assessment consistent with the scope of Health Service Psychology.

1. Demonstrates ability to conduct initial assessments, write comprehensive intake reports, and make appropriate treatment recommendations and referrals based on client's clinical needs, diversity characteristics, and contextual variables
2. Considers the biological, cognitive, behavioral, developmental, and sociocultural components of health and illness in initial and other assessments
3. Demonstrates ability to appropriately select assessment instruments and interpret test results based on clients' clinical needs and diversity characteristics
4. Demonstrates ability to collect relevant data using multiple sources and methods appropriate to the goals and questions of the assessment
5. Demonstrates ability to accurately interpret assessment data according to professional standards and guidelines
6. Demonstrates ability to use assessment data to inform case conceptualization, intervention, and recommendations
7. Demonstrates ability to use assessment instruments and interpret assessment data being sensitive to clients' cultural identity(ies)
8. Demonstrates ability to integrate assessment data into comprehensive, culturally sensitive reports
9. Accurately, effectively, timely, and sensitively communicates (orally and/or in writing) the results and implications of the assessment

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

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B. The degree objective was met for you 5 4 3 2 1

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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:
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VII. INTERVENTION (Sections A-D)

Demonstrates knowledge and skill in implementing interventions for prevention and treatment consistent with the scope of Health Service Psychology. The level of intervention includes those directed at an individual, a group, an organization, a community, or other systems level

A: Demonstrates ability to provide effective services to a wide range of individual clients with diverse presenting concerns

1. Demonstrates ability to establish and maintain an effective therapeutic relationship with diverse clients presenting with different type of concerns.
2. Demonstrates ability to gather data and to facilitate exploration
3. Demonstrates ability to integrate data into meaningful conceptualizations
4. Demonstrates ability to conceptualize using different theoretical orientations
5. Demonstrates ability to formulate treatment strategies that integrate theory, current evidence-based information, assessment findings, diversity and contextual variables
6. Demonstrates sensitivity, awareness, and skills regarding diversity issues in clinical work
7. Demonstrates ability to integrate issues of identity into their case conceptualization, treatment planning, and interventions

8. Appropriately utilizes complementary approaches/services based on client need and diversity/cultural/contextual variables
9. Utilizes multicultural guidelines to inform all aspects of the intervention process
10. Demonstrates ability to handle theirs and their client's affect
11. Demonstrates ability to use the self as a therapeutic tool
12. Demonstrates effective timing of interventions with their individual clients
13. Demonstrates ability to use Empirically-Validated treatments
14. Demonstrates flexibility in therapeutic techniques, including the ability to adapt evidence-based approaches, based on assessment data, treatment goals, diversity and contextual variables, and evaluation of intervention effectiveness
15. Demonstrates ability to accurately diagnose clients
16. Demonstrates ability to handle termination issues
17. Maintains accurate documentation records

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:
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B. The degree objective was met for you 5 4 3 2 1

Comments:
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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

____

B: Demonstrates ability to assess crisis situations and provide effective interventions

1. Demonstrates ability to assess the intensity/magnitude of clients' crisis situation
2. Demonstrates ability to use evidence-based methodology to conduct suicide risk assessment
3. Demonstrates ability to use appropriate interventions in crisis situations according to best practices and evidence-based information
4. Demonstrates ability to adapt intervention strategies evaluating effectiveness, issues of diversity, and contextual variables
5. Demonstrates ability to handle their affect in response to the client's affect or the nature of the crisis presented
6. Demonstrates ability to appropriately consult while assessing and responding to crises
7. Maintains accurate documentation records

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

B. The degree objective was met for you 5 4 3 2 1

Comments:
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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

C: Demonstrates knowledge and skill in group therapy work

1. Demonstrates ability to refer appropriate clients to groups
2. Demonstrates effective use of pre-group interviews
3. Builds rapport and cohesion in group work
4. Demonstrates ability to integrate data into meaningful conceptualizations for group members and for the group as a whole
5. Demonstrates ability to integrate theory and practice of group work
6. Demonstrates effective timing of interventions according to the group stage
7. Demonstrates ability to integrate diversity issues into their conceptualization, treatment planning, and interventions in group
8. Demonstrates ability to formulate treatment strategies based on group dynamics
9. Implements interventions informed by current group therapy scientific literature/ evidence-based treatment
10. Demonstrates collaboration and effective communication with group co-leader

11. Demonstrates receptiveness to feedback about group counseling skills and ability to implement feedback and new ideas into group therapy practice
12. Demonstrates ability to handle their own and the group's affect
13. Maintains accurate documentation records
14. Demonstrates ability to handle termination issues of group work

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:
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B. The degree objective was met for you 5 4 3 2 1

Comments:
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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:
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D: Demonstrates ability to plan and conduct <u>outreach</u> programs that are culturally and developmentally appropriate

1. Demonstrates consideration of needs of the target audience
2. Demonstrates ability to engage the audience in an effective manner
3. Demonstrates knowledge about the content area
4. Demonstrates ability to include up to date research information about the content area
5. Presents in a manner that is inclusive and/or affirming of issues of diversity
6. Demonstrates flexibility including the ability to adapt the presentation in response to the needs of the audience

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

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B. The degree objective was met for you 5 4 3 2 1

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C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

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VIII. CLINICAL SUPERVISION
Demonstrates ability to establish a supervisory relationship that has the purpose of enhancing the professional functioning of a practicum student and monitoring the quality of the professional services offered by this trainee

1. Demonstrates knowledge of supervision models and practices
2. Applies knowledge scientific/scholarly work in the supervision of a practicum trainee
3. Demonstrates commitment to supervision
4. Demonstrates ability to establish and maintain a safe and supportive supervisory relationship
5. Demonstrates respect and offers support for their supervisee
6. Demonstrates sensitivity to issues of power/privilege
7. Demonstrates ability to monitor their supervisee professional functioning and quality of services provided
8. Demonstrates ability to offer ongoing/formative feedback and suggestions about their supervisees' clinical work
9. Provides support for the development of case conceptualizations
10. Demonstrates ability to provide effective formative and summative feedback through mid and end of semester evaluations of their supervisees' professional functioning
11. Demonstrates cultural sensitivity in the supervisory relationship with their supervisees

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:

____
____
____
____
____

B. The degree objective was met for you 5 4 3 2 1

Comments:

C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

1. Demonstrates knowledge and respect for the roles and perspectives of other professions and professionals
2. Applies knowledge about other professions in consultation with other health care professionals, inter-professional groups, and/or systems
3. Appropriately consults with peers/other trainees and senior staff

4. Demonstrates ability to effectively communicate and consult with parents/family members while respecting client's confidentiality/scope of signed releases of information
5. Demonstrates sensitivity, awareness, and skills regarding diversity in their provision of consultation services

A. Degree training opportunities were available to meet this objective 5 4 3 2 1

Comments:
____

B. The degree objective was met for you 5 4 3 2 1

Comments:
____

C. Strengths and limitations. The quality of the training in meeting this objective was 5 4 3 2 1

Comments:
____

In order to evaluate its efforts in recruiting diverse interns and to make changes as appropriate, the program would like to learn more about your experience with recruitment, and the internship as a whole, in regards to issues of diversity.

1. Do you identify with an underrepresented/marginalized group? _____Yes _____No

2. How did you learn about this internship site? (e.g., APPIC Directory on-line search, Listserv e-mail, APA Minority Fellows, etc.)

   ____
   ____

3. I perceived this internship site to be sensitive to issues of social justice, diversity, and inclusion:

   When searching/applying for internship sites:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

   When interviewing with this internship site:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

   During the internship training as a whole:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Comments:
____
____
____
____
____
____
____
____

4. The way in which this internship site advertised its values towards social justice, diversity, and inclusion influenced my decision to apply to the program:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

5. Which professional organizations for individuals of underrepresented/marginalized groups would you like to see this site advertise the internship program with in the future?

____
____
____

End of Internship Checklist

1. Internship Application and Acceptance Letter _____
2. Self-Assessments:
    a. Beginning of year_____
    b. End of year_____
3. Evaluation of Intern by Supervisor(s):
    a. Evaluation of Intern by Supervisor:
        i. 1st quarter _____
        ii. 2nd quarter_____
        iii. 3rd quarter_____
        iv. End of Internship Evaluation_____
    b. Group Supervisor(s)
        i. Mid-Fall _____
        - If applicable 2nd group___

        ii. End Fall_____
        - If applicable 2nd group____

        iii. Mid-Spring_____
        - If applicable 2nd group____

        iv. End Spring_____
        - If applicable 2nd group____

4. Evaluation of Performance in Seminar:
    a. Diversity Seminar: Fall_____ Spring____
    b. Supervision Seminar: Fall___ Spring____
    c. Supervision Presentation Evaluation _____
5. Evaluations of Seminars by Interns:
    a. Diversity Seminar: _______

    b. Supervision Seminar: _____
    c. Integrated Seminar: ______
6. Outreach Presentation:
    a. Evaluation of Outreach Presentation_____
    b. Copy of Presentation in file _____
7. Evaluations by Supervisor of Supervision
    a. Mid-Semester Spring Evaluation _____
    b. End of Semester Spring Evaluation_____
8. Evaluations of Intern Supervisors by Prac Supervisees
    a. Mid-Semester Evaluation of Intern Supervisor by Supervisee_____
    b. End of Semester Evaluation of Intern Supervisor by Supervisee___
9. Case presentation reports and Evaluations
    a. Fall presentation_____
    b. Spring presentation_____
    c. Evaluations (Fall & Spring) ____
10. Practicum Seminar Teaching Presentation Evaluation _____
11. Evaluations of Supervisors by Intern:
    a. Evaluation of Individual Supervisor by Intern:
        i. 1st quarter _____
        ii. 2nd quarter_____
        iii. 3rd quarter_____
        iv. End of Internship Evaluation_____
    b. Group Supervisor(s)
        i. Mid fall _____, _____(2nd supervisor if applicable)
        ii. End fall_____, ______(2nd supervisor if applicable)
        iii. Mid Spring_____, ______(2nd supervisor if applicable)
        iv. End Spring_____, ______(2nd supervisor if applicable)

    c. Supervisor of Supervision
        i. Mid-Semester____
        ii. End of Semester____
12. Summer Project_____
13. Program Evaluation_____

14. Research Presentation Evaluations_____
15. Passing Criteria Form _____
16. Hours log _____
17. Evaluation of Internship Training_____
18. Evaluation of the Training Director_____
19. Miscellaneous _____
20. Certificate of Completion _____

_____________________________ __________

Intern Signature Date

_____________________________ __________

Primary Supervisor Signature Date

_____________________________ __________

Training Director Signature Date

Passing Criteria

Competencies	Measured by	Passing Criter	Criteria Met
I. **RESEARCH**	**Evaluation of Psychology Interns by Supervisor Form** Supervisors integrate information from digital recordings, supervision discussions, case/supervision/outreach presentations, supervisor meetings ' feedback, etc. to complete the evaluation form.	**Minimum average of 4.0 in the overall competency and a 3.0 or above on all of the items evaluated under that competency, on the final evaluation of the internship year.**	
II. **ETHICAL AND LEGAL STANDARDS**			
III. **INDIVIDUAL AND CULTURAL DIVERSITY**			
IV. **PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS**			
V. **COMMUNICATION AND INTERPERSONAL SKILLS**			
VI. **ASSESSMENT**			
VII. **INTERVENTION** A. Individual Therapy B. Crisis Intervention C. Group Therapy D. Outreach Programming			A. ___ B. ___ C. ___ D. ___
VIII. **SUPERVISION**			
IX. **CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS**			

______________________ ________

Training Director **Date**

DUE PROCESS AND GRIEVANCE PROCEDURES FOR PSYCHOLOGY INTERNS

The following guidelines have been drawn from multiple sources including:

Lamb, D.H., Presser, N., Pfost, K., Baum, M., Jackson, V.R., & Jarvis, P. (1987). Confronting professional impairment during internship: Identification, due process, and remediation. *Professional Psychology: Research and Practice, 18,* 597-603.

Lamb, D.H., Cochran, D.H., Jackson, V.R. (1995). Training and organizational issues associated with identifying and responding to intern impairment. *Professional Psychology: Research and Practice, 22*(4), 291-296.

Texas A&M University Student Counseling Services Due Process and Grievance Procedures for Psychology Interns.

Texas State University Counseling Center Interns Evaluation, Review and Grievance Procedures. Arizona State University Counseling and Consultation Evaluation Procedures.

General Guidelines for Due Process

Due process ensures that judgments or decisions made by the training program about interns are not arbitrary or personally biased. The training program has adopted specific evaluation procedures which are applied to all interns. The appeals procedures presented below are available to the intern so that the intern has ample opportunity to ensure fairness is involved in the decision-making process.

<u>General due process guidelines include</u>:

1. presenting to interns, in writing, the program's expectations in regards to professional functioning at the outset of training;
2. stipulating the procedures for evaluation, including when, how, and by whom evaluations will be conducted;
3. using input from multiple professional sources when making decisions or recommendations regarding the intern performance;
4. specifying the definition of "problem behavior."
5. articulating the various procedures and actions involved in making decisions regarding competent functioning and deficiencies;
6. communicating, early and often, with graduate programs about the performance of interns while on internship;
7. methods for instituting a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies;
8. providing the intern with a written statement of procedural policy describing how the intern may appeal the program's actions or decisions;
9. ensuring that interns have a reasonable amount of time to respond to any action(s) taken by the program; and
10. documenting in writing, the action(s) taken by the program and the rationale to all relevant parties (e.g., the intern's academic advisor or training director, intern supervisor).

EXPECTATIONS OF PSYCHOLOGY INTERNS

With regard to the intern behavior and performance during the internship experience, the general expectations of the training program are that the intern will:

- Practice within the bounds of the APA Ethical Code of Conduct (www.apa.org/ethics/)
- Practice within the bounds of the laws and regulations of the State of Virginia;
- Practice in a manner that conforms to the professional standards of The College of William & Mary and the Counseling Center.
- Fulfill the internship requirements established by the W&M Counseling Center

I. The Evaluation Process

In accordance with our training philosophy, supervisors provide ongoing feedback to interns to assist in their professional development. It is important for interns to understand that communications between interns and supervisors are not confidential. However, as the supervisory relationship is an intimate one in nature, supervisors will use discretion when deciding what is appropriate and necessary to communicate to other supervisors and the Training Committee.

Each intern receives two hours per week of one-on-one supervision from their individual supervisor(s). Interns receive additional supervision of core experiential component activities. In the context of these supervisory relationships, interns receive ongoing feedback regarding their professional strengths and areas/skills in need of development.

Interns are supervised by experienced practitioners in the mental health field. Primary individual supervision is provided by psychologists licensed in the Commonwealth of Virginia. Formal evaluations within the individual supervision context occur quarterly. At these intervals, training staff may pool input regarding the performance of the interns in all aspects of their training. Evaluations are shared with the intern's graduate program as necessitated by remediation plan or academic program requirements.

The Director of Training will meet with the intern cohort as a group and individually throughout the training program in order to provide opportunities to discuss how the training experience is progressing. In addition, interns may request to meet at any time with the Director of Training or Counseling Center Director to discuss any matters of concern, including those related to feedback and evaluation.

Evaluation Processes include:

1. Ongoing Feedback

Staff members involved in the training program are responsible for providing ongoing feedback to interns regarding their strengths, areas for growth, and progress towards successful completion of the internship year.

2. Supervisor Meetings

During supervisor/training committee meetings, training staff share observations regarding interns' skills and areas for growth. Feedback is based upon all aspects of the intern's training experiences, including: reports by all clinical supervisors, case presentations, informal consultations regarding cases, collaboration during team days, observations by seminar leaders, and observations of interdisciplinary communication and professional behavior. The purpose of this process is to ensure an integrated approach towards developing the interns' competencies. Interns may be invited to supervisors/training committee meetings as a way to provide opportunities for open, direct communication and mutual feedback.

3. Written Evaluation

Written evaluation forms are used to provide feedback and document the intern's clinical skills and professional development. Individual supervision written evaluations occur quarterly and are compiled by

each of the intern's primary individual supervisors. Each supervisor meets with the intern to discuss the evaluation, and all sign it to indicate that the evaluation has been reviewed. The formal evaluations become a part of the intern's permanent file. The intern is encouraged to maintain a copy of the evaluations for their own records.

4. Providing Evaluation

Interns are asked to reflect on their own progress and experience during the evaluation periods. They complete written evaluations of their supervisors after the supervisor has completed and reviewed the formal evaluation with the intern.

II. Determining Adequate Intern Performance

The training staff considers interns performance in profession-wide competencies (use of research, ethical and legal standards, professional values, attitudes and behaviors, communication and interpersonal skills, assessment, intervention, supervision, and consultation and inter-professional/interdisciplinary skills) in determining adequate performance.

Definition of "Learning need" and "Not meeting performance standards"

Any behavior that does not meet the standard for satisfactory functioning at the Counseling Center according to agency policies and procedures, training requirements and guidelines, or instruction by licensed clinical supervisor while operating under their license, can be categorized as "Learning need" or "Not meeting performance standards" depending on the following factors:

a) intent and impact regarding professional practice in psychology and delivery of services within this agency
b) Functioning as an agent or employee of the College of William and Mary and/or
c) Severity and seriousness of the behavior

A "learning need" can be defined as any of the following:

a) an intern's behavior that is identified as an important area for growth or focused learning.
b) Marginal competency in basic skills (as noted in the description of a score of "2" or below in the evaluation)
c) any behavior that is not consistent with the expected level of development for an intern
d) any behavior that doesn't change with feedback and/or time

Any member of the staff can identify a "learning need" at any time during the internship year, and upon consultation with the Training Director, this could result in a "growth plan." A learning need that does not change as a function of the growth plan could become an issue classified as "not meeting performance standards."

"Not meeting performance standards" can be defined as any of the following:

a) An inability and/or unwillingness to acquire and integrate professional standards into one's repertoire.
b) An inability to acquire professional skills and reach an accepted level of competency.
c) An inability to control personal stress, psychological dysfunction, or emotional reactions.
d) An inability or unwillingness to acknowledge, understand, or address problematic behavior when identified.
e) Quality of service delivered results in negative outcomes and/or harm for clients.
f) Problematic behavior impacts multiple areas of professional functioning.
g) Problematic behavior could have ramifications in ethics and legalities if not addressed.
h) Disproportionate amounts of resources are required to support intern functioning.
i) Intern's behavior does not change as a function of feedback, remediation efforts, or time.
j) Intern's behavior negatively affects WMCC public image or the image of the profession.

Problematic behavior that doesn't adequately improve through supervision, academics, or didactics could be attended to by the training committee with consultation from any entity which may be able to provide relevant remedies to adequately address the identified issue. These entities include but are not limited to professional standards, legal counsel, human resources, state licensing boards, professional consultants, national professional organizations, etc. Any such consultations will be documented and kept in a confidential file.

III. Procedures for Responding to Performance Concerns by an Intern

All trainees' progress during the year is regularly discussed in meetings including staff involved in the planning and implementation of the training program. Routine developmental issues that are the focus of training, seminars, and clinical supervision are often identified. Supervisors make every effort to manage these within the normal scope of training activities. At any time during the year, a CC staff member may determine some aspect(s) of an intern's performance as not meeting expected level of development ("learning need") or is inadequate ("Not meeting Performance Standards").

A. Procedures to address a "learning need" – growth plan

At any point during the training year any member of the training staff can identify a "learning need" and, through consultation with the Training Director, suggest a growth plan to help the intern develop a given competency. Similarly, an intern may request the development of a growth plan for their professional development. In either case, the trainee would be informed of the creation of the plan, a written plan would be developed, and the Supervisors Committee will be informed.

As stated above, a "learning need" that does not change as a function of the growth plan could become an issue classified as "Not meeting performance standards."

An intern has the opportunity to respond, in writing, to the growth plan if there is disagreement within 1 week of learning of the plan. The disagreement can be addressed with the Supervisors/Training Committee by providing a written statement and/or presenting a statement in person. Supervisors/Training Committee will then discuss the decision on whether to put the growth plan in effect by majority vote. In the event of a tie, the Training Director will make the tie-breaking decision.

B. Procedures used when an intern is "not meeting performance standards" - Remediation

At any point during the training year any member of the training staff can identify concerning behavior that may qualify as "not meeting performance standards." In this event, the following procedures will be initiated:

1. The intern will be notified in writing that a concern has been identified, what the concern is, and that a review of the concern is occurring among the Supervisors/Training Committee to determine a course of action. The intern can respond to the identified concern by providing a written statement and/or requesting to present a statement in person to the Supervisors/Training Committee

2. In discussing the identified issue(s) and considering the intern's statement (if one is given), the Supervisors/Training Committee will then determine the best course of action via majority vote. In the event of a tie, the Training Director will make the tie-breaking decision. The Supervisors/Training Committee may determine, that one or more of the following responses to the identified concern is warranted:

- **No Action Required or Written Growth Plan**

The identified issue does not warrant any further action or the behavior is either part of a normal developmental issue or a "learning need" that can be addressed in the course of ongoing supervision or a "growth plan." In such case, the supervisor and intern will be notified and recommendations to address the behavior may be included.

- **Written Remediation Plan**

The intern will be given a remediation plan specifying the following:

a. Description of the unsatisfactory behavior
b. Actions required to correct the unsatisfactory behavior (e.g. increasing supervision, changing the format, emphasis, and/or focus of supervision, recommending personal therapy and/or psychological assessment, reducing the intern's clinical or other work load and/or requiring specific academic course work or other forms of training)
c. Timeline for correction
d. Explanation of the procedure that will be used to determine whether satisfactory progress has been made
e. Possible consequences if the problem is not corrected

A copy will be sent to the intern's academic program.

- **Suspension of Clinical Privileges**

If it is determined that the intern's problem behavior might impact client welfare, the intern's clinical privileges may be suspended. The intern will be informed in writing about potential consequences resulting from suspension, which might include inability to complete program hours or other requirements. The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior
b. Actions required to correct the unsatisfactory behavior and restore clinical privileges
c. Timeline for correction
d. Explanation of the procedure that will be used to determine whether satisfactory progress has been made
e. Possible consequences if the problem is not corrected

A copy will be sent to the intern's academic program.

- **Administrative Leave**

The intern may be placed on administrative leave, accompanied by suspension of all duties and responsibilities in the agency. The intern will be informed in writing about potential consequences, which might include inability to complete program hours or other requirements. The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior
b. Actions required to correct the unsatisfactory behavior
c. Timeline for correction
d. Explanation of the procedure that will be used to determine whether satisfactory progress has been made
e. Possible consequences if the problem is not corrected

A copy will be sent to the intern's academic program.

- **Dismissal**

The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior and attempts to address it
b. Grounds for decision to dismiss

A copy will be sent to the intern's academic program.

Dismissal from the internship program might occur under the following circumstances:

a. It is determined that remediation cannot be successfully accomplished.
b. Serious violation of ethical standards
c. Serious violation of the WMCC policy and procedures
d. Serious violation of College Policy
e. Violation of federal or state statute
f. Any other condition that jeopardizes intern, client or staff welfare
g. Evidence that harm has been caused to client(s)

3. The Training Director and/or supervisor/staff member(s) will meet with the intern to review the outcome of Supervisors Committee decision; the intern may also request to meet with the Supervisors Committee as a whole. The intern may choose to accept the conditions or may choose to appeal the decision. The procedures for appealing the decision are presented in Section IV.

4. If the intern chooses not to appeal the Supervisors Committee's decision it is expected that the intern's performance will be reviewed no later than the next evaluation period or the timeline specified in the plan or letter.

5. If the intern's performance is deemed satisfactory at the next review period the intern will be informed in writing and no further action will be taken. A copy will be sent to the intern's academic program.

6. However, if the Supervisors Committee determines that there has not been sufficient improvement in the intern's performance to remove the conditions stipulated, the Supervisors Committee may adopt any one of the following measures:

1. Issue an extension of the remediation for a specified time period in which the Supervisors Committee will once again determine if sufficient improvement in the intern's behavior has been made.

2. Determine which further action is necessitated and follow outlined procedures (see actions in section B:3 above).

IV. Appeal Process regarding Remediation

A. If the intern wishes to appeal the decision made by the Training Director and supervisor/staff member(s) the intern must inform the Director of Training in writing and explain the grounds for the appeal within five (5) working days of receipt of the decision.

B. In no later than seven (7) working days of receipt of the appeal, an **Appeal Panel** will be formed. This panel will be chaired by the Training Director and consist of two staff members selected by the Training Director and two selected by the intern (5 total members). An appeal hearing will be conducted in which relevant information may be requested by and/or provided to the Appeal

Committee by the intern or other relevant training staff members. The intern retains the right to hear all facts with the opportunity to dispute or explain his or her behavior during the appeal hearing. The CC Director, who has final decision-making authority, will not sit on the Appeal Panel.

A. The Appeal Panel will render a decision, in writing, to accept or reject the initial action taken by the Supervisors/Training Committee. All decisions and recommendations by the Appeal Panel are determined by majority vote.
   i. In the event that the initial action is upheld, the Training Director will notify the intern in writing of this decision within 24 hours. If the intern chooses, the intern can exercise a final appeal to the CC Director. The intern's decision and rationale to exercise a final appeal to the CC Director should be expressed in writing to the Training Director within 48 hours of receipt of the Appeal Panel's decision. In this case, the Intern and Appeal Panel may provide all relevant information to the CC Director, who will render a final decision within 10 business days of notification of the Intern's final appeal request.
   ii. If the initial decision is overruled, the Training Director will notify the intern in writing of this decision within 24 hours. In the event that the Appeal Panel suggests any recommendations, the Training Director will include those in the written notification. The intern meets with the Training Director and supervisor/training staff members(s) who outline the new recommendations for action as determined by the Appeal Panel.

B. Once a final decision has been made, the intern, intern's academic program and other appropriate individuals are informed in writing of the action taken.

V. Intern Complaint Procedures

In order to protect the needs and rights of all interns, a complaint procedure has been developed. While it is hoped that any concerns or complaints can be discussed and resolved informally, a formal mechanism is appropriate in light of the power differential between interns and supervisors. In general, interns are encouraged to work actively to create an experience that fits their needs and interests and to work with the CC staff to ensure that their needs are met. Giving feedback to staff members/supervisors or the Director of Training is encouraged in order to create an environment that facilitates open dialogue and feedback, and supports professional development.

Complaints may be initiated in the following situations:

1. an intern has a complaint concerning any staff member/supervisor regarding a situation other than an evaluation,
2. an intern has a complaint concerning another intern or trainee,

Complaints Regarding Non-Training Issues:

1. The intern is encouraged to speak directly with the colleague involved for a resolution.

2. If the situation is not resolved, or if the intern prefers not to speak directly to a colleague one-on-one, the intern may inform the Training Director in order to either a) facilitate a discussion of the complaint with the identified colleague, b) address the issue directly with this staff member, or c) determine the appropriate procedure or office to address the complaint.

3. If the complaint is not or cannot be resolved in this manner then the intern may provide a written statement to the Supervisors Committee who will make recommendations for resolution.

4. If the complaint remains unresolved, the Director of the CC will meet with the Supervisros Committee to review and act upon the complaint.

All employees of the College of William Mary, including trainees, have the right to file formal grievances with the College. Guidelines for grievance procedures are outlined in W&M Human Resources Grievance Procedures. In the case of perceived harassment or discrimination (sexual, racial or other), which is not resolved through this procedure, the intern should refer to the W&M Sexual Harassment Policy

I ________________________________ have read, understood, and agreed with the Due Process and Grievance Procedures described above. I had the opportunity to discuss these processes with the Training Director and have questions answered.

_____________________ Date ______________________

Psychology Intern (print)

____

Psychology Intern (sign)

Intern ___________________________

GOALS FOR THE INTERNSHIP YEAR

Considering the different areas of strength and growth based on the self-evaluation, please describe what your major goals are for the internship year.
Please describe these goals in terms of the following aims:

I. RESEARCH

____
____
____
____
____

II. ETHICAL AND LEGAL STANDARDS

____
____
____
____
____
____

III. INDIVIDUAL AND CULTURAL DIVERSITY

____
____
____
____
____

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS

____
____
____
____
____

V. COMMUNICATION AND INTERPERSONAL SKILLS

VI. ASSESSMENT

VII. INTERVENTION

A. Individual Therapy

B. Crisis Intervention

C. Group Therapy

D. Outreach Programming

VIII. SUPERVISION

IX. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS

Self-Assessment: Beginning of Internship

William & Mary Counseling Center

Intern: ____ Date:___________

Please use this evaluation form to assess your skill in the following competencies. The goal of this self-assessment is to help you engage in self-reflection in terms of strengths and areas of growth and help your supervisor and others involved in training of interns be aware and intentional about your goals.

Please rate your skills using the following 5-point scale.

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

I. RESEARCH
Demonstrates knowledge, skills, and competence in Research

Rating: _________

1. Demonstrates knowledge, skills, and competence to critically evaluate research according to methods, procedures, practices, and attention to diversity and contextual variables ________
2. Demonstrates knowledge, skills, and competence to use existing knowledge in clinical practice and other professional activities, taking into consideration issues of diversity ______
3. Demonstrates ability to locate, appraise, and assimilate evidence from scientific studies on college mental health and local clinical data (trends in mental health issues in college populations, results from research comparing W&M students health related issues/needs to those of students in other universities, etc.)______
4. Appropriately utilizes scholarly work and applies scientific knowledge in the different roles assumed at the agency ______
5. Appropriately disseminates research information in presentations (case presentation, supervision presentation, research presentation), outreach events, seminars, consultation, teaching in practicum student seminar, etc.

Summary Comments:

II. ETHICAL AND LEGAL STANDARDS
Demonstrates knowledge, skills, and competence in Ethical and Legal Standards

Rating: _________

1. Demonstrates ability to monitor their behavior to conduct themselves following the APA Ethical Principles and Code of Conduct as well as APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change of the American Psychological Association ______

2. Demonstrates knowledge and ability to follow the Virginia Law regarding the ethical practice of Psychologists________
3. Demonstrates knowledge regarding the relevant laws, regulations, rules, policies, standards and guidelines governing health service psychology ______
4. Understands and follows the Center's policies and procedures ______
5. Recognized ethical dilemmas and apply ethical decision-making processes ______
6. Appropriately seeks consultation when ethical or legal issues require resolution
7. Behaves in an ethical manner in all professional activities ______
8. Maintains accurate documentation records ______

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY

Demonstrates knowledge, skills, and competence as it relates to addressing diversity in all professional activities

Rating: _________

1. Incorporates theoretical and research knowledge on multiculturalism ______
2. Demonstrates sensitivity of how self and others are shaped by individual and cultural diversity and the cultural context and sub-cultures in which people function.
3. Integrates knowledge of self and others as cultural beings across professional roles and functions ______
4. Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases affect how they understand and interact with people different from themselves ___
5. Demonstrates awareness of own and others' multiple identities and the intersection of these identities ______
6. Demonstrates sensitivity to issues of power and privilege as they interact with others ______
7. Demonstrates an understanding of the manner in which people of diverse cultures and belief systems perceive mental health issues and interventions ______
8. Understands oppression and discrimination in society and other environments including university settings, and understands how these environments are microcosms for the larger society__________________

Summary Comments:

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS (Sections A-B)
Demonstrates the development of a professional identity congruent with Health Service Psychology
Rating: _________

A: Behaves in ways that reflect the <u>values and attitudes of Health Service psychology</u>.
Rating: _________

1. Demonstrates integrity, accountability, a professional demeanor, eagerness/readiness to learn, and concern for others, across the different roles assumed at the agency ______
2. Engages in self-reflection regarding personal and professional functioning ______
3. Demonstrates ability to monitor their reactions and behaviors ______
4. Demonstrates ability to recognize areas of strength ______
5. Demonstrate ability to recognize areas of growth ______
6. Seeks the means to ameliorate the impact of potential problems on the delivery of services, including engagement in activities to maintain and improve performance, well-being, and professional effectiveness ______
7. Uses diverse resources for professional development including staff resources (supervision and consultation), workshops, conferences, and/or professional organizations ______
8. Responds professionally in increasingly complex situations with a greater degree of independence as the internship year progresses ______

Summary Comments:

B: Demonstrates ability to <u>effectively use supervision</u>

Rating: _________

1. Demonstrates effective preparation for supervision ______
2. Demonstrates receptiveness to new ideas and approaches ______

3. Actively seeks and demonstrates openness to/in supervision _____
4. Demonstrates receptiveness to feedback about counseling deficits/strengths _____
5. Demonstrates effective use of what is learned in future sessions ______
6. Demonstrates openness to looking at own issues ______
7. Demonstrates awareness of multicultural issues within the supervisory relationship ______
8. Demonstrates ability to seek supervisory help resulting from a self-perceived need ______

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _________

1. Develops and maintains effective relationships with a wide range of individuals including colleagues, peers, supervisors, supervisees, other staff/professionals, parents, communities, organizations, and those receiving professional services, ______
2. Produces and comprehends oral, nonverbal, and written communications, demonstrating knowledge and understanding of professional language and concepts ______
3. Demonstrates effective communication and interpersonal skills, understanding the impact of their interpersonal and communication practices ______
4. Demonstrates effective communication and interpersonal skills being sensitive to issues of power and privilege ______
5. Demonstrates ability to manage difficult communication well ______
6. Appropriately manages emotional reactions while communicating/interacting with others _____

Summary Comments:

VI. ASSESSMENT

Demonstrates competence in conducting intake and objective assessment consistent with the scope of Health Service Psychology.

Rating: __________

1. Demonstrates ability to conduct initial assessments, write comprehensive intake reports, and make appropriate treatment recommendations and referrals based on client's clinical needs, diversity characteristics, and contextual variables ______
2. Considers the biological, cognitive, behavioral, developmental, and sociocultural components of health and illness in initial and other assessments ______
3. Demonstrates ability to appropriately select assessment instruments and interpret test results based on clients' clinical needs and diversity characteristics ______

4. Demonstrates ability to collect relevant data using multiple sources and methods appropriate to the goals and questions of the assessment ______
5. Demonstrates ability to accurately interpret assessment data according to professional standards and guidelines ______
6. Demonstrates ability to use assessment data to inform case conceptualization, intervention, and recommendations ______
7. Demonstrates ability to use assessment instruments and interpret assessment data being sensitive to clients' cultural identity(ies) ______
8. Demonstrates ability to integrate assessment data into comprehensive, culturally sensitive reports ______
9. Accurately, effectively, timely, and sensitively communicates (orally and/or in writing) the results and implications of the assessment ______

Summary Comments:

VII. INTERVENTION (Sections A-D)

Demonstrates knowledge and skill in implementing interventions for prevention and treatment consistent with the scope of Health Service Psychology. The level of intervention includes those directed at an individual, a group, an organization, a community, or other systems level

Overall Rating: _________

A: Demonstrates ability to provide effective services to a wide range of individual clients with diverse presenting concerns

Rating: _________

1. Demonstrates ability to establish and maintain an effective therapeutic relationship with diverse clients presenting with different type of concerns. ______
2. Demonstrates ability to gather data and to facilitate exploration ______
3. Demonstrates ability to integrate data into meaningful conceptualizations ______
4. Demonstrates ability to conceptualize using different theoretical orientations ______
5. Demonstrates ability to formulate treatment strategies that integrate theory, current scientific literature, assessment findings, diversity and contextual variables ______
6. Demonstrates sensitivity, awareness, and skills regarding diversity issues in clinical work ______
7. Demonstrates ability to integrate diversity issues into their case conceptualization, treatment planning, and interventions ______
8. Appropriately utilizes complementary approaches/services based on client need and diversity/cultural/contextual variables ______
9. Utilizes multicultural guidelines to inform all aspects of the intervention process ______
10. Demonstrates ability to handle theirs and their client's affect ______
11. Demonstrates ability to use the self as a therapeutic tool ______

12. Demonstrates effective timing of interventions with their individual clients ______
13. Demonstrates ability to use Empirically-Validated treatments ______
14. Demonstrates flexibility in therapeutic techniques, including the ability to adapt evidence-based approaches, based on assessment data, treatment goals, diversity and contextual variables, and evaluation of intervention effectiveness ______
15. Demonstrates ability to accurately diagnose clients ______
16. Demonstrates ability to handle termination issues ______
17. Maintains accurate documentation records ______

Summary Comments:

B: Demonstrates ability to assess crisis situations and provide effective interventions

Rating _________

1. Demonstrates ability to assess the intensity/magnitude of clients' crisis situation ______
2. Demonstrates ability to thoroughly assess suicidality; this assessment is informed by the scientific literature in regards to safety assessment ______
3. Demonstrates ability to use appropriate interventions in crisis situations according to best practices and the scientific literature ______
4. Demonstrates ability to adapt intervention strategies evaluating effectiveness, issues of diversity, and contextual variables ______
5. Demonstrates ability to handle their affect in response to the client's affect or the nature of the crisis presented ______
6. Demonstrates ability to appropriately consult while assessing and responding to crises ______
7. Maintains accurate documentation records ______

Summary Comments:

C: Demonstrates knowledge and skill in group therapy work

Rating: _________

1. Demonstrates ability to refer appropriate clients to groups _____
2. Demonstrates effective use of pre-group interviews _____
3. Builds rapport and cohesion in group work _____

4. Demonstrates ability to integrate data into meaningful conceptualizations for group members and for the group as a whole _____
5. Demonstrates ability to integrate theory and practice of group work ______
6. Demonstrates effective timing of interventions according to the group stage _____
7. Demonstrates ability to integrate diversity issues into their conceptualization, treatment planning, and interventions in group ______
8. Demonstrates ability to formulate treatment strategies based on group dynamics ______
9. Implements interventions informed by current group therapy scientific literature/ evidence-based treatment______
10. Demonstrates collaboration and effective communication with group co-leader _____
11. Demonstrates receptiveness to feedback about group counseling skills and ability to implement feedback and new ideas into group therapy practice _____
12. Demonstrates ability to handle their own and the group's affect ______
13. Maintains accurate documentation records ______
14. Demonstrates ability to handle termination issues of group work ______

Summary Comments:

D: Demonstrates ability to plan and conduct outreach programs that are culturally and developmentally appropriate

Rating: __________

1. Demonstrates consideration of needs of the target audience ______
2. Demonstrates ability to engage the audience in an effective manner ______
3. Demonstrates knowledge about the content area ______
4. Demonstrates ability to include up to date research information about the content area ______
5. Presents in a manner that is inclusive and/or affirming of issues of diversity ______
6. Demonstrates flexibility including the ability to adapt the presentation in response to the needs of the audience ______

Summary Comments:

VIII. CLINICAL SUPERVISION

Demonstrates ability to establish a supervisory relationship that has the purpose of enhancing the professional functioning of a practicum student and monitoring the quality of the professional services offered by this trainee

Rating: _________

1. Demonstrates knowledge of supervision models and practices ______
2. Applies knowledge scientific/scholarly work in the supervision of a practicum trainee ______
3. Demonstrates commitment to supervision ______
4. Demonstrates ability to establish and maintain a safe and supportive supervisory relationship ______
5. Demonstrates respect and offers support for their supervisee ______
6. Demonstrates sensitivity to issues of power/privilege. ___
7. Demonstrates ability to monitor their supervisee professional functioning and quality of services provided ______
8. Demonstrates ability to offer ongoing/formative feedback and suggestions about their supervisees' clinical work ______
9. Provide support for the development of case conceptualization ______
10. Demonstrates ability to provide effective formative and summative feedback through mid and end of semester evaluations of their supervisees' professional functioning ______
11. Demonstrates cultural sensitivity in the supervisory relationship with their supervisees ______

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS
Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _________

1. Demonstrates knowledge and respect for the roles and perspectives of other professions ______
2. Applies knowledge about other professions in consultation with other health care professionals, inter-professional groups, and/or systems ______
3. Appropriately consults with peers/other trainees and senior staff ______
4. Demonstrates ability to effectively communicate and consult with parents/family members while respecting client's confidentiality/scope of signed releases of information ______

5. Demonstrates sensitivity, awareness, and skills regarding diversity in their provision of consultation services _____

Evaluation of Psychology Interns by Supervisors

College of William and Mary Counseling Center

Intern: ____
Clinical Supervisor: ____
Evaluation Period: _______________ to __________ Date:__________

The goal of this evaluation is primarily that of stimulating feedback regarding the perceived status and progress of the intern being evaluated. As such, the ratings should be reflective of the expected developmental progress at the time of the evaluation; at the beginning of the year, interns are evaluated according to what the profession describes as "readiness to enter internship" and at the end of year based on the competencies expected for "entry level practice." Given this framework, interns could make progress on any given aim/competency and receive the same score on two different evaluation periods considering what is developmentally expected at that point in the internship year. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee's training, progress, and how skills can be acquired or improved.

A score of 1 or 2 on any given item should be accompanied by specific data or description in the narrative/comment section addressing why the intern is receiving such rating for that competency.

Passing Criteria: An average score of 4 is required on each of the overall nine professional competencies and a minimum score of 3 on any given item within each competency area by the last evaluation of the competency area during the internship.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

Mark the work that you supervised	Mark the methods used to supervise/evaluate
o Individual Psychotherapy	o Video recordings
o Group Psychotherapy	o Co-therapy
o Day Crisis Intervention	o Verbal summary of cases
o Intake Assessment	o Case documentation/written notes
o Objective/Personality Assessment	o Assessment data
o Symptom Assessment	o Written intakes or assessment reports
o On-call Crisis Intervention	o Case presentations
o Outreach	o Outreach/Research presentations
o Consultation	o Case Conference
o Supervision Provision	o Didactic seminars
o Other (Please describe) ______________________	o Feedback provided by other supervisors/senior staff
	o Other (Please describe) _________________________

I. RESEARCH
Demonstrates knowledge, skills, and competence in Research

Rating: __________

1. Demonstrates knowledge, skills, and competence to critically evaluate research according to methods, procedures, practices, and attention to diversity and contextual variables ________
2. Demonstrates knowledge, skills, and competence to use existing knowledge in clinical practice and other professional activities, taking into consideration issues of diversity ______
3. Demonstrates ability to locate, appraise, and assimilate scientific evidence on college mental health and local clinical data (trends in mental health issues in college populations, results from research comparing W&M students health related issues/needs to those of students in other universities, etc.)______
4. Appropriately utilizes scholarly work and applies existing evidence in the different roles assumed at the agency ______
5. Appropriately disseminates research information in presentations (case presentation, supervision presentation, research presentation), outreach events, seminars, consultation, teaching in practicum student seminar, etc.

Summary Comments:

II. ETHICAL AND LEGAL STANDARDS
Demonstrates knowledge, skills, and competence in Ethical and Legal Standards

Rating: _________

1. Demonstrates ability to monitor their behavior to conduct themselves following the APA Ethical Principles and Code of Conduct as well as APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change of the American Psychological Association ______
2. Demonstrates knowledge and ability to follow the Virginia Law regarding the ethical practice of Psychologists________
3. Demonstrates knowledge regarding the relevant laws, regulations, rules, policies, standards and guidelines governing health service psychology ______
4. Understands and follows the Center's policies and procedures ______
5. Recognized ethical dilemmas and apply ethical decision-making processes ______
6. Appropriately seeks consultation when ethical or legal issues require resolution ______
7. Behaves in an ethical manner in all professional activities ______
8. Maintains accurate documentation records ______

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY
Demonstrates knowledge, skills, and competence as it relates to addressing diversity in all professional activities

Rating: _________

1. Incorporates theoretical and research knowledge on multiculturalism ______
2. Demonstrates sensitivity of how self and others are shaped by individual and cultural diversity and the cultural context and sub-cultures in which people function.
3. Integrates knowledge of self and others as cultural beings across professional roles and functions ______
4. Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases affect how they understand and interact with people different from themselves ___
5. Demonstrates awareness of own and others' multiple identities and the intersection of these identities ______
6. Demonstrates sensitivity to issues of power and privilege as they interact with others ______
7. Demonstrates an understanding of the manner in which people of diverse cultures and belief systems perceive mental health issues and interventions ______

8. Understands oppression and discrimination in society and other environments including university settings, and understands how these environments are microcosms for the larger society__________________

Summary Comments:

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS (Sections A-B)
Demonstrates the development of a professional identity congruent with Health Service Psychology
Rating: __________

A: Behaves in ways that reflect the values and attitudes of Health Service psychology.
Rating: _________

1. Demonstrates integrity, accountability, a professional demeanor, eagerness/readiness to learn, and concern for others, across the different roles assumed at the agency ______
2. Engages in self-reflection regarding personal and professional functioning ______
3. Demonstrates ability to monitor their reactions and behaviors ______
4. Demonstrates ability to recognize areas of strength ______
5. Demonstrate ability to recognize areas of growth ______
6. Seeks the means to ameliorate the impact of potential problems on the delivery of services, including engagement in activities to maintain and improve performance, well-being, and professional effectiveness ______
7. Uses diverse resources for professional development including staff resources (supervision and consultation), workshops, conferences, and/or professional organizations ______
8. Responds professionally in increasingly complex situations with a greater degree of independence as the internship year progresses ______

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _________

1. Demonstrates effective preparation for supervision ______
2. Demonstrates receptiveness to new ideas and approaches ______
3. Actively seeks and demonstrates openness to/in supervision _____
4. Demonstrates receptiveness to feedback about professional deficits/strengths _____
5. Demonstrates effective use of what is learned in future sessions ______
6. Demonstrates openness to looking at own issues ______
7. Demonstrates awareness of multicultural issues within the supervisory relationship ______

8. Demonstrates ability to seek supervisory help resulting from a self-perceived need ______

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _________

1. Develops and maintains effective relationships with a wide range of individuals including colleagues, peers, supervisors, supervisees, other staff/professionals, parents, communities, organizations, and those receiving professional services ________
2. Produces and comprehends oral, nonverbal, and written communications, demonstrating knowledge and understanding of professional language and concepts ______
3. Demonstrates effective communication and interpersonal skills, understanding the impact of their interpersonal and communication practices ______
4. Demonstrates effective communication and interpersonal skills being sensitive to issues of power and privilege ______
5. Demonstrates ability to manage difficult communication well ______
6. Appropriately manages emotional reactions while communicating/interacting with others _____

Summary Comments:

VI. ASSESSMENT

Demonstrates competence in conducting intake and objective assessment consistent with the scope of Health Service Psychology.

Rating: __________

1. Demonstrates ability to conduct initial assessments, write comprehensive intake reports, and make appropriate treatment recommendations and referrals based on client's clinical needs, diversity characteristics, and contextual variables ______
2. Considers the biological, cognitive, behavioral, developmental, and sociocultural components of health and illness in initial and other assessments ______
3. Demonstrates ability to appropriately select assessment instruments and interpret test results based on clients' clinical needs and diversity characteristics ______
4. Demonstrates ability to collect relevant data using multiple sources and methods appropriate to the goals and questions of the assessment ______
5. Demonstrates ability to accurately interpret assessment data according to professional standards and guidelines ______
6. Demonstrates ability to use assessment data to inform case conceptualization, intervention, and recommendations ______
7. Demonstrates ability to use assessment instruments and interpret assessment data being sensitive to clients' cultural identities ______
8. Demonstrates ability to integrate assessment data into comprehensive, culturally sensitive reports ______

9. Accurately, effectively, timely, and sensitively communicates (orally and in writing) the results and implications of the assessment ______
10. Demonstrates ability to utilize case formulation and diagnosis for intervention planning in the context of human development and diversity ________

Summary Comments:

VII. INTERVENTION (Sections A-B)
Demonstrates knowledge and skill in implementing interventions for prevention and treatment consistent with the scope of Health Service Psychology. The level of intervention includes those directed at an individual, a group, an organization, a community, or other systems level

Overall Rating: _________

A: Demonstrates ability to provide effective services to a wide range of individual clients with diverse presenting concerns

Rating: _________

1. Demonstrates ability to establish and maintain an effective therapeutic relationship with diverse clients presenting with different type of concerns. ______
2. Demonstrates ability to gather data and to facilitate exploration ______
3. Demonstrates ability to integrate data into meaningful conceptualizations ______
4. Demonstrates ability to conceptualize using different theoretical orientations ______
5. Demonstrates ability to formulate treatment strategies that integrate theory, current evidence-based information, assessment findings, diversity and contextual variables ______
6. Demonstrates sensitivity, awareness, and skills regarding diversity issues in clinical work ______
7. Demonstrates ability to integrate issues of identity into their case conceptualization, treatment planning, and interventions ______
8. Appropriately utilizes complementary approaches/services based on client need and diversity/cultural/contextual variables ______
9. Utilizes multicultural guidelines to inform all aspects of the intervention process ______
10. Demonstrates ability to handle theirs and their client's affect ______
11. Demonstrates ability to use the self as a therapeutic tool ______
12. Demonstrates effective timing of interventions with their individual clients ______
13. Demonstrates ability to use Empirically-Validated treatments ______
14. Demonstrates flexibility in therapeutic techniques, including the ability to adapt evidence-based approaches, based on assessment data, treatment goals, diversity and contextual variables, and evaluation of intervention effectiveness ______
15. Demonstrates ability to accurately diagnose clients ______
16. Demonstrates ability to handle termination issues ______
17. Maintains accurate documentation records ______

Summary Comments:

B: Demonstrates ability to assess crisis situations and provide effective interventions

Rating _________

1. Demonstrates ability to assess the intensity/magnitude of clients' crisis situation ______
2. Demonstrates ability to use evidence-based methodology to conduct suicide risk assessment ______
3. Demonstrates ability to use appropriate interventions in crisis situations according to best practices and evidence-based information ______
4. Demonstrates ability to adapt intervention strategies evaluating effectiveness, issues of diversity, and contextual variables ______
5. Demonstrates ability to handle their affect in response to the client's affect or the nature of the crisis presented ______
6. Demonstrates ability to appropriately consult while assessing and responding to crises ______
7. Maintains accurate documentation records ______

Summary Comments:

Demonstrates knowledge and skill in group therapy work: Please refer to Group Therapy Skills Evaluation

Demonstrates ability to plan and conduct outreach programs that are culturally and developmentally appropriate: Please refer to Outreach Presentation Evaluation

VIII. CLINICAL SUPERVISION

Demonstrates ability to establish a supervisory relationship that has the purpose of enhancing the professional functioning of a practicum student and monitoring the quality of the professional services offered by this trainee: Please refer to Supervisory Skills Evaluation

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _________

1. Demonstrates knowledge and respect for the roles and perspectives of other professions and professionals ______

2. Applies knowledge about other professions in consultation with other health care professionals, inter-professional groups, and/or systems ______
3. Appropriately consults with peers/other trainees and senior staff ______
4. Demonstrates ability to effectively communicate and consult with parents/family members while respecting client's confidentiality/scope of signed releases of information ______
5. Demonstrates sensitivity, awareness, and skills regarding diversity in their provision of consultation services ______

____________________________ ____________

Supervisor **Date**

Intern's Comments:

____________________________ ____________

Psychology Intern **Date**

Evaluation of Psychology Interns by Supervisors

Group Skills

College of William and Mary Counseling Center

Intern: _________
Group Supervisor: ________
Evaluation Period: _______
Date of Evaluation: ________

The goal of this evaluation is primarily that of stimulating feedback regarding the perceived status and progress of the intern being evaluated. As such, the ratings should be reflective of the expected developmental progress at the time of the evaluation; at the beginning of the year, interns are evaluated according to what the profession describes as "readiness to enter internship" and at the end of year based on the competencies expected for "entry level practice." Given this framework, interns could make progress on any given aim/competency and receive the same score on two different evaluation periods considering what is developmentally expected at that point in the internship year. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee's training, progress, and how skills can be acquired or improved.

A score of 1 or 2 on any given item should be accompanied by specific data or description in the narrative/comment section addressing why the intern is receiving such rating for that competency.

Passing Criteria: An average score of 4 is required on each of the overall nine professional competencies and a minimum score of 3 on any given item within each competency area by the last evaluation of the competency area during the internship.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

Mark the work that you supervised	Mark the methods used to supervise/evaluate
o Group	o Video Recording & Supervision Discussion
	o Other (Please describe) ____

C: Demonstrates knowledge and skill in <u>group</u> therapy work

Rating: _________

1. Demonstrates ability to refer appropriate clients to groups _____
2. Demonstrates effective use of pre-group interviews _____
3. Builds rapport and cohesion in group work _ ____
4. Demonstrates ability to integrate data into meaningful conceptualizations for group members and for the group as a whole ____
5. Demonstrates ability to integrate theory and practice of group work _ _____
6. Demonstrates effective timing of interventions according to the group stage _ ____
7. Demonstrates ability to integrate diversity issues into their conceptualization, treatment planning, and interventions in group ___ ___
8. Demonstrates ability to formulate treatment strategies based on group dynamics __ ____
9. Implements interventions informed by current group therapy scientific literature/ evidence-based treatment__ ____
10. Demonstrates collaboration and effective communication with group co-leader _____
11. Demonstrates receptiveness to feedback about group counseling skills and ability to implement feedback and new ideas into group therapy practice _____
12. Demonstrates ability to handle their own and the group's affect __ ____
13. Maintains accurate documentation records ______
14. Demonstrates ability to handle termination issues of group work ___ __

Summary Comments:

____________________________ _____________

Supervisor **Date**

Intern's Comments:

_______________________________ _______________
Psychology Intern **Date**

Evaluation of Psychology Interns by Supervisors
Supervisory Skills
College of William and Mary Counseling Center

Intern: ____
Supervisor of Supervision: ____
Evaluation Period: ____ Date: ___

The goal of this evaluation is primarily that of stimulating feedback regarding the perceived status and progress of the intern being evaluated. As such, the ratings should be reflective of the expected developmental progress at the time of the evaluation; at the beginning of the year, interns are evaluated according to what the profession describes as “readiness to enter internship” and at the end of year based on the competencies expected for “entry level practice.” Given this framework, interns could make progress on any given aim/competency and receive the same score on two different evaluation periods considering what is developmentally expected at that point in the internship year. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee’s training, progress, and how skills can be acquired or improved.

A score of 1 or 2 on any given item should be accompanied by specific data or description in the narrative/comment section addressing why the intern is receiving such rating for that competency.

Passing Criteria: An average score of 4 is required on each of the overall nine professional competencies and a minimum score of 3 on any given item within each competency area by the last evaluation of the competency area during the internship.

Please rate trainee using the following 5-point scale:

Level 1. Inadequate Performance: The intern performs inadequately for a psychology intern in this area. The intern exhibits behaviors indicating lack of readiness for the work that is required in the internship setting. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required to provide the intern immediate augmented supervision or structured training opportunities.

Level 2. Limited knowledge and skill: The intern is moving towards acquiring ability in the competency being measured. Requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Emerging Competence: The intern uses the skill being evaluated intermittently. The intern may still need some assistance from didactic training and/or supervisory activities to further develop the knowledge, awareness, and skill in the competency being evaluated.

Level 4. Competent: The intern performs at the level expected for entry level practice. Demonstrates the ability to consistently utilize the knowledge, awareness or skill with minimum structured assistance. The intern is generally self-sufficient; exhibits the ability to generalize knowledge and skills to new situations and is able to appropriately self-assess when further assistance/supervision is needed, such as in non-routine cases.

Level 5. Advanced Competence: The intern demonstrates mastery of the competency being evaluated. Routinely performs at or beyond levels expected for an early career professional. Consistently uses the skill independently; this is the case even in complex cases.

N/A. Not enough information obtained at this time to provide an evaluation of competency.

Work supervised	Methods used to supervise/evaluate
○	○
	○

I. RESEARCH
Demonstrates knowledge, skills, and competence in Research

Rating: ___

1. Demonstrates knowledge, skills, and competence to critically evaluate supervision research according to methods, procedures, practices, and attention to diversity and contextual variables __
2. Demonstrates knowledge, skills, and competence to use existing knowledge in the role of supervisor __
3. Demonstrates ability to locate, appraise, and assimilate scientific evidence in regard to the practice of clinical supervision_ _
4. Appropriately utilizes scholarly work and applies existing evidence in the role of supervisor __
5. Appropriately disseminates research information in supervision presentation. __

Summary Comments:

II. ETHICAL AND LEGAL STANDARDS
Demonstrates knowledge, skills, and competence in Ethical and Legal Standards

Rating: __

1. Demonstrates ability to monitor their behavior to conduct themselves following the APA Ethical Principles and Code of Conduct as well as APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change of the American Psychological Association __

2. Demonstrates knowledge and ability to follow the Virginia Law regarding the ethical practice of Psychologists___
3. Demonstrates knowledge regarding the relevant laws, regulations, rules, policies, standards and guidelines governing health service psychology ___
4. Understands and follows the Center's policies and procedures and is able to guide and monitor supervisee in this regard ___
5. Recognized ethical dilemmas and apply ethical decision-making processes as a supervisor __
6. Appropriately seeks consultation when ethical or legal issues require resolution __
7. Behaves in an ethical manner as a supervisor; serves as a role model regarding ethical behavior for supervisee. __
8. Maintains documentation of supervision __

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY
Demonstrates knowledge, skills, and competence as it relates to addressing diversity in in role of supervisor
Rating: ___

1. Incorporates theoretical and research knowledge on multiculturalism __
2. Demonstrates sensitivity of how self and others are shaped by individual and cultural diversity and the cultural context and sub-cultures in which people function. __
3. Integrates knowledge of self and others as cultural beings across professional roles and functions ___
4. Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases affect how they understand and interact with people different from themselves __
5. Demonstrates awareness of own and others' multiple identities and the intersection of these identities ___
6. Demonstrates sensitivity to issues of power and privilege as they interact with others __
7. Demonstrates an understanding of the manner in which people of diverse cultures and belief systems perceive mental health issues and interventions and is able to utilize this knowledge as a supervisor. __
8. Understands oppression and discrimination in society and other environments including university settings, and understands how these environments are microcosms for the larger society_____

Summary Comments:

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS (Sections A-B)

Demonstrates the development of a professional identity congruent with Health Service Psychology
Rating: ___

A: Behaves in ways that reflect the values and attitudes of Health Service psychology.
Rating: ___

1. Demonstrates integrity, accountability, a professional demeanor, eagerness/readiness to learn, and concern for others, in the role of supervisor__
2. Engages in self-reflection regarding personal and professional functioning __
3. Demonstrates ability to monitor their reactions and behaviors __
4. Demonstrates ability to recognize areas of strength and areas of growth ___
5. Seeks the means to ameliorate the impact of potential problems on the delivery of services, including engagement in activities to maintain and improve performance, well-being, and professional effectiveness __
6. Uses diverse resources for professional development including staff resources (supervision and consultation), workshops, conferences, and/or professional organizations __
7. Responds professionally in increasingly complex situations with a greater degree of independence as the internship year progresses __

Summary Comments:

B: Demonstrates ability to effectively use supervision
Rating: __

1. Demonstrates effective preparation for supervision __
2. Demonstrates receptiveness to new ideas and approaches ___
3. Actively seeks and demonstrates openness to/in supervision __
4. Demonstrates receptiveness to feedback about professional deficits/strengths __
5. Demonstrates effective use of what is learned in future sessions __
6. Demonstrates openness to looking at own issues __
7. Demonstrates awareness of multicultural issues within the supervisory relationship __
8. Demonstrates ability to seek supervisory help resulting from a self-perceived need ___

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: ___

1. Develops and maintains effective relationships with a wide range of individuals including colleagues, peers, supervisors, supervisees, other staff/professionals, parents, communities, organizations, and those receiving professional services, __
2. Produces and comprehends oral, nonverbal, and written communications, demonstrating knowledge and understanding of professional language and concepts __
3. Demonstrates effective communication and interpersonal skills, understanding the impact of their interpersonal and communication practices __
4. Demonstrates effective communication and interpersonal skills being sensitive to issues of power and privilege ___
5. Demonstrates ability to manage difficult communication well __
6. Appropriately manages emotional reactions while communicating/interacting with others __

Summary Comments:

VIII. CLINICAL SUPERVISION

Demonstrates ability to establish a supervisory relationship that has the purpose of enhancing the professional functioning of a practicum student and monitoring the quality of the professional services offered by this trainee

Rating: ___

1. Demonstrates knowledge of supervision models and practices __
2. Applies knowledge scientific/scholarly work in the supervision of a practicum trainee __
3. Demonstrates commitment to supervision __
4. Demonstrates ability to establish and maintain a safe and supportive supervisory relationship __
5. Demonstrates respect and offers support for their supervisee __
6. Demonstrates sensitivity to issues of power/privilege __
7. Demonstrates ability to monitor their supervisee professional functioning and quality of services provided __
8. Demonstrates ability to offer ongoing/formative feedback and suggestions about their supervisees' clinical work __
9. Provides support for the development of case conceptualizations __
10. Demonstrates ability to provide effective formative and summative feedback through mid and end of semester evaluations of their supervisees' professional functioning __
11. Demonstrates cultural sensitivity in the supervisory relationship with their supervisees __

Summary Comments:

_____________________________ _____________

Supervisor **Date**

Intern's Comments:

_____________________________ _____________

Psychology Intern **Date**

Clinical Information

Contact Information:

WMCC (Internal Use Only)

Permanent Staff:
Joy Badalis: (910) 366-8772
Felicia Brown-Anderson: (757) 254-8422 Kevin Clancey:
(908) 894-3087
Miles Davison: (215) 840-5034
Ali Pappas-Bourdage: (386) 295-6731
Carina Sudarsky-Gleiser: (757) 532-2485

Interns:
Gabby Drong
Alyssa Provencio
Carolina Rosado

On-Call Phone:
(757) 221-7416

Campus Partners

WMPD:
(757) 221-4596
Dean of Students:
(757) 221-2510
Dean On-Call:
(757) 784-5305
Student Health Center:
(757) 221-2998
Residence Life Duty Phone:
(757) 209-1167
(757) 221-4557
Human Resources:
askHR@wm.edu
(757) 221-3169
Information Technology (IT):
https://www.wm.edu/offices/it/gethelp/index.php

Off-Campus Numbers

Colonial Behavioral Health (CBH):
(757) 220-3200

Riverside Doctor's Hospital ER (Williamsburg):
(757) 585-2250

Sentara Hospital ER (Williamsburg):
(757) 984-7111

Williamsburg Pavilion Admissions:
(757) 941-6410

Avalon (sexual assault resource):
(757) 258-5022

Referrals

Dean of Students Office – 1-2510

Stacey Harris – Dean of Students
Vacant - Associate Dean of Students and Director of Parent & Family Programs
Jenny Call - Director of Care Support Services
Wilmarie Rodriguez - Senior Associate Dean of Students & Executive Director of Student Success
Cenie Bellamy - Assistant Dean of Students & Director of Academic Wellbeing
Dave Gilbert - Senior Associate Dean of Students & Director of Community Values & Restorative Practices
Marc Sloan - Assistant Director of Community Values and Restorative Practices
Amelia Cross - Associate Director of Care Support Services
Myrissa Nichols - Assistant Director of Student Accessibility Services

Student Health Center 1-4386 for appointment 1-2998

David Dafashy, M.D. – Director
Elizabeth D. De Falcon, M.D., F.A.A.P.
Chris Massengill, M.D.
Karla Beckman, C.A.N.P.
Darlene Hinojosa, F.N.P.-B.C., C.U.N.P.
Stacia Guillen, F.N.P.-C.
Brittany Ptachick, F.N.P.-C.

A referral to the Student Health Center can be generated through Titanium and then faxed, along with the signed release-of-information to the SHC.
- see “Creating Health Center Referral Notes” in Titanium Guidelines handout

Health Promotion **McLeod Tyler Wellness Center 1st Floor**
Vacant – Assistant Director
T. Davis, PhD. CHES – Assistant Director
Vacant – Assistant Director & Sexual Violence Prevention Specialist

Psychiatrists
Trish Roy- WMCC Psychiatrist

Referrals to off-campus Psychiatry and Therapists
Christine Ferguson helps with referrals to the community. An internal referral form through Titanium to Christine is needed. Signed release-of-information is needed to communicate with external referrals.

See list of therapists – G: drive

Deidre Connelly **1-3386** **Wm & Mary Hall 207**
Sports Psychologist who is part of CC staff; her office is located within the Athletic Department, William & Mary Hall. She is available to provide stress management skills, as well as work with students with performance related stress/concerns.

Career Services **1-3231** **Career Center office suites next to Sadler Center**

Center for Student Diversity **1-2300**
Kimberly Weatherly - Assistant Dean and Director, Center for Student Diversity
Shene’ Owens - Associate Director, Center for Student Diversity
Dyamond Howell - Assistant Director, Center for Student Diversity

International Student Office **1-3590** **Reves Center**

Campus Ministers **– see handout of “Campus Ministries United” – CaMU**

Substance Abuse Treatment

New Leaf Clinic 757-615-2288

The Counseling Center, LLC 757-229-4645
206 Packets Court, Suite C
Williamsburg
(McLaws Circle area)

The Haven

The Haven is a peer-based ***confidential***, resource center for those impacted by sexual violence and harassment, relationship abuse and intimate-partner violence, stalking, and other gender-based discrimination.

Liz Cascone-Director
Office: Sadler Center, Suite 146P
(757) 221-7478 or at lizcascone@wm.edu

Title IX Compliance and Equity Office

Faculty/Staff/Students may contact the Title IX Coordinator or Deputy Title IX Coordinator with questions or concerns, or to file a complaint regarding sex- and gender-based discrimination, including sexual assault and other forms of sexual harassment.

Costello, Carla
Deputy Compliance Officer/Title IX & ADA Coordinator
Email: cacostello@wm.edu
Phone: 757-221-1254
Office: James Blair 108

Fassanella, Terry
Senior Compliance & Title IX Investigator
Email: tafassanella@wm.edu
Phone: 757-221-2517
Office: James Blair 111

Mason, Pamela
Chief Compliance Officer/FOIA Officer
Email: phmaso@wm.edu
Phone: 757-221-3167
Office: James Blair 109

<u>**Telemental Health Tips**</u>

Zoom Settings:

· Always conduct sessions on the HIPAA-compliant version of Zoom (indicated when your profile reads @private.wm.edu). · Visit https://zoom.us/profile/setting for comprehensive Zoom settings.

· Require a password and authentication for all sessions (both scheduled and instant meetings).

· Create a new Zoom meeting ID and password for every session instead of scheduling repeating Zoom sessions.

· Disable the "join before host" function and consider enabling the waiting room to admit clients to the meeting when you are ready to start the session.

· Consider adding a reminder for yourself 5-15 minutes before a session begins.

· Consider scheduling the next session and email the Zoom link prior to ending a session.

· Use ambiguous language when naming Zoom sessions (e.g., "LM Meeting") and sending Zoom link details in case someone accesses the client's email.

Recording and Storing Zoom Sessions:

· Clients must agree to use both audio and video and to be recorded.

· Use "gallery view" so recordings capture both yours and clients' faces.

· Save your recorded Zoom session to the V drive IMMEDIATELY following a session. Not doing so can pose concerns about violating HIPAA.

· Name recordings in V: with your client initials and the session date.

· Select the setting that adds a timestamp to your Zoom recording.

· Delete videos weekly from your Zoom storage and every 30 days from the V:

Technological Equipment and Issues:

· Conduct sessions on a screen that is large enough to see your client clearly (e.g., a laptop or desktop monitor). Use a tablet or smartphone as a last resort and only in the case of technological difficulties.

· Ensure that your camera image is sharp and bright, you have a diffuse light source in front of you (not above or behind) to avoid shadows on your face, your lens is at eye level, and your face is centered in the camera view. Instruct clients to consider the same set-up.

· Minimize other windows and notifications to reduce distractions during sessions.

· Test your Zoom with a colleague to confirm your settings, ability to record, and quality of your video prior to starting clinical work.

· Sign in a few minutes before each session to test audio and video prior to the client joining the session.

· When in doubt, contact W&M IT for help.

Clinical Considerations:

· At the outset of the therapeutic relationship, ensure the client's phone number, email address, and physical home address are accurate in the file.

· Remind the client that they must be physically located in the state of Virginia to attend all Zoom sessions.

· Confirm the client's physical location/address at the beginning of each session. At some point this may not be necessary if you recognize their surroundings.

· You may need to gently coach a client about setting up their own environment.

· Because you cannot control the environment, you may have to address issues in the client's environment that can interrupt the work. These can include distracting electronics, disruptive pets or people, the client's lack of privacy, boundary-crossing behaviors, etc. that might not otherwise occur in-person.

THERAPY SESSION PROCESS-CONTENT NOTES

CLIENT VERBALIZATIONS	CLIENT'S NON-VERBALS	THERAPIST REACTIONS/ FEELINGS	THERAPIST BEHAVIOR/ INTERVENTION	WHAT COULD HAVE BEEN DONE DIFFERENTLY

JULY 2021

CCAPS 2021 Manual

(CCAPS-62 and CCAPS-34)

Counseling Center Assessment of Psychological Symptoms

Center for
Collegiate Mental Health
(CCMH)

The Pennsylvania State University
Center for Counseling and Psychological Services
Student Affairs

Contact Information

The CCAPS family of instruments is managed by the Center for Collegiate Mental Health (CCMH).
Please contact CCMH to learn about current distribution policies.

Center for Collegiate Mental Health
Counseling and Psychological Services
The Pennsylvania State University
501 Student Health Center
University Park, PA 16802

Email: ccmh@psu.edu
Web: http://ccmh.psu.edu
Phone: 814-865-1419

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Introduction

The first version of the Counseling Center Assessment of Psychological Symptoms (the CCAPS-70) was originally developed by Counseling and Psychological Services at the University of Michigan, circa 2001, for the purpose of creating a high-quality, multi-dimensional assessment instrument that was low-cost and clinically useful for college counseling centers. Based on this foundation, the current family of the CCAPS instruments, clinical reports, and related research are managed by the Center for the Collegiate Mental Health (CCMH), an international practice-research-network that exists as a service to the field of college student mental health counseling. CCMH is located at Penn State's office of Counseling and Psychological Services. The CCAPS instruments are intended to meet the clinical, research, and administrative needs of the counseling center field while also contributing valuable information to the science of collegiate mental health. Please note that this manual will be updated as new information becomes available and users should verify that they are in possession of the most recent version.

Use of the CCAPS locates you within an international practice-research-network (PRN) of clients, practitioners, and researchers who are working together to improve the treatment and understanding of college student mental health. CCMH is working on "bringing science and practice together" so that both aspects are equal partners in the pursuit of common and mutually beneficial goals related to college student mental health. The CCAPS instruments exemplify this mission by linking thousands of clinicians, millions of clients, vast amounts of data, and researchers together to develop population-specific clinical tools for use in assessment, treatment planning, and outcome evaluation of college students seeking mental health treatment.

The CCAPS instruments only exist in their advanced form today because hundreds of counseling centers have made the effort to contribute de-identified, anonymous data to CCMH over the course of years so that researchers can continuously refine the instruments. Depending on how you access the CCAPS, you may already be contributing data or have the choice to contribute data. If you want to find out how to contribute data to CCMH, please contact CCMH (ccmh@psu.edu).

CCAPS Instruments

OVERVIEW AND HISTORY

The CCAPS development began in 2000 at the University of Michigan's Counseling and Psychological Services with the goal of developing a psychometrically sound instrument, designed for college students, to serve the assessment and outcome needs of counseling centers. The current instruments, the CCAPS-62 and CCAPS-34, have been continuously researched, refined, and developed by CCMH using a balanced rational/empirical approach for the purpose of creating instruments that are statistically robust and clinically relevant.

- **2000** – Early conceptual development.
- **2001** – Pilot study using 167 proposed items, covering 11 proposed subscales, with a sample of 113 students at the University of Michigan. This led to a 101-item working version.
- **2002–2004** – Factor analysis of the 101-item version using 2,155 clinical cases resulted in the CCAPS-70 (70 items, 9 subscales, 5 free items retained for clinical utility).
- **2006** – The CCAPS-70 was donated to Penn State's CCMH to develop collaboratively with the University of Michigan on behalf of the counseling center field.
- **2008** – The CCAPS-70 was integrated into Titanium Schedule with clinical norms based on approximately 8,000 students at the University of Michigan.
- **2009** – The CCAPS-62 and CCAPS-34 were developed, based on the analysis of 22,000 cases of CCAPS-70 data from the 2009 Pilot Study, and integrated into Titanium Schedule with an updated profile report and norms.
- **2010** – The CCAPS-62 and CCAPS-34 profile reports were redesigned to display up to 10 administrations, T-scores were replaced with percentiles, and reliable change indicators (RCI's) were added.
- **2011** – The development and validation of the CCAPS-62 was published in the *Journal of Counseling Psychology* (Locke et al., 2011)
- **2012** – The development and validation of the CCAPS-34 was published in *Measurement and Evaluation in Counseling and Development* (Locke et al., 2012).
- **2012** – The Profile Report, for both the CCAPS-62 and CCAPS-34, was updated to include a newly developed Distress Index (Nordberg et al., 2016), high/low distress cut scores, suicidal and homicidal ideation tracking, and updated norms based on 60,000 students seen in counseling centers during 2010-2011.
- **2012** – A second validation article on the CCAPS-62, focused on cut scores and clinical utility, was published in the *Journal of Counseling Psychology.* (McAleavey et al., 2012)

- **2015** – The CCAPS profile report was redesigned with the following new features:
  - Redesigned layout with both graphical and tabular presentation of up to 15 administrations.
  - SI/HI responses are graphed over time.
  - Graphical representation of high/mid/low distress zones and floor zones.
  - Treatment Response Features were added to the CCAPS-34, including:
    - — Average Treatment-Response Curves, calculated from the baseline score per subscale.
    - — Use of attended individual therapy appointments for measuring "dose" of treatment.
    - — Alerts for each subscale when clients are not changing as expected.
  - Updated norms based on more than 230,000 clients.
- **2018** – The following revisions were made to the CCAPS profile report and CCAPS manual:
  - Based on clinical feedback from numerous counseling center staff as well as the recommendation of the CCMH Advisory Board, the term "Homicidal Ideation (HI)" was replaced with "Thoughts of Hurting Others (THO)." The intent was to improve the face validity of the construct (as measured by the CCAPS), as Thoughts of Hurting Others (THO) more accurately reflects the content of the item, "I have thoughts of hurting others."
  - Updated norms based on more than 388,000 clients.
  - High cut points were adjusted on some CCAPS-62 and CCAPS-34 scales using data from 67,613 clients between 2015 and 2017.
- **2019** – The following modifications were made to the CCAPS profile report and manual:
  - Low cut points were updated on all CCAPS-62 and CCAPS-34 scales using data from 448,904 clients between 2016 and 2018.
- **2020** – The following changes were made to the CCAPS profile report and manual:
  - Based on feedback from the CCMH Advisory Board, members, and students receiving services, the "Hostility" subscale was renamed to "Frustration/Anger" to better capture the interpretation and meaning of the items within the subscale.

CCAPS Versions

CCAPS-62

The CCAPS-62 (Locke et al., 2011), released in June 2009, is a 62-item instrument with eight subscales related to psychological symptoms or distress in college students and also includes a general measure of distress, the Distress Index (DI). The eight subscales are: (1) Depression, (2) Generalized Anxiety, (3) Social Anxiety, (4) Academic Distress, (5) Eating Concerns, (6) Family Distress, (7) Frustration/Anger, and (8) Substance Use. The CCAPS-62 takes approximately 7-10 minutes to complete. Due to its more comprehensive nature, increased sensitivity to assessing low-range distress, and inclusion of family-related questions, the CCAPS-62 is best suited for initial and post-treatment assessments, though it can also be utilized as a repeated measurement to monitor ongoing treatment. Clinicians find the larger range of items within each subscale clinically useful during initial assessment.

CCAPS-34

The CCAPS-34 (Locke et al., 2012) was released in September 2009. It is a 34-item instrument with seven subscales related to psychological symptoms or distress in college students and also includes the Distress Index. All items of the CCAPS-34 are present in CCAPS-62 under the same subscales, and the DI is composed of the same items in both instruments. The CCAPS-34 does not have a Family Distress subscale and the Substance Use subscale of the CCAPS-62 becomes Alcohol Use in the CCAPS-34, because all subscale items refer to alcohol. The CCAPS-34 takes approximately 2-3 minutes to complete and, due to its brevity, is better suited for repeated measurements of clients at every session or a specific session interval.

CCAPS-70

The CCAPS-70 was made available to Titanium Schedule users, on a pilot basis, in January 2008 with norms based on a smaller sample of students from one university. This instrument is now considered to be obsolete in both factor structure and norms.

Before Using the CCAPS

TRAINING REQUIREMENTS

Do not attempt to use or interpret the CCAPS until you have been trained.

The CCAPS instruments are psychometrically rigorous assessment tools that should be used only by those with appropriate training. A minimum level of training should include: (1) a Master's degree in psychology, counseling, social work, or a closely related field and formal training in the ethical administration and interpretation of clinical assessments, (2) a full review of this manual and comprehension of all concepts, (3) a training that provides

a working understanding of both the psychometric and clinical concepts used in the Profile Report, and (4) a review of case examples with discussion. Questions about training can be directed to ccmh@psu.edu.

READING LEVEL

Both the CCAPS-34 and CCAPS-62 scored a 50.4 on the Flesch Reading Ease test and are equivalent to a grade 9 reading level. Graded reading levels were determined by the Flesch-Kincaid Grade Level test found in Microsoft Word 2016.

HOW TO ADMINISTER THE CCAPS

The CCAPS 2021 can be administered via paper and pencil (see Appendix A), but it is highly recommended that the CCAPS be administered via one of the following options, which provide automated scoring and access to the profile report. Use of the following requires an active membership with CCMH:

- Electronic medical record (EMR) systems commonly used in counseling centers, including Titanium Schedule, Medicat, Point and Click, and Pyramed.
- The CCMH website (http://ccmh.psu.edu).

CLINICAL JUDGMENT

The CCAPS has been carefully designed to provide clinically relevant and statistically sound information that is derived from, and dependent on, a client's self-reported distress. As such, the CCAPS should be viewed as a clinical tool that supports and augments clinical judgment, but does not replace it.

MULTICULTURAL CONSIDERATIONS

Those using the CCAPS should always assume that a client's responses to individual items, subscale scores, and change over time will be influenced by their unique socio-cultural-linguistic context. Cultural validity for psychometric instruments is a journey rather than a destination, and culturally competent clinical judgment is critically important when interpreting any psychometric instrument. The CCAPS subscales have been found to retain their integrity (i.e., factor structure) across a variety of population groups (Locke et al., 2011). However, we strongly encourage those using the CCAPS to actively integrate culturally informed clinical knowledge with information provided by the CCAPS.

There are several areas of concern addressed by the CCAPS for which clinicians are especially encouraged to consider cultural influences. For instance, culture and socialization may impact clients' general tendency to rate their distress as higher or lower overall. Examples might include culturally driven somatization, withholding of information due to perception concerns or mistrust of mental health professionals, generic cross-cultural challenges (e.g., finding appropriate food), familial expectations (e.g., academic performance), or simply misunderstanding of a word or phrase (e.g., "purge" is often misunderstood by international students). Cultural factors may also influence a client's willingness to endorse different types of items. For example, it is more common in some cultural groups (e.g., Asian cultures; Uba, 1994) to endorse somatic complaints that may or may not be associated with mental health concerns. In such cases, it is important to assess the array of potential causes for these symptoms, both medical and psychological, and to note that factors such as cultural norms and social acceptability can impact both the manifestation and expression of mental health concerns.

SOCIAL DESIRABILITY

The desire to be viewed in a positive light by others (social desirability) impacts all self-report measures, including those that assess psychological distress. In addition, assessment tools are directly impacted by clients' agendas, such as over-reporting to communicate urgency or under-reporting in order to present themselves in a favorable light. Locke et al. (2011) and McAleavey, et al. (2012) found that, in aggregate, low scores for both clients and non-clients were associated with increased levels of social desirability. Conversely, this also means that elevated scores are associated with decreased levels of social desirability (e.g., the client is less concerned with how they appear to others).

Clinicians are encouraged to consider both low and high scores in the context of the client's comfort level with evaluation and treatment. In the event that it becomes clear that social desirability is impacting a client's scores during treatment, we recommend a collaborative dialogue to help the client report distress accurately and openly. This can represent a valuable intervention related to the client's ability to be authentic in therapy.

CONSIDERATIONS WHEN IMPLEMENTING THE CCAPS

The implementation of a new assessment instrument (especially when one has not been used historically) can elicit a wide range of clinician reactions ranging from excitement to fear. Because of this, it is important to commit sufficient time to professional development experiences that educate clinicians about the instrument's history and features, explain how to use it in conjunction with existing clinical expertise and judgement, and provide time/space to discuss reactions, questions, and concerns in a collaborative manner. In one study examining the implementation of the CCAPS within a large university counseling center, researchers found that most clients have no complaints about completing the instrument on a regular basis, even when it is newly introduced.

However, clients who disliked the instrument tended to be paired with clinicians who didn't integrate the results into treatment or expressed dissatisfaction with the instrument (Martin, Hess, Ain, Nelson, & Locke, 2012).

It is critical to collaboratively engage the client when using the CCAPS for repeated measurement over time. For example, if clients are not aware of how the information is being used, they may be reluctant to complete the survey as directed or may not answer honestly. Clinicians are encouraged to have a direct discussion with clients at the beginning of treatment that highlights how the instrument can impact treatment, including the opportunities to monitor progress and assess various types of distress in comparison to peers. It can also be useful to mention that the clinician will be monitoring the results on a regular basis even if the Profile Report is not explicitly mentioned in session. Outlining the benefits of using the CCAPS can help clients see the utility in completing the measure and become more comfortable discussing it in therapy.

Getting Started

The CCAPS 2021 Profile Report represents more than a decade of research intended to meet the clinical needs of mental health providers in college counseling centers. The CCAPS Profile Report includes a set of features designed to translate the individual responses of one client into a set of information that can directly inform clinical work. This "Getting Started" section is intended to provide a brief overview of the instrument's Normative Sample and Profile Report features.

CCAPS NORMATIVE SAMPLE INFORMATION

The "engine" behind the CCAPS Profile Report is the CCAPS normative sample, a large set of CCAPS responses from college students seeking treatment in counseling centers that have been contributed to CCMH over time. The Profile Report is generated by comparing one client's responses to the normative sample, or sub-samples, depending on the feature.

2018 Normative Sample Demographics

The total 2018 normative sample is used to generate percentile scores and includes approximately 388,266 students seeking services at 236 college counseling centers during the 2015-2017 academic years. The total normative sample includes CCAPS data contributed by counseling centers via Titanium Schedule and data submitted to the CCAPS Web Service via Medicat, Point and Click, and Pyramed. Of the normative sample, demographic data was contributed via Titanium Schedule for approximately 241,199 students from 155 centers. The demographic characteristics of this portion of the total 2018 Normative Sample are as follows:

Age:

Range: 18–60 years
Modal age: 19 years
Mean age: 22.09 years
SD = 4.21

Gender:

63.6% female
34.8% male
0.5% transgender
1.1% self-identified

Race/Ethnicity:

8.6% African American/Black
0.5% American Indian or Alaskan Native
7.9% Asian/Asian American
8.2% Hispanic/Latino/a
0.2% Native Hawaiian or Pacific Islander
4.8% Multiracial
68.1% White/Caucasian
1.6% Other (self-identify)

Academic Status:

21.7% freshman
20.4% sophomores
22.2% juniors
20.3% seniors
15.4% graduate students or other

Average Treatment-Response Curves

Treatment-response curves were not updated in the current CCAPS 2021 Manual, thus, the response curves and demographic characteristics provided below are retained from the 2015 normative sample. The average response curves are based on a smaller subset of clients from the total normative sample and describe the average client response to individual counseling. Clients included in this sample attended individual counseling sessions, had at least two CCAPS administrations (one at baseline prior to treatment, and at least one other administration at any point in treatment), and attended at least two sessions. These criteria resulted in a sample of about 30,000 clients from 126 centers who were seen for variable treatment lengths. The characteristics from this subsample are as follows:

Age:

Range: 18–42 years
Modal age: 19 years
Mean age: 22.56 years
SD = 4.88

Gender:

66.9% female
32.0% male
0.4% transgender
0.7% self-identified

Race/Ethnicity:

71.2% White/Caucasian
8.4% Black/African American
5.5% Asian/Asian American
8.0% Hispanic/Latino/a
4.6% Multiracial
1.7% Other
0.4% American Indian or Alaskan Native
0.3% Native Hawaiian or Pacific Islander

Academic Status:

16.7% first-year students
19.3% sophomores
23.6% juniors
23.1% seniors
17.3% graduate students or other

CRITERIA SCREEN

When you request a CCAPS Profile Report within supported software a "Criteria Screen" will be displayed in order to specify the parameters of the report. This screen will vary slightly by software vendor. The CCAPS Profile Report can then be run based on the default values (these will be correct in most cases) or you can customize them to design a report specific to your needs.

Sample criteria screen:

Report Type: (•) Treatment Response ( ) All CCAPS Administrations
CCAPS Date: 4/7/2021 (34)
CCAPS Scoring: (•) CCAPS-34 ( ) CCAPS-62
Orientation: (•) Portrait ( ) Landscape
Baseline Date: 2/24/2021 (62)
[ ] Save Baseline for Center [ ] Save Baseline for Me
Print | Preview | Cancel

The CCAPS Profile Report criteria include:

1. **Report Type:**
   a. **Treatment Response (individual counseling):** This default report is applicable in most circumstances (first appointment or ongoing treatment) when a client is being seen for either initial assessment or ongoing individual counseling and the clinician is interested in the client's response to treatment. This report includes treatment response features (see below for details), excludes CCAPS administrations without an individual therapy appointment on the same day, and includes dates of individual therapy appointments (as a dose of treatment) even if a CCAPS was not administered on that day. (not available for the CCAPS-62).
   b. **All CCAPS Administrations:** Excludes treatment response features and includes all CCAPS administrations regardless of appointment attendance.
2. **CCAPS Date:** The default setting selects the most recent CCAPS administration. You may select an older administration date if desired.
3. **CCAPS Version (62 or 34):** The default setting will match the version selected in Step #2. If the version selected in Step #1 is a 62, you can choose to score it as a 62 or as a 34. If the version selected in Step #1 is a 34, you will not be able to choose a different version.
4. **Orientation:** Choosing "Portrait" orientation (default) will result in a vertically oriented report that includes the header, graphical, and tabular sections. The "Landscape" report excludes the tabular section.
5. **Baseline Date:** The baseline is meant to represent the start of treatment. The default setting will be the first administration of the current academic year. You may select a different administration date if desired. (Some software implementations may allow you to save the baseline preference).

CCAPS 2021 PROFILE REPORT OVERVIEW AND BRIEF DESCRIPTIONS

CCAPS 34 Profile Report v 07/2021
Name: SAMPLE | Date: 7/31/2021 | Appointments: 13
Student ID: 987654321 | Age: 23 | Administrations: 13

↓ Percentile Score → (0–100); Alerts

		Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Alcohol Use	Distress Index	SI	THO
1)	Baseline: 4/9/2021	97	95	96	88	79	81	72	97	4	0
2)	4/21/2021	93 *	88	85	82	83	85	72	95 *	3	0
3)	4/28/2021	98	97	89	97	58	67	48	97	4	0
4)	5/8/2021	68	81	80	69	58	39	48	71	2	0
5)	5/18/2021	93	66	85	82	67	61	48	84	4	0
6)	6/2/2021	98	88	85	93	38	92	48	97	4	0
7)	6/23/2021	97	85	89	100	67	92	48	97	4	1
8)	7/1/2021	93	88	80	93	38	81	48	94	4	0
9)	7/8/2021	97	95	98	100	38	98	78	99	4	2
10)	7/10/2021	90	81	93	100	38	85	65	93	3	1
11)	7/15/2021	58	61	54	76	38	81	48	63	2	0
12)	7/22/2021	68	61	54	69	38	61	48	59	2	0
13)	Current: 7/31/2021	78	55 ↓	61 ↓	69	38 ↓	47 ↓	48	61 ↓	2	0
14)											
15)											

#	Depression	
4	I don't enjoy being around people as much as I used to	2
5	I feel isolated and alone	3
11	I feel worthless	3
12	I feel helpless	3
21	I feel sad all the time	2
25	***I have thoughts of ending my life (SI)***	***2***
	Generalized Anxiety	
2	My heart races for no good reason	3
7	I am anxious that I might have a panic attack while in public	1
9	I have sleep difficulties	2
10	My thoughts are racing	2
15	I have spells of terror or panic	2
17	I feel tense	2
	Social Anxiety	
1	I am shy around others	3
19	I make friends easily **	2
22	I am concerned that other people do not like me	2
24	I feel uncomfortable around people I don't know	1
26	I feel self conscious around others	3
	Academic Distress	
8	I feel confident that I can succeed academically **	1
	Academic Distress *(continued)*	
28	I am not able to concentrate as well as usual	2
30	It's hard to stay motivated for my classes	3
33	I am unable to keep up with my schoolwork	2
	Eating Concerns	
3	I feel out of control when I eat	0
6	I think about food more than I would like to	0
13	I eat too much	0
	Frustration /Anger	
18	I have difficulty controlling my temper	1
20	I sometimes feel like breaking or smashing things	0
23	I get angry easily	1
29	***I am afraid I may lose control and act violently***	***0***
32	I frequently get into arguments	1
34	***I have thoughts of hurting others (THO)***	***0***
	Alcohol Use	
14	I drink alcohol frequently	0
16	When I drink alcohol I can't remember what happened	0
27	I drink more than I should	0
31	I have done something I have regretted because of drinking	0

The CCAPS Profile Report is created by transforming a client's raw item responses into a set of clinically relevant and psychometrically sound information that can be used to inform clinical practice. This section describes each of

the features of the profile report. A full understanding of these is required for an accurate interpretation.

Treatment Response Features

Features designated as [Treatment Response Feature] are designed to help clinicians understand how a given client (being treated with individual counseling) is changing per subscale, in comparison to clients with the same number of individual counseling sessions who started with a similar baseline subscale score. These features are available if:

- The Current Administration is being scored as a CCAPS-34
- The "Treatment Response" report type is selected in Step #1 of the Criteria Screen.

Header Section

1. **Version** – indicates whether the current CCAPS administration is scored as a 62- or 34-item version.
2. **Student Information** – displays information about the client (may vary by software).
3. **Appointments** – the number of attended appointments included in this report, inclusive of baseline and current administrations. Note: the total number of appointments may exceed what is displayed in the tabular data section. [Treatment Response Feature]
4. **Administrations** – the number of CCAPS administrations included in this report, inclusive of baseline and current administration. Note: the total number of administrations may exceed what is displayed in the tabular data section.

Graphical Data Section

5. **Subscales** – each subscale of the CCAPS has its own section and graphical profile.
6. **Plotted Percentile Scores** – the subscale scores for each administration, listed in the tabular data section, are plotted using a percentile range of 0 to 100%. Up to 15 administrations can be plotted. (Note: In the event that a client has more than 15 appointments/ administrations the plotted point of the baseline score will not be connected to the next CCAPS score, indicating the discontinuity between these two scores.)
7. **Appointment without a CCAPS Administration** – If a client attended an individual counseling appointment (date listed in Tabular Data) but did not complete a CCAPS on that date, there will be no plotted score.
8. **High Distress Range** – the red zone, unique to each subscale, represents a range of scores above the high cut score, associated with high or elevated distress.
9. **Moderate Distress Range** – the yellow zone, unique to each subscale, represents a range of scores above the low cut score, and below the high cut score, associated with moderate distress.
10. **Low Distress Range** – the white zone, unique to each subscale, indicates low or no distress.
11. **Scale Floor** – the gray zone, at the bottom of each subscale, represents a range of unattainable percentile scores. That is, the top of the gray zone represents the lowest possible percentile score for the subscale, due to the floor effects of the subscale. These can be further understood by examining the normative sample histograms in Appendix C.
12. **SI Graph** – this graph, on the right-hand side, plots the client's endorsement of "Suicidal Ideation" (SI) over time. More specifically, this graph plots the client's endorsement of the item, "I have thoughts of ending my life" over time using the CCAPS scale of 0 to 4.
13. **THO Graph** – this graph, on the right-hand side, plots the client's endorsement of "Thoughts of Hurting Others" (THO) over time. More specifically, this graph plots the client's endorsement of the item, "I have thoughts of hurting others" over time using the CCAPS scale of 0 to 4.
14. **Average Response Curve** – within each subscale graph, the green dotted line represents the average response curve for clients starting with a similar baseline subscale score. Response curves are plotted starting at the administration after baseline. [Treatment Response Feature]
15. **Alert Row (Alert)** – a blue dot in this row represents an "off track" warning. This means that the client's most recent subscale score is more elevated than would be expected for 90% of the treatment-seeking population who (a) started with a similar baseline subscale score and (b) have had the same dose of treatment (attended appointments). [Treatment Response Feature]
16. **Alert Row (No Alert Possible)** – if an alert for a given subscale cannot be computed, a double-dash (--) will be presented. Alerts are only computed for up to 20 administrations/appointments and alerts cannot be computed for some specific baseline/subscale combinations (e.g., a very high baseline score and the initial treatment appointments). [Treatment Response Feature]

Tabular Data Section

17. **Tabular Data** – a listing of up to 15 CCAPS administrations and/or treatment appointments with percentile scores of each subscale on each administration date. Dates are in ascending order, with the most recent administration at the bottom. Tabular percentile scores are plotted in graphical area above for each subscale. If a client has more than 15

appointments/administrations, the report will display the Baseline administration and the 14 most recent appointments/administrations (depending on report type). In this situation, a thick line will separate the Baseline from the next administration.

18. **Missing Data Indicator (*)** – a percentile score accompanied by a star (*) indicates that one or more answers were missing for that subscale on that date.
19. **Unscored Indicator (--)** – a double dash is displayed (--) when a subscale could not be scored, for that administration date, because at least 33% of the items on that subscale had missing answers.
20. **Appointment without CCAPS** – if the client attended an individual counseling appointment but did not complete a CCAPS on the same date, there will be a date in the left-hand column, and unscored indicators (--) in the subscale cells. [Treatment Response Feature]
21. **CCAPS without Appointment** – if a CCAPS administration does not have an individual counseling appointment on the same day, a "dagger symbol" (†) will be displayed after the date. It is recommended that the CCAPS be administered on the same day as clinical appointments to ensure a timely review.
22. **Baseline Administration** – the CCAPS administration date representing the start of treatment. This may be the default administration (first administration of the current academic year) or a custom date. Average response curves and alerts are calculated from baseline subscale scores. [Treatment Response Feature]
23. **Current Administration** – the most recent CCAPS administration.
24. **Suicidal Ideation (SI) Data** – this column displays the client's raw score for the item, "I have thoughts of ending my life" across all administrations.
25. **Thoughts of Hurting Others (THO) Data** – this column displays the client's raw score for the item, "I have thoughts of hurting others" across all administrations.
26. **Reliable Change Indicators (RCI)** – the "current" administration (the bottom row of tabular data) will show an RCI indicator if the amount of change between "Baseline" and "Current" meets the criteria for reliable change on each subscale. A reliable decrease is illustrated with a downward pointing arrow; a reliable increase is demonstrated with an upward pointing arrow.

Current Administration Section (portrait orientation only)

27. **Raw Answers** – raw responses for the current administration are grouped by subscale.
28. **Reverse-Score Indicator (**)** – items that are reverse scored, when computing subscale percentile scores, are noted with a double asterisk (**) after the item text.
29. **Critical Items** – items that should be reviewed at every administration are presented in bold, italics, and blue.

CCAPS 2021 QUICK REFERENCE INTERPRETATION GUIDE (FIRST APPOINTMENT)

The CCAPS should always be scored and reviewed prior to meeting with a client. The following interpretive strategy is recommended for new clients at their first appointment:

1) **Subscale Scores:** Review subscale scores one by one and note subscales in the "elevated" range (red zone). These may indicate a high level of distress that should be further assessed for diagnostic concerns. Consider scores in the middle range (yellow zone) as areas to be aware of, but a lesser priority. Scores in the low range (white zone) are unlikely to represent important areas of assessment, though clients do minimize concerns on occasion.
2) **Pattern of Scores:** Does the Profile Report indicate a single spike on one or two subscales, or widespread elevation? A single spike on one scale is likely to represent a well-defined presenting concern, whereas multiple elevated scores may be indicative of pervasive distress, comorbid concerns, high levels of situational distress, chronic distress, poor distress tolerance, or personality patterns. Multiple elevated scores are a reminder to the clinician that a more structured interview approach may be needed to ensure there is sufficient time to assess each area of distress.
3) **Review Critical Items** (CCAPS-62 numbering below):
   a. 12 – I lose touch with reality (Depression): Many students endorse this item with general distress and depression. However, it is worth following up to determine if dissociative experiences are present and to understand their perspective when endorsing.
   b. 46 – I have thoughts of ending my life (Depression): This item reflects Suicidal Ideation (SI) and should always be reviewed.
   c. 52 – I'm afraid I may lose control and act violently (Frustration/Anger): If endorsed, the student may feel like they are having trouble maintaining control. This item can be helpful when evaluating impulsivity (current or past).
   d. 60 – I have thoughts of hurting others (Frustration/Anger): This item reflects the potential for Thoughts of Hurting Others (THO) and should always be reviewed.

4) **Scan Through the Raw Scores** – Take note of outliers, patterns, or specific symptoms. For example:

   a. A client may have a very low subscale score, but strongly endorse several items that illustrate the client's unique concern (e.g., panic attacks but no other anxiety symptoms).

   b. A client may endorse a specific subset of items (e.g., somatic symptoms of anxiety or low self-esteem in depression), which offers insight into the client's unique experience and distress.

5) **Assess for Valid Responding** – A quick scan of the raw scores will offer insight into whether or not a Profile Report is valid:

   a. Did the client use the same answer for all questions, including reverse-scored items? If yes, this is suggestive of invalid responding.

   b. Did the client make use of the full response range from 0 to 4? A typical profile should include items endorsed at every level (0, 1, 2, 3, and 4).

   c. Subscale consistency – items within a subscale should generally be answered in a similar manner. Take note of conflicting responses (e.g., I feel great about my body but am very dissatisfied with my weight) and reverse-scored items. If someone is responding with random responses (or all of the same answer), reverse-scored items will generally appear to contradict other items. Contradictory responses within a subscale should be further assessed.

   d. Missing data – note any missing responses to individual questions. This can be accidental or intentional.

6) **Compare the Profile Report to the Clinical Interview:**

   a. Under-reporting – when a Clinical Interview reveals much more distress than the Profile Report, consider the role of image management, pleasing others, and social desirability.

   b. Over-reporting – when a Clinical Interview reveals much less distress than the Profile Report, consider dynamics such as attention-seeking, motivation for appearing distressed, interpersonal style, etc.

CCAPS 2021 QUICK REFERENCE INTERPRETATION GUIDE (TREATMENT MONITORING)

When used on a regular basis the CCAPS-34 provides information about how a client's self-reported distress is changing over time. (Review the "CCAPS 2021 Quick Reference Interpretation Guide [First Appointment]" on page 10 for basic interpretation steps.) The following additional steps are useful when reviewing a CCAPS-34 Profile Report, with Treatment Response Features, during the course of treatment.

1. **CCAPS Instructions Calibration:** The CCAPS instructions ask the client to evaluate each item "over the past two weeks." Many students do not read instructions carefully or may refer to a generalized internal scale (e.g., "has this ever happened to me?" or "how do I feel in this moment?"). When using the CCAPS on a regular basis, the first step is to reach agreement with your client about the time frame they will use for future administrations. It is recommended that you ask clients to evaluate each question using the time frame, "since my last appointment" or "during the last two weeks," whichever is shorter. Depending on the client, it may also be important to discuss the rating scale of 0 to 4 so that they are more consistent and accurate in their responses.

2. **Baseline:** Ensure that the correct baseline date is being used. The baseline determines the start of treatment and is used to calculate Treatment Response Features. Adjust as needed.

3. **Dosage Delivered:** Consider the number of attended appointments (treatment dosage). How does this compare to treatment expectations, treatment limits, and treatment goals? Do you need to make any changes or begin planning for next steps?

4. **Review Subscales:** An examination of subscale scores over time provides a variety of information for consideration during treatment.

   a. Which subscales began above the high cut score? (red zone) These will typically represent the areas of high distress and should be a focus of treatment. How are these subscales changing?

   b. Are any subscales getting worse? If so, what does this mean for your client?

   c. How are the subscales moving in relation to each other? For example, Depression and Anxiety may decline even while Academic Distress increases reflecting decreased symptoms but elevated academic-related stress.

5. **Average Treatment-Response Curve:** The response curves offer a visual indicator of the average treatment response for clients who started with a similar baseline score. How do your client's scores compare to the average response curves? If the student's scores are below, or close to, the average response curve, this means the client's improvement is broadly similar to, or better than, clients who (a) have attended the same number of appointments and (b) had a similar baseline score for that subscale. Conversely, if clients' scores are consistently above the average response curve, this means they are changing more slowly than their peers.

6. **Alerts:** Alerts provide an "off track" warning to focus your attention on subscales that are either improving extremely slowly or deteriorating – such that you may want to examine your treatment plan. An alert means that the client's most recent subscale score is more elevated than would be expected for 90% of the treatment-seeking population who (a) started with a similar baseline score and (b) have attended the same number of counseling appointments. If you have an alert, take time to review your client's situation, diagnosis, treatment, and progress to determine if changes are needed. One or more alerts may represent a lull in progress, emotional lability, a chronic crisis situation, poor response to treatment, or a severe/persistent symptom pattern.
7. **Reliable Change Indicators (RCI):** Review the "Current" row in the tabular data to see if the amount of change between Baseline and Current represents reliable change for each subscale.
8. **SI/THO Review**: Take a moment to review how your client is responding to the SI/THO questions over time. Any positive endorsement, or change in endorsement, should be reviewed with the client.

CCAPS Profile Report Features – Detailed Descriptions

DISPLAY OF MULTIPLE ADMINISTRATIONS

The CCAPS 2021 Profile Report will display up to 15 administrations and/or appointments, including the Baseline administration (first administration) and the Current administration (most recent). The "Treatment Response" report will include individual counseling appointments with or without a CCAPS administration associated with it, as both types of appointments represent a dose of treatment. The "All CCAPS Administrations" report will simply display all administrations of the CCAPS. If more than 15 administrations are present, the selected baseline and the 14 most recent administrations will be presented.

INDIVIDUAL QUESTIONS AND ANSWERS

When a client completes the CCAPS questionnaire, the items are intentionally randomized. Questions are grouped by subscale in the Profile Report to make it convenient for the clinician. This can be helpful for a more nuanced understanding of a subscale score (e.g., what type of depressive symptoms are endorsed).

Critical Items

Items that carry information about risk are highlighted in blue, bold, and italics in the individual answers in the current administration. They are highlighted to draw your attention to potential risk and encourage follow-up questioning if needed. The CCAPS-62 contains four critical items addressing suicidal ideation (SI), thoughts of hurting others (THO), violent behavior, and potential thought disturbance. It is important to note that the SI/THO items were intentionally designed to be sensitive to low-level ideation. Endorsement above a 0 should be further assessed in the clinical interview.

The CCAPS-34 contains three critical items – those pertaining to risk of suicidal ideation (SI), thoughts of hurting others (THO), and violent behavior. The fourth critical item pertaining to thought disturbance was not included on the CCAPS-34 (see Locke et al., 2011 for more details). Clinicians are encouraged to monitor these items and gather additional information to assess for risk.

Critical Items:

- I lose touch with reality (#12 on CCAPS-62)
- I have thoughts of ending my life (#46 on CCAPS-62, #25 on CCAPS-34)
- I am afraid I may lose control and act violently (#52 on CCAPS-62, #29 on CCAPS-34)
- I have thoughts of hurting others (#60 on CCAPS-62, #34 on CCAPS-34)

Suicidal Ideation and Thoughts of Hurting Others (SI/THO) Tracking

The CCAPS Profile Report reprints (and graphs) the client's responses to the SI/THO items. Answers to these items are printed regardless of the client's response (a dash will appear if an item was not answered) because the presence and absence of suicidal ideation and thoughts of hurting others is essential to know when assessing clients. Particular attention should be paid to increasing levels or sudden changes in either item.

- SI = I have thoughts of ending my life (#46 on CCAPS-62, #25 on the CCAPS-34)
- THO = I have thoughts of hurting others (#60 on CCAPS-62, #34 on the CCAPS-34)

SUBSCALES

The CCAPS-62 has 8 subscales including Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Family Distress, Frustration/Anger, and Substance Use. The CCAPS-34 has 7 subscales: Substance Use becomes Alcohol Use and there is no Family Distress subscale. In addition, each subscale in the CCAPS-34 is comprised of fewer items. Clients are instructed to evaluate each item based on the "last two weeks." Please keep this in mind when considering each subscale, and inquire with clients to be sure they understand the reporting period.

Depression

The Depression subscale of the CCAPS-62 and CCAPS-34 captures feelings of isolation, worthlessness, lack of enjoyment and hope, sadness and suicidal ideation. The subscale on the CCAPS-62 also consists of questions that examine disassociation, lack of enthusiasm, unwanted thoughts, and tearfulness. The Depression subscale does not assess for weight gain or loss, psychomotor agitation, insomnia/hypersomnia, or fatigue. It does not assess for chronicity or frequency of symptoms.

Generalized Anxiety

The Generalized Anxiety subscale of the CCAPS-62 and CCAPS-34 contains questions that assess for racing thoughts, sleep difficulties, tension, racing heart, and panic attacks or fear of panic attacks. The CCAPS-62 version also asks questions about being easily startled and having nightmares/flashbacks. This subscale does not have questions that specifically assess for obsessive symptoms, excessive worry, concentration, irritability, fatigue, or restlessness.

Social Anxiety

The Social Anxiety subscale of the CCAPS-62 and CCAPS-34 contains questions aimed at assessing shyness, ability to make friends easily, self-consciousness, and feeling discomfort around people. The CCAPS-62 also contains a question that specifically focuses on fear of speaking in front of large audiences. The subscale does not assess for avoidance of social situations, recognition that one's fear is excessive, or fear that a person's behavior will lead to humiliation/embarrassment.

Academic Distress

The Academic Distress subscale of the CCAPS-62 and CCAPS-34 focuses on academic confidence, motivation, enjoyment, and concentration. The CCAPS-62 also asks about a student's ability to keep up with their schoolwork. This subscale does not collect information on a student's GPA or actual performance. It is important to keep in mind that high-performing students can experience high levels of academic distress while low-performing students may deny academic distress.

Eating Concerns

The Eating Concerns subscale of the CCAPS-62 and CCAPS-34 consists of questions that focus on preoccupation with food, worry about eating too much, and feeling a lack of control when eating. The CCAPS-62 also inquires about dieting, purging, feelings toward self based on eating habits, and satisfaction with weight and body shape. The Eating Concerns subscale does not ask about weight gain and/or loss, excessive exercise, fear of weight gain, amenorrhea, overeating during discrete time periods, or the chronicity of behavior. Non-native English speakers may easily misunderstand the word "purge".

Frustration/Anger

The Frustration/Anger subscale of the CCAPS-62 and CCAPS-34 (formerly the Hostility subscale) was renamed in 2021. The Frustration/Anger subscale captures difficulty controlling temper, thoughts of hurting others, fear of acting out violently, frequently getting into arguments, feeling easily angered, and the desire to break things. The CCAPS-62 also assesses for irritability. A high score on this scale does not necessarily mean that a client is dangerous or aggressive. Rather, high scores represent high levels of frustration, anger, suppressed feelings, and difficulty managing emotions or reactions.

Family Distress (CCAPS-62 only)

The Family Distress subscale of the CCAPS-62 assesses for history of family abuse, negative feelings toward family members, and hope for improved family interaction. In addition, the subscale also inquires whether the student feels loved by their family members and views the family as happy.

Substance Use (CCAPS-62) or Alcohol Use (CCAPS-34)

The Substance Use subscale of the CCAPS-62 contains questions about consuming drugs or alcohol more than one should, black-out symptoms due to alcohol use, enjoyment associated with being intoxicated, and regrets due to events related to drinking. The CCAPS-34 assesses only for alcohol use and does not contain any questions pertaining to drug use. The CCAPS-62 and CCAPS-34 do not assess for withdrawal, tolerance, legal issues, or failure to fulfill responsibilities.

Distress Index

Description

The Distress Index (DI) provides an overall measure of a client's general psychological distress using items from the Depression, Generalized Anxiety, Social Anxiety, Academic Distress, and Frustration/Anger CCAPS-34 Subscales. This index should *NOT* replace a careful examination of all CCAPS subscales, as the DI cannot measure specific types of distress and it does not include items from the Eating Concerns, Family Distress, and Substance/Alcohol Use Subscales. Thus, evaluation of an elevated Distress Index in conjunction with other subscales offers the ability to distinguish two equal distress scores: for example, a client who is anxious about academic performance compared to another client who is feeling somewhat depressed, angry, and experiencing eating behaviors that feel out of control. As such, the DI is primarily useful for examining questions about generic distress.

Background

The Distress Index (DI) was created in response to CCMH member requests for a consolidated measure of overall distress (Nordberg et al., 2016) while avoiding

the problems of an arbitrary total score. In reviewing the psychological assessment landscape, it was determined that some instruments provide a "total score" or other broad-based distress scores, but other sources caution against this practice (McAleavey, Nordberg, Kraus, & Castonguay, 2012). Specifically, it has been highlighted that aggregated scores are convenient and have several useful properties; however, they have recently been questioned related to psychometric properties and clinical utility, especially when calculated within an existing, validated multi-dimensional instrument. In order to allow for seamless integration between the CCAPS-62 and CCAPS-34 over time, the Distress Index is calculated only from CCAPS-34 items. Thus, the Distress Index is identical for the CCAPS-62 and CCAPS-34 so that the scores can be compared.

The Distress Index was developed by evaluating several different models, including a second-order factor model (which identifies subscales that may be influenced by a common higher-order factor), a bifactor model (which targets items that are related to a general factor as well as a subscale-specific factor), and a simple total score composed of every item on the CCAPS. Upon completion of these analyses, the bifactor model was selected as the best fit for the Distress Index.

PERCENTILE SCORES

There are a number of approaches for converting individual item responses into a subscale score that can be interpreted. The CCAPS Profile Report uses percentile scores because they are easy for both clinicians and clients to understand. A percentile score reflects a client's position relative to the current normative sample. For example, a percentile score of 85 on the Depression Subscale means that the client's score is greater than 85% of other clients in the normative sample. Higher percentile scores always reflect greater distress.

Percentiles offer several advantages over raw scores and normalized scores (e.g., t- or z-scores) when used in clinical settings. Without providing too much statistical detail, a percentile score converts your client's raw subscale score into an easily interpretable "description" of how severe your client's distress is, relative to the normative sample. This is important because the distribution of raw scores, within the normative sample, varies for each subscale (e.g., 0 to 4). For example, a raw score of 2.0 represents the 66th percentile for Depression and the 85th percentile for Eating Concerns. Without the percentile scores, a clinician might assume that the same raw scores, on different subscales, reflect the same level of distress.

Because the distribution of CCAPS subscale scores varies within the normative sample, it is important to be aware that percentiles will not be equally sensitive at all points. For example, when a subscale is positively skewed (high number of responses indicating no or minimal distress, e.g., Eating Concerns) in the normative sample, a relatively small change in the raw score at the low end of the scale will produce a comparatively large percentile change. Conversely, at the high end of the scale (small number of responses reporting high levels of distress), a relatively large raw score change will produce a much smaller percentile score change. Clinicians should review and understand the subscale distributions in Appendix C to more fully understand how percentiles will work for each subscale.

In general, the CCAPS subscales have minimal ceiling effects (i.e., the subscales are good at differentiating among high levels of distress on most subscales), and relatively common floor effects (i.e., the subscales are not as good at discriminating among low-distress scores). These characteristics are ideal for utilization within clinical settings as practitioners are most concerned about elevated scores (and change therein).

SEVERITY INDICATORS / CUT SCORES

Each subscale of the CCAPS has two interpretive thresholds, or cut-scores, which are used to facilitate interpretation of CCAPS scores in clinical practice. The cut scores effectively divide each subscale into three ranges of distress: Low, Moderate, and High. Initial development of the cut scores was published in 2012 (McAleavey et al., 2012).

The high cut scores were recalculated in 2018 using data from 67,613 clients between 2015 and 2017. Similar to the process used by McAleavey et al. (2012), the data were divided into two sub-samples according to a 70%/30% split. The larger sub-sample was used to determine the high cut score that best discriminates between students with and without a diagnosis on that subscale according to Youden's Index (i.e. "training"), and the smaller sample was used to validate the score (i.e. "testing"). For subscales without a corresponding diagnosis, high cut scores were set to the 70th percentile. Using this procedure, high cut scores were retained if they remained unchanged from those established in 2012. However, the high cut scores were updated if they were different than those set in 2012.

Low cut scores were recalculated in 2019 using data from 448,904 students between 2016 and 2018. Low cut scores were first established in 2012 to distinguish between students not in treatment and students seeking treatment at university counseling centers (see McAleavey et al. 2012 for more information). However, this approach could not be used in 2021 due to the lack of a large, up-to-date, and representative non-clinical sample. After testing many approaches, CCAPS 2021 low cut points for normally distributed subscales (Depression, Generalized Anxiety, Social Anxiety, Academic Distress, and the Distress Index) were set to the 30th percentile (first administration, clinical data). Low cut points for skewed distributions

(Eating Concerns, Frustration/Anger, Substance/Alcohol Use, and Family Distress) were set to the mean (first administration, clinical data).

Cut scores are represented through color shading in both the graphical and tabular sections of the CCAPS 2021 Profile Report:

- Low (white) — Scores in this range are consistent with college students who report no, or minimal, distress in each area.
- Moderate (yellow) — Scores in this range are most consistent with college students who report moderate distress in each area, and further assessment is recommended to determine the nature of the distress.
- High (red) — Sometimes described as "elevated", scores in this range are consistent with high levels of distress that should be further assessed for a diagnosis if the subscale is associated with a diagnostic area (i.e., Depression, Generalized Anxiety, Social Anxiety, Eating Concerns, and Substance/ Alcohol Use). The liklihood of a diagnosis increases as the score increases above the high cut point. For subscales that are not associated with a particular diagnosis (Academic Concerns, Family Distress, and Frustration/Anger), an elevated score represents levels of distress greater than 70% or more of the clinical normative sample.

The high cut points were updated for the following CCAPS Subscales in 2018:

— Depression (Both CCAPS-34 and 62)
— Generalized Anxiety (CCAPS-62 Only)
— Social Anxiety (CCAPS-62 Only)
— Frustration/Anger (CCAPS-34 Only)
— Substance Use (CCAPS-62 Only)
— Distress Index (Both CCAPS-34 and 62)

Low cut points were updated for all subscales in 2019.

RELIABLE CHANGE INDEX (RCI)

One frequently used measure of change in distress in the psychotherapy literature is the Reliable Change Index (RCI; Jacobson & Revenstorf, 1988; Jacobson & Truax, 1991). RCIs represent the minimum amount of change on a single subscale that must take place before that change can be regarded as real change with 95% certainty. RCIs are calculated for each subscale based on its unique psychometric properties, therefore, each subscale has a different RCI. On the CCAPS, RCIs are calculated based on the raw scores, not percentiles, using scores from the 2015-2017 sample of clinical data.

RCIs are displayed on the "Current" row of tabular data for both the CCAPS-62 and the CCAPS-34 by comparing the "Baseline" administration to the "Current" administration for both the CCAPS-62 and CCAPS-34. For a given subscale, a reliable decrease is illustrated with a downward pointing arrow; a reliable increase is illustrated with an upward pointing arrow. Because RCI's provide a simple pre/post test of change (irrespective of the number of sessions attended), they are included when other Treatment Response Features are turned off.

Treatment Response Features

BASELINE INDICATOR

When multiple CCAPS administrations are present, the earliest CCAPS administration during the current academic year is marked as the "Baseline" administration by default. (This can be changed at the Criteria Screen). Subsequent administrations are compared to baseline for computing RCIs, Change Curves, and Alerts.

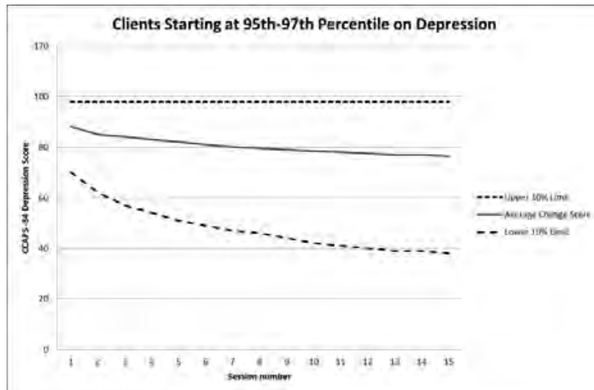
AVERAGE TREATMENT-RESPONSE CURVES AND "OFF-TRACK" ALERTS

Overview

The CCAPS 2021 incorporates two additional types of clinical feedback (average response curves and clinical alerts) that are drawn from the literature on expected treatment response (ETR) (e.g., Lueger et al., 2001; Finch, Lambert, & Schaalje, 2001; Lutz, Martinovich, & Howard, 1999). ETR research suggests that these types of tools aid in identification of clients at risk for treatment failure, thereby increasing the odds of positive treatment outcome (Lutz et al., 2006). The CCAPS 2021 provides Average Treatment-Response Curves for each subscale, which were created from the 2015 CCAPS normative sample consisting of approximately 30,000 clients in treatment at counseling centers. The response curves are calculated for each baseline score and then plotted for each attended individual therapy appointment (dose of treatment) to illustrate the average subscale score of the normative sample at each session number.

In addition to the average response curve, the CCAPS 2021 Profile Report also includes an "off-track" alert system that is intended to alert the clinician if a client is not making expected progress. For the current CCAPS administration, an off-track alert (indicated by a blue dot on the Alert row) is generated when a client's change, at a given session number and subscale, is less than what can be expected for 90% of clients who have a similar baseline subscale score. The alert means that the client is "off track" of the average response curve for a given point in treatment. Clients who are "on track" for a given subscale will show no alert, indicating that their progress is consistent with 90% of the population who began treatment with a similar baseline subscale score. Research has shown that feedback for off-track clients improves outcomes and reduces deterioration during treatment, while feedback for on-track clients did not affect outcome (Lambert, Hansen, & Finch, 2001).

For a graphical representation of average response curves and alerts, please refer to the image below, which illustrates a “bin” of clients whose baseline score on the Depression subscale fell between the 95th and 97th percentile:



The central green line is displayed on the CCAPS profile report and represents the average score (50th percentile) at a given session number for all clients in this starting bin, including those who improve rapidly, those who change very little, those who fluctuate throughout treatment, and those who deteriorate. As such, the average treatment-response curve represents the average amount of change, over time, across all clients with a similar starting score.

The upper dashed line (not displayed in the Profile Report) represents the cut score of average change (for this starting subscale/bin) above which are 10% of clients who will show the least amount of improvement. If a client’s score falls at or above this line, an “off-track” alert will be displayed. In a hypothetical counseling center with 1000 students, approximately 130 clients will “alert” at some point on the Depression subscale across all starting bins. For some subscales, a very high baseline score will mean that alerts cannot be computed for some session numbers. This is most likely to occur early in treatment for a client who has an extremely high baseline score. In this situation, they would actually need to score higher than the maximum score to produce an alert.

The lower dashed line (not displayed in the Profile Report) represents the cut score of average change below which are 10% of clients with the most improvement. There is no “alert” for clients at or below this line (i.e., an “on track” notification), as research has shown that only “off track” warnings are helpful in improving outcomes. However, the lack of an alert effectively indicates that a client is “on track.”

Taking all of this into account, it is important to understand that a client’s scores over time are not expected to fit the average response curve. Rather, the average response curve is intended to act as a reference point that can be used to evaluate a client’s response to treatment. Many clients will be well below this line, indicating on track or rapid improvement; some clients will fluctuate or stay below but near the line; and a few clients will have scores that produce an off-track alert.

Development

The calculations for the response curves included within the CCAPS 2021 profile report were retained from the CCAPS 2015 version, which utilized a sample of clients from academic years 2012-2014. Clients were included for analyses if they attended individual therapy appointments and had at least two CCAPS administered that were associated with appointments. The closest CCAPS within the two weeks before the first attended therapy appointment was used as the baseline administration to assess the client’s initial severity score in each of the CCAPS subscales.

Clients’ initial CCAPS subscale scores were “binned” based on percentile range. A “bin” comprised a range of initial severity scores that encompassed at least 1% of the overall sample. For example, a bin within Depression might comprise clients whose initial baseline raw scores on the Depression subscale ranged from 2.6 to 2.8. Each of the CCAPS subscales includes multiple bins, with different subscales having different numbers of bins depending on the subscale’s distribution. In order to allow for differences in rate of progress in therapy based on a client’s initial severity on each subscale, a unique response curve was calculated for each bin within each of the subscales. Questions about the bins can be directed to ccmh@psu.edu.

Generation of the response curves involved stepwise testing of latent growth curve models. In summary, the number of sessions and beginning severity levels were included within the model as significant predictors of client change on the CCAPS. This is consistent with prior research showing that psychological distress measured at intake is a significant predictor of rate of change, with clients presenting with higher distress showing more change than those with lower scores (Finch et al., 2001).

To calculate the alert levels, two-way tolerance intervals were calculated to contain 80% of the subscale bin’s population at a 95% confidence, which allowed for the upper-limit values to be established at 90%. Within each subscale bin of initial CCAPS subscale severity level, there exists a CCAPS score for which 90% of the population is expected to fall below in a given session. Feedback in the format of a blue dot in the CCAPS 2021 profile report is provided when a client’s CCAPS score in the subscale is “off track,” meaning the score goes above the upper limit value at that particular session. The feedback is indicative that the client might be in the 10% of the treatment-seeking clients who have been found to deteriorate (Lambert & Ogles, 2004), and who have experienced less symptom reduction than we would expect for 90% of

clients. If the client is considered to be "on track," meaning their CCAPS subscale score is below the upper tolerance limit, then no blue dot will appear for the subscale, indicating that the student's progress is still consistent with 90% of the population who started treatment with similar levels of severity.

Recommendations for Using the CCAPS

Each counseling center should review the preferences of its staff, technology, space, and workflow, along with clinical, research, and administrative needs, to determine how best to implement the CCAPS instruments. Generally speaking, the CCAPS-62 provides more information that may be useful at intake and termination, while the CCAPS-34 is designed for repeated administrations. It is recommended that centers thoroughly review the actual items within each instrument when making a decision about how to best implement these measures. Below is a more detailed description of recommended uses of the CCAPS instruments at the various stages of treatment (Initial Assessment, Ongoing Treatment Monitoring, Termination).

DOCUMENTATION

Clinical use of the CCAPS should be documented in the clinical record in accordance with relevant professional standards and legislation. The following guidelines are suggested:

- Because the CCAPS contains items that may represent risk, it is recommended that the CCAPS be administered in-person immediately prior to a clinical appointment. If the instrument is administered at a time other than immediately prior to an appointment, clinical staff should review the profile report before the client leaves.
- Review – It is recommended that the following elements be documented when reviewing the CCAPS:
    - — Validity of the administration.
    - — Elevated scales and consistency with the clinical interview.
    - — Critical items endorsed above a 0, especially both items on suicidal/homicidal ideation, along with the client's response to a request for more information.
    - — Change over time, including improvement and/or deterioration.

INITIAL ASSESSMENT

Both the CCAPS-62 and CCAPS-34 can be used for initial assessment, but the CCAPS-62 is a more comprehensive initial assessment tool, while the CCAPS-34 is narrower in its clinical scope and specifically designed for repeated measurement. The CCAPS-62 provides a broader and more detailed assessment of symptoms (e.g., addition of the Family Distress subscale and more specific items included within each subscale) and is therefore preferred for this purpose. For example, some clinicians find the range of items in the Depression subscale particularly useful for providing insight into the kind of depression the client is experiencing. The CCAPS-62 takes 7-10 minutes to complete, on average, though some clients could take longer.

Centers with time constraints may prefer the CCAPS-34, which takes 2-3 minutes to administer and provides a rapid, objective assessment of psychological symptoms but has less specificity. Of note, the Family Distress subscale and questions related to substance use are excluded from CCAPS-34. Data analyses have shown that the CCAPS-34 subscale scores correlate very highly with CCAPS-62 subscale scores, in aggregate, but substantial differences may exist for a single client. For example, if a client strongly endorses two or three Depression items on the CCAPS-62 that are excluded from the CCAPS-34, the client's Depression score could be significantly lower on the CCAPS-34. For those centers that prefer to administer the CCAPS-34 at the initial appointment, adding questions to the paperwork (drug use, purging behavior, family issues, etc.) might be helpful to compensate for the excluded items from the CCAPS-62.

In general, it is recommended that the CCAPS instrument be administered and scored in advance of each session to allow the clinician time to review the CCAPS Profile Report and have it in hand during the session for reference. Please refer to the Clinicians' Guide for an explanation of the profile reports and suggestions for use.

REPEATED MEASUREMENT

Both the CCAPS-62 and CCAPS-34 can be used for treatment monitoring or outcome evaluation. Profile reports for both instruments will display up to 15 administrations for comparison. However, the CCAPS-34 was specifically designed as a short version that is psychometrically sound, sensitive to change, comparable to the CCAPS-62, and quick to complete at just 2-3 minutes. As such, it is strongly recommended that the CCAPS-34 be utilized for repeated measurement (every session) to evaluate client changes across treatment and maximize the utility of the treatment response feature. If assessing clients at every session is not feasible for logistical reasons, it is recommended that clients at least be administered the CCAPS at a regular interval (i.e. every 3rd session).

Sensitivity to Change

One of the central purposes of the CCAPS instruments (especially the CCAPS-34) is to assess change in psychological symptoms during treatment. The

CCAPS-34 has been found to be sensitive to change (Youn et al., advance publication). Specifically, these authors reported significant decreases in psychological symptoms for students in treatment. Additionally, changes in CCAPS-34 scores for students in treatment were significantly greater than for students not in treatment, as would be expected for a sensitive instrument. This difference was especially pronounced for clients initially assessed above the high cut scores. These findings highlight the ability of the CCAPS-34 to accurately detect changes for students in treatment, particularly for those students with elevated levels of distress.

This property of the CCAPS (sensitivity to change) was used to examine the effectiveness of services provided by counseling centers (MacAleavey et al., 2017). This study found that the average change (using effect sizes) experienced by counseling center clients was equivalent to the average change observed in meta-analytic studies of randomized clinical trials (RCTs) for specific areas of distress, such as depression and anxiety.

When assessing client change, many factors need to be considered. Assessing change using the CCAPS-34 has many advantages but also several considerations that must be evaluated. Not all clients are expected to experience all psychological problems assessed by the CCAPS-34. In addition, not every subscale is expected to change at the same rate. For example, Depression is usually considered to be episodic in nature, and generally has a natural course of increases and decreases. Further treatments for depression typically produce noticeable changes in depressive symptoms within a relatively short time period (less than two months), which may or may not be sustained. In contrast, eating disorders and social anxiety are often very difficult to treat and can be quite entrenched, making this a longer-term change process for some clients. In sum, client change on the CCAPS will vary greatly depending on the nature and severity of the presenting concerns.

Using the CCAPS to Examine the Effectiveness of Treatment in Counseling Centers

Because of its ability to detect change, the CCAPS-34 has been used to compare the effectiveness of treatment provided in counseling centers to randomized controlled trials (RCTs). The results show that, for clients who present with significant distress (i.e., above the high cut score on a given subscale at intake), the CCAPS-34 subscales demonstrate change that is comparable to RCTs (McAleavey et al., 2014). These results suggest that the treatment provided in counseling centers is associated with symptom reduction equivalent to that resulting from treatments studied in RCTs. This same study also found that not all clients recover (i.e., drop below the low cut) before the end of treatment. Taken together, these findings suggest that the CCAPS is useful for examining change during treatment, that counseling center treatment is effective, and that clients may need more treatment to fully recover.

COMMON PATTERNS OF CHANGE OVER TIME

Completing the CCAPS-34 on a regular basis over the course of treatment can help both therapists and clients recognize and appreciate progress that has been made – or become aware of and address lack of progress or worsening of symptoms. It can be very helpful for some clients to see evidence of how they have changed over time to reinforce the efforts they have been making in therapy. On the contrary, for clients who may not have made progress, seeing the evidence for this may also serve as a motivation to try something different in therapy.

Several common patterns of change and some possible interpretations and implications are reviewed below.

Decreasing Scores

Some clients enter therapy with elevated levels of distress and demonstrate a clear and consistent decrease in the intensity of their distress, as indicated by the graphical profile report on the CCAPS (see Appendix B for a case example). Decreasing scores in accordance with the average response curves likely indicate that a client's subjective level of symptom distress is reducing in response to treatment. These changes should be discussed with the client as they can highlight gains in therapy, exploration of new strategies that could be extended to additional areas of concern, and/or a discussion about end of treatment planning.

Increasing Scores

During therapy, some clients may report increased symptom distress on the CCAPS-34, as indicated by the graphical profile report on the CCAPS (see Appendix E for a case example). This is valuable clinical information and should not be ignored. Several interpretations are possible. If a client was initially underreporting, increasing scores may represent a healthy shift towards authentic reporting, which will then facilitate more effective treatment. It could be that the individual is making effective use of therapy and addressing their issues; while ultimately helpful, this process can be very distressing to some individuals, especially those who cope by avoiding. To the contrary, the specific type of therapy being conducted might not be effective with this particular client. Other interpretations are that environmental factors may be contributing to an increase in distress or that the client's symptoms are simply worsening over time. For example, an elevation in academic distress may be linked to receiving a poor grade on an exam. A pattern of increasing scores should be discussed openly with the client to determine possible explanations and treatment implications.

Labile Scores

An unstable pattern of scores may be indicative of serious or chronic concerns (see Appendix B for a case example). For some clients, a sudden spike in CCAPS-34 scores can correspond to being in subjective crisis. This is often a "warning sign" to the therapist that the client is struggling with their current life circumstances. Interestingly, the specific scales that are elevated may be less meaningful than the overall change in reported distress. For example, a client may have sudden spikes in multiple scales related to the loss of a family member. A pattern of instability across one or more subscales over time (increases and decreases without any predictable pattern) may also be indicative of difficulties with mood lability, affect regulation, distress tolerance associated with some types of personality pathology, or unstable environmental factors.

Stable Elevated Scores

One of the more vexing profiles is one that demonstrates stable high distress with little to no change over time (see Appendix B for a case example). This profile can be indicative of more serious and long-term mental health issues. For example, individuals with a long history of depression or problems that are characterological in nature may not respond favorably to brief therapy. Another interpretation is that the treatment model or interventions utilized are not effective for the particular client for some reason. A discussion of this pattern with the client is often helpful, as it can enable therapists and clients to collaborate in making changes in therapy or consider alternative treatment approaches.

It is important to note that consistent CCAPS scores do not necessarily mean the client has not made gains in therapy or that therapy is ineffective. Because the CCAPS-34 is not a measure of clinician effectiveness, a pattern with little to no change should not be used to evaluate the effectiveness of a therapist. Research has reported that changes in therapy happen over time and are not always immediate. For example, from a trans-theoretical perspective, experts have asserted that not all clients are in a working stage in therapy (Norcross, Krebs, & Prochaska, 2011; Rochlen, Rude, & Augustine, 2005). Thus, some clients may not be ready to change or the progress made in therapy might be in areas of self-awareness, insight, or worldview, which might not be reflected in CCAPS responses. Common presenting concerns where this might occur are eating or body image issues, substance use, and personality issues.

AREAS FOR EXPLORATION

Examination of the Profile Report for the CCAPS-62 can help to provide direction and prioritization when considering areas for additional exploration in a first appointment. This can be especially valuable if a client is hesitant to raise a concern directly with the clinician. For example, a client with significant eating and body image concerns may not immediately present this issue during a clinical interview. However, if the client has an elevated score on the Eating Concerns subscale, the clinician may be cued to initiate a discussion about the client's responses and the meaning of an elevated percentile score.

Further, some clients may not recognize that their level of distress is cause for concern. A common example of this can be found with the Substance Use subscale. Students may perceive their alcohol use as normative if they associate with a heavy drinking peer group or may not recognize the impact of substance use on their daily functioning. Therefore, if a client scored in the 90th percentile on Substance Use, the clinician can use this information to engage in motivational interviewing that might include sharing the score and its meaning (i.e., "Your score is greater than 90% of clients seen in counseling centers.").

MONITORING CHANGES IN CRITICAL OR SPECIFIC ITEMS OVER TIME

The CCAPS-34 can be especially helpful in allowing therapists to monitor high-risk factors, such as suicidal ideation, thoughts of hurting others, or items that are relevant to a specific client over time. Monitoring critical items at every session (e.g., SI/THO) can alert therapists to areas of risk that clients may not otherwise volunteer. Similarly, if a client is working on a specific symptom or group of symptoms (e.g., fear of panic attacks, or attitude towards food), then a weekly administration and review will allow the therapist to specifically track these concerns week to week even if they are not the focus of counseling in a specific session.

REFERRAL CONSIDERATIONS

Because the CCAPS Profile Report offers an objective and reliable comparison to a large comparative group, and therefore is a useful metric of distress severity, the results can be helpful during the treatment planning and referral process. When combined with a clinical interview, the CCAPS may help to determine a specific provider level for the client (trainee vs. senior staff), the recommended treatment setting (specialized clinic vs. generalist practice), and the optimal length of treatment (short-term vs. long-term therapy). As such, clinicians are encouraged to consider the meaning of a client's distress, as measured by the CCAPS in conjunction with collateral information, when evaluating treatment options. For example, consider the client who presents as emotionally distraught (over recent events) with a CCAPS Profile Report with all low scores. This suggests that the client may be appropriate for short-term counseling with a trainee. Conversely, a client who presents in a guarded manner with multiple moderate or elevated scores (including Frustration/Anger) may be a better fit for a more experienced clinician.

ASSESSING THE NEED FOR URGENT SERVICES

The CCAPS-62 can be useful when considering the appropriate timeframe for follow-up with a client. For instance, a student with elevated scores on many CCAPS-62 subscales may need services urgently and be unable to wait for treatment. Clinicians should consider this information carefully as they determine the most appropriate timeframe and level of care needed to help the student to remain safe and function adequately in their daily life.

Supervision and Training

The CCAPS instruments have clinical utility in therapy as well as in the supervision of trainees or unlicensed professionals. These instruments provide quick access to information about the distress of clients on a supervisees' caseload. Supervisors can compare the information gathered from the CCAPS instruments with clinical documentation and supervisee's reports to better understand how a supervisee's clinical work is progressing.

DIAGNOSTIC SKILL DEVELOPMENT

Supervisors may utilize the information provided on the subscales of the CCAPS to assist supervisees in learning about the manifestation of specific diagnoses, as well as how and when to adequately follow up on specific symptoms to more accurately determine a diagnosis. By considering areas of distress endorsed on the CCAPS in combination with information from the clinical interview, supervisors can help supervisees to consider appropriate diagnoses and determine what questions would assist with differential diagnoses.

CLIENT CONCEPTUALIZATION

The CCAPS instruments can be used in supervision to enrich a collaborative conceptualization of a client. Because the CCAPS provides a wide variety of information on a repeated measures basis, supervisors can discuss with the supervisee how they are conceptualizing the client and how the CCAPS may support or challenge that understanding. The instruments can provide additional information that supervisees may not be considering in developing their understanding of the client.

TREATMENT PLANNING AND GOAL SETTING

The CCAPS instruments are also used in supervision to determine client goals for therapy and a treatment plan. By examining CCAPS profiles on a week to week basis, supervisors can assist supervisees in developing relevant and potentially measureable client goals. For example, a goal to decrease distress caused by Generalized Anxiety could be developed and the client's progress towards that goal could be evaluated in supervision over time.

INTERPRETING PROFILE REPORTS

Reviewing the CCAPS Profile Reports for clients on a supervisee's caseload provides an efficient way for supervisors to review the progress and current levels of distress. Reviewing the Profile Reports for all clients on a supervisee's caseload may generate discussions about a supervisee's clinical strengths and areas of growth. For example, most clinicians have experienced feeling "stuck," or as if they have made little progress with a client. The repeated use of the CCAPS with each client allows supervisees and supervisors to discuss the treatment process for clients who do not appear to be improving (e.g., distress is not decreasing on the Profile Report) and offers the opportunity to evaluate how multiple factors are influencing a client's situation. Such a discussion can lead to a fruitful exploration of other theoretical and evidence-based practices that provide greater efficacy when used to address specific presenting concerns.

SELF-REFLECTIVE PRACTICE

Supervisees can benefit from considering how the CCAPS instruments enable them to critically reflect on their work. By tracking their clients' progress regularly, supervisees can begin to recognize the areas of distress in which they feel greater competence and efficacy, and which are areas for growth and development. For example, a supervisor may note that a supervisee has had several clients with elevated Social Anxiety scores that have not decreased over time. This can develop into a beneficial discussion about the supervisee's recognition of this pattern, and effective approaches to treating this area of concern. Discussion about the potential client and therapist characteristics that may be impacting change or lack thereof is often useful in these instances. It is important to note that the CCAPS instruments are not designed to evaluate supervisee competence or efficacy, but can allow the supervisor and supervisee to gain insight into specific areas of supervisee strength and growth.

Administrative Uses

The CCAPS instruments can enable administrators to examine center-wide data to address agency and institutional needs.

FUNDING

When counseling center administrators recognize that additional funding may be necessary to meet an increase in demand and/or particular area of client concern, CCAPS data obtained across counseling center staff can be presented in aggregate form to funding sources to support

such requests. CCMH offers the following two National Comparison Reports to help centers evaluate services and advocate for resources: (1) Initial Distress Report; and (2) Pre-Post Change Report. The Initial Distress Report compares the average score on CCAPS subscales reported by clients at a given center with current normative subscale scores obtained from a national sample, as well as the difference between the two, including a description of the effect size. The Pre-Post Change Report describes the change experienced by clients at the center upon receiving services. National Comparison Reports can focus the comparisons among centers within colleges or universities of similar size, type, etc. These reports can help support requests for additional funding, staff, or training to meet the needs of a unique student body. For example, data obtained on the prevalence and severity of suicidal ideation and depression on one's campus may help support a grant application for additional funding related to a campus-wide suicide prevention program.

TRAINING

The Initial Distress and Pre-Post Change Reports can provide an overview of the focus of clinical work in a given counseling center. This information should not be solely used to evaluate a center's effectiveness. Instead, information on prominent client concerns and levels of distress in various areas can highlight potential areas for additional staff training on prevention and intervention. For example, a Pre-Post Change Report that consistently indicates the change experienced by clients at a given center in the area of Social Anxiety is greater than 5% and less than 95% of other counseling centers, may prompt a counseling center director to initiate staff development or training related to treating social anxiety among college students.

OUTREACH AND PREVENTION

An aggregate report of student concerns obtained from the CCAPS (CCMH Initial Distress and Pre-Post Change Reports) can be used to consider outreach or consultation opportunities at one's campus. Administrators can monitor the prevalence of various areas of distress endorsed by clients who present for services at their particular center. By developing a data-supported view of the campus, administrators can direct attention to possible issues or groups who may benefit from outreach or prevention efforts.

In addition to the CCAPS, the CCMH Standardized Data Set (SDS) asks a wealth of demographic information about clients that may help administrators identify various characteristics of the students they serve. For example, a center may recognize that few international students use its services. This information may prompt staff to foster relationships with international student offices and student organizations to help encourage students using their services to seek out the counseling center as needed. When the SDS is administered in combination with the CCAPS, it is possible to develop a report that helps administrators see what areas of distress are more or less common to students with various demographic characteristics, which may help staff target outreach and prevention efforts for groups most in need of services. For example, using data provided by the SDS and CCAPS, counseling center staff may learn that sorority members are experiencing a more frequent and higher level of distress in the area of eating concerns compared to other women presenting to the center. Such information may prompt staff to target disordered eating or body image programming to sorority members.

NEEDS ASSESSMENT

The CCAPS instruments can be useful in identifying areas of particular strength or prevalence for a counseling center. For example, administrators can use CCAPS data to identify specific client concerns that staff members seem particularly effective in addressing, as evidenced by consistent decreases in client-reported symptom distress in that area. Aggregate data can also help administrators determine if staff should develop particular specialties. For example, if a center identifies substance use as a larger issue among its clients than clients from the normative sample (via the CCMH Initial Distress Report), administrators may consider implementing staff training in this area or hiring a provider with specialized training in prevention and intervention of substance use if one is not already on staff.

Psychometric Information

The CCAPS instruments were created through rigorous psychometric development resulting in multiple publications in peer-reviewed journals. This section includes a review of published psychometric characteristics, updated and/or unpublished psychometric characteristics, and quick reference tables.

CCAPS 2021 SUBSCALE DESCRIPTIVE STATISTICS

Descriptive statistics for the CCAPS-62 (N=263,787) and CCAPS-34 (both CCAPS-34 and CCAPS-62 administrations scored as CCAPS-34) (N=388,266) subscales based on the 2015-2017 sample (min=0, max=4):

	CCAPS-62			CCAPS-34		
Subscales	**Mean**	**SD**	**Internal Consistency (alpha)**	**Mean**	**SD**	**Internal Consistency (alpha)**
Depression	1.74	0.92	0.91	1.68	1.03	0.87
Generalized Anxiety	1.79	0.93	0.85	1.93	1.02	0.82
Social Anxiety	1.99	0.95	0.84	1.96	1.02	0.82
Academic Distress	1.90	1.00	0.82	1.98	1.09	0.82
Eating Concerns	1.01	0.86	0.89	0.95	1.12	0.88
Frustration/Anger	1.01	0.84	0.85	0.86	0.82	0.83
Family Distress	1.30	0.96	0.85	n/a	n/a	n/a
Substance/Alcohol Use	0.71	0.84	0.83	0.63	0.88	0.83
Distress Index	n/a	n/a	n/a	1.75	0.82	0.91

PUBLISHED PSYCHOMETRIC DETAILS

CCAPS-62

Locke, B. D., Buzolitz, J. S., Lei, P.-W., Boswell, J. F., McAleavey, A. A., Sevig, T. D., Dowis, J. D., & Hayes, J. A. (2011). Development of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62). *Journal of Counseling Psychology, 58(1),* 97-109. doi:10.1037/a0021282

- Early development details
- Factor structure
- Factor structure by identity groups (cultural validity)
- Subscale convergent validity (non-clinical)
- Social desirability
- Test-retest

McAleavey, A. A., Nordberg, S. S., Hayes, J. A., Castonguay, L. G., Locke, B. D., & Lockard, A. J. (2012). Clinical validity of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62): Further evaluation and clinical applications. *Journal of Counseling Psychology, 59(4),* 575-590. doi:10.1037/a0029855

- Subscale concurrent validity (clinical)
- Clinical/non-clinical cut-score development (low-cut score)
- Diagnostic differentiation (high cut score)

CCAPS-34

Locke, B. D., McAleavey, A. A., Zhao, Y., Lei, P.-W., Hayes, J. A., Castonguay, L. G., Li, H., Tate, R., Lin, Y.-C. (2012). Development and initial validation of the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34). *Measurement and Evaluation in Counseling and Development, 45,* 151-169. doi:10.1177/0748175611432642

- Short-form development
- Subscale convergent validity (non-clinical)
- Test-retest

CCAPS-34 SHORT-FORM RELIABILITY

Subscale correlations between the full CCAPS-62 and shorter CCAPS-34 using the 2018 normative sample:

Subscales	Correlation
Depression	0.96
Generalized Anxiety	0.96
Social Anxiety	0.97
Academic Distress	0.98
Eating Concerns	0.91
Frustration/Anger	0.98
Family Distress	n/a
Substance/Alcohol Use	0.96

CCAPS-62 CUT POINTS

	Low Cut Point		High Cut Point	
	Raw score	Percen-tile	Raw score	Percen-tile
Depression	1.23	33	1.92	58
Generalized Anxiety	1.22	32	1.89	57
Social Anxiety	1.43	32	2.57	73
Academic Distress*	1.2	30	2.4	70
Eating Concerns	1.02	61	1.8	82
Frustration/ Anger*	1	60	1.43	74
Family Distress*	1.31	58	1.83	73
Substance Use	0.69	64	1	73

** Indicates elevated cut points that were set at the 70th (or next closest possible) percentile for the CCAPS 2021 due to the lack of a related DSM-IV diagnosis. Note: High cut scores updated in 2018; Low cut scores updated in 2019*

CCAPS-34 CUT POINTS

	Low Cut Point		High Cut Point	
	Raw score	Percen-tile	Raw score	Percen-tile
Depression	1	32	1.83	58
Generalized Anxiety	1.33	33	2.1	61
Social Anxiety	1.4	35	2.5	74
Academic Distress*	1.25	32	2.5	70
Eating Concerns	0.96	67	1.5	79
Frustration/ Anger*	0.84	61	1.17	72
Alcohol Use	0.6	65	1.1	78
Distress Index*	1.3	31	2.25	71

** Indicates elevated cut points that were set at the 70th (or next closest possible) percentile for the CCAPS 2021 due to the lack of a related DSM-IV diagnosis. Note: High cut scores updated in 2018; Low cut scores updated in 2019*

RELIABLE CHANGE INDICES (RCIs)

The RCIs for each subscale are presented here in raw-score.

Reliable Change Index (RCI)		
	CCAPS-62	CCAPS-34
Depression	0.88	1.05
Generalized Anxiety	1.03	1.07
Social Anxiety	0.98	1.09
Academic Distress	1.14	1.38
Eating Concerns	0.87	1.34
Frustration/Anger	0.84	0.98
Family Distress	0.96	n/a
Substance/Alcohol Use	0.69	1.12
Distress Index	0.79	

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Locke, B. D., McAleavey, A. A., Zhao, Y., Lei, P.-W., Hayes, J. A., Castonguay, L. G., Li, H., Tate, R., & Lin, Y.-C. (2012). Development and initial validation of the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34). *Measurement and Evaluation in Counseling and Development, 45,* 151-169. doi:10.1177/0748175611432642

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Appendix A:

Copies of Instruments

CCAPS-62

CCAPS-34

Counseling Center Assessment of Psychological Symptoms — **CCAPS-62**

Name: ______________________________ **Date:** ______________

INSTRUCTIONS: The following statements describe thoughts, feelings, and experiences that people may have. Please indicate how well each statement describes you, **during the past two weeks**, from "not at all like me" (0) to "extremely like me" (4), by marking the correct number. Read each statement carefully, select only one answer per statement, and please do not skip any questions.

	Not at all like me	....			Extremely like me
1. I get sad or angry when I think of my family	0	1	2	3	4
2. I am shy around others	0	1	2	3	4
3. There are many things I am afraid of	0	1	2	3	4
4. My heart races for no good reason	0	1	2	3	4
5. I feel out of control when I eat	0	1	2	3	4
6. I enjoy my classes	0	1	2	3	4
7. I feel that my family loves me	0	1	2	3	4
8. I feel disconnected from myself	0	1	2	3	4
9. I don't enjoy being around people as much as I used to	0	1	2	3	4
10. I feel isolated and alone	0	1	2	3	4
11. My family gets on my nerves	0	1	2	3	4
12. I lose touch with reality	0	1	2	3	4
13. I think about food more than I would like to	0	1	2	3	4
14. I am anxious that I might have a panic attack while in public	0	1	2	3	4
15. I feel confident that I can succeed academically	0	1	2	3	4
16. I become anxious when I have to speak in front of audiences	0	1	2	3	4
17. I have sleep difficulties	0	1	2	3	4
18. My thoughts are racing	0	1	2	3	4
19. I am satisfied with my body shape	0	1	2	3	4
20. I feel worthless	0	1	2	3	4
21. My family is basically a happy one	0	1	2	3	4
22. I am dissatisfied with my weight	0	1	2	3	4
23. I feel helpless	0	1	2	3	4
24. I use drugs more than I should	0	1	2	3	4
25. I eat too much	0	1	2	3	4
26. I drink alcohol frequently	0	1	2	3	4
27. I have spells of terror or panic	0	1	2	3	4
28. I am enthusiastic about life	0	1	2	3	4
29. When I drink alcohol I can't remember what happened	0	1	2	3	4
30. I feel tense	0	1	2	3	4
31. When I start eating I can't stop	0	1	2	3	4
32. I have difficulty controlling my temper	0	1	2	3	4
33. I am easily frightened or startled	0	1	2	3	4

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MPC149125 Version: CCAPS-62, 2009

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	Not at all like me	....			Extremely like me
34. I diet frequently	0	1	2	3	4
35. I make friends easily	0	1	2	3	4
36. I sometimes feel like breaking or smashing things	0	1	2	3	4
37. I have unwanted thoughts I can't control	0	1	2	3	4
38. There is a history of abuse in my family	0	1	2	3	4
39. I experience nightmares or flashbacks	0	1	2	3	4
40. I feel sad all the time	0	1	2	3	4
41. I am concerned that other people do not like me	0	1	2	3	4
42. I wish my family got along better	0	1	2	3	4
43. I get angry easily	0	1	2	3	4
44. I feel uncomfortable around people I don't know	0	1	2	3	4
45. I feel irritable	0	1	2	3	4
46. I have thoughts of ending my life	0	1	2	3	4
47. I feel self conscious around others	0	1	2	3	4
48. I purge to control my weight	0	1	2	3	4
49. I drink more than I should	0	1	2	3	4
50. I enjoy getting drunk	0	1	2	3	4
51. I am not able to concentrate as well as usual	0	1	2	3	4
52. I am afraid I may lose control and act violently	0	1	2	3	4
53. It’s hard to stay motivated for my classes	0	1	2	3	4
54. I feel comfortable around other people	0	1	2	3	4
55. I like myself	0	1	2	3	4
56. I have done something I have regretted because of drinking	0	1	2	3	4
57. I frequently get into arguments	0	1	2	3	4
58. I find that I cry frequently	0	1	2	3	4
59. I am unable to keep up with my schoolwork	0	1	2	3	4
60. I have thoughts of hurting others	0	1	2	3	4
61. The less I eat, the better I feel about myself	0	1	2	3	4
62. I feel that I have no one who understands me	0	1	2	3	4

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BRINGING SCIENCE AND PRACTICE
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Counseling Center Assessment of Psychological Symptoms — CCAPS-34

Name: ______________________________ **Date:** ____________

INSTRUCTIONS: The following statements describe thoughts, feelings, and experiences that people may have. Please indicate how well each statement describes you, **during the past two weeks**, from "not at all like me" (0) to "extremely like me" (4), by marking the correct number. Read each statement carefully, select only one answer per statement, and please do not skip any questions.

	Not at all like me	....			Extremely like me
1. I am shy around others	0	1	2	3	4
2. My heart races for no good reason	0	1	2	3	4
3. I feel out of control when I eat	0	1	2	3	4
4. I don't enjoy being around people as much as I used to	0	1	2	3	4
5. I feel isolated and alone	0	1	2	3	4
6. I think about food more than I would like to	0	1	2	3	4
7. I am anxious that I might have a panic attack while in public	0	1	2	3	4
8. I feel confident that I can succeed academically	0	1	2	3	4
9. I have sleep difficulties	0	1	2	3	4
10. My thoughts are racing	0	1	2	3	4
11. I feel worthless	0	1	2	3	4
12. I feel helpless	0	1	2	3	4
13. I eat too much	0	1	2	3	4
14. I drink alcohol frequently	0	1	2	3	4
15. I have spells of terror or panic	0	1	2	3	4
16. When I drink alcohol I can't remember what happened	0	1	2	3	4
17. I feel tense	0	1	2	3	4
18. I have difficulty controlling my temper	0	1	2	3	4
19. I make friends easily	0	1	2	3	4
20. I sometimes feel like breaking or smashing things	0	1	2	3	4
21. I feel sad all the time	0	1	2	3	4
22. I am concerned that other people do not like me	0	1	2	3	4
23. I get angry easily	0	1	2	3	4
24. I feel uncomfortable around people I don't know	0	1	2	3	4
25. I have thoughts of ending my life	0	1	2	3	4
26. I feel self conscious around others	0	1	2	3	4
27. I drink more than I should	0	1	2	3	4
28. I am not able to concentrate as well as usual	0	1	2	3	4
29. I am afraid I may lose control and act violently	0	1	2	3	4
30. It's hard to stay motivated for my classes	0	1	2	3	4
31. I have done something I have regretted because of drinking	0	1	2	3	4
32. I frequently get into arguments	0	1	2	3	4
33. I am unable to keep up with my schoolwork	0	1	2	3	4
34. I have thoughts of hurting others	0	1	2	3	4

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Appendix B:

Sample Profile Reports

Sample #1
Initial Consultation Vignette

Sue is a 20 year old, single, White, female who indicated that she preferred not to answer the question regarding her sexual orientation. Sue is a junior with a GPA of 3.1. She sought therapy to receive help in controlling her binging and purging behaviors.

Sue has been binging and purging for several years. When she presented for therapy she was purging three to four times daily. The frequency with which she binges and purges was taking up a lot of her time and causing her to withdraw from friends and social activities. Sue had not menstruated for three months. In addition to disordered eating symptoms, Sue reported frequent binge drinking to the point of blacking out two to four times weekly.

PROFILE INTERPRETATION

Sue's Profile Report *(Figure 1)* depicts relatively low scores on most areas of distress with the exception of Eating Concerns and Substance Use. She presented with self-reported concerns about an eating disorder. Sue was questioned about the quantity and frequency of alcohol use and was provided feedback about scoring higher than 95% of other college students seeking counseling on the CCAPS. In response, she acknowledged that binge drinking may be problematic and may also be tied to binging and purging.

In light of the information provided on the CCAPS-62, the intake therapist was able to engage Sue in a conversation about substance abuse and its relationship with her primary presenting problem. The therapist referred Sue for longer term private therapy to address both eating and substance use concerns.

Figure 1. Initial Consultation CCAPS-62 Profile Report

CCAPS 62 Profile Report v 07/2021	**Name:** SAMPLE #1	**Date:** 8/5/2021	**Appointments:** --
	Student ID: 987654321	**Age:** 20	**Administrations:** 1

← Percentile Score →

100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0

	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Family Distress	Substance Use	Distress Index	SI	THO
1) Current: 8/5/2021	25	9	12	19	97	34	22	96	11	0	0
2)											
3)											
4)											
5)											
6)											
7)											
8)											
9)											
10)											
11)											
12)											
13)											
14)											
15)											

	Depression	
8	I feel disconnected from myself	1
9	I don't enjoy being around people as much as I used to	1
10	I feel isolated and alone	2
12	***I lose touch with reality***	***0***
20	I feel worthless	2
23	I feel helpless	2
28	I am enthusiastic about life **	3
37	I have unwanted thoughts I can't control	0
40	I feel sad all the time	1
46	***I have thoughts of ending my life (SI)***	***0***
55	I like myself **	3
58	I find that I cry frequently	1
62	I feel that I have no one who understands me	1
	Generalized Anxiety	
3	There are many things I am afraid of	0
4	My heart races for no good reason	0
14	I am anxious that I might have a panic attack while in public	0
17	I have sleep difficulties	0
18	My thoughts are racing	0
27	I have spells of terror or panic	0
30	I feel tense	0
33	I am easily frightened or startled	1
39	I experience nightmares or flashbacks	3
	Social Anxiety	
2	I am shy around others	0
16	I become anxious when I have to speak in front of audiences	3
35	I make friends easily **	4
41	I am concerned that other people do not like me	2
44	I feel uncomfortable around people I don't know	0
47	I feel self conscious around others	0
54	I feel comfortable around other people **	4
	Academic Distress	
6	I enjoy my classes **	3
15	I feel confident that I can succeed academically **	3
51	I am not able to concentrate as well as usual	1

	Academic Distress *(continued)*	
53	It's hard to stay motivated for my classes	1
59	I am unable to keep up with my schoolwork	0
	Eating Concerns	
5	I feel out of control when I eat	4
13	I think about food more than I would like to	4
19	I am satisfied with my body shape **	1
22	I am dissatisfied with my weight	2
25	I eat too much	4
31	When I start eating I can't stop	4
34	I diet frequently	1
48	I purge to control my weight	4
61	The less I eat, the better I feel about myself	1
	Frustration /Anger	
32	I have difficulty controlling my temper	1
36	I sometimes feel like breaking or smashing things	1
43	I get angry easily	0
45	I feel irritable	1
52	***I am afraid I may lose control and act violently***	***0***
57	I frequently get into arguments	0
60	***I have thoughts of hurting others (THO)***	***0***
	Family Distress	
1	I get sad or angry when I think of my family	0
7	I feel that my family loves me **	3
11	My family gets on my nerves	1
21	My family is basically a happy one **	4
38	There is a history of abuse in my family	0
42	I wish my family got along better	0
	Substance Use	
24	I use drugs more than I should	1
26	I drink alcohol frequently	4
29	When I drink alcohol I can't remember what happened	2
49	I drink more than I should	3
50	I enjoy getting drunk	3
56	I have done something I have regretted because of drinking	2

Sample #2
Decreasing Profile Vignette

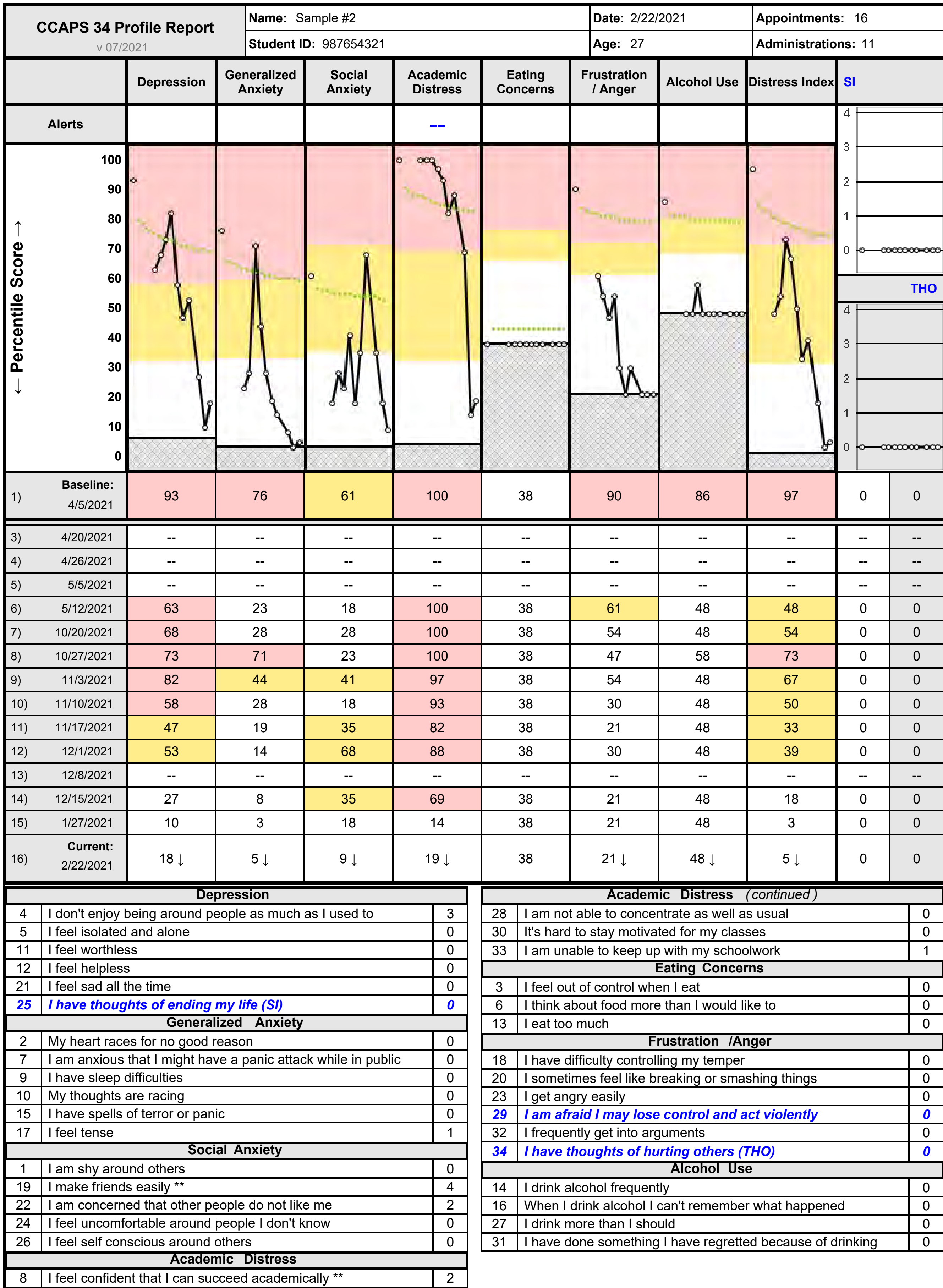
Robin is a 27 year old, White, heterosexual female, returning student who is a junior with a GPA of 3.09. Robin is a veteran of the Army National Guard and did a one year tour of duty in Iraq. She was self-referred to counseling and complained of having a difficult time adjusting to her return to college. She also complained of feeling lost, disliking herself, and symptoms of depression.

As Robin told her story in the initial two sessions it became clear that issues of focus and concentration had always plagued her academically and socially. An assessment for ADHD was recommended. Robin was diagnosed with ADHD- Inattentive Type and treated with stimulant medication approximately mid-way through treatment. Starting the medication and learning behavioral strategies to use during interpersonal interactions and in academic situations greatly improved Robin's self-confidence, social functioning and academic performance. After individual therapy, Robin transitioned to group therapy to continue her work.

PROFILE INTERPRETATION

Robin's Profile Report *(Figure 2)* depicts a steady decrease in her level of distress across a number of subscales. While she exhibited some relief from Depression, Anxiety, Frustration/Anger, and Substance Use concerns soon after beginning therapy, the most dramatic and lasting changes began after she started taking a stimulant medication to treat ADHD. Robin presented to treatment in a subjective state of crisis, which helps explain rather significant decreases in symptomatology quickly after beginning therapy.

Figure 2. Decreasing CCAPS-34 Profile Report



CCAPS 34 Profile Report v 07/2021	Name: Sample #2	Date: 2/22/2021	Appointments: 16
	Student ID: 987654321	Age: 27	Administrations: 11

	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Alcohol Use	Distress Index	SI	THO
Alerts				--						
1) Baseline: 4/5/2021	93	76	61	100	38	90	86	97	0	0
3) 4/20/2021	--	--	--	--	--	--	--	--	--	--
4) 4/26/2021	--	--	--	--	--	--	--	--	--	--
5) 5/5/2021	--	--	--	--	--	--	--	--	--	--
6) 5/12/2021	63	23	18	100	38	61	48	48	0	0
7) 10/20/2021	68	28	28	100	38	54	48	54	0	0
8) 10/27/2021	73	71	23	100	38	47	58	73	0	0
9) 11/3/2021	82	44	41	97	38	54	48	67	0	0
10) 11/10/2021	58	28	18	93	38	30	48	50	0	0
11) 11/17/2021	47	19	35	82	38	21	48	33	0	0
12) 12/1/2021	53	14	68	88	38	30	48	39	0	0
13) 12/8/2021	--	--	--	--	--	--	--	--	--	--
14) 12/15/2021	27	8	35	69	38	21	48	18	0	0
15) 1/27/2021	10	3	18	14	38	21	48	3	0	0
16) Current: 2/22/2021	18 ↓	5 ↓	9 ↓	19 ↓	38	21 ↓	48 ↓	5 ↓	0	0

#	Depression	
4	I don't enjoy being around people as much as I used to	3
5	I feel isolated and alone	0
11	I feel worthless	0
12	I feel helpless	0
21	I feel sad all the time	0
25	***I have thoughts of ending my life (SI)***	***0***
	Generalized Anxiety	
2	My heart races for no good reason	0
7	I am anxious that I might have a panic attack while in public	0
9	I have sleep difficulties	0
10	My thoughts are racing	0
15	I have spells of terror or panic	0
17	I feel tense	1
	Social Anxiety	
1	I am shy around others	0
19	I make friends easily **	4
22	I am concerned that other people do not like me	2
24	I feel uncomfortable around people I don't know	0
26	I feel self conscious around others	0
	Academic Distress	
8	I feel confident that I can succeed academically **	2

#	Academic Distress *(continued)*	
28	I am not able to concentrate as well as usual	0
30	It's hard to stay motivated for my classes	0
33	I am unable to keep up with my schoolwork	1
	Eating Concerns	
3	I feel out of control when I eat	0
6	I think about food more than I would like to	0
13	I eat too much	0
	Frustration /Anger	
18	I have difficulty controlling my temper	0
20	I sometimes feel like breaking or smashing things	0
23	I get angry easily	0
29	***I am afraid I may lose control and act violently***	***0***
32	I frequently get into arguments	0
34	***I have thoughts of hurting others (THO)***	***0***
	Alcohol Use	
14	I drink alcohol frequently	0
16	When I drink alcohol I can't remember what happened	0
27	I drink more than I should	0
31	I have done something I have regretted because of drinking	0

Sample #3
Labile Profile Vignette

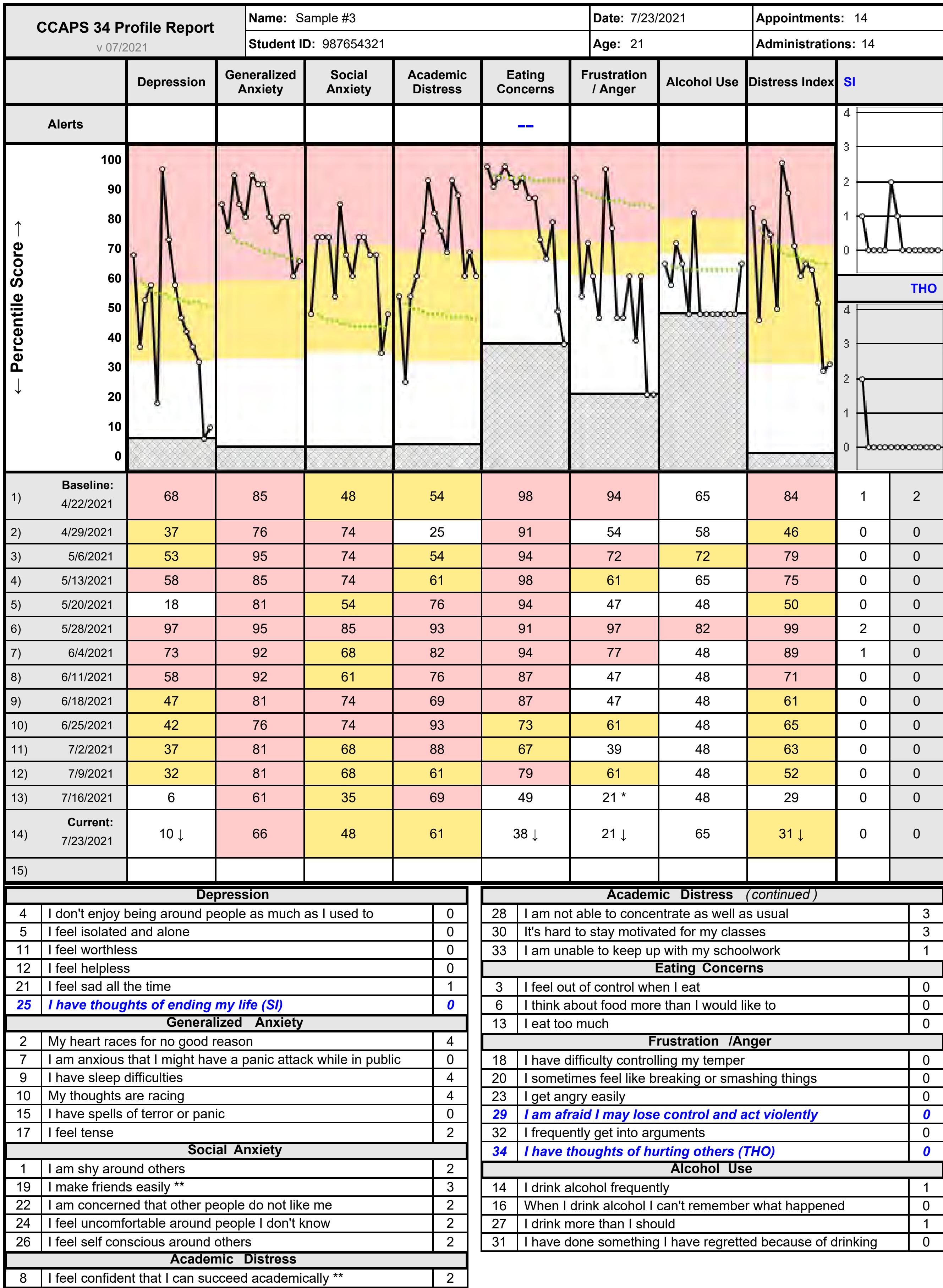
Dan is a 21 year old, African-American, heterosexual male. He is a junior majoring in creative writing with a GPA of 3.78. He reports smoking marijuana daily and views this as a lifestyle choice that he is not interested in giving up. He presented to therapy for issues related to relationship difficulties. Dan noted that in high school he was emotionally hurt in several romantic relationships and then developed a more hostile view toward women. He described a pattern of avoiding emotional intimacy with women. His primary concern was the desire to have a close relationship with another woman he was interested in. He also noted significant tension with family members.

Dan decided to bring his father to his 6th therapy session to address his feelings. His father did not attend and Dan was very upset. He was tearful for most of the session. His father's absence seemed to create a crisis for Dan. During therapy, Dan struggled to connect with his true feelings and often talked about difficult matters, including the death of his sibling, with little affect.

PROFILE INTERPRETATION

Dan's profile *(Figure 3)* illustrates labile responding with almost every scale demonstrating some level of fluctuation during treatment. There is a significant elevation in almost every scale during the 6th session, which coincides with his distress over his father not attending that session, and his subsequent state of crisis. In this case, significant variability in the Profile Report is likely due to an entrenched pattern of avoidance of intense affect and difficult feelings.

Figure 3. Labile CCAPS-34 Profile Report



CCAPS 34 Profile Report v 07/2021	Name: Sample #3	Date: 7/23/2021	Appointments: 14
	Student ID: 987654321	Age: 21	Administrations: 14

	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Alcohol Use	Distress Index	SI	THO
Alerts					--					

	Date	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Alcohol Use	Distress Index	SI	THO
1)	Baseline: 4/22/2021	68	85	48	54	98	94	65	84	1	2
2)	4/29/2021	37	76	74	25	91	54	58	46	0	0
3)	5/6/2021	53	95	74	54	94	72	72	79	0	0
4)	5/13/2021	58	85	74	61	98	61	65	75	0	0
5)	5/20/2021	18	81	54	76	94	47	48	50	0	0
6)	5/28/2021	97	95	85	93	91	97	82	99	2	0
7)	6/4/2021	73	92	68	82	94	77	48	89	1	0
8)	6/11/2021	58	92	61	76	87	47	48	71	0	0
9)	6/18/2021	47	81	74	69	87	47	48	61	0	0
10)	6/25/2021	42	76	74	93	73	61	48	65	0	0
11)	7/2/2021	37	81	68	88	67	39	48	63	0	0
12)	7/9/2021	32	81	68	61	79	61	48	52	0	0
13)	7/16/2021	6	61	35	69	49	21 *	48	29	0	0
14)	Current: 7/23/2021	10 ↓	66	48	61	38 ↓	21 ↓	65	31 ↓	0	0
15)											

#	Depression	
4	I don't enjoy being around people as much as I used to	0
5	I feel isolated and alone	0
11	I feel worthless	0
12	I feel helpless	0
21	I feel sad all the time	1
25	***I have thoughts of ending my life (SI)***	***0***
	Generalized Anxiety	
2	My heart races for no good reason	4
7	I am anxious that I might have a panic attack while in public	0
9	I have sleep difficulties	4
10	My thoughts are racing	4
15	I have spells of terror or panic	0
17	I feel tense	2
	Social Anxiety	
1	I am shy around others	2
19	I make friends easily **	3
22	I am concerned that other people do not like me	2
24	I feel uncomfortable around people I don't know	2
26	I feel self conscious around others	2
	Academic Distress	
8	I feel confident that I can succeed academically **	2

#	Academic Distress *(continued)*	
28	I am not able to concentrate as well as usual	3
30	It's hard to stay motivated for my classes	3
33	I am unable to keep up with my schoolwork	1
	Eating Concerns	
3	I feel out of control when I eat	0
6	I think about food more than I would like to	0
13	I eat too much	0
	Frustration /Anger	
18	I have difficulty controlling my temper	0
20	I sometimes feel like breaking or smashing things	0
23	I get angry easily	0
29	***I am afraid I may lose control and act violently***	***0***
32	I frequently get into arguments	0
34	***I have thoughts of hurting others (THO)***	***0***
	Alcohol Use	
14	I drink alcohol frequently	1
16	When I drink alcohol I can't remember what happened	0
27	I drink more than I should	1
31	I have done something I have regretted because of drinking	0

Sample #4
High-Distress Stable Profile Vignette

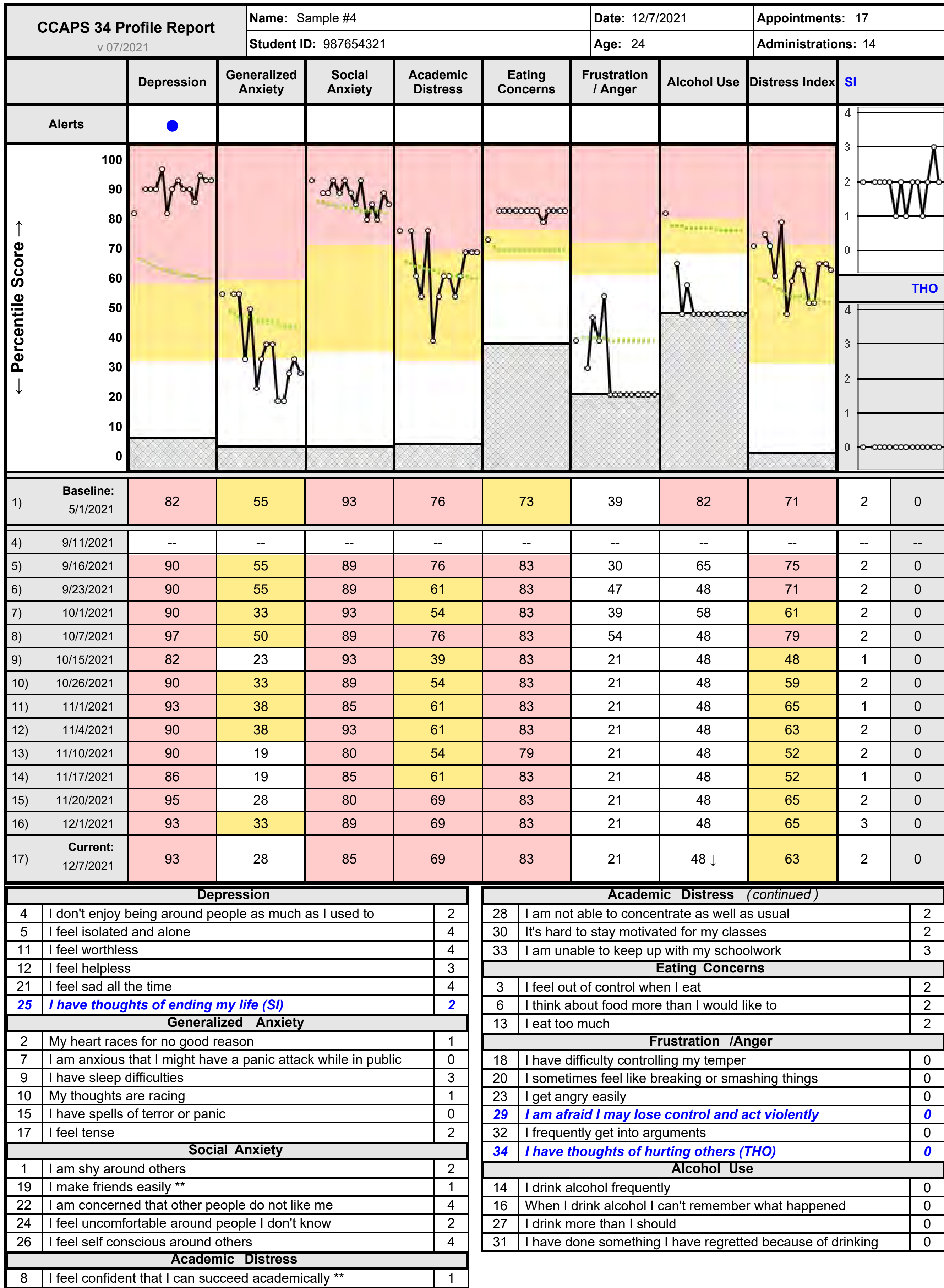
Ashley is a 24 year old, White, Asian-American female, who is a junior in college. She is in a serious dating relationship and lives with her boyfriend. She has a history of difficult relationships, especially with her mother who reportedly has a serious mental illness. Ashley presented to therapy with a desire to address her feelings of isolation and social difficulties.

Ashley was very concrete in therapy and struggled to connect with her therapist. She cried at times, but tended to avoid affect in general. She struggled to assert her feelings and needs with others. Ashley had strong fears of judgment and rejection from others. Therapy focused on trying to help Ashley accept and experience her emotions more. Her symptoms did not respond to insight- oriented therapy, even after a total of 17 appointments, and was eventually referred for longer term therapy. She did succeed in decreasing her use of alcohol.

PROFILE INTERPRETATION

Ashley's profile *(Figure 4)* illustrates a general lack of meaningful change - especially regarding Depression (where an alert was generated) and with the notable exception of Alcohol Use where an RCI was achieved. Over 17 appointments, there was very little improvement in her depression symptoms (and SI) and relatively minor improvement in other subscales. Her persistent avoidance of emotions and lack of insight tended to keep the therapist and others at a distance. Ashley's profile prompted discussion with her therapist (both in therapy and supervision) about how best to understand Ashley's concerns and help her make desired changes. Her profile was indicative of the need for longer term therapeutic work.

Figure 4. Stable CCAPS-34 Profile Report



CCAPS 34 Profile Report v 07/2021	Name: Sample #4	Date: 12/7/2021	Appointments: 17
	Student ID: 987654321	Age: 24	Administrations: 14

		Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Alcohol Use	Distress Index	SI	THO
Alerts		●									
1)	Baseline: 5/1/2021	82	55	93	76	73	39	82	71	2	0
4)	9/11/2021	--	--	--	--	--	--	--	--	--	--
5)	9/16/2021	90	55	89	76	83	30	65	75	2	0
6)	9/23/2021	90	55	89	61	83	47	48	71	2	0
7)	10/1/2021	90	33	93	54	83	39	58	61	2	0
8)	10/7/2021	97	50	89	76	83	54	48	79	2	0
9)	10/15/2021	82	23	93	39	83	21	48	48	1	0
10)	10/26/2021	90	33	89	54	83	21	48	59	2	0
11)	11/1/2021	93	38	85	61	83	21	48	65	1	0
12)	11/4/2021	90	38	93	61	83	21	48	63	2	0
13)	11/10/2021	90	19	80	54	79	21	48	52	2	0
14)	11/17/2021	86	19	85	61	83	21	48	52	1	0
15)	11/20/2021	95	28	80	69	83	21	48	65	2	0
16)	12/1/2021	93	33	89	69	83	21	48	65	3	0
17)	Current: 12/7/2021	93	28	85	69	83	21	48 ↓	63	2	0

#	Item	Score
	Depression	
4	I don't enjoy being around people as much as I used to	2
5	I feel isolated and alone	4
11	I feel worthless	4
12	I feel helpless	3
21	I feel sad all the time	4
25	***I have thoughts of ending my life (SI)***	***2***
	Generalized Anxiety	
2	My heart races for no good reason	1
7	I am anxious that I might have a panic attack while in public	0
9	I have sleep difficulties	3
10	My thoughts are racing	1
15	I have spells of terror or panic	0
17	I feel tense	2
	Social Anxiety	
1	I am shy around others	2
19	I make friends easily **	1
22	I am concerned that other people do not like me	4
24	I feel uncomfortable around people I don't know	2
26	I feel self conscious around others	4
	Academic Distress	
8	I feel confident that I can succeed academically **	1

#	Item	Score
	Academic Distress *(continued)*	
28	I am not able to concentrate as well as usual	2
30	It's hard to stay motivated for my classes	2
33	I am unable to keep up with my schoolwork	3
	Eating Concerns	
3	I feel out of control when I eat	2
6	I think about food more than I would like to	2
13	I eat too much	2
	Frustration /Anger	
18	I have difficulty controlling my temper	0
20	I sometimes feel like breaking or smashing things	0
23	I get angry easily	0
29	***I am afraid I may lose control and act violently***	***0***
32	I frequently get into arguments	0
34	***I have thoughts of hurting others (THO)***	***0***
	Alcohol Use	
14	I drink alcohol frequently	0
16	When I drink alcohol I can't remember what happened	0
27	I drink more than I should	0
31	I have done something I have regretted because of drinking	0

Sample #5
Increasing Profile Vignette

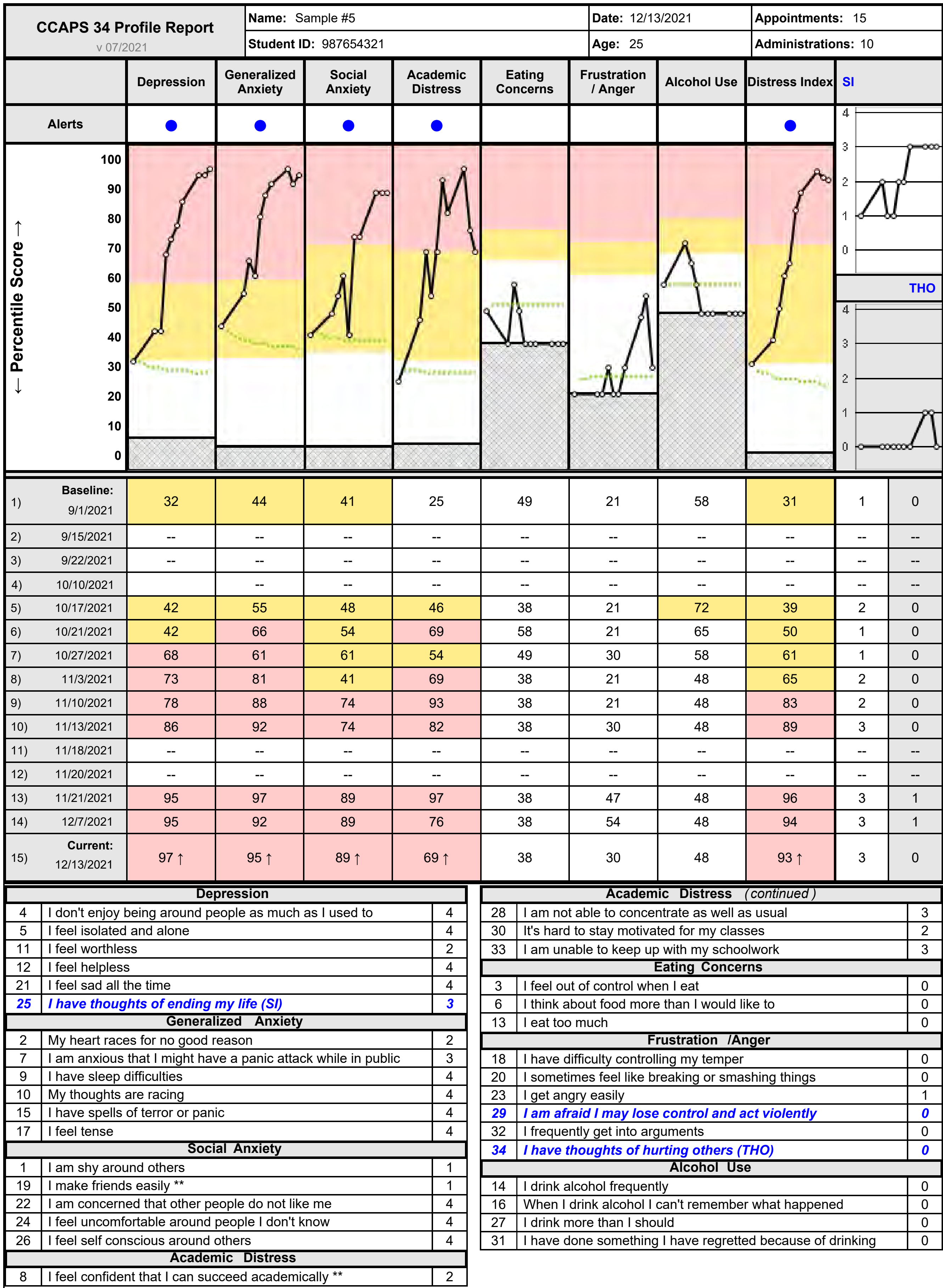
Becky is a 25 year old African-American female student in her first year of grad school. She is currently single and identifies as heterosexual. Religion is important to her. Becky's initial presenting concerns were related to anxiety and panic, especially about academic performance standards in graduate school. She acknowledged a past sexual assault but did not identify it as a problem.

After several sessions of treatment focusing on anxiety, Becky was triggered after running into the perpetrator of her past sexual assault. This experience lead her to pursue charges against the perpetrator but also to begin experiencing increasing levels of symptoms leading up to the trial. Her symptoms decreased gradually after the trial, but this profile report illustrates the period of intensifying symptoms.

PROFILE INTERPRETATION

Becky's profile *(Figure 5)* demonstrates a clear pattern of increasing symptom severity after a past sexual assault became the primary presenting concern. It is worth noting that Eating, Frustration/Anger, and Alcohol Use did not increase while Depression, Anxiety, Social Anxiety, and Academic Distress did. As a result of her increasingly severe symptoms, and lack of response to treatment, she was referred for psychiatric services. Treatment focused increasingly on management of symptoms, stabilization, and safety planning within the context of a very stressful and ongoing life event.

Figure 5. Increasing CCAPS-34 Profile Report



CCAPS 34 Profile Report (v 07/2021)	Name: Sample #5	Date: 12/13/2021	Appointments: 15
	Student ID: 987654321	Age: 25	Administrations: 10

	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration / Anger	Alcohol Use	Distress Index	SI	THO
Alerts	●	●	●	●				●		
1) Baseline: 9/1/2021	32	44	41	25	49	21	58	31	1	0
2) 9/15/2021	--	--	--	--	--	--	--	--	--	--
3) 9/22/2021	--	--	--	--	--	--	--	--	--	--
4) 10/10/2021		--	--	--	--	--	--	--	--	--
5) 10/17/2021	42	55	48	46	38	21	72	39	2	0
6) 10/21/2021	42	66	54	69	58	21	65	50	1	0
7) 10/27/2021	68	61	61	54	49	30	58	61	1	0
8) 11/3/2021	73	81	41	69	38	21	48	65	2	0
9) 11/10/2021	78	88	74	93	38	21	48	83	2	0
10) 11/13/2021	86	92	74	82	38	30	48	89	3	0
11) 11/18/2021	--	--	--	--	--	--	--	--	--	--
12) 11/20/2021	--	--	--	--	--	--	--	--	--	--
13) 11/21/2021	95	97	89	97	38	47	48	96	3	1
14) 12/7/2021	95	92	89	76	38	54	48	94	3	1
15) Current: 12/13/2021	97 ↑	95 ↑	89 ↑	69 ↑	38	30	48	93 ↑	3	0

Depression		
4	I don't enjoy being around people as much as I used to	4
5	I feel isolated and alone	4
11	I feel worthless	2
12	I feel helpless	4
21	I feel sad all the time	4
25	***I have thoughts of ending my life (SI)***	***3***
Generalized Anxiety		
2	My heart races for no good reason	2
7	I am anxious that I might have a panic attack while in public	3
9	I have sleep difficulties	4
10	My thoughts are racing	4
15	I have spells of terror or panic	4
17	I feel tense	4
Social Anxiety		
1	I am shy around others	1
19	I make friends easily **	1
22	I am concerned that other people do not like me	4
24	I feel uncomfortable around people I don't know	4
26	I feel self conscious around others	4
Academic Distress		
8	I feel confident that I can succeed academically **	2

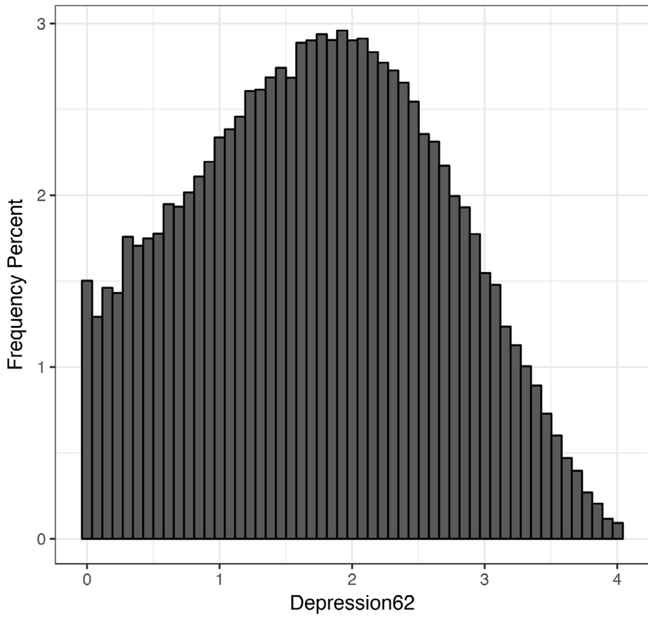
Academic Distress *(continued)*		
28	I am not able to concentrate as well as usual	3
30	It's hard to stay motivated for my classes	2
33	I am unable to keep up with my schoolwork	3
Eating Concerns		
3	I feel out of control when I eat	0
6	I think about food more than I would like to	0
13	I eat too much	0
Frustration /Anger		
18	I have difficulty controlling my temper	0
20	I sometimes feel like breaking or smashing things	0
23	I get angry easily	1
29	***I am afraid I may lose control and act violently***	***0***
32	I frequently get into arguments	0
34	***I have thoughts of hurting others (THO)***	***0***
Alcohol Use		
14	I drink alcohol frequently	0
16	When I drink alcohol I can't remember what happened	0
27	I drink more than I should	0
31	I have done something I have regretted because of drinking	0

Appendix C:

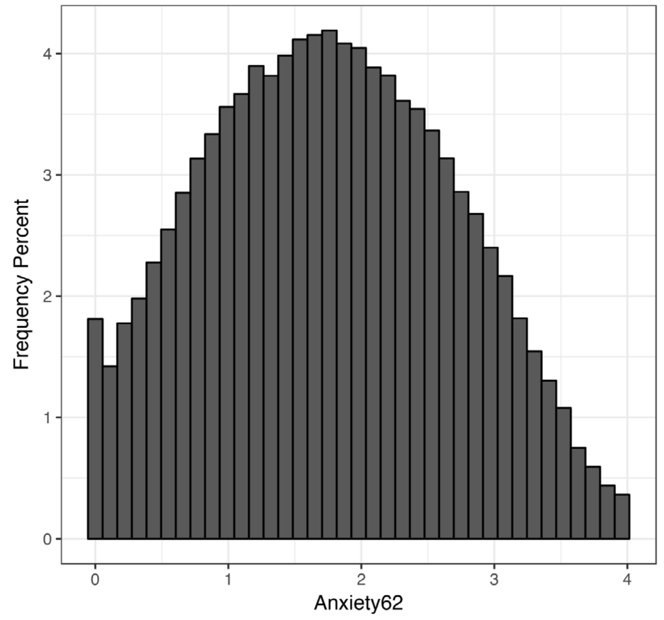
Histograms of Subscale Distributions for the CCAPS 2021

CCAPS-62 Distributions

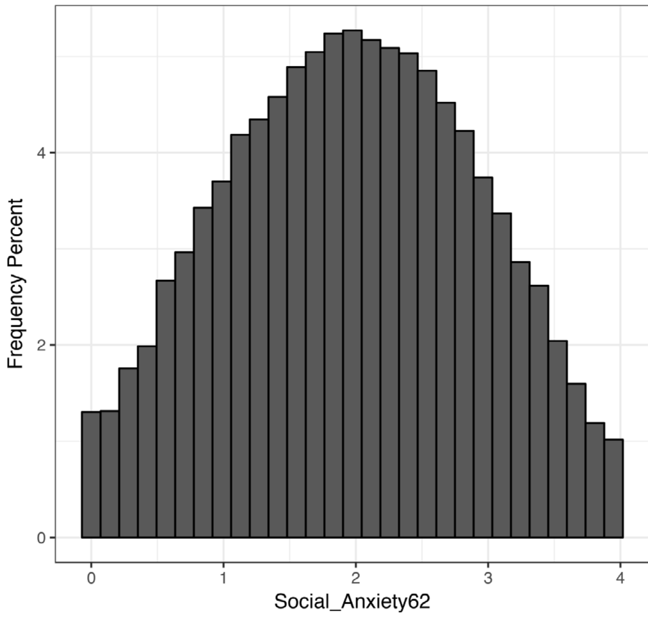
DEPRESSION CCAPS-62



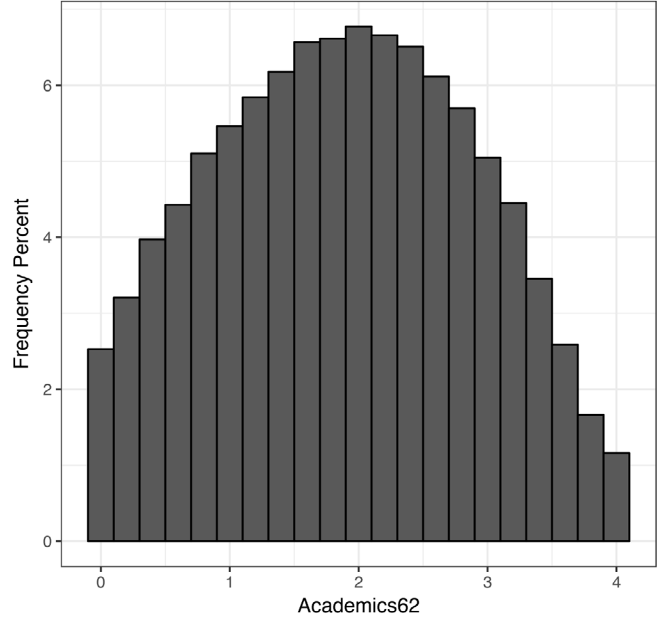
GENERALIZED ANXIETY CCAPS-62



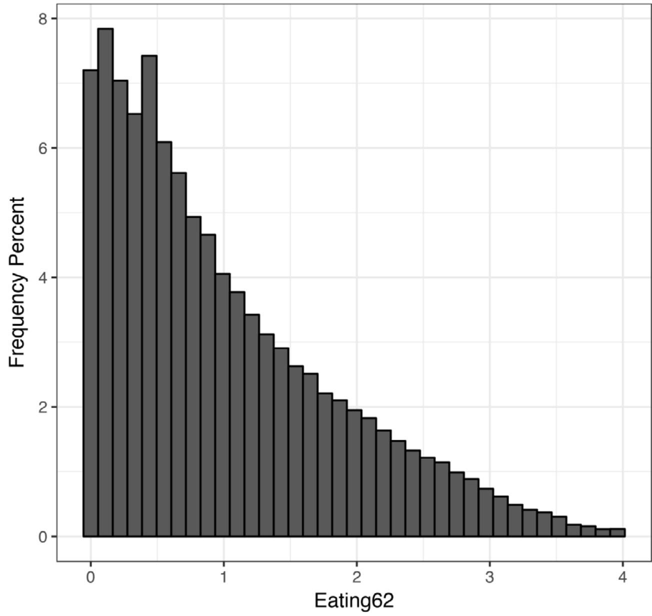
SOCIAL ANXIETY CCAPS-62



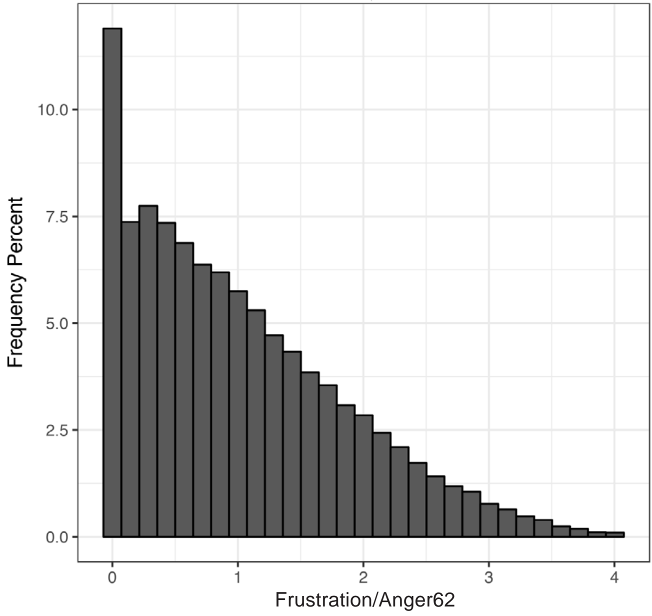
ACADEMIC DISTRESS CCAPS-62



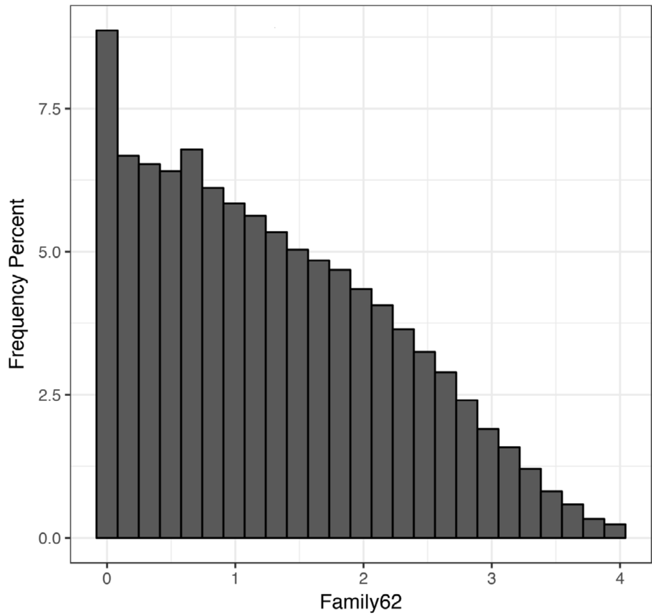
EATING CONCERNS CCAPS-62



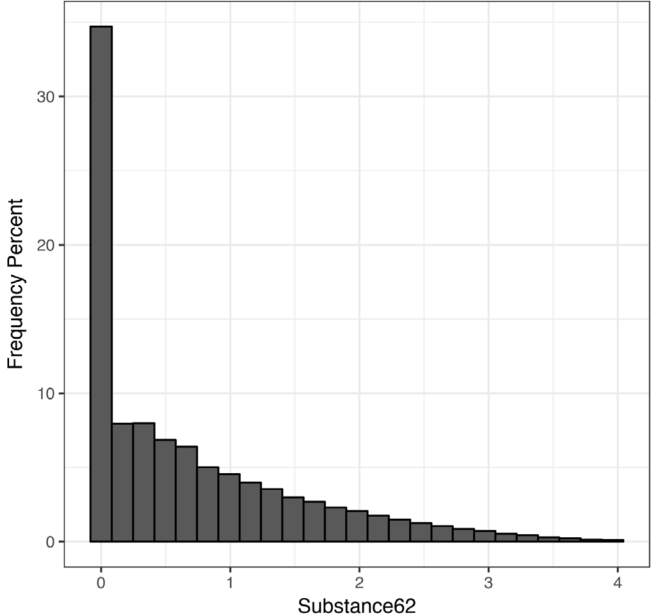
FRUSTRATION/ANGER CCAPS-62



FAMILY DISTRESS CCAPS-62

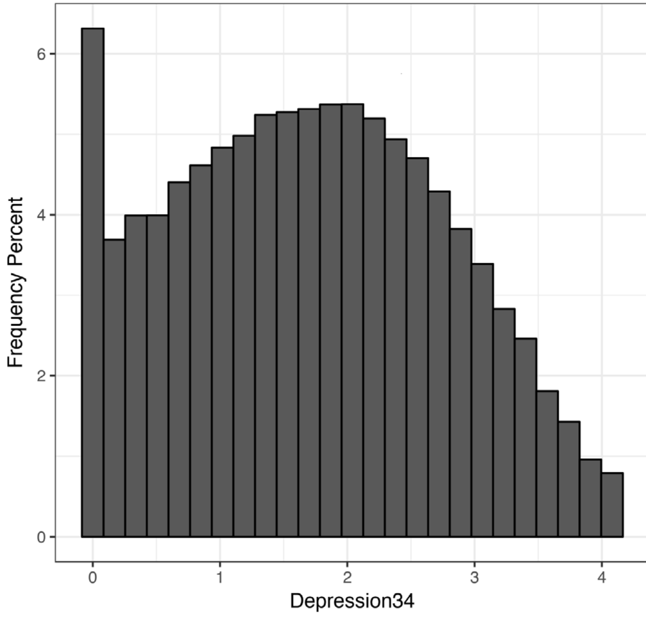


SUBSTANCE USE CCAPS-62

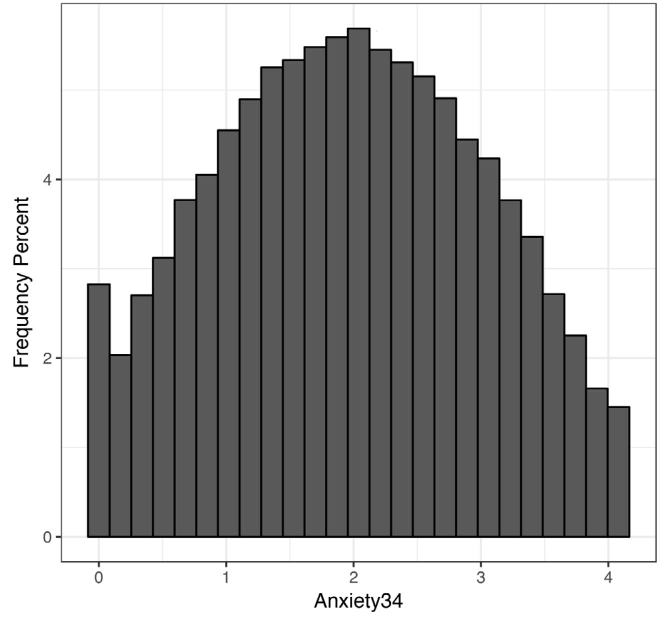


CCAPS-34 Distributions

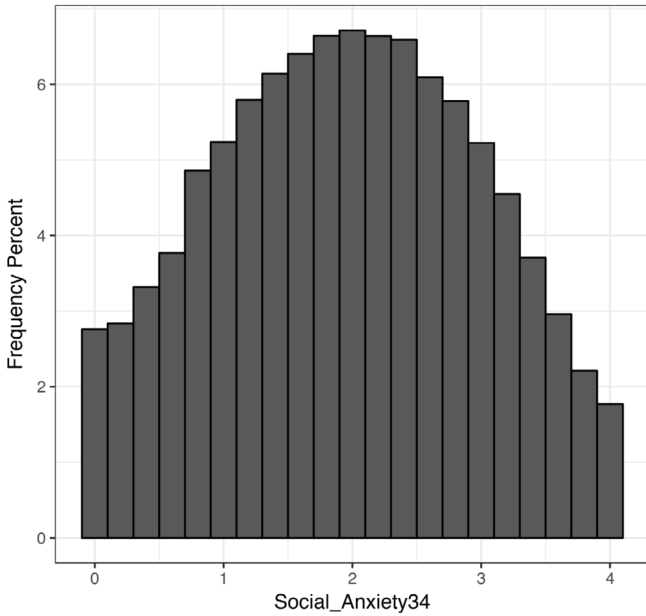
DEPRESSION CCAPS-34



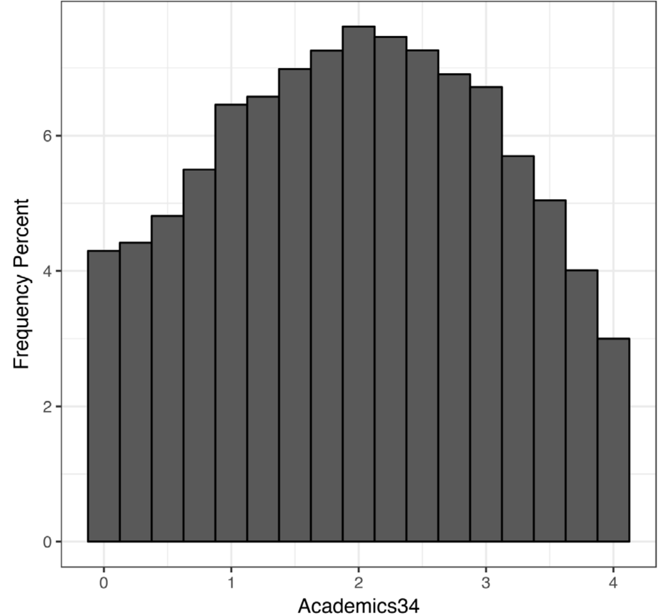
GENERALIZED ANXIETY CCAPS-34



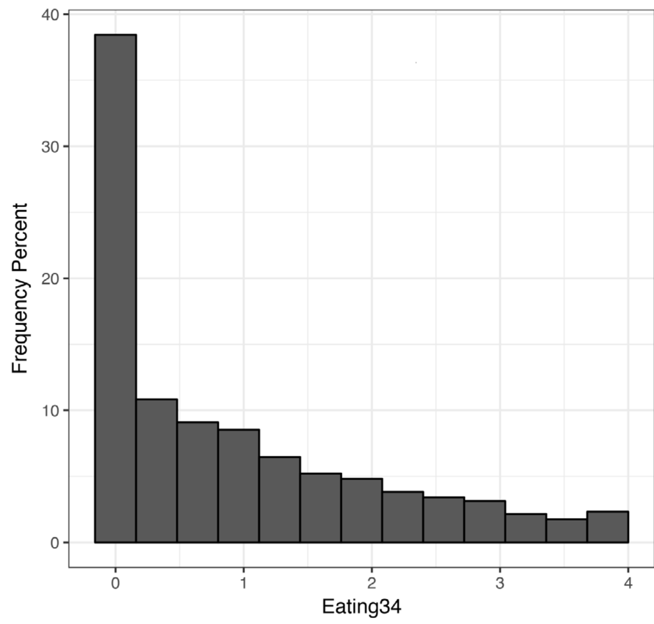
SOCIAL ANXIETY CCAPS-34



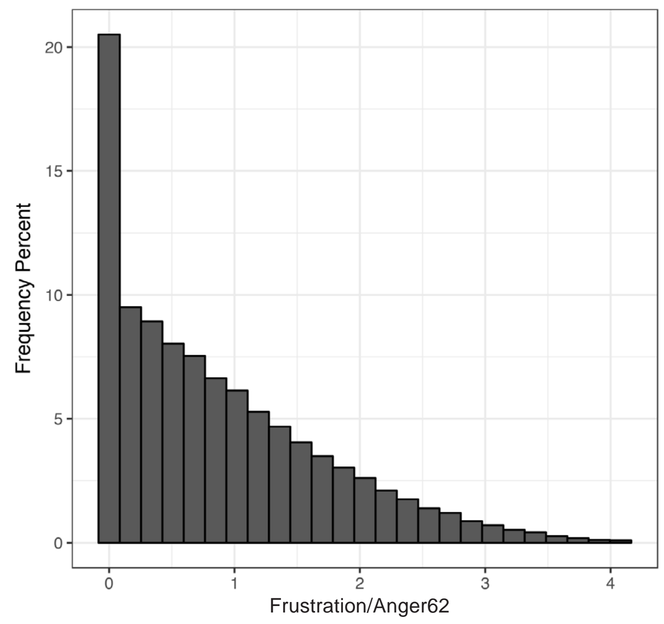
ACADEMIC DISTRESS CCAPS-34



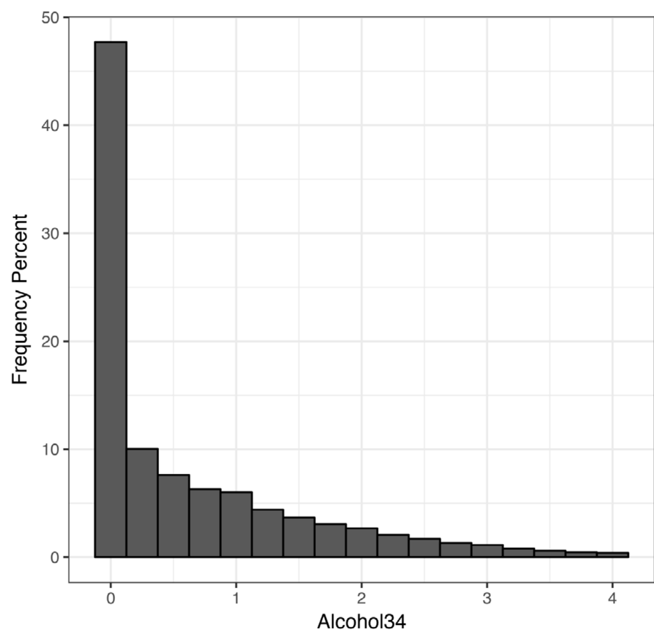
EATING CONCERNS CCAPS-34



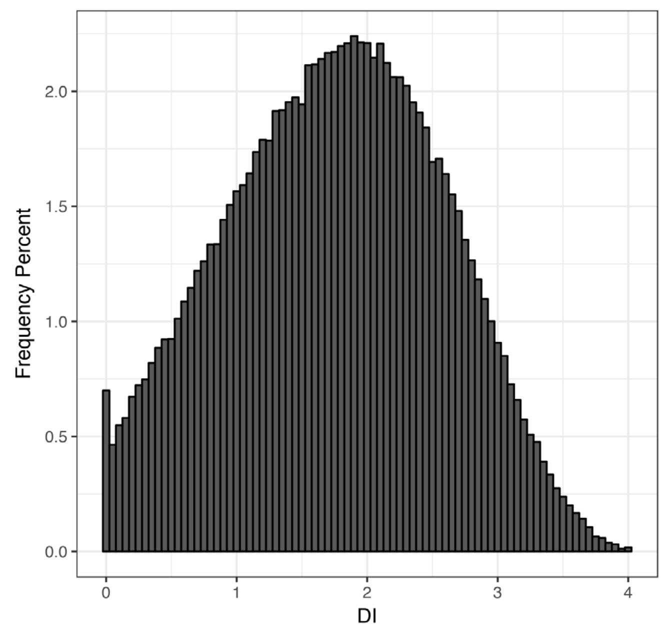
FRUSTRATION/ANGER CCAPS-34



ALCOHOL USE CCAPS-34



DISTRESS INDEX



Appendix D:

Items Sorted by Subscale

Items Sorted by Subscale					
CCAPS Version		Scale	Item	Reverse Scored	Distress Index
34	62				
	8	Depression	I feel disconnected from myself		
4	9	Depression	I don't enjoy being around people as much as I used to		Yes
5	10	Depression	I feel isolated and alone		Yes
	12	Depression	I lose touch with reality		
11	20	Depression	I feel worthless		Yes
12	23	Depression	I feel helpless		Yes
	28	Depression	I am enthusiastic about life	Yes	
	37	Depression	I have unwanted thoughts I can't control		
21	40	Depression	I feel sad all the time		Yes
25	46	Depression	I have thoughts of ending my life		Yes
	55	Depression	I like myself	Yes	
	58	Depression	I find that I cry frequently		
	62	Depression	I feel that I have no one who understands me		
	3	Generalized Anxiety	There are many things I am afraid of		
2	4	Generalized Anxiety	My heart races for no good reason		Yes
7	14	Generalized Anxiety	I am anxious that I might have a panic attack in public		Yes
9	17	Generalized Anxiety	I have sleep difficulties		Yes
10	18	Generalized Anxiety	My thoughts are racing		Yes
15	27	Generalized Anxiety	I have spells of terror or panic		Yes
17	30	Generalized Anxiety	I feel tense		Yes
	33	Generalized Anxiety	I am easily frightened or startled		
	39	Generalized Anxiety	I experience nightmares or flashbacks		
1	2	Social Anxiety	I am shy around others		
	16	Social Anxiety	I become anxious when I have to speak in front of audiences		
19	35	Social Anxiety	I make friends easily	Yes	
22	41	Social Anxiety	I am concerned that other people do not like me		Yes
24	44	Social Anxiety	I feel uncomfortable around people I don't know		
26	47	Social Anxiety	I feel self conscious around others		Yes
	54	Social Anxiety	I feel comfortable around other people	Yes	
	6	Academic Distress	I enjoy my classes	Yes	
8	15	Academic Distress	I feel confident I can succeed academically	Yes	
28	51	Academic Distress	I am not able to concentrate as well as usual		Yes
30	53	Academic Distress	It's hard to stay motivated for my classes		Yes
33	59	Academic Distress	I am unable to keep up with my school work		Yes
3	5	Eating Concerns	I feel out of control when I eat		
6	13	Eating Concerns	I think about food more than I would like to		
	19	Eating Concerns	I am satisfied with my body shape	Yes	
	22	Eating Concerns	I am dissatisfied with my weight		
13	25	Eating Concerns	I eat too much		
	31	Eating Concerns	When I start eating I can't stop		
	34	Eating Concerns	I diet frequently		
	48	Eating Concerns	I purge to control my weight		
	61	Eating Concerns	The less I eat, the better I feel about myself		
18	32	Frustration/Anger	I have difficulty controlling my temper		
20	36	Frustration/Anger	I sometimes feel like breaking or smashing things		Yes
23	43	Frustration/Anger	I get angry easily		Yes
	45	Frustration/Anger	I feel irritable		
29	52	Frustration/Anger	I am afraid I may lose control and act violently		Yes
32	57	Frustration/Anger	I frequently get into arguments		
34	60	Frustration/Anger	I have thoughts of hurting others		
	1	Family Distress	I get sad or angry when I think of my family		
	7	Family Distress	I feel that my family loves me	Yes	
	11	Family Distress	My family gets on my nerves		
	21	Family Distress	My family is basically a happy one	Yes	
	38	Family Distress	There is a history of abuse in my family		
	42	Family Distress	I wish my family got along better		
	24	Substance / Alcohol Use	I use drugs more than I should		
14	26	Substance / Alcohol Use	I drink alcohol frequently		
16	29	Substance / Alcohol Use	When I drink alcohol I can't remember what happened		
27	49	Substance / Alcohol Use	I drink more than I should		
	50	Substance / Alcohol Use	I enjoy getting drunk		
31	56	Substance / Alcohol Use	I have done something I have regretted because of drinking		

Items Sorted Numerically					
CCAPS Version		Scale	Item	Reverse Scored	Distress Index
34	62				
	1	Family Distress	I get sad or angry when I think of my family		
1	2	Social Anxiety	I am shy around others		
	3	Generalized Anxiety	There are many things I am afraid of		
2	4	Generalized Anxiety	My heart races for no good reason		Yes
3	5	Eating Concerns	I feel out of control when I eat		
	6	Academic Distress	I enjoy my classes	Yes	
	7	Family Distress	I feel that my family loves me	Yes	
	8	Depression	I feel disconnected from myself		
4	9	Depression	I don't enjoy being around people as much as I used to		Yes
5	10	Depression	I feel isolated and alone		Yes
	11	Family Distress	My family gets on my nerves		
	12	Depression	I lose touch with reality		
6	13	Eating Concerns	I think about food more than I would like to		
7	14	Generalized Anxiety	I am anxious that I might have a panic attack in public		Yes
8	15	Academic Distress	I feel confident I can succeed academically	Yes	
	16	Social Anxiety	I become anxious when I have to speak in front of audiences		
9	17	Generalized Anxiety	I have sleep difficulties		Yes
10	18	Generalized Anxiety	My thoughts are racing		Yes
	19	Eating Concerns	I am satisfied with my body shape	Yes	
11	20	Depression	I feel worthless		Yes
	21	Family Distress	My family is basically a happy one	Yes	
	22	Eating Concerns	I am dissatisfied with my weight		
12	23	Depression	I feel helpless		Yes
	24	Substance/Alcohol Use	I use drugs more than I should		
13	25	Eating Concerns	I eat too much		
14	26	Substance/Alcohol Use	I drink alcohol frequently		
15	27	Generalized Anxiety	I have spells of terror or panic		Yes
	28	Depression	I am enthusiastic about life	Yes	
16	29	Substance/Alcohol Use	When I drink alcohol I can't remember what happened		
17	30	Generalized Anxiety	I feel tense		Yes
	31	Eating Concerns	When I start eating I can't stop		
18	32	Frustration/Anger	I have difficulty controlling my temper		
	33	Generalized Anxiety	I am easily frightened or startled		
	34	Eating Concerns	I diet frequently		
19	35	Social Anxiety	I make friends easily	Yes	
20	36	Frustration/Anger	I sometimes feel like breaking or smashing things		Yes
	37	Depression	I have unwanted thoughts I can't control		
	38	Family Distress	There is a history of abuse in my family		
	39	Generalized Anxiety	I experience nightmares or flashbacks		
21	40	Depression	I feel sad all the time		Yes
22	41	Social Anxiety	I am concerned that other people do not like me		Yes
	42	Family Distress	I wish my family got along better		
23	43	Frustration/Anger	I get angry easily		Yes
24	44	Social Anxiety	I feel uncomfortable around people I don't know		
	45	Frustration/Anger	I feel irritable		
25	46	Depression	I have thoughts of ending my life		Yes
26	47	Social Anxiety	I feel self conscious around others		Yes
	48	Eating Concerns	I purge to control my weight		
27	49	Substance/Alcohol Use	I drink more than I should		
	50	Substance/Alcohol Use	I enjoy getting drunk		
28	51	Academic Distress	I am not able to concentrate as well as usual		Yes
29	52	Frustration/Anger	I am afraid I may lose control and act violently		Yes
30	53	Academic Distress	It's hard to stay motivated for my classes		Yes
	54	Social Anxiety	I feel comfortable around other people	Yes	
	55	Depression	I like myself	Yes	
31	56	Substance/Alcohol Use	I have done something I have regretted because of drinking		
32	57	Frustration/Anger	I frequently get into arguments		
	58	Depression	I find that I cry frequently		
33	59	Academic Distress	I am unable to keep up with my school work		Yes
34	60	Frustration/Anger	I have thoughts of hurting others		
	61	Eating Concerns	The less I eat, the better I feel about myself		
	62	Depression	I feel that I have no one who understands me		

Appendix E:

CCAPS 2021 Raw-Score to Percentile Conversion Tables

The conversion tables for both instruments are provided below. Raw scores that are not displayed under the referent subscale are rounded up to the next available score/percentile combination.

Percentile Table for the CCAPS-62

Percentile	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration/ Anger	Family Distress	Substance Use	Distress Index
1			0.00						0.00
2	0.00	0.00							0.10
3	0.08	0.11	0.14	0.00					0.20
4	0.15		0.29						0.25
5		0.22							0.35
6	0.23		0.43	0.20					0.40
7	0.31	0.33			0.00				0.45
8									0.50
9	0.38	0.44	0.57				0.00		0.55
10				0.40					0.60
11	0.46								0.65
12		0.56	0.71			0.00			0.70
13	0.54								
14				0.60					0.75
15	0.62	0.67	0.86		0.11		0.17		0.80
16									0.85
17	0.69								
18		0.78							0.90
19	0.77		1.00	0.80		0.14			0.95
20									
21	0.85	0.89							1.00
22					0.22		0.33		1.05
23	0.92		1.14						
24									1.10
25	1.00	1.00		1.00					
26									1.15
27						0.29			
28	1.08	1.11	1.29		0.33		0.50		1.20
29									1.25
30	1.15			1.20					
31									1.30
32		1.22	1.43						
33	1.23								1.35
34						0.43			
35	1.31						0.67	0.00	1.40
36		1.33			0.44				
37			1.57	1.40					1.45
38	1.38								
39									1.50
40		1.44							
41	1.46					0.57	0.83		1.55
42			1.71		0.56				
43	1.54			1.60				0.17	1.60
44		1.56							
45									
46	1.62								1.65
47			1.86				1.00		
48		1.67			0.67	0.71			1.70
49	1.69								
50				1.80					1.75
51								0.33	
52	1.77								1.80
53		1.78	2.00		0.78		1.17		
54						0.86			1.85
55	1.85								
56									1.90
57		1.89		2.00	0.89				
58	1.92		2.14				1.33	0.50	
59									1.95
60						1.00			
61	2.00	2.00			1.00				2.00
62									
63			2.29	2.20			1.50		2.05
64	2.08	2.11						0.67	
65					1.11	1.14			2.10
66									
67	2.15								2.15
68		2.22	2.43				1.67		
69	2.23				1.22	1.29		0.83	2.20
70				2.40					
71									2.25
72	2.31	2.33			1.33				
73			2.57				1.83	1.00	2.30
74						1.43			
75	2.38				1.44				2.35
76		2.44		2.60					
77	2.46		2.71		1.56		2.00	1.17	2.40
78						1.57			
79		2.56							2.45
80	2.54				1.67				
81						1.71	2.17	1.33	2.50
82	2.62	2.67	2.86	2.80	1.78				
83									2.55
84	2.69				1.89	1.86		1.50	2.60
85		2.78	3.00				2.33		
86	2.77				2.00				2.65
87				3.00		2.00		1.67	2.70
88	2.85	2.89			2.11		2.50		
89			3.14		2.22			1.83	2.75
90	2.92	3.00				2.14			2.80
91	3.00			3.20	2.33		2.67	2.00	2.85
92		3.11	3.29		2.44	2.29			2.90
93	3.08				2.56	2.43	2.83	2.17	2.95
94	3.15	3.22	3.43					2.33	3.00
95	3.23	3.33		3.40	2.67	2.57	3.00		3.05
96	3.31		3.57		2.78	2.71		2.50	3.10
97	3.38	3.44		3.60	2.89	2.86	3.17	2.67	3.20
98	3.46	3.56	3.71		3.11	3.00	3.33	2.83	3.30
99	3.62	3.67	3.86	3.80	3.33	3.29	3.50	3.17	3.40
100	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

Percentile Table for the CCAPS-34

Percentile	Depression	Generalized Anxiety	Social Anxiety	Academic Distress	Eating Concerns	Frustration/ Anger	Alcohol Use	Distress Index
1								0.00
2								0.10
3		0.00	0.00					0.20
4				0.00				0.25
5		0.17						0.35
6	0.00		0.20					0.40
7								0.45
8		0.33						0.50
9			0.40	0.25				0.55
10	0.17							0.60
11		0.50						0.65
12								0.70
13			0.60					
14	0.33	0.67		0.50				0.75
15								0.80
16								0.85
17								
18	0.50		0.80					0.90
19		0.83		0.75				0.95
20								
21						0.00		1.00
22	0.67							1.05
23		1.00	1.00					
24								1.10
25				1.00				
26								1.15
27	0.83							
28		1.17	1.20					1.20
29								1.25
30						0.17		
31								1.30
32	1.00			1.25				
33		1.33						1.35
34								
35			1.40					1.40
36								
37	1.17							1.45
38		1.50			0.00			
39				1.50		0.33		1.50
40								
41			1.60					1.55
42	1.33							
43								1.60
44		1.67						
45								
46				1.75				1.65
47	1.50					0.50		
48			1.80				0.00	1.70
49					0.33			
50		1.83						1.75
51								
52								1.80
53	1.67							
54			2.00	2.00		0.67		1.85
55		2.00						
56								1.90
57								
58	1.83				0.67		0.25	
59								1.95
60								
61		2.17	2.20	2.25		0.83		2.00
62								
63	2.00							2.05
64								
65							0.50	2.10
66		2.33						
67					1.00	1.00		2.15
68	2.17		2.40					
69				2.50				2.20
70								
71		2.50						2.25
72						1.17	0.75	
73	2.33				1.33			2.30
74			2.60					
75								2.35
76		2.67		2.75				
77						1.33		2.40
78	2.50						1.00	
79					1.67			2.45
80			2.80					
81		2.83				1.50		2.50
82	2.67			3.00			1.25	
83					2.00			2.55
84								2.60
85		3.00	3.00			1.67		
86	2.83						1.50	2.65
87					2.33			2.70
88		3.17		3.25		1.83		
89			3.20				1.75	2.75
90	3.00					2.00		2.80
91					2.67			2.85
92		3.33				2.17	2.00	2.90
93	3.17		3.40	3.50				2.95
94					3.00	2.33	2.25	3.00
95	3.33	3.50					2.50	3.05
96			3.60		3.33	2.50		3.10
97	3.50	3.67		3.75		2.67	2.75	3.20
98	3.67		3.80		3.67	2.83	3.00	3.30
99	3.83	3.83				3.17	3.25	3.40
100	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

Appendix F:

Scoring

CCAPS instruments can be scored by hand, via Titanium Schedule or other certified EMR, SPSS syntax, and the CCMH website.

Calculating raw subscale scores by hand

All items in the CCAPS-62 and 34 are scored on a five point scale (0 = Not at all like me, 1, 2, 3, 4 = Extremely like me). Some items are reverse-scored prior to computing the subscales (see Appendices). To score the CCAPS-62 or CCAPS-34 manually:

1. Reverse score the appropriate items.
2. Do not score at all if more than 50% of all items are missing, or if all item values are the same (e.g. all 1s), and do not score any individual subscales in which 33% or more of the subscale items are missing.
3. Average the items scores for each subscale to create the subscale raw score. This step is best performed using an AVERAGE or MEAN function in computer software that can account for any missing item responses.
4. These raw scores can be used to look up percentiles using the tables in Appendix C.

NOTE: SPSS Syntax for reverse-scoring, identifying invalid administrations, and computing subscales raw scores can be downloaded from the CCMH website.

Calculating normalized scores from raw subscale scores

Normalized scores are necessary for comparing scores between subscales and between the CCAPS-62 and the CCAPS-34, and also put the subscale scores on a common metric that may be used with other instruments. The resulting distribution of scores has a mean of 0 and a standard deviation of 1. Please remember that a score of 0 in this case represents the average counseling client, and does not, therefore, represent absence of distress.

1. Subtract the subscale mean in the overall clinical sample from the subscale raw score.
2. Divide by the subscale standard deviation of the overall clinical sample.

SPSS Scoring Syntax

For those wishing to compute and analyze any version of the CCAPS within SPSS, please visit the Member Information Folder on the CCMH website or reach out to CCMH for access. This folder provides syntax and computation instructions for users attempting to (a) reverse score the appropriate items, (b) select only valid administrations, and then (c) compute the subscale raw scores.

Center for
Collegiate Mental Health
(CCMH)

The Pennsylvania State University
Center for Counseling and Psychological Services
Student Affairs

WMCC Disposition Questions

An initial consultation/triage meeting is designed to be a consultation with a student/client who is seeking services to address an issue or concern they are having. While they may have an idea of what they think will be helpful, your professional expertise is an important part of that person ultimately addressing the issue that they are concerned about. You have specific knowledge about how particular conditions can be alleviated or exacerbated by certain interventions. Based on all of the information you have, and the information about their situation that they provide, you will make recommendations to the client regarding the service(s) that could be **MOST helpful** to them. While financial factors, transportation, parental and social support, and other environmental factors should be taken into account, the first question you and the client should work to answer is "what would best meet their clinical need at this time?" Once you have answered this question, work to find a reasonable approach to using the resources we have to meet that need. You can work with your supervisor, other staff, and/or the Mental Health Services Coordinator to develop this plan.

Here are some questions that can help guide your thinking as you plan:

Is this their first therapy experience? (Could some psychoeducational and or transitional experience in brief treatment be helpful?)

Are they able to identify goals? (Specific goals with observable or measurable outcomes lend themselves to brief treatment)

What is their previous level of need or previous experience with therapy? (When was the last time this person functioned without services and for how long? Is their current stress level or transitional phase likely to exacerbate issues or diminish them? Are they requesting a specific frequency of contact or specific type of intervention?)

Are they demonstrating behaviors indicating high need or high risk? (Patterns of substance use/abuse that involve risky behaviors; maybe not in crisis but with extensive history of previous mental health experience either with or without previous treatment; recent crisis (honor, legal involvement, conduct issues); to adequately address issues bi-weekly therapy is likely not a good fit or is contraindicated; recent significant loss; low CAF score or level of current functioning; CCAPS profile; timing of the semester and ability to reassess at a later time; really specific clinical presentation that requires a specific intervention that is beyond expertise or ability to impact well in this setting; need for access to on-demand or frequent crisis services)

Is there some combination of services that could address the issue(s) adequately? (e.g. community therapy ongoing and group at WMCC; academic support from Dean's office with brief treatment)

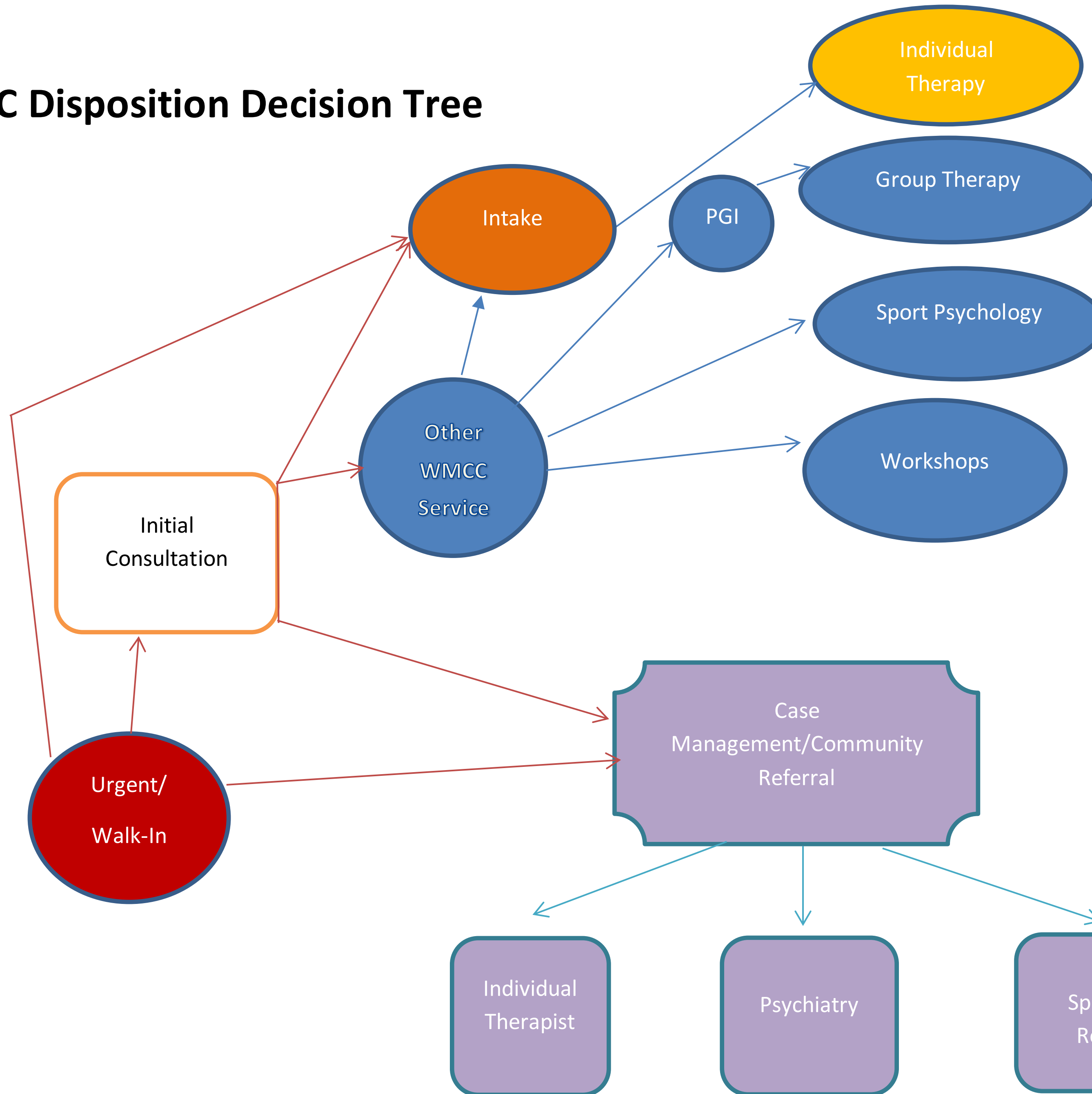
Is the presenting issue likely to respond to short term and/or Bi-weekly sessions? (Is the client's presenting issue amenable to brief models of treatment? Is the client able to tolerate biweekly sessions? Does the client see their issue as able to be addressed in a time sensitive manner?)

Is the presenting issue better suited for another resource? (Would Motivational Interviewing; Mindfulness; and/or Academic and Career advising, better address the needs?)

Are the extenuating factors compelling or can they be overcome (Can underinsurance or financial issues be further addressed; can brief therapy help overcome family of origin barriers to treatment?)

Does the client have the flexibility or capability of following through with the plan? (Level of functioning indicates they can carry out steps of plan without help or they need support of MHSC to make transition to appropriate treatment modality. Currently ready for group or need brief individual therapy to be ready)

WMCC Disposition Decision Tree



CAMPUS RESOURCES

Always consider if a campus resource may be the best referral for a client and/or a helpful supplement to treatment. Common referrals made by the WMCC are to:

Student Health Center

Dean of Students Office

Financial Aid

Campus Rec

Reeve's Center for International Students

Crafting a Case Conceptualization

What is case conceptualization? How is it different from a summary?
A case conceptualization is an explanation of how the therapist understands the client's problem or issue. The therapist's conceptualization is a generated from the information that they have gathered from the client regarding their experience, and is articulated through the lens of a particular theoretical orientation or other manner of organizing individual biopsychosocial data. The client provides the specifics of their experience and symptoms, if any. The theory helps the therapist to understand how client's experience has come to be; and what can be done to change it.

The following are some questions that can guide you as you conceptualize clients:

- What is the presenting problem or the client's explanation for why they are seeking help and/or support at this time? What are the therapist's ideas about what is bringing the client in at this time?

- What factors have contributed to the current situation based on their:
  - Identity variables
  - Cultural and contextual history
  - Biological and physical context
  - Family of origin
  - Developmental milestones and other significant markers of transition
  - Academic history
  - Current level of social support
  - Relationship with substances, food, exercise, etc.
  - Previous attempts to solve problems and/or address challenges

- How has the client adaptively or maladaptively managed his or her problem(s)/issue(s) thus far? Has this been a pattern over time?

- What relational or intrapsychic dynamics did you hear or observe in hearing the client's story? What are the common themes?

- Based on your orientation, what factors underlie the client's presenting concern? How do these factors maintain, exacerbate, or otherwise influence the client's concern?

- What ties it all together? How do you make sense of the information being presented?

- What do you think needs to happen for the client to reach some positive resolution or growth?

WHEN TO CONSULT?
A RESOURCE GUIDE

This guide is meant to help ensure that follow-up is conducted if certain red flags emerge during an initial assessment.

1. **Has the client stated specific or vague references to suicide?**

2. **Has the client stated specific or vague references to homicide?**

3. **Has the client indicated any history of abuse (emotional, physical, sexual)? Are you suspicious of any abuse or neglect that the client has referenced experiencing as a minor?**
   - Even if client is over 18 y/o, are minors currently in the home with alleged perpetrator (e.g., younger siblings)?
   - Inquire about whether the alleged perpetrator still has a caretaking role of minors generally
   - Remind client of applicable limit of confidentiality and inform them of your need to consult with a supervisor

4. **Has the client referenced other issues that could be reportable to CPS?**
   - Minors witnessing domestic violence in the home
   - Substance use/alcohol use is creating a dangerous environment (e.g., intoxicated parent driving children around, selling of drugs in the home)
   - Neglectful behavior (e.g., leaving children in home unsupervised for extended periods of time or overnight)

** If any of these are present, be sure to consult **ASAP** by following the below steps:

<table>
<tr><th>Initial Assessment</th><th>Ongoing Client</th></tr>
<tr><td>1) Consult with supervisor
** if unavailable, go to step 2</td><td>1) Consult with supervisor
** if unavailable, go to step 2</td></tr>
<tr><td>2) Consult with Team Leader
** if unavailable, go to step 3</td><td>2) Consult with any available senior staff</td></tr>
<tr><td>3) Consult with any available senior staff</td><td></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">** If client is to be transported to hospital, Team and the on-call staff should be involved. The individual supervision and Mental Health Services Coordinator should also be informed as soon as possible.</td></tr>
</table>

Risk Assessment Checklist

Suicidal Risk Ax:

Current: _________

Past:____________

Active vs. Passive thoughts:
____

Plan:_____________

Intent:_____________

Attempts: _____________

If yes to any of above:

Duration:____________

Frequency:___________

Last occurrence of ideation:_________

Protective Factors:____________

Homicidal Risk Ax:

Current: _________

Past:____________

Thoughts/Ideation: ___________

Plan:_____________

Intent:_____________

Hx of causing harm/physical injury to others:
____

If yes to any of above:

Onset:____________

Last occurrence:_________

Non-Suicidal Self-Injury Ax:

Current: _________

Past:____________

If yes to any of above:

Method of self-injury/Instrument used:__________

Bodily Location of self-injury:____________

Frequency:________________

Duration:______________

Last occurrence: _____________

Did self-injury require medical attention/severity of injury (scarring/bruising/etc.):_______________?

Suicide Risk Assessment for John Doe

Prepared by ______________________________ Date ________________

1a. Chronic Risk Factors
1b. Acute Risk Factors
1c. Protective Factors
1d. Suicidal Ideation, Planning, and Intent

2. Based on the assessment findings listed above, indicate your judgment of this client's risk for suicide.

Risk Level	Chronic Risk Factors	Acute Risk Factors
Low		
Moderate		
High		

I deation – threats to kill/hurt self, looking for access to means, talking/writing about death

S ubstance abuse – increased or excessive use of alcohol or drugs

P urposelessness – No reason for living; no sense of purpose in life

A nxiety – Anxiety, agitation, unable to sleep or sleeping all the time

T rapped – Feeling trapped, like no way out, resistance to help

H opelessness – Hopeless about the future

W ithdrawal – Withdrawing from friends, family and society

A nger – Rage, uncontrolled anger, seeking revenge

R ecklessness – Acting reckless or engaging in risky activities; impulsivity

M ood change – Dramatic mood change

Risk and Protective Factors at a Glance

Domain	Category	Risk Factors	Protective Factors
Bio-psycho-social	Biological	**Mental disorders,** particularly mood disorders such as major depression and bipolar disorder. Also schizophrenia and anxiety disorders; recent psychiatric symptoms; history of mental disorders **Substance use** - Alcohol and other substance use disorders Co-morbidity - Combined mental health and substance abuse issues **Medical** – Loss of health from physical illness, loss of functioning, body parts or physical integrity; low CSF 5-HIAA, low cholesterol blood levels, low blood glucose, chronic physical pain	Effective clinical care for mental, physical and substance use disorders Motivation for treatment Support through ongoing medical and mental health care relationships
Bio-psycho-social	Psychological	**Certain personality types**– Borderline and antisocial disorders with poor reality testing, ineffective coping styles; sexual identity conflict; impulsive/aggressive or depressive/withdrawn temperament types **States of Mind** – Self-hate, despair, low self-esteem, feeling of being cut off from other people; psychic pain, feelings of hopelessness or helplessness; suicide ideation **Developmental history** - emotional or sexual trauma or abuse; previous suicide attempt(s), previous psychiatric treatment **Family history** of violence, suicide or alcoholism or drug abuse; parental psychopathology	Coping skills; problem-solving abilities Sense of optimism; self-efficacy beliefs Individual strengths; social contacts
Bio-psycho-social / Socio-cultural	Social	**Stressful life events -** Loss (relational, social, identity, status, work, or financial), unemployment, family conflicts, lack of social support, geographic mobility, legal issues, arrests, incarceration, alternative lifestyles **Exposure to suicide** - influence of media, others (family, peers, significant others) who have died by suicide, local clusters of suicide that have a contagious influence	Support networks Conflict resolution and nonviolent handling of disputes Strong family connections
Socio-cultural	Cultural	**Cultural, religious, spiritual beliefs** – positive or negative perception of suicide, belief that suicide is a noble resolution of personal dilemmas Stigma vs. cultural acceptance of violence Experience of humiliation or shame	Cultural and religious beliefs, practices and activities that discourage suicide and support self preservation
Socio-cultural	Environment	**Barriers -** Unwillingness to seek help due to stigma, unable to access health care services/treatment Easy access to lethal methods, especially guns Economic conditions; natural disasters/other traumatic events	Access to mental health care, support for help-seeking Restricted access to lethal means of suicide
Socio-cultural	Demographic	-Male gender (for completions); female gender (for non-fatal attempts) Single, divorced, separated, widowed, people living alone or socially isolated; lesbian, gay, & bisexual youth Whites, Native Americans; teens and the elderly	Social and community support

Patient 2

Patient is an 18 year old single Caucasian female college freshman with a history of a suicide attempt one year ago by overdose (and brief hospitalization) secondary to academic stress in her senior year in high school. She reportedly had been physically ill and "worn out," earning an incomplete which was later changed to a "D," resulting in her not being valedictorian of her graduating class. She currently reports feeling fatigued and overwhelmed by her academic workload. She has just received a diagnosis of mononucleosis.

Patient states that she feels "like [she is] going crazy." She describes many negative thoughts most specifically with regard to not doing well academically. Patient's boyfriend broke up with her three weeks ago and is currently courting a friend of hers. Current symptoms appear precipitated by this. She stated, "I'm lonely. No one loves me… I'm not worth squat to anyone, I'm just using up the world's resources and have don't have anything to give back, I just take up useless space…I want him to know how much pain he's caused me."

Mental status exam revealed a tearful young woman who maintained poor eye contact. She spoke in soft tones throughout, giving one word answers. Memory appears good and she was oriented x 4. Insight and judgment are poor. Patient reports poor sleep, anhedonia, increased guilt, decreased energy and concentration. Appetite is reported as okay. She admitted to having suicide ideation, stating that "if it gets any worse, I simply want out." She reported having hoarded a considerable amount of medication from last year, "so I'll be ready." Sleep has been poor (3-4 hours per night), eating erratic; she admits to binge drinking during which she vents rage toward anyone near her.

OBSERVATIONAL RATING OF RISK ASSESSMENT AND INTERVENTION COMPETENCIES			
SPECIFIC CORE COMPETENCY	**SKILLS INVOLVED IN COMPETENCY**	**RATING** ***0= not observed*** ***1= partially observed*** ***2= fully observed***	**COMMENTS**
Know and Manage your Attitudes and Reactions toward Suicide	Asked about suicide without anxiety or discomfort Used Clear and Specific terminology/ not euphemisms	0 1 2 0 1 2	
Focus on current suicidality	Assessed areas related to suicidality: 1. Suicidal ideation a. Severity b. Frequency c. Onset 2. Plan 3. Intent 4. Access to means 5. Rehearsal behaviors 6. Precipitating factors 7. Past attempts a. Previous hospitalization b. Previous reach out for help 8. Previous treatment 9. Commitment to treatment 10. Substance use/abuse 11. Impulsivity 12. Current or past self-injury 13. Family history of suicide/mental health conditions 14. Reasons for living 15. Protective factors 16. Coping skills 17. Social support (favorable) 18. Social support (unfavorable) 19. Other relevant issues addressed	 0 1 2	

Documentation of Assessment	Includes all factors assessed Used quotes related to ideation and/or behavioral examples of client mental status (Believability, evidence of participation in process, reasonable plan development, willingness to involve others, prior experiences with reaching out for help) Consultation with Supervisor or other professional clinical staff Provided clear rationale for decision making and recommendations	0 1 2 0 1 2 0 1 2 0 1 2	
Develop and Enact Collaborative Evidence Based Treatment/Safety Plan (for those determined not to meet criteria for PEP)	Worked collaborative with client to generate means of maintaining safety (0= no plan; 1 = therapist generated plan; 2=collaborative plan) Engages important others in planning Instills hope Details of assessment are incorporated into specific tailoring of the plan for the client (took action to decrease means; increase coping or support; provide resources, etc.)	0 1 2 0 1 2 0 1 2 0 1 2	
Demonstrates the ability to determine when PEP protocol is clinically warranted and follows PEP protocol	Completes risk assessment to determine PEP status Follows PEP Protocol Consults with supervisor/senior staff before PEP is initiated	0 1 2 0 1 2 Yes No	

Documentation Tips

--Always document based on client report: “The client reported…”'; “They noted that…”, “According to the client,…”

-Pick and stick to one verb tense “reports” vs. “reported”

-- If you’re going to quote a client, it should be exact. If you aren’t sure, find a different way to say it!

--Use flexible language in documentation: “It appears that…”: “It’s likely that”; “Symptoms may be influenced by…”. Avoid absolutes: “Client’s symptoms are a result of…”; “Group counseling will be beneficial…”, etc.

--Avoid words such as “really” or “very” unless quoting the client

--Avoid subjective language

Progress Notes: Key Phrases

Mood/Affect:
Appropriate with/to content
Congruent with content
Incongruent with content
Tearful at times
Laughing inappropriately
Mood lability
Lethargic
Subdued
Ruminative
Pensive
Insightful
Melancholic mood
Anxious as evidenced by
____
Annoyed
Agitated
Angry
Dysphoric
Hypervigilant
Cautious
Vulnerable
Appears preoccupied with
____

Tangential thinking
Extreme attention to detail
Apprehensive

Sx:
Difficulty with concentration
Significant weight loss/gain
Sleep disturbance
Restless sleep
Insomnia or hypersomnia
Increased agitation
Fidgetiness or restlessness
Recurrent thoughts of death
Anhedonia (unable to experience pleasure)
Diminished pleasure in daily activities
Feelings of worthlessness
Self-deprecating remarks
Excessive or inappropriate guilt
Indecisiveness
Emotional lability
Emotional dysregulation

Bright

Euphoric
Euthymic
Positive
Pleasant
Calm
Initially calm but appeared anxious as
session progressed
Confident affect
Appears detached
Indifferent
Flat
Blunted
Constricted affect
Appears disengaged
Appears disengaged from environment
Appears disoriented
Bizarre behavior and thinking as evidenced
by
____
Distressed
Distraught
Stressed
Depressed as evidenced by:
____
Sad

Appetite changes (increase/decrease)
Psychomotor agitation or retardation
Rapid speech observed
Irritable mood
Depressed mood
Suicidal ideation
Sad or empty feelings
Fatigue
Anergia (lack of energy)
Discouraged
Verbally expresses conflicted
emotions/thoughts
about:_________
Panic attacks:
Reports increased heart rate, rapid breathing, sense of impending doom, increased perspiration, nausea or gastrointestinal distress

Action:
Client disclosed ___________
Expresses willingness to implement self-care techniques.
Implements recommended coping strategies/
techniques
Follows through with HW
Verbalizes intent to:
____
ex: contact psychiatrist for appt.
Shows reservations about follow through w/
recommendations
to:____________

Issues/Themes:
Academic concerns
Academic performance
Academic responsibilities
Broad generalizations re:
____
Career decisions
Developmental issues
Family relationships
Family relationships; esp. re:
____
Sibling relationships
Intimacy
Interpersonal concerns
Explored peer relationships
Fear of:
____
Food issues, particularly w/_____________
Eating concerns
Body image issues
Self-esteem
Self-worth
Self-hatred
Self-efficacy
Self-protective tendency/stance
Conflict w/
____

Expresses conflict
re:__________________

Plan/Rec:
Monitor Sx of depression/anxiety
Rec psychiatric assessment
Rec career counseling
Rec see academic advisor
Rec see international student advisor
Rec consult with financial aid or registrar
Rec medical assessment
Demonstrates willingness/committed
to:_____________________
Actively develops insight related to:
______
Shows connection between personal actions
and underlying theme of:_________
Takes problem-solving approach to:_______
Chooses option of _______ to:___________
Appears to reconcile:__________________

Daily stress
Financial concerns
Maturational issues
Phase-of-life concerns
Post-graduation plans
Personal responsibility
Meaning and purpose
Religious/spiritual issues, esp. ___________
Values
Issues of loss/grief
Locus of control
Disconnections from his/her emotions
Trust issues
Substance usage
Work concerns

Termination
Reviewed events since last visit including:
____
Multicultural issues
Acculturation
Prejudice (racism, sexism, ageism,
homophobia, etc.)

Rec community resources
Rec academic tutoring
Rec consult with professor
Rec a wellness approach to lifestyle
Rec increased balance in lifestyle
Bibliotherapy
Continue to offer counseling support
Coping strategies
Continue to process feelings and thoughts
especially in regards to:_________
Coping strategies include:_____________

Risk Management:

Work towards counseling termination
Plan for transition to community resources
Plan for summer break

Ethics
& Law

________Attendance

________Participation

________Quality of presentation (if applicable)

________Preparedness

_______Overall Rating:

Comments:

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Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

American Psychological Association

Transgender and gender nonconforming[1] (TGNC) people are those who have a gender identity that is not fully aligned with their sex assigned at birth. The existence of TGNC people has been documented in a range of historical cultures (Coleman, Colgan, & Gooren, 1992; Feinberg, 1996; Miller & Nichols, 2012; Schmidt, 2003). Current population estimates of TGNC people have ranged from 0.17 to 1,333 per 100,000 (Meier & Labuski, 2013). The Massachusetts Behavioral Risk Factor Surveillance Survey found 0.5% of the adult population aged 18 to 64 years identified as TGNC between 2009 and 2011 (Conron, Scott, Stowell, & Landers, 2012). However, population estimates likely underreport the true number of TGNC people, given difficulties in collecting comprehensive demographic information about this group (Meier & Labuski, 2013). Within the last two decades, there has been a significant increase in research about TGNC people. This increase in knowledge, informed by the TGNC community, has resulted in the development of progressively more trans-affirmative practice across the multiple health disciplines involved in the care of TGNC people (Bockting, Knudson, & Goldberg, 2006; Coleman et al., 2012). Research has documented the extensive experiences of stigma and discrimination reported by TGNC people (Grant et al., 2011) and the mental health consequences of these experiences across the life span (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), including increased rates of depression (Fredriksen-Goldsen et al., 2014) and suicidality (Clements-Nolle, Marx, & Katz, 2006). TGNC people's lack of access to trans-affirmative mental and physical health care is a common barrier (Fredriksen-Goldsen et al., 2014; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Grossman & D'Augelli, 2006), with TGNC people sometimes being denied care because of their gender identity (Xavier et al., 2012).

In 2009, the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (TFGIGV) survey found that less than 30% of psychologist and graduate student participants reported familiarity with issues that TGNC people experience (APA TFGIGV, 2009). Psychologists and other mental health professionals who have limited training and experience in TGNC-affirmative care may cause harm to TGNC people (Mikalson, Pardo, & Green, 2012; Xavier et al., 2012). The significant level of societal stigma and discrimination that TGNC people face, the associated mental health consequences, and psychologists' lack of familiarity with trans-affirmative care led the APA Task Force to recommend that psychological practice guidelines be developed to help psychologists maximize the effectiveness of services offered and avoid harm when working with TGNC people and their families.

Purpose

The purpose of the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (hereafter *Guidelines*) is to assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people. Trans-affirmative practice is the provision

The American Psychological Association's (APA's) Task Force on Guidelines for Psychological Practice with Transgender and Gender Nonconforming People developed these guidelines. lore m. dickey, Louisiana Tech University, and Anneliese A. Singh, The University of Georgia, served as chairs of the Task Force. The members of the Task Force included Walter O. Bockting, Columbia University; Sand Chang, Independent Practice; Kelly Ducheny, Howard Brown Health Center; Laura Edwards-Leeper, Pacific University; Randall D. Ehrbar, Whitman Walker Health Center; Max Fuentes Fuhrmann, Independent Practice; Michael L. Hendricks, Washington Psychological Center, P.C.; and Ellen Magalhaes, Center for Psychological Studies at Nova Southeastern University and California School of Professional Psychology at Alliant International University.

The Task Force is grateful to BT, Robin Buhrke, Jenn Burleton, Theo Burnes, Loree Cook-Daniels, Ed Delgado-Romero, Maddie Deutsch, Michelle Emerick, Terry S. Gock, Kristin Hancock, Razia Kosi, Kimberly Lux, Shawn MacDonald, Pat Magee, Tracee McDaniel, Edgardo Menvielle, Parrish Paul, Jamie Roberts, Louise Silverstein, Mary Alice Silverman, Holiday Simmons, Michael C. Smith, Cullen Sprague, David Whitcomb, and Milo Wilson for their assistance in providing important input and feedback on drafts of the guidelines. The Task Force is especially grateful to Clinton Anderson, Director, and Ron Schlittler, Program Coordinator, of APA's Office on LGBT Concerns, who adeptly assisted and provided counsel to the Task Force throughout this project. The Task Force would also like to thank liaisons from the APA Committee on Professional Practice and Standards (COPPS), April Harris-Britt and Scott Hunter, and their staff support, Mary Hardiman. Additionally, members of the Task Force would like to thank the staff at the Phillip Rush Center and Agnes Scott College Counseling Center in Atlanta, Georgia, who served as hosts for face-to-face meetings.

This document will expire as APA policy in 2022. After this date, users should contact the APA Public Interest Directorate to determine whether the guidelines in this document remain in effect as APA policy.

Correspondence concerning this article should be addressed to the Public Interest Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002.

[1] For the purposes of these guidelines, we use the term *transgender and gender nonconforming* (TGNC). We intend for the term to be as broadly inclusive as possible, and recognize that some TGNC people do not ascribe to these terms. Readers are referred to Appendix A for a listing of terms that include various TGNC identity labels.

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of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people (Korell & Lorah, 2007). The *Guidelines* are an introductory resource for psychologists who will encounter TGNC people in their practice, but can also be useful for psychologists with expertise in this area of practice to improve the care already offered to TGNC people. The *Guidelines* include a set of definitions for readers who may be less familiar with language used when discussing gender identity and TGNC populations (see Appendix A). Distinct from TGNC, the term "cisgender" is used to refer to people whose sex assigned at birth is aligned with their gender identity (E. R. Green, 2006; Serano, 2006).

Given the added complexity of working with TGNC and gender-questioning youth[2] and the limitations of the available research, the *Guidelines* focus primarily, though not exclusively, on TGNC adults. Future revisions of the *Guidelines* will deepen a focus on TGNC and gender-questioning children and adolescents. The *Guidelines* address the strengths of TGNC people, the challenges they face, ethical and legal issues, life span considerations, research, education, training, and health care. Because issues of gender identity are often conflated with issues of gender expression or sexual orientation, psychological practice with the TGNC population warrants the acquisition of specific knowledge about concerns unique to TGNC people that are not addressed by other practice guidelines (APA, 2012). It is important to note that these *Guidelines* are not intended to address some of the conflicts that cisgender people may experience due to societal expectations regarding gender roles (Butler, 1990), nor are they intended to address intersex people (Dreger, 1999; Preves, 2003).

Documentation of Need

In 2005, the APA Council of Representatives authorized the creation of the Task Force on Gender Identity and Gender Variance (TFGIGV), charging the Task Force to review APA policies related to TGNC people and to offer recommendations for APA to best meet the needs of TGNC people (APA TFGIGV, 2009). In 2009, the APA Council of Representatives adopted the Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination, which calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment; encourages psychologists to take a leadership role in working against discrimination; supports the provision of adequate and necessary mental and medical health care; recognizes the efficacy, benefit, and medical necessity of gender transition; supports access to appropriate treatment in institutional settings; and supports the creation of educational resources for all psychologists (Anton, 2009). In 2009, in an extensive report on the current state of psychological practice with TGNC people, the TFGIGV determined that there was sufficient knowledge and expertise in the field to warrant the development of practice guidelines for TGNC populations (APA TFGIGV, 2009). The report identified that TGNC people constituted a population with unique needs and that the creation of practice guidelines would be a valuable resource for the field (APA TFGIGV, 2009). Psychologists' relative lack of knowledge about TGNC people and trans-affirmative care, the level of societal stigma and discrimination that TGNC people face, and the significant mental health consequences that TGNC people experience as a result offer a compelling need for psychological practice guidelines for this population.

Users

The intended audience for these *Guidelines* includes psychologists who provide clinical care, conduct research, or provide education or training. Given that gender identity issues can arise at any stage in a TGNC person's life (Lev, 2004), clinicians can encounter a TGNC person in practice or have a client's presenting problem evolve into an issue related to gender identity and gender expression. Researchers, educators, and trainers will benefit from use of these *Guidelines* to inform their work, even when not specifically focused on TGNC populations. Psychologists who focus on TGNC populations in their clinical practice, research, or educational and training activities will also benefit from the use of these *Guidelines*.

Distinction Between Standards and Guidelines

When using these *Guidelines*, psychologists should be aware that APA has made an important distinction between *standards* and *guidelines* (Reed, McLaughlin, & Newman, 2002). Standards are mandates to which all psychologists must adhere (e.g., the *Ethical Principles of Psychologists and Code of Conduct*; APA, 2010), whereas guidelines are aspirational. Psychologists are encouraged to use these *Guidelines* in tandem with the *Ethical Principles of Psychologists and Code of Conduct*, and should be aware that state and federal laws may override these *Guidelines* (APA, 2010).

In addition, these *Guidelines* refer to psychological practice (e.g., clinical work, consultation, education, research, and training) rather than treatment. Practice guidelines are practitioner-focused and provide guidance for professionals regarding "conduct and the issues to be considered in particular areas of clinical practice" (Reed et al., 2002, p. 1044). Treatment guidelines are client-focused and address intervention-specific recommendations for a clinical population or condition (Reed et al., 2002). The current *Guidelines* are intended to complement treatment guidelines for TGNC people seeking mental health services, such as those set forth by the World Professional Association for Transgender Health Standards of Care (Coleman et al., 2012) and the Endocrine Society (Hembree et al., 2009).

[2] For the purposes of these guidelines, "youth" refers to both children and adolescents under the age of 18.

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Compatibility

These *Guidelines* are consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010), the *Standards of Accreditation for Health Service Psychology* (APA, 2015), the APA TFGIGV (2009) report, and the APA Council of Representatives Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination (Anton, 2009).

Practice Guidelines Development Process

To address one of the recommendations of the APA TFGIGV (2009), the APA Committee on Sexual Orientation and Gender Diversity (CSOGD; then the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns) and Division 44 (the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues) initiated a joint Task Force on Psychological Practice Guidelines with Transgender and Gender Nonconforming People in 2011. Task Force members were selected through an application and review process conducted by the leadership of CSOGD and Division 44. The Task Force included 10 members who had substantial psychological practice expertise with TGNC people. Of the 10 task force members, five individuals identified as TGNC with a range of gender identities and five identified as cisgender. In terms of race/ethnicity, six of the task force members identified as White and four identified as people of color (one Indian American, one Chinese American, one Latina American, and one mixed race).

The Task Force conducted a comprehensive review of the extant scholarship, identified content most pertinent to the practice of psychology with TGNC people, and evaluated the level of evidence to support guidance within each guideline. To ensure the accuracy and comprehensiveness of these *Guidelines*, Task Force members met with TGNC community members and groups and consulted with subject matter experts within and outside of psychology. When the Task Force discovered a lack of professional consensus, every effort was made to include divergent opinions in the field relevant to that issue. When this occurred, the Task Force described the various approaches documented in the literature. Additionally, these *Guidelines* were informed by comments received at multiple presentations held at professional conferences and comments obtained through two cycles of open public comment on earlier *Guideline* drafts.

This document contains 16 guidelines for TGNC psychological practice. Each guideline includes a Rationale section, which reviews relevant scholarship supporting the need for the guideline, and an Application section, which describes how the particular guideline may be applied in psychological practice. The *Guidelines* are organized into five clusters: (a) foundational knowledge and awareness; (b) stigma, discrimination, and barriers to care; (c) life span development; (d) assessment, therapy, and intervention; and (e) research, education, and training.

Funding for this project was provided by Division 44 (Society for the Psychological Study of LGBT Issues); the APA Office on Lesbian, Gay, Bisexual, and Transgender (LGBT) Concerns; a grant from the Committee on Division/APA Relations (CODAPAR); and donations from Randall Ehrbar and Pamela St. Amand. Some members of the Task Force have received compensation through presentations (e.g., honoraria) or royalties (e.g., book contracts) based in part on information contained in these *Guidelines.*

Selection of Evidence

Although the number of publications on the topic of TGNC-affirmative practice has been increasing, this is still an emerging area of scholarly literature and research. When possible, the Task Force relied on peer-reviewed publications, but books, chapters, and reports that do not typically receive a high level of peer review have also been cited when appropriate. These sources are from a diverse range of fields addressing mental health, including psychology, counseling, social work, and psychiatry. Some studies of TGNC people utilize small sample sizes, which limits the generalizability of results. Few studies of TGNC people utilize probability samples or randomized control groups (e.g., Conron et al., 2012; Dhejne et al., 2011). As a result, the Task Force relied primarily on studies using convenience samples, which limits the generalizability of results to the population as a whole, but can be adequate for describing issues and situations that arise within the population.

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.

Rationale. Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender (Bethea & McCollum, 2013; Institute of Medicine [IOM], 2011). In many cultures and religious traditions, gender has been perceived as a binary construct, with mutually exclusive categories of male or female, boy or girl, man or woman (Benjamin, 1966; Mollenkott, 2001; Tanis, 2003). These mutually exclusive categories include an assumption that gender identity is always in alignment with sex assigned at birth (Bethea & McCollum, 2013). For TGNC people, gender identity differs from sex assigned at birth to varying degrees, and may be experienced and expressed outside of the gender binary (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Gender as a nonbinary construct has been described and studied for decades (Benjamin, 1966; Herdt, 1994; Kulick, 1998). There is historical evidence of recognition, societal acceptance, and sometimes reverence of diversity in gender identity and gender expression in several different cultures (Coleman et al., 1992; Feinberg, 1996; Miller

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& Nichols, 2012; Schmidt, 2003). Many cultures in which gender nonconforming persons and groups were visible were diminished by westernization, colonialism, and systemic inequity (Nanda, 1999). In the 20th century, TGNC expression became medicalized (Hirschfeld, 1910/1991), and medical interventions to treat discordance between a person's sex assigned at birth, secondary sex characteristics, and gender identity became available (Meyerowitz, 2002).

As early as the 1950s, research found variability in how an individual described their[3] gender, with some participants reporting a gender identity different from the culturally defined, mutually exclusive categories of "man" or "woman" (Benjamin, 1966). In several recent large online studies of the TGNC population in the United States, 30% to 40% of participants identified their gender identity as other than man or woman (Harrison et al., 2012; Kuper et al., 2012). Although some studies have cultivated a broader understanding of gender (Conron, Scout, & Austin, 2008), the majority of research has required a forced choice between man and woman, thus failing to represent or depict those with different gender identities (IOM, 2011). Research over the last two decades has demonstrated the existence of a wide spectrum of gender identity and gender expression (Bockting, 2008; Harrison et al., 2012; Kuper et al., 2012), which includes people who identify as either man or woman, neither man nor woman, a blend of man and woman, or a unique gender identity. A person's identification as TGNC can be healthy and self-affirming, and is not inherently pathological (Coleman et al., 2012). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth, as well as societal stigma and discrimination (Coleman et al., 2012).

Between the late 1960s and the early 1990s, health care to alleviate gender dysphoria largely reinforced a binary conceptualization of gender (APA TFGIGV, 2009; Bolin, 1994; Hastings, 1974). At that time, it was considered an ideal outcome for TGNC people to conform to an identity that aligned with either sex assigned at birth or, if not possible, with the "opposite" sex, with a heavy emphasis on blending into the cisgender population or "passing" (APA TFGIGV, 2009; Bolin, 1994; Hastings, 1974). Variance from these options could raise concern for health care providers about a TGNC person's ability to transition successfully. These concerns could act as a barrier to accessing surgery or hormone therapy because medical and mental health care provider endorsement was required before surgery or hormones could be accessed (Berger et al., 1979). Largely because of self-advocacy of TGNC individuals and communities in the 1990s, combined with advances in research and models of trans-affirmative care, there is greater recognition and acknowledgment of a spectrum of gender diversity and corresponding individualized, TGNC-specific health care (Bockting et al., 2006; Coleman et al., 2012).

Application. A nonbinary understanding of gender is fundamental to the provision of affirmative care for TGNC people. Psychologists are encouraged to adapt or modify their understanding of gender, broadening the range of variation viewed as healthy and normative. By understanding the spectrum of gender identities and gender expressions that exist, and that a person's gender identity may not be in full alignment with sex assigned at birth, psychologists can increase their capacity to assist TGNC people, their families, and their communities (Lev, 2004). Respecting and supporting TGNC people in authentically articulating their gender identity and gender expression, as well as their lived experience, can improve TGNC people's health, well-being, and quality of life (Witten, 2003).

Some TGNC people may have limited access to visible, positive TGNC role models. As a result, many TGNC people are isolated and must cope with the stigma of gender nonconformity without guidance or support, worsening the negative effect of stigma on mental health (Fredriksen-Goldsen et al., 2014; Singh, Hays, & Watson, 2011). Psychologists may assist TGNC people in challenging gender norms and stereotypes, and in exploring their unique gender identity and gender expression. TGNC people, partners, families, friends, and communities can benefit from education about the healthy variation of gender identity and gender expression, and the incorrect assumption that gender identity automatically aligns with sex assigned at birth.

Psychologists may model an acceptance of ambiguity as TGNC people develop and explore aspects of their gender, especially in childhood and adolescence. A nonjudgmental stance toward gender nonconformity can help to counteract the pervasive stigma faced by many TGNC people and provide a safe environment to explore gender identity and make informed decisions about gender expression.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Rationale. The constructs of gender identity and sexual orientation are theoretically and clinically distinct, even though professionals and nonprofessionals frequently conflate them. Although some research suggests a potential link in the development of gender identity and sexual orientation, the mechanisms of such a relationship are unknown (Adelson & American Academy of Child and Adolescent Psychiatry [AACAP] Committee on Quality Issues [CQI], 2012; APA TFGIGV, 2009; A. H. Devor, 2004; Drescher & Byne, 2013). *Sexual orientation* is defined as a person's sexual and/or emotional attraction to another person (Shively & De Cecco, 1977), compared with *gender identity*, which is defined by a person's felt, inherent sense of gender. For most people, gender identity develops earlier than sexual orientation. Gender identity is often established in young toddlerhood (Adelson & AACAP CQI, 2012; Kohlberg, 1966), compared with aware-

[3] The third person plural pronouns "they," "them," and "their" in some instances function in these guidelines as third-person singular pronouns to model a common technique used to avoid the use of gendered pronouns when speaking to or about TGNC people.

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ness of same-sex attraction, which often emerges in early adolescence (Adelson & AACAP CQI, 2012; D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Ryan, 2009; Savin-Williams & Diamond, 2000). Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood. The developmental pathway of gender identity typically includes a progression through multiple stages of awareness, exploration, expression, and identity integration (Bockting & Coleman, 2007; A. H. Devor, 2004; Vanderburgh, 2007). Similarly, a person's sexual orientation may progress through multiple stages of awareness, exploration, and identity through adolescence and into adulthood (Bilodeau & Renn, 2005). Just as some people experience their sexual orientation as being fluid or variable (L. M. Diamond, 2013), some people also experience their gender identity as fluid (Lev, 2004).

The experience of questioning one's gender can create significant confusion for some TGNC people, especially for those who are unfamiliar with the range of gender identities that exist. To explain any discordance they may experience between their sex assigned at birth, related societal expectations, patterns of sexual and romantic attraction, and/or gender role nonconformity and gender identity, some TGNC people may assume that they must be gay, lesbian, bisexual, or queer (Bockting, Benner, & Coleman, 2009). Focusing solely on sexual orientation as the cause for discordance may obscure awareness of a TGNC identity. It can be very important to include sexual orientation and gender identity in the process of identity exploration as well as in the associated decisions about which options will work best for any particular person. In addition, many TGNC adults have disguised or rejected their experience of gender incongruence in childhood or adolescence to conform to societal expectations and minimize their fear of difference (Bockting & Coleman, 2007; Byne et al., 2012).

Because gender and patterns of attraction are used to identify a person's sexual orientation, the articulation of sexual orientation is made more complex when sex assigned at birth is not aligned with gender identity. A person's sexual orientation identity cannot be determined by simply examining external appearance or behavior, but must incorporate a person's identity and self-identification (Broido, 2000).

Application. Psychologists may assist people in differentiating gender identity and sexual orientation. As clients become aware of previously hidden or constrained aspects of their gender identity or sexuality, psychologists may provide acceptance, support, and understanding without making assumptions or imposing a specific sexual orientation or gender identity outcome (APA TFGIGV, 2009). Because of their roles in assessment, treatment, and prevention, psychologists are in a unique position to help TGNC people better understand and integrate the various aspects of their identities. Psychologists may assist TGNC people by introducing and normalizing differences in gender identity and expression. As a TGNC person finds a comfortable way to actualize and express their gender identity, psychologists may notice that previously incongruent aspects of their sexual orientation may become more salient, better integrated, or increasingly egosyntonic (Bockting et al., 2009; H. Devor, 1993; Schleifer, 2006). This process may allow TGNC people the comfort and opportunity to explore attractions or aspects of their sexual orientation that previously had been repressed, hidden, or in conflict with their identity. TGNC people may experience a renewed exploration of their sexual orientation, a widened spectrum of attraction, or a shift in how they identify their sexual orientation in the context of a developing TGNC identity (Coleman, Bockting, & Gooren, 1993; Meier, Pardo, Labuski, & Babcock, 2013; Samons, 2008).

Psychologists may need to provide TGNC people with information about TGNC identities, offering language to describe the discordance and confusion TGNC people may be experiencing. To facilitate TGNC people's learning, psychologists may introduce some of the narratives written by TGNC people that reflect a range of outcomes and developmental processes in exploring and affirming gender identity (e.g., Bornstein & Bergman, 2010; Boylan, 2013; J. Green, 2004; Krieger, 2011; Lawrence, 2014). These resources may potentially aid TGNC people in distinguishing between issues of sexual orientation and gender identity and in locating themselves on the gender spectrum. Psychologists may also educate families and broader community systems (e.g., schools, medical systems) to better understand how gender identity and sexual orientation are different but related; this may be particularly useful when working with youth (Singh & Burnes, 2009; Whitman, 2013). Because gender identity and sexual orientation are often conflated, even by professionals, psychologists are encouraged to carefully examine resources that claim to provide affirmative services for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, and to confirm which are knowledgeable about and inclusive of the needs of TGNC people before offering referrals or recommendations to TGNC people and their families.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Rationale. Gender identity and gender expression may have profound intersections with other aspects of identity (Collins, 2000; Warner, 2008). These aspects may include, but are not limited to, race/ethnicity, age, education, socioeconomic status, immigration status, occupation, disability status, HIV status, sexual orientation, relational status, and religion and/or spiritual affiliation. Whereas some of these aspects of identity may afford privilege, others may create stigma and hinder empowerment (Burnes & Chen, 2012; K. M. de Vries, 2015). In addition, TGNC people who transition may not be prepared for changes in privilege or societal treatment based on gender identity and gender expression. To illustrate, an African American trans man may gain male privilege, but may face racism and

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societal stigma particular to African American men. An Asian American/Pacific Islander trans woman may experience the benefit of being perceived as a cisgender woman, but may also experience sexism, misogyny, and objectification particular to Asian American/Pacific Islander cisgender women.

The intersection of multiple identities within TGNC people's lives is complex and may obstruct or facilitate access to necessary support (A. Daley, Solomon, Newman, & Mishna, 2008). TGNC people with less privilege and/or multiple oppressed identities may experience greater stress and restricted access to resources. They may also develop resilience and strength in coping with disadvantages, or may locate community-based resources available to specific groups (e.g., for people living with HIV; Singh et al., 2011). Gender identity affirmation may conflict with religious beliefs or traditions (Bockting & Cesaretti, 2001). Finding an affirmative expression of their religious and spiritual beliefs and traditions, including positive relationships with religious leaders, can be an important resource for TGNC people (Glaser, 2008; Porter, Ronneberg, & Witten, 2013; Xavier, 2000).

Application. In practice, psychologists strive to recognize the salient multiple and intersecting identities of TGNC people that influence coping, discrimination, and resilience (Burnes & Chen, 2012). Improved rapport and therapeutic alliance are likely to develop when psychologists avoid overemphasizing gender identity and gender expression when not directly relevant to TGNC people's needs and concerns. Even when gender identity is the main focus of care, psychologists are encouraged to understand that a TGNC person's experience of gender may also be shaped by other important aspects of identity (e.g., age, race/ethnicity, sexual orientation), and that the salience of different aspects of identity may evolve as the person continues psychosocial development across the life span, regardless of whether they complete a social or medical transition.

At times, a TGNC person's intersection of identities may result in conflict, such as a person's struggle to integrate gender identity with religious and/or spiritual upbringing and beliefs (Kidd & Witten, 2008; Levy & Lo, 2013; Rodriguez & Follins, 2012). Psychologists may aid TGNC people in understanding and integrating identities that may be differently privileged within systems of power and systemic inequity (Burnes & Chen, 2012). Psychologists may also highlight and strengthen the development of TGNC people's competencies and resilience as they learn to manage the intersection of stigmatized identities (Singh, 2012).

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families.

Rationale. Psychologists, like other members of society, come to their personal understanding and acceptance of different aspects of human diversity through a process of socialization. Psychologists' cultural biases, as well as the cultural differences between psychologists and their clients, have a clinical impact (Israel, Gorcheva, Burnes, & Walther, 2008; Vasquez, 2007). The assumptions, biases, and attitudes psychologists hold regarding TGNC people and gender identity and/or gender expression can affect the quality of services psychologists provide and their ability to develop an effective therapeutic alliance (Bess & Stabb, 2009; Rachlin, 2002). In addition, a lack of knowledge or training in providing affirmative care to TGNC people can limit a psychologist's effectiveness and perpetuate barriers to care (Bess & Stabb, 2009; Rachlin, 2002). Psychologists experienced with lesbian, gay, or bisexual (LGB) people may not be familiar with the unique needs of TGNC people (Israel, 2005; Israel et al., 2008). In community surveys, TGNC people have reported that many mental health care providers lack basic knowledge and skills relevant to care of TGNC people (Bradford, Xavier, Hendricks, Rives, & Honnold, 2007; Xavier, Bobbin, Singer, & Budd, 2005) and receive little training to prepare them to work with TGNC people (APA TFGIGV, 2009; Lurie, 2005). The National Transgender Discrimination Survey (Grant et al., 2011) reported that 50% of TGNC respondents shared that they had to educate their health care providers about TGNC care, 28% postponed seeking medical care due to antitrans bias, and 19% were refused care due to discrimination.

The APA ethics code (APA, 2010) specifies that psychologists practice in areas only within the boundaries of their competence (Standard 2.01), participate in proactive and consistent ways to enhance their competence (Standard 2.03), and base their work upon established scientific and professional knowledge (Standard 2.04). Competence in working with TGNC people can be developed through a range of activities, such as education, training, supervised experience, consultation, study, or professional experience.

Application. Psychologists may engage in practice with TGNC people in various ways; therefore, the depth and level of knowledge and competence required by a psychologist depends on the type and complexity of service offered to TGNC people. Services that psychologists provide to TGNC people require a basic understanding of the population and its needs, as well as the ability to respectfully interact in a trans-affirmative manner (L. Carroll, 2010).

APA emphasizes the use of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006). Given how easily assumptions or stereotypes could influence treatment, evidence-based practice may be especially relevant to psychological practice with TGNC people. Until evidence-based practices are developed specifically for TGNC people, psychologists are encouraged to utilize existing evidence-based practices in the care they provide. APA also promotes collaboration with clients concerning clinical decisions, including issues related to costs, potential benefits, and the existing options and resources related to treatment (APA Presidential Task Force on Evidence-Based Practice, 2006). TGNC people could benefit from such collaboration and active engagement in decision

making, given the historical disenfranchisement and disempowerment of TGNC people in health care.

In an effort to develop competence in working with TGNC people, psychologists are encouraged to examine their personal beliefs regarding gender and sexuality, gender stereotypes, and TGNC identities, in addition to identifying gaps in their own knowledge, understanding, and acceptance (American Counseling Association [ACA], 2010). This examination may include exploring one's own gender identity and gendered experiences related to privilege, power, or marginalization, as well as seeking consultation and training with psychologists who have expertise in working with TGNC people and communities.

Psychologists are further encouraged to develop competence in working with TGNC people and their families by seeking up-to-date basic knowledge and understanding of gender identity and expression, and learning how to interact with TGNC people and their families respectfully and without judgment. Competence in working with TGNC people may be achieved and maintained in formal and informal ways, ranging from exposure in the curriculum of training programs for future psychologists and continuing education at professional conferences, to affirmative involvement as allies in the TGNC community. Beyond acquiring general competence, psychologists who choose to specialize in working with TGNC people presenting with gender-identity-related concerns are strongly encouraged to obtain advanced training, consultation, and professional experience (ACA, 2010; Coleman et al., 2012).

Psychologists may gain knowledge about the TGNC community and become more familiar with the complex social issues that affect the lives of TGNC people through first-hand experiences (e.g., attending community meetings and conferences, reading narratives written by TGNC people). If psychologists have not yet developed competence in working with TGNC people, it is recommended that they refer TGNC people to other psychologists or providers who are knowledgeable and able to provide trans-affirmative care.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Rationale. Many TGNC people experience discrimination, ranging from subtle to severe, when accessing housing, health care, employment, education, public assistance, and other social services (Bazargan & Galvan, 2012; Bradford, Reisner, Honnold, & Xavier, 2013; Dispenza, Watson, Chung, & Brack, 2012; Grant et al., 2011). Discrimination can include assuming a person's assigned sex at birth is fully aligned with that person's gender identity, not using a person's preferred name or pronoun, asking TGNC people inappropriate questions about their bodies, or making the assumption that psychopathology exists given a specific gender identity or gender expression (Nadal, Rivera, & Corpus, 2010; Nadal, Skolnik, & Wong, 2012). Discrimination may also include refusing access to housing or employment or extreme acts of violence (e.g., sexual assault, murder). TGNC people who hold multiple marginalized identities are more vulnerable to discrimination and violence. TGNC women and people of color disproportionately experience severe forms of violence and discrimination, including police violence, and are less likely to receive help from law enforcement (Edelman, 2011; National Coalition of Anti-Violence Programs, 2011; Saffin, 2011).

TGNC people are at risk of experiencing antitrans prejudice and discrimination in educational settings. In a national representative sample of 7,898 LGBT youth in K-12 settings, 55.2% of participants reported verbal harassment, 22.7% reported physical harassment, and 11.4% reported physical assault based on their gender expression (Kosciw, Greytak, Palmer, & Boesen, 2014). In a national community survey of TGNC adults, 15% reported prematurely leaving educational settings ranging from kindergarten through college as a result of harassment (Grant et al., 2011). Many schools do not include gender identity and gender expression in their school nondiscrimination policies; this leaves TGNC youth without needed protections from bullying and aggression in schools (Singh & Jackson, 2012). TGNC youth in rural settings may be even more vulnerable to bullying and hostility in their school environments due to antitrans prejudice (Kosciw et al., 2014).

Inequities in educational settings and other forms of TGNC-related discrimination may contribute to the significant economic disparities TGNC people have reported. Grant and colleagues (2011) found that TGNC people were four times more likely to have a household income of less than $10,000 compared with cisgender people, and almost half of a sample of TGNC older adults reported a household income at or below 200% of poverty (Fredriksen-Goldsen et al., 2014). TGNC people often face workplace discrimination both when seeking and maintaining employment (Brewster, Velez, Mennicke, & Tebbe, 2014; Dispenza et al., 2012; Mizock & Mueser, 2014). In a nonrepresentative national study of TGNC people, 90% reported having "directly experienced harassment or mistreatment at work and felt forced to take protective actions that negatively impacted their careers or their well-being, such as hiding who they were to avoid workplace repercussions" (Grant et al., 2011, p. 56). In addition, 78% of respondents reported experiencing some kind of direct mistreatment or discrimination at work (Grant et al., 2011). Employment discrimination may be related to stigma based on a TGNC person's appearance, discrepancies in identity documentation, or being unable to provide job references linked to that person's pretransition name or gender presentation (Bender-Baird, 2011).

Issues of employment discrimination and workplace harassment are particularly salient for TGNC military personnel and veterans. Currently, TGNC people cannot serve openly in the U.S. military. Military regulations cite "transsexualism" as a medical exclusion from service (Department of Defense, 2011; Elders & Steinman, 2014). When

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enlisted, TGNC military personnel are faced with very difficult decisions related to coming out, transition, and seeking appropriate medical and mental health care, which may significantly impact or end their military careers. Not surprisingly, research documents very high rates of suicidal ideation and behavior among TGNC military and veteran populations (Blosnich et al., 2013; Matarazzo et al., 2014). Being open about their TGNC identity with health care providers can carry risk for TGNC military personnel (OutServe-Servicemembers Legal Defense Network, n.d.). Barriers to accessing health care noted by TGNC veterans include viewing the VA health care system as an extension of the military, perceiving the VA as an unwelcoming environment, and fearing providers' negative reactions to their identity (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd, Mizock, Maguen, & Green, 2012). A recent study shows 28% of LGBT veterans perceived their VA as welcoming and one third as unwelcoming (Sherman et al., 2014). Multiple initiatives are underway throughout the VA system to improve the quality and sensitivity of services to LGBT veterans.

Given widespread workplace discrimination and possible dismissal following transition, TGNC people may engage in sex work or survival sex (e.g., trading sex for food), or sell drugs to generate income (Grant et al., 2011; Hwahng & Nuttbrock, 2007; Operario, Soma, & Underhill, 2008; Stanley, 2011). This increases the potential for negative interactions with the legal system, such as harassment by the police, bribery, extortion, and arrest (Edelman, 2011; Testa et al., 2012), as well as increased likelihood of mental health symptoms and greater health risks, such as higher incidence of sexually transmitted infections, including HIV (Nemoto, Operario, Keatley, & Villegas, 2004).

Incarcerated TGNC people report harassment, isolation, forced sex, and physical assault, both by prison personnel and other inmates (American Civil Liberties Union National Prison Project, 2005; Brotheim, 2013; C. Daley, 2005). In sex-segregated facilities, TGNC people may be subjected to involuntary solitary confinement (also called "administrative segregation"), which can lead to severe negative mental and physical health consequences and may block access to services (Gallagher, 2014; National Center for Transgender Equality, 2012). Another area of concern is for TGNC immigrants and refugees. TGNC people in detention centers may not be granted access to necessary care and experience significant rates of assault and violence in these facilities (Gruberg, 2013). TGNC people may seek asylum in the United States to escape danger as a direct result of lack of protections in their country of origin (APA Presidential Task Force on Immigration, 2012; Cerezo, Morales, Quintero, & Rothman, 2014; Morales, 2013).

TGNC people have difficulty accessing necessary health care (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012) and often feel unsafe sharing their gender identity or their experiences of antitrans prejudice and discrimination due to historical and current discrimination from health care providers (Grant et al., 2011; Lurie, 2005; Singh & McKleroy, 2011). Even when TGNC people have health insurance, plans may explicitly exclude coverage related to gender transition (e.g., hormone therapy, surgery). TGNC people may also have difficulty accessing trans-affirmative primary health care if coverage for procedures is denied based on gender. For example, trans men may be excluded from necessary gynecological care based on the assumption that men do not need these services. These barriers often lead to a lack of preventive health care for TGNC people (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012). Although the landscape is beginning to change with the recent revision of Medicare policy (National Center for Transgender Equality, 2014) and changes to state laws (Transgender Law Center, n.d.), many TGNC people are still likely to have little to no access to TGNC-related health care as a result of the exclusions in their insurance.

Application. Awareness of and sensitivity to the effects of antitrans prejudice and discrimination can assist psychologists in assessing, treating, and advocating for their TGNC clients. When a TGNC person faces discrimination based on gender identity or gender expression, psychologists may facilitate emotional processing of these experiences and work with the person to identify supportive resources and possible courses of action. Specific needs of TGNC people might vary from developing self-advocacy strategies, to navigating public spaces, to seeking legal recourse for harassment and discrimination in social services and other systems. Additionally, TGNC people who have been traumatized by physical or emotional violence may need therapeutic support.

Psychologists may be able to assist TGNC people in accessing relevant social service systems. For example, psychologists may be able to assist in identifying health care providers and housing resources that are affirming and affordable, or locating affirming religious and spiritual communities (Glaser, 2008; Porter et al., 2013). Psychologists may also assist in furnishing documentation or official correspondence that affirms gender identity for the purpose of accessing appropriate public accommodations, such as bathroom use or housing (Lev, 2009; W. J. Meyer, 2009).

Additionally, psychologists may identify appropriate resources, information, and services to help TGNC people in addressing workplace discrimination, including strategies during a social and/or medical transition for identity disclosure at work. For those who are seeking employment, psychologists may help strategize about how and whether to share information about gender history. Psychologists may also work with employers to develop supportive policies for workplace gender transition or to develop training to help employees adjust to the transition of a coworker.

For TGNC military and veteran populations, psychologists may help to address the emotional impact of navigating TGNC identity development in the military system. Psychologists are encouraged to be aware that issues of confidentiality may be particularly sensitive with active duty or reserve status service members, as the consequences of being identified as TGNC may prevent the client's disclosure of gender identity in treatment.

In educational settings, psychologists may advocate for TGNC youth on a number of levels (APA & National

Association of School Psychologists, 2014; Boulder Valley School District, 2012). Psychologists may consult with administrators, teachers, and school counselors to provide resources and trainings on antitrans prejudice and developing safer school environments for TGNC students (Singh & Burnes, 2009). Peer support from other TGNC people has been shown to buffer the negative effect of stigma on mental health (Bockting et al., 2013). As such, psychologists may consider and develop peer-based interventions to facilitate greater understanding and respectful treatment of TGNC youth by cisgender peers (Case & Meier, 2014). Psychologists may work with TGNC youth and their families to identify relevant resources, such as school policies that protect gender identity and gender expression (APA & National Association of School Psychologists, 2014; Gonzalez & McNulty, 2010), referrals to TGNC-affirmative organizations, and online resources, which may be especially helpful for TGNC youth in rural settings.

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Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Rationale. Antitrans prejudice and the adherence of mainstream society to the gender binary adversely affect TGNC people within their families, schools, health care, legal systems, workplaces, religious traditions, and communities (American Civil Liberties Union National Prison Project, 2005; Bradford et al., 2013; Brewster et al., 2014; Levy & Lo, 2013; McGuire, Anderson, & Toomey, 2010). TGNC people face challenges accessing gender-inclusive restrooms, which may result in discomfort when being forced to use a men's or women's restroom (Transgender Law Center, 2005). In addition to the emotional distress the forced binary choice that public restrooms may create for some, TGNC people are frequently concerned with others' reactions to their presence in public restrooms, including potential discrimination, harassment, and violence (Herman, 2013).

Many TGNC people may be distrustful of care providers due to previous experiences of being pathologized (Benson, 2013). Experiences of discrimination and prejudice with health care providers may be complicated by power differentials within the therapeutic relationship that may greatly affect or complicate the care that TGNC people experience. TGNC people have routinely been asked to obtain an endorsement letter from a psychologist attesting to the stability of their gender identity as a prerequisite to access an endocrinologist, surgeon, or legal institution (e.g., driver's license bureau; Lev, 2009). The need for such required documentation from a psychologist may influence rapport, resulting in TGNC people fearing prejudicial treatment in which this documentation is withheld or delayed by the treating provider (Bouman et al., 2014). Whether a TGNC person has personally experienced interactions with providers as disempowering or has learned from community members to expect such a dynamic, psychologists are encouraged to be prepared for TGNC people to be very cautious when entering into a therapeutic relationship. When TGNC people feel validated and empowered within the environment in which a psychologist practices, the therapeutic relationship will benefit and the person may be more willing to explore their authentic selves and share uncertainties and ambiguities that are a common part of TGNC identity development.

Application. Because many TGNC people experience antitrans prejudice or discrimination, psychologists are encouraged to ensure that their work settings are welcoming and respectful of TGNC people, and to be mindful of what TGNC people may perceive as unwelcoming. To do so, psychologists may educate themselves about the many ways that cisgender privilege and antitrans prejudice may be expressed. Psychologists may also have specific conversations with TGNC people about their experiences of the mental health system and implement feedback to foster TGNC-affirmative environments. As a result, when TGNC people access various treatment settings and public spaces, they may experience less harm, disempowerment, or pathologization, and thus will be more likely to avail themselves of resources and support.

Psychologists are encouraged to be proactive in considering how overt or subtle cues in their workplaces and other environments may affect the comfort and safety of TGNC people. To increase the comfort of TGNC people, psychologists are encouraged to display TGNC-affirmative resources in waiting areas and to avoid the display of items that reflect antitrans attitudes (Lev, 2009). Psychologists are encouraged to examine how their language (e.g., use of incorrect pronouns and names) may reinforce the gender binary in overt or subtle and unintentional ways (Smith, Shin, & Officer, 2012). It may be helpful for psychologists to provide training for support staff on how to respectfully interact with TGNC people. A psychologist may consider making changes to paperwork, forms, or outreach materials to ensure that these materials are more inclusive of TGNC people (Spade, 2011b). For example, demographic questionnaires can communicate respect through the use of inclusive language and the inclusion of a range of gender identities. In addition, psychologists may also work within their institutions to advocate for restrooms that are inclusive and accessible for people of all gender identities and/or gender expressions.

When working with TGNC people in a variety of care and institutional settings (e.g., inpatient medical and psychiatric hospitals, substance abuse treatment settings, nursing homes, foster care, religious communities, military and VA health care settings, and prisons), psychologists may become liaisons and advocates for TGNC people's mental health needs and for respectful treatment that addresses their gender identity in an affirming manner. In playing this role, psychologists may find guidance and best practices that have been published for particular institutional contexts to be helpful (e.g., Department of Veterans Affairs, Veterans' Health Administration, 2013; Glezer, McNiel, & Binder, 2013; Merksamer, 2011).

Guideline 7: Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

Rationale. The lack of public policy that addresses the needs of TGNC people creates significant hardships for them (Taylor, 2007). Although there have been major advances in legal protections for TGNC people in recent years (Buzuvis, 2013; Harvard Law Review Association, 2013), many TGNC people are still not afforded protections from discrimination on the basis of gender identity or expression (National LGBTQ Task Force, 2013; Taylor, 2007). For instance, in many states, TGNC people do not have employment or housing protections and may be fired or lose their housing based on their gender identity. Many policies that protect the rights of cisgender people, including LGB people, do not protect the rights of TGNC people (Currah, & Minter, 2000; Spade, 2011a).

TGNC people can experience challenges obtaining gender-affirming identity documentation (e.g., birth certificate, passport, social security card, driver's license). For TGNC people experiencing poverty or economic hardship, requirements for obtaining this documentation may be impossible to meet, in part due to the difficulty of securing employment without identity documentation that aligns with their gender identity and gender expression (Sheridan, 2009). Additionally, systemic barriers related to binary gender identification systems prevent some TGNC people from changing their documents, including those who are incarcerated, undocumented immigrants, and people who live in jurisdictions that explicitly forbid such changes (Spade, 2006). Documentation requirements can also assume a universal TGNC experience that marginalizes some TGNC people, especially those who do not undergo a medical transition. This may affect a TGNC person's social and psychological well-being and interfere with accessing employment, education, housing and shelter, health care, public benefits, and basic life management resources (e.g., opening a bank account).

Application. Psychologists are encouraged to inform public policy to reduce negative systemic impact on TGNC people and to promote positive social change. Psychologists are encouraged to identify and improve systems that permit violence; educational, employment, and housing discrimination; lack of access to health care; unequal access to other vital resources; and other instances of systemic inequity that TGNC people experience (ACA, 2010). Many TGNC people experience stressors from constant barriers, inequitable treatment, and forced release of sensitive and private information about their bodies and their lives (Hendricks & Testa, 2012). To obtain proper identity documentation, TGNC people may be required to provide court orders, proof of having had surgery, and documentation of psychotherapy or a psychiatric diagnosis. Psychologists may assist TGNC people by normalizing their reactions of fatigue and traumatization while interacting with legal systems and requirements; TGNC people may also benefit from guidance about alternate avenues of recourse, self-advocacy, or appeal. When TGNC people feel that it is unsafe to advocate for themselves, psychologists may work with their clients to access appropriate resources in the community.

Psychologists are encouraged to be sensitive to the challenges of attaining gender-affirming identity documentation and how the receipt or denial of such documentation may affect social and psychological well-being, the person's ability to obtain education and employment, find safe housing, access public benefits, obtain student loans, and access health insurance. It may be of significant assistance for psychologists to understand and offer information about the process of a legal name change, gender marker change on identification, or the process for accessing other gender-affirming documents. Psychologists may consult the National Center for Transgender Equality, the Sylvia Rivera Law Project, or the Transgender Law Center for additional information on identity documentation for TGNC people.

Psychologists may choose to become involved with an organization that seeks to revise law and public policy to better protect the rights and dignities of TGNC people. Psychologists may participate at the local, state, or national level to support TGNC-affirmative health care accessibility, human rights in sex-segregated facilities, or policy change regarding gender-affirming identity documentation. Psychologists working in institutional settings may also expand their roles to work as collaborative advocates for TGNC people (Gonzalez & McNulty, 2010). Psychologists are encouraged to provide written affirmations supporting TGNC people and their gender identity so that they may access necessary services (e.g., hormone therapy).

Life Span Development

Guideline 8. Psychologists working with gender-questioning [4] and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood.

Rationale. Many children develop stability (constancy across time) in their gender identity between Ages 3 to 4 (Kohlberg, 1966), although gender consistency (recognition that gender remains the same across situations) often does not occur until Ages 4 to 7 (Siegal & Robinson, 1987). Children who demonstrate gender nonconformity in preschool and early elementary years may not follow this trajectory (Zucker & Bradley, 1995). Existing research suggests that between 12% and 50% of children diagnosed with gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley,

[4] Gender-questioning youth are differentiated from TGNC youth in this section of the guidelines. Gender-questioning youth may be questioning or exploring their gender identity but have not yet developed a TGNC identity. As such, they may not be eligible for some services that would be offered to TGNC youth. Gender-questioning youth are included here because gender questioning may lead to a TGNC identity.

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Peterson-Badaali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). However, several research studies categorized 30% to 62% of youth who did not return to the clinic for medical intervention after initial assessment, and whose gender identity may be unknown, as "desisters" who no longer identified with a gender different than sex assigned at birth (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008; Zucker, 2008a). As a result, this research runs a strong risk of inflating estimates of the number of youth who do not persist with a TGNC identity. Research has suggested that children who identify more intensely with a gender different than sex assigned at birth are more likely to persist in this gender identification into adolescence (Steensma et al., 2013), and that when gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term TGNC identification increases (A. L. de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008; Zucker, 2008b). Gender-questioning children who do not persist may be more likely to later identify as gay or lesbian than non-gender-questioning children (Bailey & Zucker, 1995; Drescher, 2014; Wallien & Cohen-Kettenis, 2008).

A clear distinction between care of TGNC and gender-questioning children and adolescents exists in the literature. Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood, and because no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children. Lack of consensus about the preferred approach to treatment may be due in part to divergent ideas regarding what constitutes optimal treatment outcomes for TGNC and gender-questioning youth (Hembree et al., 2009). Two distinct approaches exist to address gender identity concerns in children (Hill, Menvielle, Sica, & Johnson, 2010; Wallace & Russell, 2013), with some authors subdividing one of the approaches to suggest three (Byne et al., 2012; Drescher, 2014; Stein, 2012).

One approach encourages an affirmation and acceptance of children's expressed gender identity. This may include assisting children to socially transition and to begin medical transition when their bodies have physically developed, or allowing a child's gender identity to unfold without expectation of a specific outcome (A. L. de Vries & Cohen-Kettenis, 2012; Edwards-Leeper & Spack, 2012; Ehrensaft, 2012; Hidalgo et al., 2013; Tishelman et al., 2015). Clinicians using this approach believe that an open exploration and affirmation will assist children to develop coping strategies and emotional tools to integrate a positive TGNC identity should gender questioning persist (Edwards-Leeper & Spack, 2012).

In the second approach, children are encouraged to embrace their given bodies and to align with their assigned gender roles. This includes endorsing and supporting behaviors and attitudes that align with the child's sex assigned at birth prior to the onset of puberty (Zucker, 2008a; Zucker, Wood, Singh, & Bradley, 2012). Clinicians using this approach believe that undergoing multiple medical interventions and living as a TGNC person in a world that stigmatizes gender nonconformity is a less desirable outcome than one in which children may be assisted to happily align with their sex assigned at birth (Zucker et al., 2012). Consensus does not exist regarding whether this approach may provide benefit (Zucker, 2008a; Zucker et al., 2012) or may cause harm or lead to psychosocial adversities (Hill et al., 2010; Pyne, 2014; Travers et al., 2012; Wallace & Russell, 2013). When addressing psychological interventions for children and adolescents, the World Professional Association for Transgender Health Standards of Care identify interventions "aimed at trying to change gender identity and expression to become more congruent with sex assigned at birth" as unethical (Coleman et al., 2012, p. 175). It is hoped that future research will offer improved guidance in this area of practice (Adelson & AACAP CQI, 2012; Malpas, 2011).

Much greater consensus exists regarding practice with adolescents. Adolescents presenting with gender identity concerns bring their own set of unique challenges. This may include having a late-onset (i.e., postpubertal) presentation of gender nonconforming identification, with no history of gender role nonconformity or gender questioning in childhood (Edwards-Leeper & Spack, 2012). Complicating their clinical presentation, many gender-questioning adolescents also present with co-occurring psychological concerns, such as suicidal ideation, self-injurious behaviors (Liu & Mustanski, 2012; Mustanski, Garofalo, & Emerson, 2010), drug and alcohol use (Garofalo et al., 2006), and autism spectrum disorders (A. L. de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010; Jones et al., 2012). Additionally, adolescents can become intensely focused on their immediate desires, resulting in outward displays of frustration and resentment when faced with any delay in receiving the medical treatment from which they feel they would benefit and to which they feel entitled (Angello, 2013; Edwards-Leeper & Spack, 2012). This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions to change their name or gender marker, begin hormone therapy (which may affect fertility), or pursue surgery.

Nonetheless, there is greater consensus that treatment approaches for adolescents affirm an adolescents' gender identity (Coleman et al., 2012). Treatment options for adolescents extend beyond social approaches to include medical approaches. One particular medical intervention involves the use of puberty-suppressing medication or "blockers" (GnRH analogue), which is a reversible medical intervention used to delay puberty for appropriately screened adolescents with gender dysphoria (Coleman et al., 2012; A. L. C. de Vries et al., 2014; Edwards-Leeper, & Spack, 2012). Because of their age, other medical interventions may also become available to adolescents, and psychologists are frequently consulted to provide an assessment of whether such procedures would be advisable (Coleman et al., 2012).

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Application. Psychologists working with TGNC and gender-questioning youth are encouraged to regularly review the most current literature in this area, recognizing the limited available research regarding the potential benefits and risks of different treatment approaches for children and for adolescents. Psychologists are encouraged to offer parents and guardians clear information about available treatment approaches, regardless of the specific approach chosen by the psychologist. Psychologists are encouraged to provide psychological service to TGNC and gender-questioning children and adolescents that draws from empirically validated literature when available, recognizing the influence psychologists' values and beliefs may have on the treatment approaches they select (Ehrbar & Gorton, 2010). Psychologists are also encouraged to remain aware that what one youth and/or parent may be seeking in a therapeutic relationship may not coincide with a clinician's approach (Brill & Pepper, 2008). In cases in which a youth and/or parent identify different preferred treatment outcomes than a clinician, it may not be clinically appropriate for the clinician to continue working with the youth and family, and alternative options, including referral, might be considered. Psychologists may also find themselves navigating family systems in which youth and their caregivers are seeking different treatment outcomes (Edwards-Leeper & Spack, 2012). Psychologists are encouraged to carefully reflect on their personal values and beliefs about gender identity development in conjunction with the available research, and to keep the best interest of the child or adolescent at the forefront of their clinical decisions at all times.

Because gender nonconformity may be transient for younger children in particular, the psychologist's role may be to help support children and their families through the process of exploration and self-identification (Ehrensaft, 2012). Additionally, psychologists may provide parents with information about possible long-term trajectories children may take in regard to their gender identity, along with the available medical interventions for adolescents whose TGNC identification persists (Edwards-Leeper & Spack, 2012).

When working with adolescents, psychologists are encouraged to recognize that some TGNC adolescents will not have a strong history of childhood gender role nonconformity or gender dysphoria either by self-report or family observation (Edwards-Leeper & Spack, 2012). Some of these adolescents may have withheld their feelings of gender nonconformity out of a fear of rejection, confusion, conflating gender identity and sexual orientation, or a lack of awareness of the option to identify as TGNC. Parents of these adolescents may need additional assistance in understanding and supporting their youth, given that late-onset gender dysphoria and TGNC identification may come as a significant surprise. Moving more slowly and cautiously in these cases is often advisable (Edwards-Leeper & Spack, 2012). Given the possibility of adolescents' intense focus on immediate desires and strong reactions to perceived delays or barriers, psychologists are encouraged to validate these concerns and the desire to move through the process quickly while also remaining thoughtful and deliberate in treatment. Adolescents and their families may need support in tolerating ambiguity and uncertainty with regard to gender identity and its development (Brill & Pepper, 2008). It is encouraged that care should be taken not to foreclose this process.

For adolescents who exhibit a long history of gender nonconformity, psychologists may inform parents that the adolescent's self-affirmed gender identity is most likely stable (A. L. de Vries et al., 2011). The clinical needs of these adolescents may be different than those who are in the initial phases of exploring or questioning their gender identity. Psychologists are encouraged to complete a comprehensive evaluation and ensure the adolescent's and family's readiness to progress while also avoiding unnecessary delay for those who are ready to move forward.

Psychologists working with TGNC and gender-questioning youth are encouraged to become familiar with medical treatment options for adolescents (e.g., puberty-suppressing medication, hormone therapy) and work collaboratively with medical providers to provide appropriate care to clients. Because the ongoing involvement of a knowledgeable mental health provider is encouraged due to the psychosocial implications, and is often also a required part of the medical treatment regimen that may be offered to TGNC adolescents (Coleman et al., 2012; Hembree et al., 2009), psychologists often play an essential role in assisting in this process.

Psychologists may encourage parents and caregivers to involve youth in developmentally appropriate decision making about their education, health care, and peer networks, as these relate to children's and adolescents' gender identity and gender expression (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Psychologists are also encouraged to educate themselves about the advantages and disadvantages of social transition during childhood and adolescence, and to discuss these factors with both their young clients and clients' parents. Emphasizing to parents the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated, particularly given the research that suggests that not all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth (Wallien, & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Psychologists are encouraged to acknowledge and explore the fear and burden of responsibility that parents and caregivers may feel as they make decisions about the health of their child or adolescent (Grossman, D'Augelli, Howell, & Hubbard, 2006). Parents and caregivers may benefit from a supportive environment to discuss feelings of isolation, explore loss and grief they may experience, vent anger and frustration at systems that disrespect or discriminate against them and their youth, and learn how to communicate with others about their child's or adolescent's gender identity or gender expression (Brill & Pepper, 2008).

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Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Rationale. Little research has been conducted about TGNC elders, leaving much to be discovered about this life stage for TGNC people (Auldridge, Tamar-Mattis, Kennedy, Ames, & Tobin, 2012). Socialization into gender role behaviors and expectations based on sex assigned at birth, as well as the extent to which TGNC people adhere to these societal standards, is influenced by the chronological age at which a person self-identifies as TGNC, the age at which a person comes out or socially and/or medically transitions (Birren & Schaie, 2006; Bockting & Coleman, 2007; Cavanaugh & Blanchard-Fields, 2010; Nuttbrock et al., 2010; Wahl, Iwarsson, & Oswald, 2012), and a person's generational cohort (e.g., 1950 vs. 2010; Fredriksen-Goldsen et al., 2011).

Even decades after a medical or social transition, TGNC elders may still subscribe to the predominant gender role expectations that existed at the time of their transition (Knochel, Croghan, Moore, & Quam, 2011). Prior to the 1980s, TGNC people who transitioned were strongly encouraged by providers to pass in society as cisgender and heterosexual and to avoid associating with other TGNC people (Benjamin, 1966; R. Green & Money, 1969; Hastings, 1974; Hastings & Markland, 1978). Even TGNC elders who were comfortable telling others about their TGNC identity when they were younger may choose not to reveal their identity at a later stage of life (Ekins & King, 2005; Ippolito & Witten, 2014). Elders' unwillingness to disclose their TGNC identity can result from feelings of physical vulnerability or increased reliance on others who may discriminate against them or treat them poorly as a result of their gender identity (Bockting & Coleman, 2007), especially if the elder resides in an institutionalized setting (i.e., nursing home, assisted living facility) and relies on others for many daily needs (Auldridge et al., 2012). TGNC elders are also at a heightened risk for depression, suicidal ideation, and loneliness compared with LGB elders (Auldridge et al., 2012; Fredriksen-Goldsen et al., 2011).

A Transgender Law Center survey found that TGNC and LGB elders had less financial well-being than their younger cohorts, despite having a higher than average educational level for their age group compared with the general population (Hartzell, Frazer, Wertz, & Davis, 2009). Survey research has also revealed that TGNC elders experience underemployment and gaps in employment, often due to discrimination (Auldridge et al., 2012; Beemyn & Rankin, 2011; Factor & Rothblum, 2007). In the past, some TGNC people with established careers may have been encouraged by service providers to find new careers or jobs to avoid undergoing a gender transition at work or being identified as TGNC, potentially leading to a significant loss of income and occupational identity (Cook-Daniels, 2006). Obstacles to employment can increase economic disparities that result in increased needs for supportive housing and other social services (National Center for Transgender Equality, 2012; Services and Advocacy for GLBT Elders & National Center for Transgender Equality, 2012).

TGNC elders may face obstacles to seeking or accessing resources that support their physical, financial, or emotional well-being. For instance, they may be concerned about applying for social security benefits, fearing that their TGNC identity may become known (Hartzell et al., 2009). A TGNC elder may avoid medical care, increasing the likelihood of later needing a higher level of medical care (e.g., home-based care, assisted living, or nursing home) than their same-age cisgender peers (Hartzell et al., 2009; Ippolito & Witten, 2014; Mikalson et al., 2012). Nursing homes and assisted living facilities are rarely sensitive to the unique medical needs of TGNC elders (National Senior Citizens Law Center, 2011). Some TGNC individuals who enter congregate housing, assisted living, or long-term care settings may feel the need to reverse their transition to align with sex assigned at birth to avoid discrimination and persecution by other residents and staff (Ippolito & Witten, 2014).

Older age may both facilitate and complicate medical treatment related to gender transition. TGNC people who begin hormone therapy later in life may have a smoother transition due to waning hormone levels that are a natural part of aging (Witten & Eyler, 2012). Age may also influence the decisions TGNC elders make regarding sex-affirmation surgeries, especially if physical conditions exist that could significantly increase risks associated with surgery or recovery.

Much has been written about the resilience of elders who have endured trauma (Fuhrmann & Shevlowitz, 2006; Hardy, Concato, & Gill, 2004; Mlinac, Sheeran, Blissmer, Lees, & Martins, 2011; Rodin & Stewart, 2012). Although some TGNC elders have experienced significant psychological trauma related to their gender identity, some also have developed resilience and effective ways of coping with adversity (Fruhauf & Orel, 2015). Despite the limited availability of LGBTQ-affirmative religious organizations in many local communities, TGNC elders make greater use of these resources than their cisgender peers (Porter et al., 2013).

Application. Psychologists are encouraged to seek information about the biopsychosocial needs of TGNC elders to inform case conceptualization and treatment planning to address psychological, social, and medical concerns. Many TGNC elders are socially isolated. Isolation can occur as a result of a loss of social networks through death or through disclosure of a TGNC identity. Psychologists may assist TGNC elders in establishing new social networks that support and value their TGNC identity, while also working to strengthen existing family and friend networks after a TGNC identity has been disclosed. TGNC elders may find special value in relationships with others in their generational cohort or those who may have similar coming-out experiences. Psychologists may encourage TGNC elders to identify ways they can mentor and improve the resilience of younger TGNC generations, creating a sense of generativity (Erikson, 1968) and contribu-

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tion while building new supportive relationships. Psychologists working with TGNC elders may help them recognize the sources of their resilience and encourage them to connect with and be active in their communities (Fuhrmann & Craffey, 2014).

For TGNC elders who have chosen not to disclose their gender identity, psychologists may provide support to address shame, guilt, or internalized antitrans prejudice, and validate each person's freedom to choose their pattern of disclosure. Clinicians may also provide validation and empathy when TGNC elders have chosen a model of transition that avoids any disclosure of gender identity and is heavily focused on passing as cisgender.

TGNC elders who choose to undergo a medical or social transition in older adulthood may experience antitrans prejudice from people who question the value of transition at an older age or who believe that these elders are not truly invested in their transition or in a TGNC identity given the length of time they have waited (Auldridge et al., 2012). Some TGNC elders may also grieve lost time and missed opportunities. Psychologists may validate elders' choices to come out, transition, or evolve their gender identity or gender expression at any age, recognizing that such choices may have been much less accessible or viable at earlier stages of TGNC elders' lives.

Psychologists may assist congregate housing, assisted living, or long-term care settings to best meet TGNC elders' needs through respectful communication and affirmation of each person's gender identity and gender expression. Psychologists may work with TGNC people in hospice care systems to develop an end-of-life plan that respects the person's wishes about disclosure of gender identity during and after death.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Rationale. TGNC people may seek assistance from psychologists in addressing gender-related concerns, other mental health issues, or both. Mental health problems experienced by a TGNC person may or may not be related to that person's gender identity and/or may complicate assessment and intervention of gender-related concerns. In some cases, there may not be a relationship between a person's gender identity and a co-occurring condition (e.g., depression, PTSD, substance abuse). In other cases, having a TGNC identity may lead or contribute to a co-occurring mental health condition, either directly by way of gender dysphoria, or indirectly by way of minority stress and oppression (Hendricks & Testa, 2012; I. H. Meyer, 1995, 2003). In extremely rare cases, a co-occurring condition can mimic gender dysphoria (i.e., a psychotic process that distorts the perception of one's gender; Baltieri & De Andrade, 2009; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2004).

Regardless of the presence or absence of an etiological link, gender identity may affect how a TGNC person experiences a co-occurring mental health condition, and/or a co-occurring mental health condition may complicate the person's gender expression or gender identity. For example, an eating disorder may be influenced by a TGNC person's gender expression (e.g., rigid eating patterns used to manage body shape or menstruation may be related to gender identity or gender dysphoria; Ålgars, Alanko, Santtila, & Sandnabba, 2012; Murray, Boon, & Touyz, 2013). In addition, the presence of autism spectrum disorder may complicate a TGNC person's articulation and exploration of gender identity (Jones et al., 2012). In cases in which gender dysphoria is contributing to other mental health concerns, treatment of gender dysphoria may be helpful in alleviating those concerns as well (Keo-Meier et al., 2015).

A relationship also exists between mental health conditions and the psychological sequelae of minority stress that TGNC people can experience. Given that TGNC people experience physical and sexual violence (Clements-Nolle et al., 2006; Kenagy & Bostwick, 2005; Lombardi, Wilchins, Priesing, & Malouf, 2001; Xavier et al., 2005), general harassment and discrimination (Beemyn & Rankin, 2011; Factor & Rothblum, 2007), and employment and housing discrimination (Bradford et al., 2007), they are likely to experience significant levels of minority stress. Studies have demonstrated the disproportionately high levels of negative psychological sequelae related to minority stress, including suicidal ideation and suicide attempts (Center for Substance Abuse Treatment, 2012; Clements-Nolle et al., 2006; Cochran & Cauce, 2006; Nuttbrock et al., 2010; Xavier et al., 2005) and completed suicides (Dhejne et al., 2011; van Kesteren, Asscheman, Megens, & Gooren, 1997). Recent studies have begun to demonstrate an association between sources of external stress and psychological distress (Bockting et al., 2013; Nuttbrock et al., 2010), including suicidal ideation and attempts and self-injurious behavior (dickey, Reisner, & Juntunen, 2015; Goldblum et al., 2012; Testa et al., 2012).

The minority stress model accounts for both the negative mental health effects of stigma-related stress and the processes by which members of the minority group may develop resilience and resistance to the negative effects of stress (I. H. Meyer, 1995, 2003). Although the minority stress model was developed as a theory of the relationship between sexual orientation and mental disorders, the model has been adapted to TGNC populations (Hendricks & Testa, 2012).

Application. Because of the increased risk of stress-related mental health conditions, psychologists are encouraged to conduct a careful diagnostic assessment, including a differential diagnosis, when working with TGNC people (Coleman et al., 2012). Taking into account the intricate interplay between the effects of mental health symptoms and gender identity and gender expression, psychologists are encouraged to neither ignore mental health problems a TGNC person is experiencing, nor erroneously

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assume that those mental health problems are a result of the person's gender identity or gender expression. Psychologists are strongly encouraged to be cautious before determining that gender nonconformity or dysphoria is due to an underlying psychotic process, as this type of causal relationship is rare.

When TGNC people seek to access transition-related health care, a psychosocial assessment is often part of this process (Coleman et al., 2012). A comprehensive and balanced assessment typically includes not only information about a person's past experiences of antitrans prejudice or discrimination, internalized messages related to these experiences, and anticipation of future victimization or rejection (Coolhart, Provancher, Hager, & Wang, 2008), but also coping strategies and sources of resilience (Hendricks & Testa, 2012; Singh et al., 2011). Gathering information about negative life events directly related to a TGNC person's gender identity and gender expression may assist psychologists in understanding the sequelae of stress and discrimination, distinguishing them from concurrent and potentially unrelated mental health problems. Similarly, when a TGNC person has a primary presenting concern that is not gender focused, a comprehensive assessment takes into account that person's experience relative to gender identity and gender expression, including any discrimination, just as it would include assessing other potential trauma history, medical concerns, previous experience with helping professionals, important future goals, and important aspects of identity. Strategies a TGNC person uses to navigate antitrans discrimination could be sources of strength to deal with life challenges or sources of distress that increase challenges and barriers.

Psychologists are encouraged to help TGNC people understand the pervasive influence of minority stress and discrimination that may exist in their lives, potentially including internalized negative attitudes about themselves and their TGNC identity (Hendricks & Testa, 2012). With this support, clients can better understand the origins of their mental health symptoms and normalize their reactions when faced with TGNC-related inequities and discrimination. Minority stress models also identify potentially important sources of resilience. TGNC people can develop resilience when they connect with other TGNC people who provide information on how to navigate antitrans prejudice and increase access to necessary care and resources (Singh et al., 2011). TGNC people may need help developing social support systems to nurture their resilience and bolster their ability to cope with the adverse effects of antitrans prejudice and/or discrimination (Singh & McKleroy, 2011).

Feminizing or masculinizing hormone therapy can positively or negatively affect existing mood disorders (Coleman et al., 2012). Psychologists may also help TGNC people who are in the initial stages of hormone therapy adjust to normal changes in how they experience emotions. For example, trans women who begin estrogens and antiandrogens may experience a broader range of emotions than they are accustomed to, or trans men beginning testosterone might be faced with adjusting to a higher libido and feeling more emotionally reactive in stressful situations. These changes can be normalized as similar to the emotional adjustments that cisgender women and men experience during puberty. Some TGNC people will be able to adapt existing coping strategies, whereas others may need help developing additional skills (e.g., emotional regulation or assertiveness). Readers are encouraged to refer to the World Professional Association for Transgender Health Standards of Care for discussion of the possible effects of hormone therapy on a TGNC person's mood, affect, and behavior (Coleman et al., 2012).

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Rationale. Research has primarily shown positive treatment outcomes when TGNC adults and adolescents receive TGNC-affirmative medical and psychological services (i.e., psychotherapy, hormones, surgery; Byne et al., 2012; R. Carroll, 1999; Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Davis & Meier, 2014; De Cuypere et al., 2006; Gooren, Giltay, & Bunck, 2008; Kuhn et al., 2009), although sample sizes are frequently small with no population-based studies. In a meta-analysis of the hormone therapy treatment literature with TGNC adults and adolescents, researchers reported that 80% of participants receiving trans-affirmative care experienced an improved quality of life, decreased gender dysphoria, and a reduction in negative psychological symptoms (Murad et al., 2010).

In addition, TGNC people who receive social support about their gender identity and gender expression have improved outcomes and quality of life (Brill & Pepper, 2008; Pinto, Melendez, & Spector, 2008). Several studies indicate that family acceptance of TGNC adolescents and adults is associated with decreased rates of negative outcomes, such as depression, suicide, and HIV risk behaviors and infection (Bockting et al., 2013; Dhejne et al., 2011; Grant et al., 2011; Liu & Mustanski, 2012; Ryan, 2009). Family support is also a strong protective factor for TGNC adults and adolescents (Bockting et al., 2013; Moody & Smith, 2013; Ryan et al., 2010). TGNC people, however, frequently experience blatant or subtle antitrans prejudice, discrimination, and even violence within their families (Bradford et al., 2007). Such family rejection is associated with higher rates of HIV infection, suicide, incarceration, and homelessness for TGNC adults and adolescents (Grant et al., 2011; Liu & Mustanski, 2012). Family rejection and lower levels of social support are significantly correlated with depression (Clements-Nolle et al., 2006; Ryan, 2009). Many TGNC people seek support through peer relationships, chosen families, and communities in which they may be more likely to experience acceptance (Gonzalez & McNulty, 2010; Nuttbrock et al., 2009). Peer support from other TGNC people has been found to be a moderator between antitrans discrimination and mental health, with higher levels of peer support associated with better mental health (Bockting et al., 2013). For some TGNC people, support from religious and spiritual communities provides

an important source of resilience (Glaser, 2008; Kidd & Witten, 2008; Porter et al., 2013).

Application. Given the strong evidence for the positive influence of affirmative care, psychologists are encouraged to facilitate access to and provide trans-affirmative care to TGNC people. Whether through the provision of assessment and psychotherapy, or through assisting clients to access hormone therapy or surgery, psychologists may play a critical role in empowering and validating TGNC adults' and adolescents' experiences and increasing TGNC people's positive life outcomes (Bess & Stabb, 2009; Rachlin, 2002).

Psychologists are also encouraged to be aware of the importance of affirmative social support and assist TGNC adults and adolescents in building social support networks in which their gender identity is accepted and affirmed. Psychologists may assist TGNC people in negotiating family dynamics that may arise in the course of exploring and establishing gender identity. Depending on the context of psychological practice, these issues might be addressed in individual work with TGNC clients, conjoint sessions including members of their support system, family therapy, or group therapy. Psychologists may help TGNC people decide how and when to reveal their gender identity at work or school, in religious communities, and to friends and contacts in other settings. TGNC people who decide not to come out in all aspects of their lives can still benefit from TGNC-affirmative in-person or online peer support groups.

Clients may ask psychologists to assist family members in exploring feelings about their loved one's gender identity and gender expression. Published models of family adjustment (Emerson & Rosenfeld, 1996) may be useful to help normalize family members' reactions upon learning that they have a TGNC family member, and to reduce feelings of isolation. When working with family members or significant others, it may be helpful to normalize feelings of loss or fear of what may happen to current relationships as TGNC people disclose their gender identity and expression to others. Psychologists may help significant others adjust to changing relationships and consider how to talk to extended family, friends, and other community members about TGNC loved ones. Providing significant others with referrals to TGNC-affirmative providers, educational resources, and support groups can have a profound impact on their understanding of gender identity and their communication with TGNC loved ones. Psychologists working with couples and families may also help TGNC people identify ways to include significant others in their social or medical transition.

Psychologists working with TGNC people in rural settings may provide clients with resources to connect with other TGNC people online or provide information about in-person support groups in which they can explore the unique challenges of being TGNC in these geographic areas (Walinsky & Whitcomb, 2010). Psychologists serving TGNC military and veteran populations are encouraged to be sensitive to the barriers these individuals face, especially for people who are on active duty in the U.S. military (OutServe-Servicemembers Legal Defense Network, n.d.). Psychologists may help TGNC military members and veterans establish specific systems of support that create a safe and affirming space to reduce isolation and to create a network of peers with a shared military experience. Psychologists who work with veterans are encouraged to educate themselves on recent changes to VA policy that support equal access to VA medical and mental health services (Department of Veterans Affairs, Veterans' Health Administration, 2013).

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Rationale. Relationships involving TGNC people can be healthy and successful (Kins, Hoebeke, Heylens, Rubens, & De Cuyprere, 2008; Meier, Sharp, Michonski, Babcock, & Fitzgerald, 2013) as well as challenging (Brown, 2007; Iantaffi & Bockting, 2011). A study of successful relationships between TGNC men and cisgender women found that these couples attributed the success of their relationship to respect, honesty, trust, love, understanding, and open communication (Kins et al., 2008). Just as relationships between cisgender people can involve abuse, so can relationships between TGNC people and their partners (Brown, 2007), with some violent partners threatening to disclose a TGNC person's identity to exact control in the relationship (FORGE, n.d.).

In the early decades of medical and social transition for TGNC people, only those whose sexual orientations would be heterosexual posttransition (e.g., trans woman with a cisgender man) were deemed eligible for medical and social transition (Meyerowitz, 2002). This restriction prescribed only certain relationship partners (American Psychiatric Association, 1980; Benjamin, 1966; Chivers & Bailey, 2000), denied access to surgery for trans men identifying as gay or bisexual (Coleman & Bockting, 1988), or trans women identifying as lesbian or bisexual, and even required that TGNC people's existing legal marriages be dissolved before they could gain access to transition care (Lev, 2004).

Disclosure of a TGNC identity can have an important impact on the relationship between TGNC people and their partners. Disclosure of TGNC status earlier in the relationship tends to be associated with better relationship outcomes, whereas disclosure of TGNC status many years into an existing relationship may be perceived as a betrayal (Erhardt, 2007). When a TGNC person comes out in the context of an existing relationship, it can also be helpful if both partners are involved in decision making about the use of shared resources (i.e., how to balance the financial costs of transition with other family needs) and how to share this news with shared supports (i.e., friends and family). Sometimes relationship roles are renegotiated in the context of a TGNC person coming out to their partner (Samons, 2008). Assumptions about what it means to be a "husband" or a "wife" can shift if the gender identity of one's spouse shifts

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(Erhardt, 2007). Depending on when gender issues are disclosed and how much of a change this creates in the relationship, partners may grieve the loss of aspects of their partner and the way the relationship used to be (Lev, 2004).

Although increasing alignment between gender identity and gender expression, whether it be through dress, behavior, or through medical interventions (i.e., hormones, surgery), does not necessarily affect to whom a TGNC person is attracted (Coleman et al., 1993), TGNC people may become more open to exploring their sexual orientation, may redefine sexual orientation as they move through transition, or both (Daskalos, 1998; H. Devor, 1993; Schleifer, 2006). Through increased comfort with their body and gender identity, TGNC people may explore aspects of their sexual orientation that were previously hidden or that felt discordant with their sex assigned at birth. Following a medical and/or social transition, a TGNC person's sexual orientation may remain constant or shift, either temporarily or permanently (e.g., renewed exploration of sexual orientation in the context of TGNC identity, shift in attraction or choice of sexual partners, widened spectrum of attraction, shift in sexual orientation identity; Meier, Sharp et al., 2013; Samons, 2008). For example, a trans man previously identified as a lesbian may later be attracted to men (Coleman et al., 1993; dickey, Burnes, & Singh, 2012), and a trans woman attracted to women pretransition may remain attracted to women posttransition (Lev, 2004).

Some TGNC people and their partners may fear the loss of mutual sexual attraction and other potential effects of shifting gender identities in the relationship. Lesbian-identified partners of trans men may struggle with the idea that being in a relationship with a man may cause others to perceive them as a heterosexual couple (Califia, 1997). Similarly, women in heterosexual relationships who later learn that their partners are trans women may be unfamiliar with navigating stigma associated with sexual minority status when viewed as a lesbian couple (Erhardt, 2007). Additionally, partners may find they are not attracted to a partner after transition. As an example, a lesbian whose partner transitions to a male identity may find that she is no longer attracted to this person because she is not sexually attracted to men. Partners of TGNC people may also experience grief and loss as their partners engage in social and/or medical transitions.

Application. Psychologists may help foster resilience in relationships by addressing issues specific to partners of TGNC people. Psychologists may provide support to partners of TGNC people who are having difficulty with their partner's evolving gender identity or transition, or are experiencing others having difficulty with the partner's transition. Partner peer support groups may be especially helpful in navigating internalized antitrans prejudice, shame, resentment, and relationship concerns related to a partner's gender transition. Meeting or knowing other TGNC people, other partners of TGNC people, and couples who have successfully navigated transition may also help TGNC people and their partners and serve as a protective factor (Brown, 2007). When TGNC status is disclosed during an existing relationship, psychologists may help couples explore which relationship dynamics they want to preserve and which they might like to change.

In working with psychologists, TGNC people may explore a range of issues in their relationships and sexuality (dickey et al., 2012), including when and how to come out to current or potential romantic and sexual partners, communicating their sexual desires, renegotiating intimacy that may be lost during the TGNC partner's transition, adapting to bodily changes caused by hormone use or surgery, and exploring boundaries regarding touch, affection, and safer sex practices (Iantaffi & Bockting, 2011; Sevelius, 2009). TGNC people may experience increased sexual self-efficacy through transition. Although psychologists may aid partners in understanding a TGNC person's transition decisions, TGNC people may also benefit from help in cultivating awareness of the ways in which these decisions influence the lives of loved ones.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Rationale. Psychologists work with TGNC people across the life span to address parenting and family issues (Kenagy & Hsieh, 2005). There is evidence that many TGNC people have and want children (Wierckx et al., 2012). Some TGNC people conceive a child through sexual intercourse, whereas others may foster, adopt, pursue surrogacy, or employ assisted reproductive technologies, such as sperm or egg donation, to build or expand a family (De Sutter, Kira, Verschoor, & Hotimsky, 2002). Based on a small body of research to date, there is no indication that children of TGNC parents suffer long-term negative impacts directly related to parental gender change (R. Green, 1978, 1988; White & Ettner, 2004). TGNC people may find it both challenging to find medical providers who are willing to offer them reproductive treatment and to afford the cost (Coleman et al., 2012). Similarly, adoption can be quite costly, and some TGNC people may find it challenging to find foster care or adoption agencies that will work with them in a nondiscriminatory manner. Current or past use of hormone therapy may limit fertility and restrict a TGNC person's reproductive options (Darnery, 2008; Wierckx et al., 2012). Other TGNC people may have children or families before coming out as TGNC or beginning a gender transition.

TGNC people may present with a range of parenting and family-building concerns. Some will seek support to address issues within preexisting family systems, some will explore the creation or expansion of a family, and some will need to make decisions regarding potential fertility issues related to hormone therapy, pubertal suppression, or surgical transition. The medical and/or social transition of a TGNC parent may shift family dynamics, creating challenges and opportunities for partners, children, and other family members. One study of therapists' reflections on their experiences with TGNC clients suggested that family constellation and the parental relationship was more significant for children than the parent's social and/or medical

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transition itself (White & Ettner, 2004). Although research has not documented that the transitions of TGNC people have an effect on their parenting abilities, preexisting partnerships or marriages may not survive the disclosure of a TGNC identity or a subsequent transition (dickey et al., 2012). This may result in divorce or separation, which may affect the children in the family. A positive relationship between parents, regardless of marital status, has been suggested to be an important protective factor for children (Amato, 2001; White & Ettner, 2007). This seems to be the case especially when children are reminded of the parent's love and assured of the parent's continued presence in their life (White & Ettner, 2007). Based on a small body of literature available, it is generally the case that younger children are best able to incorporate the transition of a parent, followed by adult children, with adolescents generally having the most difficulty (White & Ettner, 2007). If separated or divorced from their partners or spouses, TGNC parents may be at risk for loss of custody or visitation rights because some courts presume that there is a nexus between their gender identity or gender expression and parental fitness (Flynn, 2006). This type of prejudice is especially common for TGNC people of color (Grant et al., 2011).

Application. Psychologists are encouraged to attend to the parenting and family-building concerns of TGNC people. When working with TGNC people who have previous parenting experience, psychologists may help TGNC people identify how being a parent may influence decisions to come out as TGNC or to begin a transition (Freeman, Tasker, & Di Ceglie, 2002; Grant et al., 2011; Wierckx et al., 2012). Some TGNC people may choose to delay disclosure until their children have grown and left home (Bethea & McCollum, 2013). Clinical guidelines jointly developed by a Vancouver, British Columbia, TGNC community organization and a health care provider organization encourage psychologists and other mental health providers working with TGNC people to plan for disclosure to a partner, previous partner, or children, and to pay particular attention to resources that assist TGNC people to discuss their identity with children of various ages in developmentally appropriate ways (Bockting et al., 2006). Lev (2004) uses a developmental stage framework for the process that family members are likely to go through in coming to terms with a TGNC family member's identity that some psychologists may find helpful. Awareness of peer support networks for spouses and children of TGNC people can also be helpful (e.g., PFLAG, TransYouth Family Allies). Psychologists may provide family counseling to assist a family in managing disclosure, improve family functioning, and maintain family involvement of the TGNC person, as well as aiding the TGNC person in attending to the ways that their transition process has affected their family members (Samons, 2008). Helping parents to continue to work together to focus on the needs of their children and to maintain family bonds is likely to lead to the best results for the children (White & Ettner, 2007).

For TGNC people with existing families, psychologists may support TGNC people in seeking legal counsel regarding parental rights in adoption or custody. Depending on the situation, this may be desirable even if the TGNC parent is biologically related to the child (Minter & Wald, 2012). Although being TGNC is not a legal impediment to adoption in the United States, there is the potential for overt and covert discrimination and barriers, given the widespread prejudice against TGNC people. The question of whether to disclose TGNC status on an adoption application is a personal one, and a prospective TGNC parent would benefit from consulting a lawyer for legal advice, including what the laws in their jurisdiction say about disclosure. Given the extensive background investigation frequently conducted, it may be difficult to avoid disclosure. Many lawyers favor disclosure to avoid any potential legal challenges during the adoption process (Minter & Wald, 2012).

In discussing family-building options with TGNC people, psychologists are encouraged to remain aware that some of these options require medical intervention and are not available everywhere, in addition to being quite costly (Coleman et al., 2012). Psychologists may work with clients to manage feelings of loss, grief, anger, and resentment that may arise if TGNC people are unable to access or afford the services they need for building a family (Bockting et al., 2006; De Sutter et al., 2002).

When TGNC people consider beginning hormone therapy, psychologists may engage them in a conversation about the possibly permanent effects on fertility to better prepare TGNC people to make a fully informed decision. This may be of special importance with TGNC adolescents and young adults who often feel that family planning or loss of fertility is not a significant concern in their current daily lives, and therefore disregard the long-term reproductive implications of hormone therapy or surgery (Coleman et al., 2012). Psychologists are encouraged to discuss contraception and safer sex practices with TGNC people, given that they may still have the ability to conceive even when undergoing hormone therapy (Bockting, Robinson, & Rosser, 1998). Psychologists may play a critical role in educating TGNC adolescents and young adults and their parents about the long-term effects of medical interventions on fertility and assist them in offering informed consent prior to pursuing such interventions. Although hormone therapy may limit fertility (Coleman et al., 2012), psychologists may encourage TGNC people to refrain from relying on hormone therapy as the sole means of birth control, even when a person has amenorrhea (Gorton & Grubb, 2014). Education on safer sex practices may also be important, as some segments of the TGNC community (e.g., trans women and people of color) are especially vulnerable to sexually transmitted infections and have been shown to have high prevalence and incidence rates of HIV infection (Kellogg, Clements-Nolle, Dilley, Katz, & McFarland, 2001; Nemoto, Operario, Keatley, Han, & Soma, 2004).

Depending on the timing and type of options selected, psychologists may explore the physical, social, and emotional implications should TGNC people choose to delay or

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stop hormone therapy, undergo fertility treatment, or become pregnant. Psychological effects of stopping hormone therapy may include depression, mood swings, and reactions to the loss of physical masculinization or feminization facilitated by hormone therapy (Coleman et al., 2012). TGNC people who choose to halt hormone therapy during attempts to conceive or during a pregnancy may need additional psychological support. For example, TGNC people and their families may need help in managing the additional antitrans prejudice and scrutiny that may result when a TGNC person with stereotypically masculine features becomes visibly pregnant. Psychologists may also assist TGNC people in addressing their loss when they cannot engage in reproductive activities that are consistent with their gender identity, or when they encounter barriers to conceiving, adopting, or fostering children not typically faced by other people (Vanderburgh, 2007). Psychologists are encouraged to assess the degree to which reproductive health services are TGNC-affirmative prior to referring TGNC people to them. Psychologists are also encouraged to provide TGNC-affirmative information to reproductive health service personnel when there is a lack of trans-affirmative knowledge.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Rationale. Collaboration across disciplines can be crucial when working with TGNC people because of the potential interplay of biological, psychological, and social factors in diagnosis and treatment (Hendricks & Testa, 2012). The challenges of living with a stigmatized identity and the need of many TGNC people to transition, socially and/or medically, may call for the involvement of health professionals from various disciplines, including psychologists, psychiatrists, social workers, primary health care providers, endocrinologists, nurses, pharmacists, surgeons, gynecologists, urologists, electrologists, speech therapists, physical therapists, pastoral counselors and chaplains, and career or educational counselors. Communication, cooperation, and collaboration will ensure optimal coordination and quality of care. Just as psychologists often refer TGNC people to medical providers for assessment and treatment of medical issues, medical providers may rely on psychologists to assess readiness and assist TGNC clients to prepare for the psychological and social aspects of transition before, during, and after medical interventions (Coleman et al., 2012; Hembree et al., 2009; Lev, 2009). Outcome research to date supports the value and effectiveness of an interdisciplinary, collaborative approach to TGNC-specific care (see Coleman et al., 2012 for a review).

Application. Psychologists' collaboration with colleagues in medical and associated health disciplines involved in TGNC clients' care (e.g., hormonal and surgical treatment, primary health care; Coleman et al., 2012; Lev, 2009) may take many forms and should occur in a timely manner that does not complicate access to needed services (e.g., considerations of wait time). For example, a psychologist working with a trans man who has a diagnosis of bipolar disorder may need to coordinate with his primary care provider and psychiatrist to adjust his hormone levels and psychiatric medications, given that testosterone can have an activating effect, in addition to treating gender dysphoria. At a basic level, collaboration may entail the creation of required documentation that TGNC people present to surgeons or medical providers to access gender-affirming medical interventions (e.g., surgery, hormone therapy; Coleman et al., 2012). Psychologists may offer support, information, and education to interdisciplinary colleagues who are unfamiliar with issues of gender identity and gender expression to assist TGNC people in obtaining TGNC-affirmative care (Holman & Goldberg, 2006; Lev, 2009). For example, a psychologist who is assisting a trans woman with obtaining gender-affirming surgery may, with her consent, contact her new gynecologist in preparation for her first medical visit. This contact could include sharing general information about her gender history and discussing how both providers could most affirmatively support appropriate health checks to ensure her best physical health (Holman & Goldberg, 2006).

Psychologists in interdisciplinary settings could also collaborate with medical professionals prescribing hormone therapy by educating TGNC people and ensuring TGNC people are able to make fully informed decisions prior to starting hormone treatment (Coleman et al., 2012; Deutsch, 2012; Lev, 2009). Psychologists working with children and adolescents play a particularly important role on the interdisciplinary team due to considerations of cognitive and social development, family dynamics, and degree of parental support. This role is especially crucial when providing psychological evaluation to determine the appropriateness and timeliness of a medical intervention. When psychologists are not part of an interdisciplinary setting, especially in isolated or rural communities, they can identify interdisciplinary colleagues with whom they may collaborate and/or refer (Walinsky & Whitcomb, 2010). For example, a rural psychologist could identify a trans-affirmative pediatrician in a surrounding area and collaborate with the pediatrician to work with parents raising concerns about their TGNC and questioning children and adolescents.

In addition to working collaboratively with other providers, psychologists who obtain additional training to specialize in work with TGNC people may also serve as consultants in the field (e.g., providing additional support to providers working with TGNC people or assisting school and workplaces with diversity training). Psychologists who have expertise in working with TGNC people may play a consultative role with providers in inpatient settings seeking to provide affirmative care to TGNC clients. Psychologists may also collaborate with social service colleagues to provide TGNC people with affirmative referrals related to housing, financial support, vocational/educational counseling and training, TGNC-affirming religious or spiritual communities, peer support, and other community resources (Gehi & Arkles, 2007). This collaboration might also in-

clude assuring that TGNC people who are minors in the care of the state have access to culturally appropriate care.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Rationale. Historically, in a set of demographic questions, psychological research has included one item on either sex or gender, with two response options—male and female. This approach wastes an opportunity to increase knowledge about TGNC people for whom neither option may fit their identity, and runs the risk of alienating TGNC research participants (IOM, 2011). For example, there is little knowledge about HIV prevalence, risks, and prevention needs of TGNC people because most of the research on HIV has not included demographic questions to identify TGNC participants within their samples. Instead, TGNC people have been historically subsumed within larger demographic categories (e.g., men who have sex with men, women of color), rendering the impact of the HIV epidemic on the TGNC population invisible (Herbst et al., 2008). Scholars have noted that this invisibility fails to draw attention to the needs of TGNC populations that experience the greatest health disparities, including TGNC people who are of color, immigrants, low income, homeless, veterans, incarcerated, live in rural areas, or have disabilities (Bauer et al., 2009; Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2010; Shipherd et al., 2012; Walinsky & Whitcomb, 2010).

There is a great need for more research to inform practice, including affirmative treatment approaches with TGNC people. Although sufficient evidence exists to support current standards of care (Byne et al., 2012; Coleman et al., 2012), much is yet to be learned to optimize quality of care and outcome for TGNC clients, especially as it relates to the treatment of children (IOM, 2011; Mikalson et al., 2012). In addition, some research with TGNC populations has been misused and misinterpreted, negatively affecting TGNC people's access to health services to address issues of gender identity and gender expression (Namaste, 2000). This has resulted in justifiable skepticism and suspicion in the TGNC community when invited to participate in research initiatives. In accordance with the APA ethics code (APA, 2010), psychologists conduct research and distribute research findings with integrity and respect for their research participants. As TGNC research increases, some TGNC communities may experience being oversampled in particular geographic areas and/or TGNC people of color may not be well-represented in TGNC studies (Hwahng & Lin, 2009; Namaste, 2000).

Application. All psychologists conducting research, even when not specific to TGNC populations, are encouraged to provide a range of options for capturing demographic information about TGNC people so that TGNC people may be included and accurately represented (Conron et al., 2008; Deutsch et al., 2013). One group of experts has recommended that population research, and especially government-sponsored surveillance research, use a two-step method, first asking for sex assigned at birth, and then following with a question about gender identity (GenIUSS, 2013). For research focused on TGNC people, including questions that assess both sex assigned at birth and current gender identity allows the disaggregation of subgroups within the TGNC population and has the potential to increase knowledge of differences within the population. In addition, findings about one subgroup of TGNC people may not apply to other subgroups. For example, results from a study of trans women of color with a history of sex work who live in urban areas (Nemoto, Operario, Keatley, & Villegas, 2004) may not generalize to all TGNC women of color or to the larger TGNC population (Bauer, Travers, Scanlon, & Coleman, 2012; Operario et al., 2008).

In conducting research with TGNC people, psychologists will confront the challenges associated with studying a relatively small, geographically dispersed, diverse, stigmatized, hidden, and hard-to-reach population (IOM, 2011). Because TGNC individuals are often hard to reach (IOM, 2011) and TGNC research is rapidly evolving, it is important to consider the strengths and limitations of the methods that have been or may be used to study the TGNC population, and to interpret and represent findings accordingly. Some researchers have strongly recommended collaborative research models (e.g., participatory action research) in which TGNC community members are integrally involved in these research activities (Clements-Nolle & Bachrach, 2003; Singh, Richmond, & Burnes, 2013). Psychologists who seek to educate the public by communicating research findings in the popular media will also confront challenges, because most journalists have limited knowledge about the scientific method and there is potential for the media to misinterpret, exploit, or sensationalize findings (Garber, 1992; Namaste, 2000).

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

Rationale. The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010) include gender identity as one factor for which psychologists may need to obtain training, experience, consultation, or supervision in order to ensure their competence (APA, 2010). In addition, when APA-accredited programs are required to demonstrate a commitment to cultural and individual diversity, gender identity is specifically included (APA, 2015). Yet surveys of TGNC people suggest that many mental health care providers lack even basic knowledge and skills required to offer trans-affirmative care (Bradford et al., 2007; O'Hara, Dispenza, Brack, & Blood, 2013; Xavier et al., 2005). The APA Task Force on Gender Identity and Gender Variance (2009) projected that many, if not most, psychologists and graduate psychology students will at some point encounter TGNC people among their clients, colleagues, and trainees. Yet professional education and training in psychology includes little or no preparation for

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working with TGNC people (Anton, 2009; APA TFGIGV, 2009), and continuing professional education available to practicing mental health clinicians is also scant (Lurie, 2005). Only 52% percent of psychologists and graduate students who responded to a survey conducted by an APA Task Force reported having had the opportunity to learn about TGNC issues in school; of those respondents, only 27% reported feeling adequately familiar with gender concerns ($n = 294$; APA TFGIGV, 2009).

Training on gender identity in professional psychology has frequently been subsumed under discussions of sexual orientation or in classes on human sexuality. Some scholars have suggested that psychologists and students may mistakenly believe that they have obtained adequate knowledge and awareness about TGNC people through training focused on LGB populations (Harper & Schneider, 2003). However, Israel and colleagues have found important differences between the therapeutic needs of TGNC people and those of LGB people in the perceptions of both clients and providers (Israel et al., 2008; Israel, Walther, Gorcheva, & Perry, 2011). Nadal and colleagues have suggested that the absence of distinct, accurate information about TGNC populations in psychology training not only perpetuates misunderstanding and marginalization of TGNC people by psychologists but also contributes to continued marginalization of TGNC people in society as a whole (Nadal et al., 2010, 2012).

Application. Psychologists strive to continue their education on issues of gender identity and gender expression with TGNC people as a foundational component of affirmative psychological practice. In addition to these guidelines, which educators may use as a resource in developing curricula and training experiences, ACA (2010) has also adopted a set of competencies that may be a helpful resource for educators. In addition to including TGNC people and their issues in foundational education in health service psychology (e.g., personality development, multiculturalism, research methods), some psychology programs may also provide coursework and training for students interested in developing more advanced expertise on issues of gender identity and gender expression.

Because of the high level of societal ignorance and stigma associated with TGNC people, ensuring that psychological education, training, and supervision is affirmative, and does not sensationalize (Namaste, 2000), exploit, or pathologize TGNC people (Lev, 2004), will require care on the part of educators. Students will benefit from support from their educators in developing a professional, nonjudgmental attitude toward people who may have a different experience of gender identity and gender expression from their own. A number of training resources have been published that may be helpful to psychologists in integrating information about TGNC people into the training they offer (e.g., Catalano, McCarthy, & Shlasko, 2007; Stryker, 2008; Wentling, Schilt, Windsor, & Lucal, 2008). Because most psychologists have had little or no training on TGNC populations and do not perceive themselves as having sufficient understanding of issues related to gender identity and gender expression (APA TFGIGV, 2009), psychologists with relevant expertise are encouraged to develop and distribute continuing education and training to help to address these gaps. Psychologists providing education can incorporate activities that increase awareness of cisgender privilege, antitrans prejudice and discrimination, host a panel of TGNC people to offer personal perspectives, or include narratives of TGNC people in course readings (ACA, 2010). When engaging these approaches, it is important to include a wide variety of TGNC experiences to reflect the inherent diversity within the TGNC community.

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Appendix A
Definitions

Terminology within the health care field and transgender and gender nonconforming (TGNC) communities is constantly evolving (Coleman et al., 2012). The evolution of terminology has been especially rapid in the last decade, as the profession's awareness of gender diversity has increased, as more literature and research in this area has been published, and as voices of the TGNC community have strengthened. Some terms or definitions are not universally accepted, and there is some disagreement among professionals and communities as to the "correct" words or definitions, depending on theoretical orientation, geographic region, generation, or culture, with some terms seen as affirming and others as outdated or demeaning. American Psychological Association (APA) Task Force for *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* developed the definitions below by reviewing existing definitions put forward by professional organizations (e.g., APA Task Force on Gender Identity and Gender Variance, 2009; the Institute of Medicine, 2011; and the World Professional Association for Transgender Health [Coleman et al., 2012]), health care agencies serving TGNC clients (e.g., Fenway Health Center), TGNC community resources (Gender Equity Resource Center, National Center for Transgender Equality), and professional literature. Psychologists are encouraged to refresh their knowledge and familiarity with evolving terminology on a regular basis as changes emerge in the community and/or the professional literature. The definitions below include terms frequently used within the *Guidelines*, by the TGNC community, and within professional literature.

Ally: a cisgender person who supports and advocates for TGNC people and/or communities.

(*Appendices continue*)

Antitrans prejudice (transprejudice, transnegativity, transphobia): prejudicial attitudes that may result in the devaluing, dislike, and hatred of people whose gender identity and/or gender expression do not conform to their sex assigned at birth. Antitrans prejudice may lead to discriminatory behaviors in such areas as employment and public accommodations, and may lead to harassment and violence. When TGNC people hold these negative attitudes about themselves and their gender identity, it is called *internalized transphobia* (a construct analogous to internalized homophobia). Transmisogyny describes a simultaneous experience of sexism and antitrans prejudice with particularly adverse effects on trans women.

Cisgender: an adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth; a person who is not TGNC.

Cisgenderism: a systemic bias based on the ideology that gender expression and gender identities are determined by sex assigned at birth rather than self-identified gender identity. Cisgenderism may lead to prejudicial attitudes and discriminatory behaviors toward TGNC people or to forms of behavior or gender expression that lie outside of the traditional gender binary.

Coming out: a process by which individuals affirm and actualize a stigmatized identity. Coming out as TGNC can include disclosing a gender identity or gender history that does not align with sex assigned at birth or current gender expression. Coming out is an individual process and is partially influenced by one's age and other generational influences.

Cross dressing: wearing clothing, accessories, and/or make-up, and/or adopting a gender expression not associated with a person's assigned sex at birth according to cultural and environmental standards (Bullough & Bullough, 1993). Cross-dressing is not always reflective of gender identity or sexual orientation. People who cross-dress may or may not identify with the larger TGNC community.

Disorders of sex development (DSD, Intersex): term used to describe a variety of medical conditions associated with atypical development of an individual's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). These conditions may involve differences of a person's internal and/or external reproductive organs, sex chromosomes, and/or sex-related hormones that may complicate sex assignment at birth. DSD conditions may be considered variations in biological diversity rather than disorders (M. Diamond, 2009); therefore some prefer the terms *intersex*, *intersexuality*, or *differences in sex development* rather than "disorders of sex development" (Coleman et al., 2012).

Drag: the act of adopting a gender expression, often as part of a performance. Drag may be enacted as a political comment on gender, as parody, or as entertainment, and is not necessarily reflective of gender identity.

Female-to-male (FTM): individuals assigned a female sex at birth who have changed, are changing, or wish to change their body and/or gender identity to a more masculine body or gender identity. FTM persons are also often referred to as *transgender men*, *transmen*, or *trans men*.

Gatekeeping: the role of psychologists and other mental health professionals of evaluating a TGNC person's eligibility and readiness for hormone therapy or surgery according to the Standards of Care set forth by the World Professional Association for Transgender Health (Coleman et al., 2012). In the past, this role has been perceived as limiting a TGNC adult's autonomy and contributing to mistrust between psychologists and TGNC clients. Current approaches are sensitive to this history and are more affirming of a TGNC adult's autonomy in making decisions with regard to medical transition (American Counseling Association, 2010; Coleman et al., 2012; Singh & Burnes, 2010).

Gender-affirming surgery (sex reassignment surgery or gender reassignment surgery): surgery to change primary and/or secondary sex characteristics to better align a person's physical appearance with their gender identity. Gender-affirming surgery can be an important part of medically necessary treatment to alleviate gender dysphoria and may include mastectomy, hysterectomy, metoidioplasty, phalloplasty, breast augmentation, orchiectomy, vaginoplasty, facial feminization surgery, and/or other surgical procedures.

Gender binary: the classification of gender into two discrete categories of boy/man and girl/woman.

Gender dysphoria: discomfort or distress related to incongruence between a person's gender identity, sex assigned at birth, gender identity, and/or primary and secondary sex characteristics (Knudson, De Cuypere, & Bockting, 2010). In 2013, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013) adopted the term *gender dysphoria* as a diagnosis characterized by "a marked incongruence between" a person's gender assigned at birth and gender identity (American Psychiatric Association, 2013, p. 453). Gender dysphoria replaced the diagnosis of gender identity disorder (GID) in the previous version of the *DSM* (American Psychiatric Association, 2000).

Gender expression: the presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role. Gender expression may or may not conform to a person's gender identity.

(*Appendices continue*)

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Gender identity: a person's deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Because gender identity is internal, a person's gender identity is not necessarily visible to others. "Affirmed gender identity" refers to a person's gender identity after coming out as TGNC or undergoing a social and/or medical transition process.

Gender marker: an indicator (M, F) of a person's sex or gender found on identification (e.g., driver's license, passport) and other legal documents (e.g., birth certificate, academic transcripts).

Gender nonconforming (GNC): an adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned birth sex. Subpopulations of the TGNC community can develop specialized language to represent their experience and culture, such as the term "masculine of center" (MOC; Cole & Han, 2011) that is used in communities of color to describe one's GNC identity.

Gender questioning: an adjective to describe people who may be questioning or exploring their gender identity and whose gender identity may not align with their sex assigned at birth.

Genderqueer: a term to describe a person whose gender identity does not align with a binary understanding of gender (i.e., a person who does not identify fully as either a man or a woman). People who identify as genderqueer may redefine gender or decline to define themselves as gendered altogether. For example, people who identify as genderqueer may think of themselves as both man and woman (bigender, pangender, androgyne); neither man nor woman (genderless, gender neutral, neutrois, agender); moving between genders (genderfluid); or embodying a third gender.

Gender role: refers to a pattern of appearance, personality, and behavior that, in a given culture, is associated with being a boy/man/male or being a girl/woman/female. The appearance, personality, and behavior characteristics may or may not conform to what is expected based on a person's sex assigned at birth according to cultural and environmental standards. Gender role may also refer to the *social* role in which one is living (e.g., as a woman, a man, or another gender), with some role characteristics conforming and others not conforming to what is associated with girls/women or boys/men in a given culture and time.

Hormone therapy (gender-affirming hormone therapy, hormone replacement therapy): the use of hormones to masculinize or feminize a person's body to better align that person's physical characteristics with their gender identity. People wishing to feminize their body receive antiandrogens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

Male-to-female (MTF): individuals whose assigned sex at birth was male and who have changed, are changing, or wish to change their body and/or gender role to a more feminized body or gender role. MTF persons are also often referred to as *transgender women*, *transwomen*, or *trans women*.

Passing: the ability to blend in with cisgender people without being recognized as transgender based on appearance or gender role and expression; being perceived as cisgender. Passing may or may not be a goal for all TGNC people.

Puberty suppression (puberty blocking, puberty delaying therapy): a treatment that can be used to temporarily suppress the development of secondary sex characteristics that occur during puberty in youth, typically using gonadotropin-releasing hormone (GnRH) analogues. Puberty suppression may be an important part of medically necessary treatment to alleviate gender dysphoria. Puberty suppression can provide adolescents time to determine whether they desire less reversible medical intervention and can serve as a diagnostic tool to determine if further medical intervention is warranted.

Sex (sex assigned at birth): sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia. When the external genitalia are ambiguous, other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex, with the aim of assigning a sex that is most likely to be congruent with the child's gender identity (MacLaughlin & Donahoe, 2004). For most people, gender identity is congruent with sex assigned at birth (see *cisgender*); for TGNC individuals, gender identity differs in varying degrees from sex assigned at birth.

Sexual orientation: a component of identity that includes a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.

Stealth (going stealth): a phrase used by some TGNC people across the life span (e.g., children, adolescents) who choose to make a transition in a new environment (e.g., school) in their affirmed gender without openly sharing their identity as a TGNC person.

(*Appendices continue*)

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TGNC: an abbreviation used to refer to people who are transgender or gender nonconforming.

Trans: common short-hand for the terms transgender, transsexual, and/or gender nonconforming. Although the term "trans" is commonly accepted, not all transsexual or gender nonconforming people identify as trans.

Trans-affirmative: being respectful, aware and supportive of the needs of TGNC people.

Transgender: an adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term "transgender" is commonly accepted, not all TGNC people self-identify as transgender.

Transgender man, trans man, or transman: a person whose sex assigned at birth was female, but who identifies as a man (see FTM).

Transgender woman, trans woman, or transwoman: a person whose sex assigned at birth was male, but who identifies as a woman (see MTF).

Transition: a process some TGNC people progress through when they shift toward a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to each person's life situation. For many people, this involves developing a gender role and expression that is more aligned with their gender identity. A transition typically occurs over a period of time; TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, pronoun, and gender marker) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions).

Transsexual: term to describe TGNC people who have changed or are changing their bodies through medical interventions (e.g., hormones, surgery) to better align their bodies with a gender identity that is different than their sex assigned at birth. Not all people who identify as transsexual consider themselves to be TGNC. For example, some transsexual individuals identify as female or male, without identifying as TGNC. Transsexualism is used as a medical diagnosis in the World Health Organization's (2015) International Classification of Diseases version 10.

Two-spirit: term used by some Native American cultures to describe people who identify with both male and female gender roles; this can include both gender identity and sexual orientation. Two-spirit people are often respected and carry unique spiritual roles for their community.

Appendix B

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Guideline 7. Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

(*Appendices continue*)

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Life Span Development

Guideline 8. Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents and that not all youth will persist in a TGNC identity into adulthood.

Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

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Gender identity: a person's deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Because gender identity is internal, a person's gender identity is not necessarily visible to others. "Affirmed gender identity" refers to a person's gender identity after coming out as TGNC or undergoing a social and/or medical transition process.

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Gender questioning: an adjective to describe people who may be questioning or exploring their gender identity and whose gender identity may not align with their sex assigned at birth.

Genderqueer: a term to describe a person whose gender identity does not align with a binary understanding of gender (i.e., a person who does not identify fully as either a man or a woman). People who identify as genderqueer may redefine gender or decline to define themselves as gendered altogether. For example, people who identify as genderqueer may think of themselves as both man and woman (bigender, pangender, androgyne); neither man nor woman (genderless, gender neutral, neutrois, agender); moving between genders (genderfluid); or embodying a third gender.

Gender role: refers to a pattern of appearance, personality, and behavior that, in a given culture, is associated with being a boy/man/male or being a girl/woman/female. The appearance, personality, and behavior characteristics may or may not conform to what is expected based on a person's sex assigned at birth according to cultural and environmental standards. Gender role may also refer to the *social* role in which one is living (e.g., as a woman, a man, or another gender), with some role characteristics conforming and others not conforming to what is associated with girls/women or boys/men in a given culture and time.

Hormone therapy (gender-affirming hormone therapy, hormone replacement therapy): the use of hormones to masculinize or feminize a person's body to better align that person's physical characteristics with their gender identity. People wishing to feminize their body receive antiandrogens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

Male-to-female (MTF): individuals whose assigned sex at birth was male and who have changed, are changing, or wish to change their body and/or gender role to a more feminized body or gender role. MTF persons are also often referred to as *transgender women*, *transwomen*, or *trans women*.

Passing: the ability to blend in with cisgender people without being recognized as transgender based on appearance or gender role and expression; being perceived as cisgender. Passing may or may not be a goal for all TGNC people.

Puberty suppression (puberty blocking, puberty delaying therapy): a treatment that can be used to temporarily suppress the development of secondary sex characteristics that occur during puberty in youth, typically using gonadotropin-releasing hormone (GnRH) analogues. Puberty suppression may be an important part of medically necessary treatment to alleviate gender dysphoria. Puberty suppression can provide adolescents time to determine whether they desire less reversible medical intervention and can serve as a diagnostic tool to determine if further medical intervention is warranted.

Sex (sex assigned at birth): sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia. When the external genitalia are ambiguous, other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex, with the aim of assigning a sex that is most likely to be congruent with the child's gender identity (MacLaughlin & Donahoe, 2004). For most people, gender identity is congruent with sex assigned at birth (see *cisgender*); for TGNC individuals, gender identity differs in varying degrees from sex assigned at birth.

Sexual orientation: a component of identity that includes a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.

Stealth (going stealth): a phrase used by some TGNC people across the life span (e.g., children, adolescents) who choose to make a transition in a new environment (e.g., school) in their affirmed gender without openly sharing their identity as a TGNC person.

(*Appendices continue*)

TGNC: an abbreviation used to refer to people who are transgender or gender nonconforming.

Trans: common short-hand for the terms transgender, transsexual, and/or gender nonconforming. Although the term "trans" is commonly accepted, not all transsexual or gender nonconforming people identify as trans.

Trans-affirmative: being respectful, aware and supportive of the needs of TGNC people.

Transgender: an adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term "transgender" is commonly accepted, not all TGNC people self-identify as transgender.

Transgender man, trans man, or transman: a person whose sex assigned at birth was female, but who identifies as a man (see FTM).

Transgender woman, trans woman, or transwoman: a person whose sex assigned at birth was male, but who identifies as a woman (see MTF).

Transition: a process some TGNC people progress through when they shift toward a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to each person's life situation. For many people, this involves developing a gender role and expression that is more aligned with their gender identity. A transition typically occurs over a period of time; TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, pronoun, and gender marker) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions).

Transsexual: term to describe TGNC people who have changed or are changing their bodies through medical interventions (e.g., hormones, surgery) to better align their bodies with a gender identity that is different than their sex assigned at birth. Not all people who identify as transsexual consider themselves to be TGNC. For example, some transsexual individuals identify as female or male, without identifying as TGNC. Transsexualism is used as a medical diagnosis in the World Health Organization's (2015) International Classification of Diseases version 10.

Two-spirit: term used by some Native American cultures to describe people who identify with both male and female gender roles; this can include both gender identity and sexual orientation. Two-spirit people are often respected and carry unique spiritual roles for their community.

Appendix B

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Guideline 7. Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

(*Appendices continue*)

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Life Span Development

Guideline 8. Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents and that not all youth will persist in a TGNC identity into adulthood.

Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

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Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality, 2017 is an update of the *2002 Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (Multicultural Guidelines).*

The ***2017 Guidelines*** were developed by a five-member *Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century*, appointed by the Board for the Advancement of Psychology in the Public Interest (BAPPI), and adopted by the Council of Representatives in August 2017.

Members of the Task Force included: Caroline S. Clauss-Ehlers, Rutgers, The State University of New Jersey (Chair); David A. Chiriboga, University of South Florida; Scott J. Hunter, University of Chicago; Gargi Roysircar-Sodowsky, Antioch University New England; and Pratyusha Tummala-Narra, Boston College.

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This document will expire as APA policy in 10 years (2027). Correspondence regarding the *2017 Multicultural Guidelines* should be addressed to the American Psychological Association, Public Interest Directorate, 750 First Street, NE, Washington, 20002-4242

Overall List of Multicultural Guidelines

Guideline 1. Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

Guideline 2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

Guideline 3. Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

Guideline 4. Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

Guideline 5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

Guideline 6. Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

Guideline 7. Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.

Guideline 8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

Guideline 9. Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the *Layered Ecological Model of the Multicultural Guidelines*.

Guideline 10. Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

I. Introduction

Since the initial version of the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002) was released, there has been significant growth in research and theory regarding multicultural contexts. The guidelines were passed by the American Psychological Association (APA) Council of Representatives at the 2002 annual conference and were posted on the APA website. The attention given to these guidelines, including their publication in the *American Psychologist* (2003), speaks to the profession's recognition of the important role that diversity and multiculturalism play, both in terms of how individuals and groups define themselves, and how they approach others within the United States (U.S.) and globally (APA, 2002).

The current *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality, 2017* (i.e., *Multicultural Guidelines*) are conceptualized from a need to reconsider diversity and multicultural practice within professional psychology at a different period in time, with intersectionality as its primary purview. The 2017 version of the *Multicultural Guidelines* encourages psychologists to consider how knowledge and understanding of identity develops from and is disseminated within professional psychological practice. Endemic to this understanding is an approach that incorporates developmental and contextual antecedents of identity and how they can be acknowledged, addressed, and embraced to engender more effective models of professional engagement. The *Multicultural Guidelines* incorporate broad reference group identities (e.g., Black/African American/Black American, White/White American, and Asian/Asian American/Pacific Islander) to acknowledge within-group differences and the role of self-definition in identity.

With the *Multicultural Guidelines*, APA and its members are presented with an opportunity to participate directly, as professional psychologists, in engaging a fuller understanding of diversity and its considerations within practice, research, consultation, and education (including supervision) to directly address how development unfolds across time and intersectional experiences and identities; and to recognize the highly diverse nature of individuals and communities in their defining characteristics, despite also sharing many similarities by virtue of being human. Our conscious awareness of what it means to think, feel, regulate, behave, and create meaning has been enhanced by advances in research and clinical

scholarship affording us a contemporary consideration of psychology that incorporates human differences across their varied elements.

II. Need: Scope of Work

The *Multicultural Guidelines* developed out of the need to update the guidelines published in 2003 (APA, 2003). Per APA recommendations, approved *Multicultural Guidelines* are to be updated every 10 years, to remain current with scientific evidence and models of professional practice. In August 2015, APA developed two task forces: the *Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century* and the *Task Force on Guidelines Focused on Race/Ethnicity*. The guidelines written by each Task Force group are considered partner documents. The stated reason for the appointment of two groups by the Board for the Advancement of Psychology in the Public Interest (BAPPI) was that:

> In the intervening years, there has been enormous domestic and global change affecting the lives of individuals, communities, countries and society at large, as well as the development of substantial new multicultural conceptual and empirical scholarship. BAPPI has determined that the wealth of scholarship specific to race/ethnicity as well as the scholarship focused on other identity groups warrants splitting the *2002 Multicultural Guidelines* into two sets of guidelines going forward: one focused on “pan” or “umbrella” multicultural guidelines that captures universal concepts based on the scholarly literature across a broad cross-section of identity groups (e.g., age, disability, race, ethnicity, gender, religion/spirituality, sexual orientation and gender diversity, social class, language, immigration status), and the other focused specifically on the race/ethnicity-related scholarly developments since the *2002 Multicultural Guidelines* were adopted (APA, 2015a).

III. Purpose

The purpose of the *Multicultural Guidelines* is to provide psychologists with a framework from which to consider evolving parameters for the provision of multiculturally competent services. Services include practice, research, consultation, and education, all of which benefit from an *appreciation for*, *understanding of,* and *willingness to learn about* the multicultural

backgrounds of individuals, families, couples, groups, research participants, organizations, and communities. To simplify the presentations that follow, the *Multicultural Guidelines* often refer to the client when in fact speaking not only of the recipient of clinical services, but also the student, research participant, or consultee. With the exception of the case studies presented in Appendix B, the guidelines use nonbinary pronouns. The current *Multicultural Guidelines* also advocate for a more diverse and inclusive population of psychologists.

This version of the *Multicultural Guidelines* marks a significant extension from the initial *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002). The latter focused on race and ethnicity as the salient variables in multicultural practice. The 2002 version states: ". . . in these Guidelines, we will use the term multicultural rather narrowly, to connote interactions between racial/ethnic groups in the U.S. and the implications for education, training, research, practice, and organizational change" (p. 10). The goal of this new version is to regard the term multicultural more fully—to consider it in its broadest conceptualization. The broadening of our understanding within the *Multicultural Guidelines* reflects current trends in the literature that consider contextual factors and intersectionality among and between reference group identities, including culture, language, gender, race, ethnicity, ability status, sexual orientation, age, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment, among other variables (APA, 2002).

These variables are considered within the context of domestic and international climates as well as human rights. It is important to note that, for the purposes of the *Multicultural Guidelines*, cultural competence does not refer to a process that ends simply because the psychologist is deemed competent. Rather, cultural competence incorporates the role of cultural humility whereby cultural competence is considered a lifelong process of reflection and commitment (Hook & Watkins, 2015; Waters & Asbill, 2013). This current iteration of the *Multicultural Guidelines* also recognizes the contributions of other culturally competent models of practice such as the American Counseling Association's (ACA) *Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession* (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016); the American Psychiatric Association's *Cultural Formulation Interview* (American Psychiatric Association, 2013); and the *Standards*

and Indicators for Cultural Competence in Social Work Practice (National Association of Social Workers, 2015).

Conceptual framework. The model developed by the Multicultural Guidelines Task Force is called a *Layered Ecological Model of the Multicultural Guidelines*. This framework incorporates Bronfenbrenner's (1977, 1979) ecological model that proposes five concentric circles: (1) the *microsystem* of immediate family, friends, teachers, and institutions that have direct influence on the individual; (2) the *mesosystem* that refers to interrelations of various social entities found in the microsystem that affect a person's life (e.g., home, school, community); (3) the *exosystem* that deals with societal and cultural forces acting upon the individual without necessarily having a direct link to individual experience; (4) the *macrosystem* that corresponds with the cultural context in which the individual lives, such as cultural values and norms, as well as laws and governmental influences; and (5) the *chronosystem* that deals with the influence of the passage of time, historical trends and transitions, and the historical context that surrounds individual experience.

The *Layered Ecological Model of the Multicultural Guidelines* comprises dynamic, nested systems that transact over time (see Figure 1). Psychologists are informed by an understanding of such transactions among individuals, microsystems, exosystems, and macrosystems. At the intrapersonal system level, psychologists who are clinicians treat an individual client's anxiety, trauma, depression, suicidal ideation, family problems, employment insecurities, alcohol and other substance abuse, aggression, and disruptions in the achievement and trajectory of identities and career as well as lifetime goals and roles. More broadly, in their service to individuals, psychologists address microsystems that affect an individual's resilience, such as interactions with schools, family, peers, place of worship, workplace, and community health clinics.

In a consulting role, psychologists may engage more directly with exosystems and macrosystems. Psychologists as advocates may address how disparities and inequities in criminal justice, law enforcement, educational policy, health, and mental health care may have an adverse effect on the individual. Psychologists are encouraged to analyze the effects of variables within macrosystems such as cultural norms, developing bioscientific knowledge, politics, the media, human development, and reference group identities on human experience. Finally, psychologists

are encouraged to be aware of the chronosystem, or historical incidents, trends, and transitions that influence the individual.

IV. Layered Ecological Model of the Multicultural Guidelines

Description of the current model. The model includes two central circles (see Figure 1). One circle represents the self-definition of the individual that refers to respective roles as client, student, research participant, or consultee. The second circle represents the self-definition of the individual that refers to the clinician, educator, researcher, or consultant. The bidirectional arrows pointing between the two circles represent the dynamic interactions between these two individuals and their respective roles (e.g., interactions between clinician and client; educator and student; researcher and research participant; consultant and consultee).

These two bidirectional circles (Level 1) are layered with four surrounding circles (Levels 2–5) that represent successively expanding sources of influence. These are labeled on Figure 1 as: Bidirectional Model of Self-Definition and Relationships (Level 1) ; Community, School, and Family Context (Level 2); Institutional Impact on Engagement (Level 3); Domestic and International Climate (Level 4); and Outcomes (Level 5). These influences are reciprocal, in that while the outer layers can affect the inner layers, the reverse is also true. A description of the five levels follows.

Level 1: Bidirectional Model of Self-Definition and Relationships. The two inner circles capture a bidirectional model of self-definition and relationships. Specifically, the circle on the left represents the *individual's self-definition* in the roles of client, student, research participant, or consultee. The circle on the right represents the *individual's self-definition* in the roles of clinician, educator, researcher, or consultant (these may also involve more than two people, for example, if the client is a couple, family, or group). The bidirectional arrow that intersects the two circles represents the bidirectional relationships considered within the model.

Level 2: Community, School, and Family Context. The inner circles of the individual's self-definition are surrounded by the model's second layer: the *community, school, and family context*. Specific areas considered at this juncture of the model include family, community, school, neighborhood, workplace, place of worship, and physical space. The context represented by Level 2 has direct influence on the bidirectional relationships described in Level 1.

Level 3: Institutional Impact on Engagement. Levels 1 (individual's self-definition) and 2 (community, school, and family context) function within Level 3, the *institutional context* that considers the influence of local, state, and federal governments; medical systems; legal systems (including law enforcement); mental and behavioral health systems; and educational systems. Level 3 examines the effects of institutional context on how clients and psychologists experience the community, school, and family contexts (Level 2) and how this experience influences both the individual's self-definition and relationships with one another (i.e., client, student, consultee, research participant and clinician, educator, researcher, consultant, Level 1).

Level 4: Domestic and International Climate. The model now broadens to a fourth level that captures *domestic climate* (on the circle's left-hand side) and *international climate* (on the circle's right-hand side). Like previous circles, this layer encompasses Levels 1–3. At the top of this fourth circle is consideration of the *larger societal context* and at the bottom is consideration of *human rights*.

The psychologist is encouraged to identify and understand the ways in which the larger societal context affects the individual's self-definition and bidirectional relationships, whether as someone engaged in psychological services, the classroom, the life of an organization, or a research project. The larger societal context is also characterized by human rights concerns. The psychologist is encouraged to consider whether human rights are being compromised due to domestic and international climates. Within the context of a bidirectional relationship, the psychologist is encouraged to consider and explore the extent to which human rights are protected or threatened in work with clients, students, research participants, and consultees.

Level 5: Outcomes. The fifth layer surrounds all the model's prior levels with a focus on *outcomes*. Outcomes refer to those results, both positive and negative, that are derived from the bidirectional transactions between the client, student, research participant, and consultee and the clinician, educator, researcher, and consultant. Outcomes are influenced by interactions and experiences with Level 1 (bidirectional model of self-definition and relationships), Level 2 (community, school, and family context), Level 3 (institutional impact on engagement), and Level 4 (domestic and international climate). The psychologist is encouraged to consider how the transactions across layers in the ecological model result in a range of outcomes for the client, student, research participant, or consultee. The psychologist can also strive to understand which

level or levels in the model have directly (or indirectly) contributed to specific outcomes and consider ways to improve them.

Three Processes that Drive the *Layered Ecological Model of the Multicultural Guidelines*. Three dynamic processes influence the model: *power/privilege*, *tensions*, and *fluidity*. They are located on the dotted line that creates a circle (or another layer) around Levels 1–5 to show that they drive the ecological model. *Power/privilege* represents a continuum of power and privilege that can be experienced by participants engaged in psychological endeavors as well as by the psychologists providing services. Psychologists are encouraged to consider the social power and privilege they have in their bidirectional relationships with clients. Psychologists strive to listen and learn about the dynamics of power and privilege as experienced by those with whom they work. Through this awareness, psychologists seek to promote ways for individuals, families, couples, groups, and organizations to identify, own, and respond to their experiences.

The second process refers to the *tensions* between and among Levels 1–5. Tensions may arise between concentric circles or within bidirectional relationships. Psychologists are encouraged to recognize that these tensions are dynamic and contextual and may result not solely from issues occurring at one level of the model, but rather, through the multiple intersections and interactions between and among various levels. Psychologists are encouraged to work with the client, student, research participant, or consultee to identify tensions as they relate to interactions among systems rather than keeping the sole focus at an individual level.

Fluidity is the third dynamic process. Fluidity refers to the dynamic interaction between and among the concentric circles and shifts within the concentric circles. The transactions between the psychologists and participants engaged in psychological endeavors are constantly shifting based on the changes that occur within and between the ecological model's five levels and three dynamics. Psychologists are encouraged to consider changes in relationship patterns, life events and transitions, contextual influences, the passage of time, and the influence of internal experience on themselves as well as in work with clients, students, research participants, and consultees.

Finally, on the far left of Figure 1 is an upward facing arrow labeled "resilience." To the far right, is a downward facing arrow labeled "trauma." Through professional relationships that

promote healing, learning, knowledge gained through research participants, and collaborations built through consultation, the goal is to increase resilience and decrease trauma.

V. Documentation of Need/Distinction between Standards and Guidelines

When using these *Multicultural Guidelines*, psychologists should be aware that APA has made an important distinction between standards and guidelines (Reed, McLaughlin, & Newman, 2002; APA, 2015c). Standards are mandates to which all psychologists must adhere (e.g., the *Ethical Principles of Psychologists and Code of Conduct*, APA, 2010), whereas guidelines are aspirational and informative regarding practice considerations; APA has indicated that experience and training of professionals also allows for effective interpretation and application of guidelines. Psychologists are encouraged to use these *Multicultural Guidelines* in tandem with the *Ethical Principles of Psychologists and Code of Conduct*, and should be aware that state and federal laws may override these *Guidelines* (APA, 2010; 2015c); where this does occur, federal and state laws will take precedence.

In addition, these *Multicultural Guidelines* refer to psychological practice (e.g., clinical work, consultation, education, research, and training) rather than treatment. Practice guidelines are practitioner-focused and provide guidance for professionals in areas such as clinical practice, education, research, and consultation. Treatment guidelines are client-focused and address intervention-specific recommendations for clinical populations or conditions (Reed, McLaughlin, & Newman, 2002). The current guidelines are intended to complement treatment and other practice efforts by professional psychologists. The practice components for each guideline consider work with individuals from diverse sociocultural backgrounds who are seeking mental and behavioral health services, as well as training and supervision with students. Research components consider scientific inquiry and the generation of knowledge from within a multicultural biopsychosocial framework. Consultation refers to being responsive to considerations regarding diversity within organizations. Education, along with practice, refers to the inclusion of multicultural curricula in psychology programs, modeling cultural competence for students, and providing training and supervisory experiences in diverse community contexts.

Compatibility

These guidelines are consistent with the *APA Ethical Principles of Psychologists and Code of Conduct* (APA, 2010) and the *Standards of Accreditation for Health Service Psychology* (APA, 2015c; APA/COA, 2015).

Multicultural Guidelines Development Process

The original *Multicultural Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change* (APA, 2002) were based on the work of Sue and colleagues (1982) who presented a model of multicultural counseling competencies (MCCs). Yet the history of the decision making regarding a need for these guidelines is much older. As discussed in the *Report of the Task Force on the Implementation of the Multicultural Guidelines* (APA, 2008), "[t]he origins of the *Multicultural Guidelines* are rooted in various social, historical, and political events and inspired by a number of professional developments in the field of psychology" (p. 4), and within APA itself, over the past 50 years.

Multiple conversations, both within the field at large and within the APA directly, have taken place to address how psychology in the United States has been inattentive regarding diversity and multicultural practice, while the field at large has worked to move forward to address cultural plurality. Since the publication of the guidelines in the *American Psychologist* in 2003, multicultural competence research and specific guidelines rooted in this research have expanded to areas of immigration, sexual orientation, gender identity, social class, religion, and spirituality (APA, 2012a; APA, 2012b; APA, 2015b; Smith, 2010). Models of cultural competence have directed increasing attention to social injustice and global factors as they relate to psychological well-being and intervention (Ratts et al., 2016). The 2003 *Multicultural Guidelines* document helped operationalize psychology, which has been enhanced by collaboration across social science domains. The purpose of revisiting the original *Multicultural Guidelines* is to promote the application of multicultural knowledge to contemporary psychological practice, education, research, and consultation. The educational aspect of the *Multicultural Guidelines* is valuable; it serves to guide and inform the training and practice of professional psychology. The research aspect suggests that there are diverse research methods that can be used to generate new knowledge.

In Spring 2015 the Board for the Advancement of Psychology in the Public Interest (BAPPI) put forth a call for nominations for two task forces: the *Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century* and the *Task Force on Guidelines Focused on Race/Ethnicity*. The BAPPI Advisory Group for Recommending Appointments to the Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century and the Task Force on Guidelines Focused on Race/Ethnicity helped select task force members who were appointed after an application and review process. The *Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century* included five members, one of whom served as Task Force Chair. Members reflected a range of research, writing, clinical work, teaching, and consultation within linguistically and culturally diverse communities.

Each guideline includes three sections: (a) Introduction/Rationale (that links the guideline to the overall model and incorporates a discussion of its relevance); (b) Applications to Practice, Research, and Consultation (that illustrates how the guideline can apply to practice, research, and consultation roles); and (c) one or more relevant case illustrations. While the application section is divided into practice, research, and consultation subsections for organizational purposes, there is some overlap among these areas. Appendix A includes relevant definitions; Appendix B includes case illustrations that depict each level of the model and illustrate various guidelines; and Appendix C includes references. Case illustrations reflect the core value of demonstrating the applicability of the *Multicultural Guidelines* in professional settings.

V. Guidelines

A. Level 1: Bidirectional Model of Self-Definition and Relationships

Connection to the model. The first level encompasses the mutual influence of self-definition and relationships/interactions with others across varying contexts within the microsystem, mesosystem, exosystem, and macrosystem. Identity is complex, fluid, and intersectional, and individuals' experiences and definition of their identities may not be reflected or mirrored by assumptions or categorical thinking occurring in interactions with others. At the same time, the messages that they receive from others influence their self-definition and life outcomes as these can either promote or constrict psychological and social well-being.

Guideline 1. Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

Introduction/Rationale

Psychologists are encouraged to consider the relationship between various layers of an individual's ecological contexts and identity development and the implications of this relationship for experiences of privilege and oppression, well-being, access to resources, and barriers from and access to appropriate, quality care.

Psychologists strive to recognize the need to move beyond stereotypes when working with clients, research participants, students, and consultees. They seek to avoid overgeneralized or simplistic categories and labels of sociocultural groups. Such categorization has been described through the concept of *ethnic gloss,* that refers to an illusion of homogeneity among diverse groups that minimizes important distinctions among ethnic groups within a broader racial category; for example, American Indian, Latino/Hispanic/Latinx, Asian/Asian American/Pacific Islander, Black/African American/Black American, and White/White American (Trimble & Dickson, 2005).

Psychologists strive to understand the need to become acquainted with aspects of identity, as well as which aspects of identity are especially relevant to the presenting problem or issue. Identity is a construct that has been central to theories of psychological development. Identity reflects both individual and collective features of emotional and cognitive experience, and develops within interpersonal and structural contexts. Identity has also been conceptualized as an internal experience of "subjective self-sameness" that facilitates emotional experiences and behaviors that reflect an individual's actual or true self (Erikson, 1950; Mann, 2006). Identity has been thought to develop across contexts and time, and is shaped by cultural influences including age, generation, gender, ethnicity, race, religion, spirituality, language, sexual orientation, gender identity, social class, ability/disability status, national origin, immigration status, and historical as well as ongoing experiences of marginalization, among other variables (Comas-Díaz, 2012; Crenshaw, 1989; Greene, 2013; Hays, 2016; Olkin, 2002; Roysircar-Sodowsky & Maestas, 2000).

Similarly, group identity or social identity, which refers to one's affiliation with and feelings about one's connection with other members of a particular sociocultural group as well as having an awareness of group status as compared with other groups, shifts over the course of time and across generations as determined by social, cultural, economic, and political factors (Oyserman, 2007; Tajfel, 1981). Various dimensions of identity associated with sociocultural contexts, such as racial identity, multiracial identity, biracial identity, ethnic identity, gender identities, religious identity, and sexual orientation, have been described in psychological theories (Cross, 1991; Helms & Cook, 1999; Phinney, 1996; Rockquemore, Brunsma, & Delgado, 2009). For example, racial identity has been described as a sense of collective identity rooted in individuals' perception that they share a common heritage with a specific racial group (Helms & Cook, 1999), and ethnic identity has been defined as the extent to which individuals identify as members of their ethnic group(s) (Phinney, 1996). Biracial identity and multiracial identity have been described as involving a sense of "border crossing," where many individuals interact within and shift across different racial and cultural contexts and experience hybridity as a reference point for identity (Root, 2003; Rockquemore et al., 2009).

Research indicates that identity varies across different cultural groups as well as within such groups (Comas-Díaz, 2012; Hays, 2016; La Roche, 2013; Sue & Sue, 2016; Tummala-Narra, 2016). It is important to consider how developmental stages inform identity and a redefinition of self. Self-definition and identity labels often contribute to individuals' relationships with others and to their psychological well-being (Kiang, 2008). For example, while some individuals prefer not to define themselves along a hyphenated identity, others do describe themselves with a hyphenated identity (e.g. Mexican-American, Vietnamese-American, and Haitian-American) that may offer a sense of connection and belonging within multiple sociocultural contexts. The experience of the bicultural identity further involves the salience of one particular aspect of identity over others owing to the influence of the specific context within which an individual interacts (Sirin & Fine, 2008). Research and clinical literature also suggest differences in cultural worldviews of immigrant parents and children and youth, with parents espousing beliefs and expectations congruent with the culture of origin to a greater extent than children, contributing to varying challenges with identity and intergenerational dynamics within immigrant families (Birman & Simon, 2014; Hwang & Ting, 2008; Qin, 2009).

Generational differences within communities are also evident in the experiences of lesbian, gay, bisexual, transgender, gender nonconforming, queer (and/or questioning), and intersex (LGBTQ+) individuals. Studies with LGBTQ+ populations note that cohort and age have significant influence on identity development (APA, 2012b; APA, 2015b). Specifically, the historical period of time and context in which an individual has been raised and has engaged in a coming out process has important implications for gender identity, identity labels, disclosure of sexual orientation and identity to others, and parenting (APA, 2012b). For example, the coming out process for an older adult in contemporary U.S. society may be markedly different from that of a young adult, and older adults may experience ageism within LGBTQ+ communities, which has implications for identity, self-definition, and disclosure (APA, 2012b). Generational differences can reflect how a society at different periods of time may experience marked shifts in societal attitudes toward sexual orientation and gender identities, religious and spiritual attitudes, social justice–oriented movements (e.g., women's, gay, and civil rights movements), changing conceptualizations of family, reproductive technologies, and legislation concerning marriage equality (APA, 2012b; Drescher, 2009).

It is important to recognize that language describing identity (e.g., identity labels) conveys perceptions of and feelings about a particular group. Additionally, conceptualizations of identity labels vary with respect to the meanings they convey. For example, some scholars in the area of physical disabilities have advocated for person-first language (e.g., people with disabilities) in an effort to reduce stigma and stereotyping, whereas other scholars have supported the use of identity-first language (e.g., disabled people) to help individuals value and take pride in disability (Dunn & Andrews, 2015; Olkin, 2002).

Language concerning diverse gender identities has received growing attention over the past decade. Gender identity has been redefined as a nonbinary construct, and refers to an individual's "deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender" (APA, 2015b, p. 834; Bethea & McCollum, 2013; Bockting, 2014). This conceptualization allows for a broader realm of possible identities and new nonbinary gender-based language. It also highlights the significance of self-definition and fluidity of identity. The use of pronouns among people with nonbinary gender identities, such as *zie*, instead of *she* or *he*, moves us away from misgendered, inaccurate perceptions and conceptualizations of gender experiences (Mizock, Harrison, & Russinova,

2014). Further, third-person plural pronouns "they," "them," and "their" in some instances indicate third-person singular pronouns, avoiding the use of gendered pronouns (APA, 2015b). Identity development is dynamic and fluid, influenced by structural and interpersonal factors. Individuals and groups, for example, are influenced by structural oppression and privilege, historical trauma, migration, and dislocation. People of color, for example, may develop identity in the context of racism and stereotyping, which may constrain possibilities of self-definition. A Chinese American adolescent who has internalized the model minority stereotype, or the notion that all Asian/Asian American/Pacific Islanders are academically successful, may struggle with feeling isolated while struggling with academic work. First-generation college students from a poor background who have viewed themselves as competent and successful in high school may face class-based discrimination on campus, diminishing the ability to develop a sense of social and academic competence.

Psychologists are encouraged to attend to intersecting sociological and neurobiological contexts that contribute to diverse identities of an individual. Intersectionality, by its broadest definition, incorporates the vast array of cultural, structural, sociobiological, economic, and social contexts by which individuals are shaped and with which they identify (Howard & Renfrow, 2014). Individuals are located within a range of social groups whose structural inequalities result in marginalized identities. Unlike unidimensional identity models, intersectionality addresses "the vexed dynamics of difference and the solidarity of sameness" (Cho, Crenshaw, & McCall, 2013, p. 787).

For example, Black/African American/Black American lesbian women may have some similarities to and differences from other oppressed groups in the meanings that are assigned to their multiple positionalities. Black/African American/Black American women may identify with the oppressive and discriminatory experiences of White/White American women as well as Black/African American/Black American men. Conversely, Black/African American/Black American lesbian women's experiences may not be equivalent to those of these groups. They may experience discrimination as Black/African American/Black American women who are lesbian. This experience does not necessarily reflect the sum of oppressions of racism, sexism, and heteronormativity (i.e., race + sex + heterosexism), but rather unique identities and social locations as Black/African American/Black American lesbian women that are not based in or

driven by the perspectives of White/White American women or of Black/African American/Black American men (Bowleg, 2008; Crenshaw, 1989).

Intersectional identities also include experiences of privileged contexts that intersect with those of oppression. An older White/White American gay man from an upper middle class background is discriminated against because of his sexual orientation, but is privileged because of his dominant racial, gender, and social class statuses. An Alaska Native college student may experience privilege relative to family and friends who don't have access to higher education, and at the same time may face discrimination based on the intersectional oppressions of race, gender, and social class on the college campus. A Laotian immigrant woman with a disability may experience a sense of safety and privilege due to her legal immigration status in the United States, but can experience discrimination and a lack of access to appropriate resources within and outside of her family and ethnic community based on her disability status. A Jewish American adolescent may experience privilege as a result of being perceived as White, but is the target of anti-Semitic slurs at school and in social media.

Thus, individuals' perspectives are shaped by the multiplicity of identities and contexts to which they belong, some oppressed and some privileged. Aspects of identity such as race, gender, and class work dynamically. The intersections of multiple identities transform the oppression and privilege aspects of layered interlocking identities. A possible transformation occurs when marginalized individuals practice self-empowerment and social justice advocacy for others.

Intersectionality stands in contrast to linear, discrete, or "single axis" variables assumed to cause between-group differences that encourage deriving knowledge from the notion that all members of a structural category, for example, immigrant generation status, have essentially the same experience (Grzanka, 2014). Thus, intersectionality captures the vast within-group differences in identities found among members of marginalized and dominant groups. Intersectionality theory argues that focusing solely on the effect of one or two reference group identities (e.g., interaction of race and age studied through covariate analyses) on overall identity fails to consider the multiple social and cultural identities that intersect within an individual's life.

By recognizing that an individual's identity is derived from interacting systemic effects, psychologists strive to understand associated human biases informed by systems of power,

privilege, oppression, social dictates, constraints, values, and negative perceptions of marginalized societies. On the other hand, applying a linear approach keeps invisible the forces of patriarchy, cisgenderism, heteronormativity (i.e., meaning that heterosexuality is the norm, and sexual relations are only fitting between people of different sexes), class oppression, ableism, and other forms of institutionalized oppression (Shin, 2015).

Applications to Practice, Research, and Consultation

Practice. Psychologists understand that identity and self-definition are fluid and dynamic. Psychologists are also encouraged to strive toward attunement to life experiences, transitions, and identity labels, and how identity experience may change over time and context (Akhtar, 2011; Sue & Sue, 2016; Tsai, Chentsova-Dutton, & Wong, 2002). Educators' and supervisors' modeling of culturally competent practices plays an important role in helping students develop cultural competence. Psychologists who are educators are also encouraged to provide coursework focused on the multidimensional nature of identity.

Attunement to an individual's self-definition requires careful listening to self-defined narratives (Seeley, 2000; Tummala-Narra, 2016). Some scholars have emphasized the importance of the therapist's cultural humility (Gallardo, 2014; Owen, et al., 2016; Tervalon & Murray-García, 1998). Cultural humility has been defined as a "lifelong process of self-reflection, self-critique, continual assessment of power imbalances, and the development of mutually respectful relationships and partnerships" (Gallardo, 2014, p. 3; Morse, García, & Trimble, in press; Tervalon & Murray-García, 1998). The concept of cultural humility has also been referred to as "an other-oriented stance, which is marked by openness, curiosity, lack of arrogance, and genuine desire to understand clients' cultural identities" (Owen et al., 2016, p. 31). Studies have indicated that clients' perceptions of therapists' cultural humility is associated with improved therapeutic outcomes. In addition, evidence indicates that the therapist's attention to clients' identifications of what is salient concerning their identity statuses rather than relying on the therapist's assumptions is an important factor in therapeutic processes and outcomes (Owen, et al., 2014; Owen et al., 2016).

It is also important that clinicians, researchers, and consultants attend to their own lack of knowledge and/or training concerning language that is affirming of an individual's or group's actual identity experiences. For example, psychologists may not be exposed to language that

affirms an individual's sexual orientation, gender identity, racial identity, religious identity, or disability (APA, 2015b; Bockting, 2014; Comas-Díaz, 2012; Drescher, 2009; Mustanski, Kuper, & Greene, 2014; Olkin, 2002). With regard to assessment and psychotherapy, clinicians can invite clients to describe their identities and labels, rather than relying on preconceived conceptualizations. While therapeutic outcomes are not determined solely through matching therapeutic dyads based on sociocultural similarities (Sue & Sue, 2016), the therapist's willingness to engage with sociocultural issues is critical for clients' feelings of safety and comfort in disclosing and exploring painful experiences related to their sociocultural identities and/or experiences of oppression. Therefore, psychologists engage in actively listening for the various layers of the client's identity and consider the structural, contextual, and interpersonal nature of identity development.

Through a focus on how contexts of identities inform biases, psychologists strive to develop a formulation of a client's surrounding world and also recognize how their own range of identities interacts with those of the client, thus engaging differences as well as commonalities that have an impact on and influence their work together. An intersectional framework encourages a depth of curiosity to learn from diverse perspectives for a holistic understanding of the psychologist's self as well as the person of the client.

The psychologist's analysis of power that deconstructs, for example, class dynamics, can translate to both social change and a psychotherapeutic change process (Cho, Crenshaw, & McCall, 2013), merging macro upstream levels and micro downstream levels of analysis and change (See definitions in research section below; Howard & Renfrow, 2014). Because of their personal level of social privilege owing to their professional identity (Roysircar, 2008), psychologists carry the power of being agents of social justice in their respective occupations. For instance, some intersectionality scholars have become activists through efforts to identify social justice interventions for subjugated social groups and to lead coalitions against systemic operations of power and privilege (Clough & Fine, 2007; Grabe & Else-Cole, 2012). Intersectionality scholars practice self-reflection and are constantly engaged in the critique of their own work and refinement of their ideas and practices (Clough & Fine, 2007).

One illustration of a training model focused on intersectionality, GRACES, consolidates potential identities into social categories (gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, gender identity, sexuality, sexual

orientation, and spirituality), providing a scaffold from which to consider power, oppression, strength, and connection in the world of clients, therapists, and therapy (Butler, 2015). One way to explore practitioner biases is to insert various hypothetical clients with different intersecting identities into the same case study (Butler, 2015). Practitioners may find that they react differently to a case depending on the client's intersecting identities. Practitioners may reflect that they are drawn toward areas of difference that they feel most comfortable in addressing and that are most pertinent to them and avoid differences that they feel they know less about. As such, practitioners may need to work to take risks in exploring controversial aspects of difference.

Self-disclosing and exploring intersecting identities requires some level of vulnerability for both the psychologist and the client. The relationship-building process provides both the psychologist and the client time to gain some comfort in having identity conversations. Psychologists also strive to understand that the task of self-disclosure may be difficult or uncomfortable for the client. Strategies such as clinician authenticity, tone, spontaneity, therapist self-reflection, practice, patience with stumbling, supervision, and consultation can be implemented to make the client feel comfortable in identity self-disclosure (Dee Watts-Jones, 2010). The conversation on intersecting identities can open the relational environment to discuss differences and share common experiences, strengthen the working alliance, and foster broader routes toward change (Dee Watts-Jones, 2010).

Research. Cole (2009) made a useful distinction between looking "downstream" for causes (that is, in individual behavior that may be associated with a social category membership) and "upstream" at macro societal processes that define systems of social inequality, such as laws, cultural mores, institutional practices, and public policies. Currently, intersectional researchers (cf., Bowleg, 2008; Cole, 2009; Sirin & Fine, 2008) have demonstrated that scholars can attend to structural dynamics resulting in social identities through the use of qualitative and quantitative research designs as well as interdisciplinary research teams (e.g., comprising psychologists, sociologists, political scientists, women studies faculty, ethnic studies faculty, legal scholars).

Qualitative methods and/or mixed methods have proven more sensitive to social complexities and personal subjectivities than demographic questionnaires that rely on preexisting frameworks to place social groups in nominal, ordinal, or frequency order and count individual experiences as an additive aggregate (Grzanka, 2014). The additive approach that posits that

social inequality increases with each additional stigmatized identity is antithetical to the theoretical fidelity of intersectionality because people's experiences are not conceptualized as discrete, independent, and summative (Bowleg, 2008).

Questions on intersectionality focus on meaningful constructs like minority stress, voluntary integration of diverse cultural groups, equality versus inequity, homophobia, sexism, cisgenderism, classism, ableism, and racism (Grzanka, 2014). Rather than looking for orthogonality in constructs, this approach has investigated interdependence, multidimensionality, and mutually constitutive relationships (Crenshaw, 1989; Greene, 2013).

Some examples of self-reflective "scholar-activism" have been described by Clough and Fine (2007). These researchers have described their respective experiences of working as academic researchers with incarcerated women of color and people leaving prison after incarceration. They shared deeply personal stories of how their positions of privilege became highlighted and intensified during the research process. They also questioned the politics and efficacy of participatory action research and other forms of scholar-activism that do more for those on the scholar side of the equation than for those being studied, e.g., the individuals and groups under the social scientific microscope.

Although the issue of intersectionality has gained increased attention in psychology, research concerning the experiences of people facing multiple forms of marginality is still emerging (Fine, 2010). In conducting research, psychologists are encouraged to include open-ended questions related to identity in both quantitative and qualitative studies. The ability for research participants to describe their identities provides more accurate demographic data.

For example, surveys that do not allow for self-identification, but rather require checking broad categorical self-designations, such as those related to race ("Asian," "American Indian," "Hispanic" "Alaska Native," "Black," "White"), limit the researcher's understanding of how participants may experience and define identity (Trimble & Dickson, 2005). Researchers can then investigate within- and across-group differences concerning various dimensions of identity (e.g., age, gender, race, ethnicity, language, immigration status, religion, spirituality, sexual orientation, social class, disability status). Identity-related research can also incorporate longitudinal investigations focused on shifts in identity, and their implications for psychological development and mental health. Further, psychological research can promote a more nuanced understanding of intersectional identities through more collaboration with individuals and

communities who can provide their self-descriptions of individual and group identity; this has been a core foundation of modern socioneurobiological approaches to cross-cultural research regarding identity and affiliation (cf., Decety & Ickes, 2009).

Additionally, researchers are encouraged to study groups belonging to multiple subordinated groups (Cole, 2009); for instance, the category of Black/African American/Black American women needs to include women of different nationalities, immigration statuses, social classes, gender identities, and sexualities. Cole (2009) argues that who is included within an intersectional category involves more than just being inclusive. It also improves psychologists' ability to theorize and empirically investigate the ways various social categories (e.g., classes, sexualities) structure individual and social life across the board. Cole (2009) further states that intersectional researchers seek sites of commonality across differences; however, this does not mean defining homogenous groups. The shift to the possibility of finding a common ground between groups deemed to be fundamentally different opens up opportunities to build coalitions among diverse groups who are disadvantaged by public policy.

At the same time, it is critically important from an intersectional standpoint that in recognizing similarities, researchers remain sensitive to nuanced differences across groups, even when similarities are found. For example, middle class Black/African American/Black American men and working class White/White American men may both experience job stressors, but their experiences of stress are not equivalent or identical (Roysircar, Thompson, & Boudreau, 2017).

Consultation. Consultants aim to address organizational issues that may stem from a lack of understanding related to identity (Ainslie, 2009; Fine, 2010). For example, a consultant who is guiding the development of a community-based intervention in the aftermath of a hate-based crime is encouraged to carefully assess the historical and ongoing structural factors that contributed to the traumatic stress experienced by the particular community, and how the event shaped individual and collective identities.

Consultants are also responsible for educating and collaborating with their clients (e.g., individuals, groups, communities) about the importance of respecting their own and others' self-definitions of identity. Consultants can also inform educational institutions that intersectional identities comprise both a personal agentic process of self-definition (e.g., this is how I choose to identify myself) and structural institutional dynamics and labels (e.g., this is how others, including the institution, identify me). Psychologists can point to intersectional oppression when

explaining the complexities of identity and self-definition. Readers are encouraged to consult *Case A: Tuan: Identity Transformation and Intersectionality over the Lifespan* and *Case B: An Example of Inclusive Research* in Appendix B, that illustrate key concepts presented in Guideline 1.

Guideline 2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

Introduction/Rationale

Psychologists' worldviews are rooted in their professional knowledge, personal life experiences, and interactions with others across their ecological contexts, and these worldviews influence their empirical and clinical conceptualizations and approaches. Multicultural and feminist scholars have emphasized that people are cultural beings whose beliefs, attitudes, and life histories influence their clinical and research conceptualizations (APA, 2003; Arredondo et al., 1996; Brown, 2010; Fouad & Brown, 2000; Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010; Kelly & Greene, 2010; Sue & Sue, 2016). Socialization concerning age, sex, gender, race, ethnicity, sexual orientation, religion and spirituality, social class, and disability has important implications for psychologists' conscious and unconscious preferences and inclinations when formulating diagnoses, analyzing and interpreting research data, and planning interventions (Greenwald & Banaji, 1995; Saewyc, 2011; Sue, Arredondo, & McDavis, 1992).

Psychotherapy research indicates that therapists' attitudes, cultural empathy, and cultural humility predict therapist's self-reported cultural competence in practice and client's perceptions of therapist's cultural competence (Lee & Tracey, 2008; Owen et al., 2016; Tummala-Narra, Singer, Li, Esposito, & Ash, 2012b). Further, clients' perceptions of the therapist's multicultural orientation and ability to address multicultural issues effectively in psychotherapy are related to

clinical processes, such as the working alliance, that have important implications for improved psychological functioning (Maxie, Arnold, & Stephenson, 2006; Owen, Tao, Leach, & Rodolfa, 2011; Worthington, Soth-McNett, & Moreno, 2007; Tao, Owen, Pace, & Imel, 2015). It is important to consider that clients' ratings of therapists' multicultural competence and therapists' self-perceived multicultural competence have been found to be discrepant. Therapists' multicultural competence may also vary from client to client within the same caseload. As such, multicultural competence can be context driven and multiply determined by therapist characteristics and client-therapist dynamics (Worthington & Dillon, 2011). Specifically, studies indicate that multicultural competence is associated with improved psychological well-being for clients who report higher levels of therapists' multicultural competence relative to other clients being seen by the same therapist (Dillon, et al., 2016).

Psychologists' pre-existing beliefs and assumptions influence the ways in which they respond to clinical and research data. Both conscious and unconscious factors may lead psychologists toward unwarranted assumptions about the client or data. In a clinical setting, an example of cultural conflict occurs when a clinician assumes that the client is enmeshed with a parent, or in other words, has a pathological relationship with the parent, without carefully assessing the client's cultural worldview concerning family relationships. In fact, psychological understandings of what constitutes childhood, adolescence, adulthood, and older adulthood are to some extent culturally constructed and context-dependent, where a particular behavior of a parent or of a child is considered normative in one context, but considered maladaptive or pathological in another. An example of cultural conflict that can manifest in the research process is when researchers analyze interview data without attending to reflexivity, or being actively aware of how their own perspectives and life experiences may affect the interpretation of the participant's narrative.

While categorizing individuals is a way of organizing information, particularly when meeting people whose experiences are unfamiliar, there is significant risk of misunderstanding, misinterpretation, and misdiagnosis (Foddy, Platow, & Yamagishi, 2009; Macrae, Milne, & Bodenhausen, 2005). Over the past decade, scholars have documented the prevalent negative conscious and unconscious (e.g., implicit, aversive) stereotyping of and bias against women, racial and ethnic minorities, sexual minorities, religious minorities, transgender and gender nonconforming individuals, older adults, people with disabilities, and people from low income

backgrounds, and their negative effects on mental health outcomes and health disparities (Allen, 2016; Bockting, 2014; Chalfin, 2014; Dovidio, 2009; García Coll & Marks, 2012; Greene, 2010; Helms, 2008; Lamont, Swift, & Abrams, 2015; Rostosky, Riggle, Horne, & Miller, 2009; Smith, 2013; Saewyc, 2011; Steele, 2010). Specifically, both subtle and explicit forms of discrimination are associated with mental health problems such as depression, anxiety, substance abuse, and suicidal ideation and behavior (Alvarez, Juang, & Liang, 2006; Blume, Lovato, Thyken, & Denny, 2012; Helms, Nicolas, & Green, 2010; Lamont et al., 2015; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Tummala-Narra, Alegría, & Chen, 2012a). The internalization of stereotypes, both "positive" (e.g., model minority stereotype) and negative, may perpetuate privilege for some and has been associated with mental health problems, such as depression and individual and collective self-esteem (Fryberg, Markus, Oyserman, & Stone, 2008; Goodley & Runswick-Cole, 2011; Szymanski, Kashubeck-West, & Meyer, 2008; Yoo, Burrola, & Steger 2010).

Studies have indicated that color-blind racial ideology and individuals taking on a "color-blind" approach, wherein people's sociocultural identities and experiences are minimized and the universal dimensions of human experience are solely emphasized, is not effective for therapeutic process or outcome (Helms, 2008; Johnson & Williams, 2015). In fact, scholars have suggested that such an approach based on color-blind racial ideology contributes to disengagement from the negative or painful affect that accompanies discussions about sociocultural issues to the detriment of clients (Neville, Awad, Brooks, Flores, & Bluenel, 2013). The denial or minimization of sociocultural differences and similarities can have important implications for how psychologists understand not only the client's experience but also the dynamics between the therapist and client, as these dynamics often involve mutual influence of the therapist's and the client's sociocultural histories and experiences (Altman, 2010; Burkard, Knox, Clarke, Phelps, & Inman, 2014; Miville et al., 1999; Owen et al., 2016; Tummala-Narra, 2016).

Studies have noted a strong association between a clinician's personal exploration and investment in issues of diversity and professional practices related to issues of sociocultural diversity (Gallardo, 2014; Miville, Romans, Johnson, & Lone, 2004; Ruth, 2012; Tummala-Narra et al., 2012b) Specifically, psychologists who examine their beliefs about their own and others' worldviews on an ongoing basis are less likely to impose their beliefs in their professional work (Stuart, 2004; Sue & Sue, 2016). Therapist's knowledge of cultural norms,

beliefs, and values of clients, and sociopolitical influences such as racism, xenophobia, anti-Muslim prejudice and discrimination, anti-Semitism, sexism, transphobia, cisgenderism, homophobia, heterosexism, classism, and ableism, all of which influence the therapeutic relationship, has been considered a critical part of culturally competent practice (Atkinson & Hackett, 1995; Maxie et al., 2006). Although it is not possible to gain a thorough understanding of every cultural group, routine engagement with and curiosity regarding issues of diversity allows psychologists to develop their attunement and challenge preexisting stereotypes and assumptions (Fields, 2010). It is important to recognize that psychologists address their own resistances in addressing issues of diversity as a way of coping with anxiety, sadness, or other uncomfortable, difficult emotions, or as a way of avoiding the tasks involved with challenging the status quo (Hays, 2016; Tummala-Narra, 2016). For example, a therapist who has religious beliefs that consider homosexuality to be a sin may feel uncomfortable exploring a client's sexual orientation. A therapist who believes that clients who live in poverty only want to discuss their struggles with gaining access to resources may not explore other significant challenges faced by their clients, such as traumatic loss or the ending of a relationship (Smith, 2013).

Psychologists' recognition of their own assumptions and stereotypes are further connected with their theoretical and empirical formulations. Significant research has informed us of the limitations of models that have been developed within a Western, White/White American, male, middle class, heterosexual, cisgender framework when addressing health and behavioral concerns of individuals across diverse sociocultural backgrounds (Harding, 2006; Alvares, 2011; Mateo, Cabanis, Cruz de Echeverría Loebell, & Krach, 2012; Mertens, 2014). Psychologists are encouraged to apply their knowledge to determine when models and theories are most applicable and suitable to the individuals, communities, and organizations with which they interact. As has been suggested by Mays (2015), given "our divergent positionalities, [psychologists have] the capacity to reorient, to 'concoct sense' away from dominance" (p. 227) when that position of understanding has been shown to diminish personhood or the capacity to engage across cultural understandings. A focus on intersectionality has increased the capacity psychologists have for considering the multitude of positions and components of identity and personhood that exist within the array of communities, individuals, educational settings, and organizations. As such, psychologists are encouraged to become aware of the ways in which theoretical models of

understanding of domains such as development and mental health are shaped by the social, economic, and political contexts under which they were developed and ultimately presented.

To first appreciate and then engage with the similarities and differences they encounter when working with different communities and cultures, psychologists strive to undergo training that utilizes a variety of theoretical models, from which they are able to organize and conceptualize the information they are presented with as part of their interactions with diverse individuals in the varied settings and contexts in which they practice (Leong & Lee, 2006). The theoretical approaches that are available for organizing and interpreting experience and data are diverse themselves (e.g., systems, cognitive-behavioral, psychodynamic, humanistic, feminist, integrative), although at their best, they are tied to solid sources of empirical validation and remain open to ongoing testing with regard to their validity and reliability across contexts, identities, and cultural concerns. There have, in fact, been various developments in the integration of multicultural issues in various theories of psychotherapy over the past two decades (Hays, 2016; Quinn, 2012; Tummala-Narra, 2016; Wachtel, 2009).

Cole (2009) has outlined three specific questions psychologists might ask when they are considering the applicability of a particular theoretical model of approach to their working with diverse communities and individuals in research (although it has been argued that this applies more universally across psychological practice; cf., Grzanka, 2014). Cole's (2009) questions include the following: "1. Who is included in this category [being investigated]? 2. What role does inequality play? and 3. Where are the similarities [across and within social categories under consideration]?" Through appreciating the historical and current foundations of a specific model, and its constraints with regard to how it is best applied, psychologists strive to conduct practice that is informed by an understanding of the differential power dynamics that exist within the relationships they form professionally. They also practice with an awareness of the implicit heterogeneity of the groups they counsel, teach, or consult with, or with whom they are working as part of a study. This highlights the need for psychologists to "take seriously the cultural and political history of groups, as well as the ways these socially constructed categories depend on one another for meaning and are jointly associated with outcomes" (Cole, 2009, p. 178).

It is important to note that psychologists may consciously or unconsciously choose theoretical formulations and/or therapeutic approaches that offer the ease of relying on categorization rather than critically approaching issues of identity, development, and social

context with complexity and nuance, as the latter requires modifying existing assumptions and theories, as well as approaches to practice, research, consultation, and education. Thus, psychologists strive toward in-depth and ongoing examination and reflection concerning their own cultural worldviews, experiences, and theoretical conceptualizations, and their impact on practice, research, consultation, and education.

Applications to Practice, Research, and Consultation

Practice. Psychologists are encouraged to approach practice, research, consultation, and education with attention to self-examination and self-reflection concerning their attitudes, beliefs, values, and assumptions about individuals from cultural groups and sociocultural backgrounds similar to and different from their own. Psychologists consider the role of their own worldviews and sociocultural histories on clinical observations in assessment, interpretation of psychological tests, and formulation of diagnoses. Additionally, psychologists seek to become well informed regarding the strengths of a particular theoretical orientation while also considering challenges, given varied cultural considerations and difficulties with applicability, when evidence about the use of this model across cultures is lacking.

Psychologists can engage in personal reflection on multicultural issues through ongoing reading; dialogue with colleagues, friends, and family members; and their own psychotherapy experiences (McWilliams, 2014; Tummala-Narra, 2016). Psychologists working with students in educational and supervisory roles are encouraged to model culturally competent practice to support student development in this area.

It is important that psychologists pursue continuing education and ongoing training and consult with colleagues regarding multicultural and diversity issues (Hansen et al., 2006; Lee & Tracey, 2008; Maxie et al., 2006; Worthington, Soth-McNett, & Moreno, 2007). Effective diversity trainings consider the experiences of clinicians and how their sociocultural backgrounds may influence their receptivity to and engagement with such trainings (Dickson, Argus-Calvo, & Tafoya, 2010). Further, psychologists engage in consultation with peers and colleagues to develop awareness of their assumptions about culture and context. They strive to engage in reflective processes concerning cultural awareness throughout the course of their professional lives.

Psychologists are encouraged not to base their understandings of a cultural group on limited knowledge and exposure to that cultural group. For example, it is not acceptable for researchers to assume that they understand the "Latino/Hispanic/Latinx" culture because they conducted a project in Mexico. Overgeneralizations and stereotypic thinking may lead to engaging in inaccurate assessment and misdiagnosis, inappropriate treatment, and microaggressions in research and clinical settings (Pierce, Carew, Pierce-Gonzalez, & Willis,1978; Sue et al., 2007).

Sue and colleagues (2007) defined racial microaggressions as "brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273). Microaggressions further involve a sense of ambiguity and subtlety, in contrast with more explicit forms of discrimination (Owen, Tao, Imel, Wampold, & Rodolfa, 2014; Sue et al., 2007). Microaggressions are often experienced in everyday life by people of minority status (e.g., people of color, LGBTQ+ individuals, religious minorities, people with disabilities), and their cumulative effects have been associated with various forms of psychological stress (e.g., anxiety) (Blume et al., 2012; Owen et al., 2014).

Research. Researchers attend to how design, methodology (including sampling and instrumentation), and data analysis are potentially shaped by their worldviews and assumptions. A collaborative approach that values the perspectives and sociocultural locations and identities of research participants, and the self-reflexivity of the researcher(s) is a hallmark of culturally informed empirical studies. Research concerning interactive aspects of cultural worldviews and experiences can provide a better understanding of psychologists' role as cultural beings in their work.

For example, researchers of psychotherapy process have documented that microaggressions have a negative impact on the working alliance (Owen et al., 2014). A clinician who assumes that most people with physical disabilities are marginalized initiates a conversation in the first session with a client about his physical disability and states, "I'm sure it's been really hard to deal with people's reactions to your disability." While the clinician's intention is to connect and empathize with the client, the clinician has not yet adequately explored the client's experiences with disability, which may be distinct from those of other people with disabilities. It is also possible that the client wishes to focus on a different aspect of

identity. As such, researchers and clinicians strive toward complex understandings of clients' identities and self-definitions (as mentioned in Guideline 1) to avoid categorizing and overgeneralizing experiences, that can contribute to misinterpretation of data.

Consultation. The power dynamics inherent in clinical, research, supervisory, and consulting relationships may contribute to categorical thinking. It is important that supervisors create a space that offers a basic sense of respect, where they initiate discussion with the supervisee about the supervisee's experience of the supervision. It would also be helpful for supervisors to consult with colleagues who can help them to work through any conflictual or painful emotions. While this type of situation requires the ability to withstand and explore painful affective experiences, modeling such exploration is critical for effective supervision and training, which does not operate through simple, categorical thinking.

A critical part of psychologists' self-examination entails conscious and deliberate attention to privilege and its influence in their everyday work. It is important that researchers, clinicians, educators, and consultants consider the effects of privilege on their interactions with participants, clients, students, and consultees, and that privileged identities (e.g., White/White American, male, heterosexual, middle class, cisgender, and able-bodied) often remain invisible to others and to themselves and are therefore assumed to be normative (McIntosh, 2015). The issue of privilege is connected with systemic issues in training that contribute to challenges associated with engaging in a dialogue concerning multicultural issues.

While courses focused specifically on multicultural issues are critical to education in psychology, a model that includes multicultural considerations across the lifespan throughout the curriculum is encouraged. Relatedly, multicultural education is not intended to be provided solely by faculty who identify as minorities (e.g., racial, gender, or sexual), as this contributes to the problem of categorization and marginalization within psychology, and it dismisses the importance of faculty from all sociocultural backgrounds investing their time and resources to examining and addressing the influence of their beliefs, attitudes, and assumptions on education and training. Readers are encouraged to consult *Case C: Marcus: Exploring Stereotypes and Microaggressions* and *Case D: Melissa: Training Experiences as a Practicum Student* in Appendix B, that illustrate key concepts presented in Guideline 2.

B. Level 2: Community/School/Family Context

Connection to the model. The model's second level examines clinical, educational, consultative, and research interactions(s) within the context of community, school, and family. Within this level, the psychologist seeks to understand the client's experience from a multicultural framework that considers the impact of community, school, workplace, social determinants, and family contexts. Two general issues to be addressed at this level include consideration of: (1) the role of language in community, school, workplace, and family contexts; and (2) the role of social and physical environments on the lives of clients.

Guideline 3. Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

Introduction/Rationale

Psychologists are encouraged to consider the role of language in their professional relationships as well as within the context of the client's experience within school, work, family, and community contexts. Language refers to the verbal and nonverbal symbols used to communicate with others (Guo et al., 2009; Javier, 2007). Through language, the individual, group, couple, family, community, and/or organization share an aspect of self and experience with someone else. Language embodies the culture and values in which is it spoken (Chen, 2015). For instance, in Spanish the word "yo" means "I" but is not capitalized as in the English language (Clauss-Ehlers, 2006). This difference reflects the focus on the collective or the larger group in many Spanish-speaking countries. This is in contrast to the frequent focus on the individual as reflected in many English-speaking cultures.

One question of language, in the context of guidelines for practice, is to consider who has ownership of language. For instance, what is the language or terminology that individuals, couples, families, groups, communities, and/or organizations want to use to define themselves? Further, who determines the terminology used and how identities are defined? For those who speak more than one language, how is the language of the psychological interaction decided

upon (Villate, Villate, & Hayes, 2016; Wong, Yin, O'Brien, 2016)? These questions underscore the complexity of language for individuals, families, communities, organizations, and helping professionals. One rationale for engaged sensitivity on the part of the psychologist is to recognize that the role of language and communication for the individual, couple, family, group, community, and/or organization relates to the fact that in language's intrinsic connection to culture, it also reflects social identity (Chiu & Chen, 2004).

On the other side of the language equation, psychologists also bring language and communication styles (both verbal and nonverbal) that reflect their lived experiences. The psychologist's language may reflect a professional culture that may or may not be responsive to the client's/student's/participant's/organization's perspective. In their work implementing evidence-based mental health interventions in post-conflict areas, Murray et al. (2014) found that conducting qualitative studies to understand the best and most appropriate local terminology related to mental health was critical in stigma reduction efforts. This resulted in adapting language in the mental and behavioral health setting "that is least stigmatising within the local setting" (Murray et al., 2014, p. 102).

The interchange of multiple contexts and cultures as reflected by language and communication are at dynamic interplay in the exchange between individual, couple, family, group, community, and/or organizations and the psychologist. It is important that the psychologist strives to recognize this nonlinear interplay, and is sensitive to its complexity. Psychologists can seek to recognize the cognitive and affective components of bilingualism and multilingualism, psychological meanings associated with each language, and the connection between cultural values and identity associated with each language (Akhtar, 2011). Linguistic terminology and its meanings can change over time and context with sociopolitical shifts (e.g., the increased use of technology, specifically social media, as a global means of communication).

Psychologists are encouraged to understand the cultural experience and reality expressed by the client as represented by language. To this end, psychologists may also engage in code-switching, engaging both professional and personal language to more fully enter and participate in the client's world (Javier, 2007). Intergenerational communication is one such example that "applies to interactions involving individuals who are from different age cohorts or age groups" (Hummert, 2015, p. 273). Intergenerational communication can be examined within the context

of intergenerational interaction and communication throughout the lifespan (Williams & Nussbaum, 2001).

Psychologists are encouraged to be aware of intergenerational language strategies, intergenerational relationships, and intergenerational conflicts that influence communication within a societal and cultural context (Williams & Nussbaum, 2001). Relatedly, psychologists strive to be aware of how language varies according to developmental stage and the impact this variability has on clinical, educational, research, and consultative interactions (Eskildsen, 2015).

Another example is language and communication through engagement between people who identify as cisgender and people who identify as transgender and gender nonconforming (APA, 2015b). Recent literature has called for the intercultural communication field to "address the lives of transgender persons and the (inter)discipline of transgender studies to develop our theorizing about gender and intersectionality and intervene in the violence against trans* persons" (Johnson, 2013, p. 135). Psychologists are encouraged to be aware of communication between cisgender and transgender and gender nonconforming individuals.

Applications to Practice, Research, and Consultation

Practice. Given that much of the psychologist's role involves communication with others in diverse professional contexts (e.g., clinical consultation, teaching, research, organizational consultation; community outreach), awareness of and sensitivity to language is encouraged in psychological practice. Services that psychologists provide for people and communities call for an understanding of the language and communication style used within a specific context. Psychologists strive to engage in developmentally appropriate communication efforts that seek to understand how people, communities, and organizations self-identify and subsequently follow the lead presented by that individual or group's identification (Wong et al., 2016). Included in communication efforts is an awareness of and responsiveness to nonverbal forms of communication (Weiste & Peräkylä, 2014).

Where language is a key concern, psychologists also strive to be aware of the use of interpreter guidelines when not versed in the language of the client. Psychologists are encouraged to use interpretation in situations where it is difficult to match on language, while recognizing the implicit challenges that occur, specifically in both assessment and clinical work where language variances can challenge effective communication (Cofresi & Gorman, 2004).

Aspirations for psychologists working with interpreters are to form a collaborative partnership that promotes an understanding of the client's experience (Costa, 2016).

Other psychologists may reflect the same language background as the client, whether it is a monolingual, bilingual/bicultural, or multilingual/multicultural experience. Psychologists are encouraged not to assume sameness between themselves and the client, but rather to understand that language and culture may be experienced differently even when a shared language exists (Javier, 2007). Just as psychologists are encouraged to follow the self-definition and use of terminology selected by the client, psychologists who share language capabilities with their clients make an effort to follow the client's lead in choice of language being spoken during the session. It is also important that psychologists reflect on the impact of their own linguistic heritage and monolingualism, bilingualism, or multilingualism on their interactions and communications to clients (Akhtar, 2011).

Substantial literature documents the notion of events being encoded in the specific language spoken when they were experienced (Javier, 2007). This literature highlights how the events that occur within a specific language environment may have a level of emotion attached to them when shared in the language in which they are experienced (Javier, 2007; Schmidt, 2012). Alternatively, evidence suggests that for some clients, speaking in the language in which the experience was not encoded may serve as a distancing mechanism (Clauss-Ehlers, 2006, Javier, 2007).

By following the client's lead in this domain, the psychologist considers the complexity associated with code-switching in psychological practice. One such example includes consideration of the use of slang or informal language that may be used in a particular context or during a particular developmental stage. For instance, adolescents may use slang to describe their experiences. Here the psychologist is encouraged to seek out an understanding of what the slang means as needed. Given that psychologists bring their own linguistic context to clinical and research interactions, they are encouraged to consider the appropriateness of using slang themselves and if motivations are driven by a desire to "look cool" in the eyes of the client, student, research participant, or organization.

Using standardized assessment tools in linguistically and culturally diverse communities evokes another area of significant consideration (Stolk, 2009). Knowledge about efficacious approaches to assessment, diagnosis, and treatment are key elements of appropriate multicultural

practice (Ferraro, 2010; Mindt, Byrd, Saez, & Manly, 2010; United States Department of Health and Human Services (USDHHS), 2001). Understanding the limitations and lack of potential applicability of a measure commonly utilized when differences in language and cultural experience are present is an important example of how psychologists may apply their knowledge. Consideration of the appropriateness of an assessment measure is a first step to be taken by the psychologist, who is then tasked to determine whether there are other standardized measures available to conduct an assessment of the client's cognitive and behavioral status (i.e., where making use of a less culturally biased measure would be helpful).

Issues with the application of standardized assessments to linguistically and culturally diverse communities include norms not being developed in the language of or for the population in which the assessment is being administered. As a result, it is often the expectation that an individual will take a test in English (as assessments are often available only in English), even though English may be a second language for the examinee; this may compromise both interpretation of findings and applicability. Further, test items may reflect the dominant culture in which the assessment is being administered rather than the examinee's heritage culture. For example, within neuropsychological assessment, many measures have been created within an English-speaking context; efforts to apply such measures to individuals where English is not the dominant language can compromise an understanding of proposed relationships between brain and behavior for the examinee. It has been strongly advised to consider matching on language whenever possible when conducting formal diagnostic evaluations, to better support an understanding of functional status, given already challenging comparisons due to normative sample absences (Díaz-Santos & Hough, 2015).

Research. Language and communication within a sociocultural context are relevant to the research enterprise. A comparison of research measures across cultures can introduce problems and fail to capture the nuances associated with the participating culture and community (Clauss-Ehlers, Serpell, & Weist, 2013; Wagner, Hansen, & Kronberger, 2014). Similar to practice considerations when conducting assessments, Wagner et al. (2014) contend that simple translations of interview questions for qualitative research may fail to represent the same semantic meaning. The use of cultural metrics to conduct linguistically and culturally sensitive research can be operationalized through several strategies (Wagner et al., 2014). The use of a bundled variable strategy is recommended for quantitative research. This approach looks at

statistical interactions between multiple variables rather than focusing on one dependent variable (Wagner et al., 2014). Thus, instead of looking at the effect of one variable across many cultures, different variables are examined across multiple cultures.

Research practice informed by multicultural considerations allows psychologists an opportunity to more directly consider and then account for sources of variance (Marshall & Batten, 2004). Communications regarding study design, implementation, analysis, and interpretation can directly and openly consider that participants will vary in their understanding of and approach to the measures and conditions. The research psychologist is encouraged to incorporate local terms or phrases in the research protocol to make the research more reflective of the participant's experience (Jacquez, Vaughn, & Wagner, 2013). In turn, greater relevance of research measures may lead to participant responses that capture experiences more readily. Psychologists are encouraged to address these challenges by acknowledging limitations and to address multiple factors with regard to self-identification and understanding. As an example, Hoare, Levy and Robinson (1993) have encouraged researchers to incorporate the community in empirical investigation. They state: "… participation de-mystifies the research process. Understanding the research process equips community members to be advocates of change" (Hoare, et al., 1993, pp. 53-54). Research psychologists are encouraged to consult with consumer engagement groups about the language and terminology being used in the research process and within relevant research measures (Green, et al., 2014). In addition, psychologists are encouraged to be aware of the role of language and informed consent to participate in research. Here, for instance, it is important that psychologists provide informed consent documents that are written in the research participant's primary language. For those participants with low literacy or who are unable to read, the research psychologist or interpreter can read the consent form in the research participant's primary language.

Consultation. As with practice and research domains, the application of sensitivity to language and communication within the consultation sphere involves understanding the culture of the entity with whom the psychologist is working. Language within the consultation arena can be an indication of the organization's cultural context. Psychologists are encouraged to be attentive to the language(s) of the organization as communicated by multiple constituencies. In this way, psychologists strive to develop a broad understanding of organizational issues. The psychologist is also encouraged to use a theoretical approach informed by intersectionality and

multicultural identity to effectively respond to existing patterns of communication, self-identity, and understanding of self within the organization that may contribute to the organization's successes and challenges (Leong & Huang, 2008; Sue, 2008; Thomas, 2008).

Psychologists can also use their professional language to engage multiple constituencies. Where relevant, psychologists may promote communication across organizational constituencies that may not be fully hearing or understanding one another. In this way, the psychologist acts as a convener, bringing groups together to express their experiences within the organization, considering how they may be similar and how they may differ. Through an engendered conversation, the psychologist is encouraged to promote organizational change. Readers are encouraged to consult *Case E. Dr. Enrique: Culturally and Linguistically Responsive Consultation* in Appendix B, that illustrates key concepts presented in Guideline 3.

Guideline 4. Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

Introduction/Rationale

The psychologist is aware that the resources available in the immediate environment provide many of the tools by which individuals can build their lives. These resources combine into what is sometimes called social capital, and include factors such as the overall wealth and safety of the neighborhood, the quality of schools, pollution and other environmental hazards, the quality and accessibility of healthcare and transportation systems, and the availability of nutritious food. A resource-rich environment can maximize the potential for a quality life, while a resource-poor environment can create barriers to self-actualization. Unfortunately, individuals from disadvantaged backgrounds are disproportionately represented in resource-poor environments (Krieger et al., 2016; Olkin, 2002; Reardon, Fox, & Townsend, 2015). The psychologist may therefore wish to pay special attention to resources available to clients, including barriers to healthcare services, the quality of such services, and other social and physical environmental factors that might either impede or facilitate interventions. In the healthcare community, the term "social determinants of health" has been defined by Healthy People 2020 (2017) to include neighborhood and built environment, health and health care, social and community context, education, and economic stability.

Psychologists are encouraged to recognize that these environmental factors do not detract from the importance to be placed on the client's personal and perceived world. Rather, they call attention to the fact that life plays out in the context of the social and physical environments where the client lives. For example, a client with a physical disability who lives alone in a rural area with few social supports may encounter great difficulty accessing mental health and behavioral health services. Conversely, a live-alone client with a similar physical disability who lives in central New York City may encounter little difficulty in accessing both transportation and health services. As another example, a student who identifies as LGBTQ+ and attends a very conservative university may encounter hostility from peers and even faculty and staff when seeking help with marital problems, as well as a lack of qualified counselors.

Research on the importance of resources has been facilitated by the inclusion, beginning with the 2000 U.S. Census and in other regional databases, of objective information down to the census block level of data on the sociodemographic characteristics of residents—not only racial and ethnic characteristics but also information on income levels, home ownership, car ownership, and other variables. The location of schools, police departments, clinics, hospitals, and even grocery and department stores—all of which represent elements of the so-called "built" environment (Opotow, 2016)—can also be accessed, as can crime statistics. Combined with the client's own perceptions of the general neighborhood, this information provides a wealth of information about the neighborhood in which a client lives. The psychologist may also wish to explore the involvement and influence of a relatively new form of the environment, that posed by social media, that may be particularly salient in the lives of those with intersectional identities (McInroy, 2016).

Applications to Practice, Research, and Consultation

Practice. When considering the many factors that may influence an individual and the effectiveness of interventions, the psychologist seeks to understand the immediate social and environmental context. The neighborhood in which a client lives can inform the psychologist about the availability of resources, as well as potential problems that may interfere with any intervention. This information may also be helpful to the client. LGBTQ+ adolescents facing harassment and bullying at school and rejection at home, for example, may be unaware of helpful resources (Tucker, et al., 2016). Safety concerns or lack of adequate public

transportation are barriers to access and may also increase the risk of dropout from treatment among clients facing poverty or with limited resources (Glaeser, Kahn, & Rappaport, 2008; Kanter, 2015).

One general finding is that clients from low-resource neighborhoods may present not only with mental health and behavioral health problems but also with problems exacerbated by living in neighborhoods characterized by poverty, poor health care, lack of access to health care, high crime rates that lead to chronic fears for personal safety, few public spaces, and inadequate staffing and resources in the public schools (Krieger et al., 2016; Reardon, Fox, & Townsend, 2015). Neighborhood safety has implications for health behaviors for individuals of all ages. For instance, unsafe neighborhoods prevent children from playing outside and older adults might feel like vulnerable targets. As noted, lack of or inadequate public transportation can be a particular problem for clients living in poverty or with limited economic resources, creating barriers to healthcare or to participation in research and/or education. Attention solely to the immediate behavioral health problems of a client, without regard to the socioenvironmental context, may result in attrition and generally poor outcomes, regardless of the quality of practice. The psychologist is therefore encouraged to consider implications of a client's social and built environments. Advocacy in the form of involvement in local and regional efforts to improve the infrastructure of communities is also recommended.

The second of the two general findings from studies of environmental influence is that individuals living in low-resource environments, including not only those from historically disadvantaged and discriminated groups but also the more mainstream, may have a greater likelihood of receiving lower-quality care from health services and greater barriers to access (Jha, Orav, & Epstein, 2011; Schoen, et al., 2013). This broad spread of effect is tempered by the fact that low-income and discriminated groups, and even middle-income individuals from those same groups, are more likely than low-income Whites/White Americans to live in low-resource areas. This means that the vulnerabilities created by life in low-resource environments are much more likely to affect disadvantaged and discriminated identity groups (Williams & Jackson, 2005). The greater exposure to crime and violence and limited access to quality school systems creates additional and often lifelong vulnerabilities for diverse populations.

The psychologist also recognizes that among those most affected by living in a low-resource environment are persons who have physical or intellectual disabilities (Freedman,

Grafova, Schoeni, & Rogowski, 2008; Goodley & Runswick-Cole, 2011; Kramer, Olsen, Mermelstein, Balcells, & Liljenquist, 2012; Olkin, 2002). Challenges to mobility, including those arising from cognitive issues, can make individuals more dependent on the resources available in their immediate environment. Individuals living in impoverished environments may generally find it difficult to leave their homes due to concerns about safety, the lack of social cohesion, and problems with transportation (Butler et al., 2016; Spivock, Gauvin, Riva, & Brodeur, 2008). Even when they do not have mobility impairments, these concerns may prevent clients from seeking and/or accessing help from mental health professionals. Despite the need, research on approaches to assuring cultural competence in meeting the needs of persons with disabilities is sparse and has yielded mixed results. Of particular concern is that there are remarkably few studies that examine the intersection of disabilities with membership in marginalized populations. As Butler and colleagues (2016, p. 29) note, "there is not a sufficient evidence base to conclude whether interventions used to promote racial and ethnic provider cultural competence will produce reductions in disparities when used to promote provider cultural competence for people with disabilities." Nevertheless, it is well noted in the literature that people with disabilities face barriers to appropriate care and resources, including discrimination and prejudice in clinical and educational settings, similar to other underserved individuals and communities (Goodley & Runswick-Cole, 2011; Olkin, 2002).

According to Berkman (2009) and others, the impact of the environmental context can be divided into three basic ways that reflect the presence of critical periods in the exposure to adverse environments. The first category deals with early exposure that leads either immediately or later to negative health consequences. Being born to a mother who herself abuses or is addicted to substances (e.g., alcohol, nicotine, narcotics, and opioids) can lead to a heightened risk for a child, particularly during adolescence, exhibiting adaptive problems and even increased risk of mortality (e.g., Borelli, Luthar, & Suchman, 2010; Mayes, & Suchman, 2006). The second category encompasses a cumulative history of exposure to problems such as pollution, high levels of crime, or inadequate educational resources. The third category involves a social trajectory where earlier exposure to adverse environments, such as high crime rates or impoverished educational experiences, may create barriers or opportunities later in life.

Research. Much of the research on social and built environments has focused on the physical health consequences of living in low-resource environments, but more remains to be

done. Already mentioned is the host of physical health problems disproportionately represented among persons living in low-resource neighborhoods, including all-cause mortality, cardiovascular disease, diabetes, asthma, and obesity (Beck, Simmons, Huang, & Kahn, 2012; Krieger, et al., 2016; Roux & Mair, 2010). The reasons for these disparities, however, are clearly complex, and deserve attention with respect to the development of effective interventions. For example, how can barriers to health care resulting from safety and other socioenvironmental factors be minimized for those with mobility impairments? Similarly, recognizing that greater obesity in children living in low-income neighborhoods may partly result from more fast food availability (Kumanyika, & Grier, 2006; Reitzel et al., 2014), what interventions are feasible? While rarely studied, higher levels of depressive symptomatology have also been reported in low-income areas (e.g., Echeverría, Diez-Roux, Shea, Borrell, & Jackson, 2008; Ostir, Eschbach, Markides, & Goodwin, 2003; Roux & Mair, 2010), as has the disproportionate numbers of LGBTQ+ youth in the juvenile justice system (e.g., Allen, Ruiz, & O'Rourke, 2016). Even more rare are studies that focus on life span issues. In sum, Lewin's (1946) call for community action research and practice still has relevance in light of continuing inequities.

Consultation. What Berkman (2009) referred to as the "social trajectory" is of particular interest to consulting psychologists. While health problems that result from early or cumulative exposure to adverse environments may be difficult to resolve, those that result from social trajectories may be more amenable to environmental interventions. Some examples include efforts to reduce crime or gun violence or to improve educational or healthcare systems. Consider an adolescent identifying as LGBTQ+ who is exposed to harassment and abuse in school and from peers, and is unable to perform according to academic potential in school. The adolescent's life trajectory, without the influence of informed interventions, may contribute to a lifetime of unrewarding and unfulfilling jobs and relationships with others. One such intervention might draw from community resources, since there is evidence that LGBTQ+ youth may build resilience from the support of family and friends (Gray, Mendelsohn, & Omoto, 2015; Shilo, Antebi, & Mor, 2015).

Once again, the research highlights the importance for psychologists of attending to policy at a societal level, in addition to treatment at the individual level. From a policy perspective, the literature underscores the value to the field of psychology, as well as to

individual psychologists, of serving as advocates for improvements in the quality of care and related services in local areas. Helping a client is only the beginning, as it helps only one individual. Helping the community—the second level of the model adopted for these guidelines—gain resources critical for health helps all. Readers are encouraged to consult *Case F. Yasmin: Bridging Different Worlds; Case G. Anthony: Having an Identity That Extends Beyond One's Disability;* and *Case H. Jung: Access to Culturally Relevant Treatment* in Appendix B, that illustrate key concepts presented in Guideline 4.

C. Level 3: Institutional Impact on Engagement

Connection to the model. The influences in Level 3 consider how the forces described in Levels 1–2 interact within a larger institutional, systemic context. The nature of engagement at the institutional level must also be considered. While psychologists may focus on the individual nature of problems presented at Level 1, three additional areas are to be considered within the multicultural framework presented: (1) the ways in which power, oppression, and privilege affect institutional influence and engagement; (2) the ongoing impact of inequities and disparities; and (3) the role of advocacy in institutional engagement.

Guideline 5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

Introduction/Rationale

At the macro level, oppression (Essed, 2002) in its various forms such as racism (Du Bois, 1903/1996; Franklin, 2004); cultural imperialism (Mohawk, 2004; Speight, 2007); classism (Liu, 2012); ableism (Goodley & Runswick-Cole, 2011; Olkin & Pledger, 2003); ageism (Lamont et al., 2015); English-only injunction (Lynch, 2006); and stigma about minority status (Hatzenbuehler, 2016; Meyer, 2003) hinder access to societal resources, which results in disparities. Ample research has indicated that people from oppressed groups experience limited

access to, less utilization of, and diminished quality of health care (Institute of Medicine, 2003; USDHHS, 2011).

If psychologists focus only on individual functioning, they may not include in their understanding structural oppression embedded in institutional practices that produce inequities and disproportionalities, resulting in negative psychosocial outcomes for underserved individuals, couples, families, and communities (Aldarondo, 2007; Liu, Pickett, & Ivey, 2007). With regard to racism, psychologists are encouraged to challenge their color-blind racial attitudes and beliefs that the world is just and fair (cf., Neville, et al., 2013). Psychologists are also encouraged to observe an ongoing self-reflective process of their own social position, exploring and owning their privilege when interacting with clients and the possibility of their clients' less privileged position (Ancis & Szymanski, 2001; Roysircar, 2004b, 2008).

With regard to the range of social and political challenges that have emerged across the world, and their potential to influence psychologists' concerns for social justice, psychologists are encouraged to advocate for accessibility and pursue treatment with social responsibility, inherent to the elements of social justice within the field of psychology. All people, including racial, ethnic, linguistic, religious, and LGBTQ+ minorities, prison inmates, immigrants and refugees, the poor, and people with disabilities have a right to equitable treatment, allocation of societal resources, and decision making.

"Citizen psychologists" have a specific focus on policy, political advocacy, and use of structural resources. In addition, they give voice to people by employing psychological knowledge and expertise in best practices in an array of civic settings from the local to the national level (Daniel, 2017). Thus, citizen psychologists aspire to understand power differentials, power dynamics, and privilege lying at the core of multicultural tensions in the United States and the impact of these on societal structures and institutionalized forms of oppression. Psychologists endeavor to promote advocacy beyond the direct support of clients to include public policy decisions, advances in human welfare services, public health, systems of care, training and education, consultation, research, funding, and issues that affect the well-being of the public at large.

Oppression is a structural phenomenon that is grounded in the culture and norms of a society, and, therefore, influences its institutional operations (Young, 1990). Understanding oppression as a structural phenomenon highlights the similarities across different types of

subjugation, such as ethnocentrism, cultural encapsulation, sexism, heterosexism, cisgendersim, homophobia, and Islamophobia. To determine whether a particular group is oppressed, Young (1990) delineated, among others, categories such as marginalization (i.e., exclusion from contributing to social life, for example, civic functions and events), powerlessness (i.e., lacking authority to be active agents of political life, such as easy access to voting), cultural imperialism (i.e., privileging the dominant group's perspectives over those of others, such as about mental health), and violence (i.e., directing destructive forces systemically at particular groups, such as American Indians, Alaska Natives (AI/AN), Native Hawaiians, Blacks/African Americans/Black Americans, Japanese Americans, and undocumented immigrants). These categories of oppression can be experienced separately or intersectionally. Traumas from intersectional oppression, it has been noted, is transmitted collectively across generations of American Indians/Alaska Natives, Native Hawaiians, and Blacks/African Americans/Black Americans (cf., Brave Heart, Chase, Elkins, & Altschul, 2011; Gone, 2013; Leary, 2005; Turner & Pope, 2009).

Disparities in the legal system. There are significant disparities in equitable treatment across the legal system. Racial profiling by the police targets individuals for suspicion of crime based on an individual's race, ethnicity, religion, or national origin, resulting in people of color being disproportionately likely to be stopped, questioned, and ultimately arrested. Racial profiling results from stereotypes that are fixed, overgeneralized beliefs about a particular group of people.

One such example is Arizona's SB 1070, that invites racial profiling against people presumed to be "foreign" based on how they look or sound and who are suspected of being in the country unlawfully; this law was ultimately upheld by the U.S. Supreme Court. Following fatal police shootings of Black/African American/Black American males in 2014 and 2015, groups such as Black Lives Matter accused law enforcement officers of being too quick to use lethal force against unarmed Blacks/African Americans/Black Americans.

Overall in 2015, about 25% of the Blacks/African Americans/Black Americans killed were unarmed, compared with 17% of White/White American people. Those who were killed were twice as likely not to have a weapon as to have one (Reese, 2015). A study in 2016 confirmed that Black/African American/Black American men and women are treated differently in the hands of law enforcement (Fryer, 2016). This study found that Black/African

American/Black American men and women are more likely to be touched, handcuffed, pushed to the ground or pepper sprayed by a police officer, even after accounting for how, where, and when they encountered the police. But when it came to police shootings, however, the study found no racial bias. The study examined more than 1,000 shootings in 10 major police departments in Texas, Florida, and California. This finding by Fryer (2016) contradicted the image of police shootings that many Americans hold after some killings have been captured on video and shown in the media. The study did not say whether the most egregious examples—those at the heart of the nation's debate on police shootings—are free of racial bias. Instead, it examined a larger pool of shootings, including nonfatal ones.

There are disparities and disproportionalities in incarceration rates by race such that Black/African American/Black American individuals were incarcerated at a rate 5.1 times greater than their White/White American counterparts (The Sentencing Project, 2015). Scholars attribute these disparities to disparate criminal justice policy as well as implicit racism in decision-making among law enforcement and justice officials (Mauer, 2011).

Poverty and homelessness, particularly in conjunction with mental illness, lead to heightened law enforcement intervention as individuals who lack housing are forced to live in public spaces and are more vulnerable to arrest for trespassing, loitering, and disorderly conduct; in addition, they may be incarcerated for long periods of time for offenses that often receive no jail time for other people (The Sentencing Project, 2015). Further, what few mental health services may be available in a jail or prison are generally not accessible to people with speech and hearing disabilities (who are entitled to them under current law and the Americans with Disabilities Act [ADA]) as well as for immigrants with low English proficiency because of the lack of language interpreters (Leigh & Vernon, 2007). For prison management, importance is placed on keeping the area safe, orderly, and escape-proof, while also making sure that appropriate programs designed to change offensive behavior and provide rehabilitation are included. Oftentimes, programs targeted at mental health receive less attention when striving to keep this balance (Jordan, 2011).

This disparity is especially problematic because there is a significant link between lack of adequate mental healthcare in prison and an increase in suicide risk and psychiatric symptoms, decompensated medical conditions, and relapse to drug use and overdose (Binswanger et al., 2011). Imprisonment without appropriate mental health care is seen to have a null or slight

criminogenic effect on subsequent criminal behavior and can also be related to recidivism (Visher & O'Connell, 2012). Psychologists are encouraged to advocate for alternatives to incarceration, such as immediate mental health and substance abuse treatment and transitional homes after release. Both the person who has been incarcerated and the community are better served when treatment barriers are removed.

Many homeless people interact with both police officers and paramedics. However, the level of trust directed toward those two professions varies greatly in the homeless community. A study showed that 92% of a polled homeless population reported that they would be willing to call paramedics in an emergency but only 69% would call the police in an emergency, even when they had no interactions with the police over the past year (Zakrison, Hamel, & Hwang, 2004). This lack of desire to call the police is detrimental for some individuals who are homeless because of their potential inability to escape or remove themselves from a dangerous or threatening situation.

Disparities in education. After World War II, some metropolitan-based psychologists began to apply their science to examine disparity or disproportionality in education. In New York City, Mamie Clark and Kenneth Clark researched the inappropriate placement of Black/African American/Black American children in classes for students with intellectual disabilities (Clark & Clark, 1939). The Clarks tested the children and found that many were above average in intelligence. This prompted a long battle with the New York Board of Education in which the Clarks fought for a change in school board policies. Owing to the Clarks' (1939) research findings on Black/African American/Black American children, the Supreme Court ruled in 1954 that segregation in public schools by race was unconstitutional (Benjamin & Crouse, 2002; Guthrie, 2003). Steele and colleagues' work on stereotype threat (Steele, 1997), a situational predicament in which people are at risk of conforming to stereotypes about their social group, has led to an increasing recognition that negative labeling of minority communities could cause a self-fulfilling prophecy and limit academic and job success. In recent studies among Black/African American/Black American college students and adults, higher levels of internalized racial oppression were associated with lesser valuing of higher education (Brown, Rosnick, & Segrist, 2016) and lower career aspirations (Brown & Segrist, 2016).

While legal segregation ended 60 years ago, schools are socially segregated by race, ethnicity, and class. Urban schools are marked by class segregation that intersects with ethnicity

and low English proficiency (National Center for Education Statistics [NCES], 2016). Latino/Hispanic//Latinx, Asian/Asian American/Pacific Islander, and English-language-learner students have increased in number, while Black/African American/Black American students have had no change and White/White American students have declined in number. Forty percent of urban students attend high poverty schools (defined as schools with more than 40% of students receiving free or reduced price lunch), whereas 10% of suburban students and 25% of rural students do so. A high concentration of students living in poverty is related to less desirable student performance. In addition, urban students—who already have less access to regular health care—are more likely to be exposed to safety and health risks that place their health and well-being in jeopardy. Student behavior problems—particularly student absenteeism, classroom discipline, weapons possession, and student pregnancy—are more common in urban schools than in other schools. Teacher absenteeism, an indicator of morale, is more of a problem in urban schools than in suburban or rural schools. Students in urban schools are less likely than most other groups to attend gifted and talented programs. However, the use of alcohol is less of a problem in urban schools than in rural schools (NCES, 2016). The general perception is that urban students achieve less in school, attain less education, and encounter less success in the labor market later in life.

The McKinney-Vento Homeless Assistance Act of 1987 has provisions to help transport homeless children to school and improve physical access to education. However, it has been seen to place disproportionate emphasis on physical access and not enough on enhancing the instructional opportunities for the children (Stone & Uretsky, 2016) or their readiness to engage in available opportunities once they are at school. Stress arises for homeless children whose families are on the brink of breakup, sometimes necessitating the choice between maintaining a stable family as a support system and the child receiving an education (Kozoll, Osborne, & García, 2003). Though the special education system has shown to greatly increase access, various schools' financial barriers, problems with screening, and bureaucratic issues can impede education for children with disabilities. Thus, the freedom to choose which school is best for a child to attend may not be available to children who come from poor families or who have disabilities.

Class inequality also occurs in college access and intersects with racial and ethnic disparities or disproportionalities in universities ranked high by the *U.S. News and World*

Report. A college degree affects a person's future income, occupation, and social relationships. Blacks/African Americans/Black Americans and Latino/Hispanic/Latinx students may attend lower-status broad-access college institutions that have fewer resources and provide lower economic payoffs, such as future earnings. Selective universities are resource rich and invest in education that keeps them competitive, including investing in students who have strong academic qualifications and can pay high tuition. Universities that are both public and selective and ranked among the top institutions of higher education may have undergraduate student bodies that are majority middle class, White/White American, and pay high in-state tuition (Berrey, 2015). These state universities' emphasis on high standardized test scores and GPA places students from poor as well as racial and ethnic minority backgrounds at a disadvantage because such academic outcomes have been correlated with high family income.

Disparities in mental health care. Economic disparities, often due to under- or unemployment, have been linked to poorer psychological well-being (Goodman, Pugach, Skolnik, & Smith, 2013; USDHHS, 2001). Among people of color, Alaska Native and American Indian populations (9.9%) and Black/African American/Black American Americans (9.6%) have the highest rates of unemployment, that far exceed that of their White/White American counterparts' (4.6%; U.S. Bureau of Labor Statistics, 2015). Using data from two nationally representative samples, the National Comorbidity Survey Replication (NCS-R) and the National Latino and Asian American Study (NLAAS), researchers found that long-term unemployment predicted large, negative effects on mental health, that were larger for Blacks/African Americans/Black Americans and Latino/Hispanic/Latinx Americans (Diette, Goldsmith, Hamilton, & Darity, 2012). Similarly, income gap between immigrants and nonimmigrants was a bigger indicator of health status than actual income, with new immigrants and refugees reporting higher unemployment than nonimmigrants (Mawani, 2014). Relatedly, 17.7 % of newly immigrated Asian Indian immigrants who were unemployed and underemployed were found to have depression, but suitably employed Asian Indians were 90.9% less likely to experience depression (Leung, Cheung, & Tsui, 2011).

Immigrant and refugee care inequality. The barriers to the use of mental health services among immigrant populations can be characterized by the examination of two distinct prevalent phenomena: that of dropping out of treatment and that of not seeking assistance or treatment for mental health difficulties until syndromes become dysfunctional enough to be significantly

debilitating (Dow, 2011). Potential reasons include a cultural disconnect with Western medicine and treatment, language barriers, and misdiagnosis, the latter of which may be seen as a particularly salient concern in the context of treatment (Dow, 2011). Even when treatment is provided, it can be disparate. In a study on outpatient services, for instance, Latino/Hispanic/Latinx, and Asian Pacific Islander immigrant youth with externalization problems (e.g., aggression, anger) were twice as likely to receive services when compared to Latino/Hispanic/Latinx children with internalization problems (e.g., low self-esteem, depression); another disparity was that internalization problems were addressed more often in nonimmigrant families (Gudiño, Lau, & Hough, 2008).

Additionally, Latino/Hispanic/Latinx immigrants who were poor often did not have access to Medicaid specialty services, received poor quality of mental health care that led them to resort to natural healers and social support systems (ííá et al., 2002), and could often not afford the cost of treatment and private insurance coverage (Thomas & Snowden 2002). Chinese immigrants reported that cost, time, language barriers, credibility of treatment, and logistical concerns affected access to mental health care (Kung, 2003). The mental health system's low responsiveness to the frequent and primary use of social as opposed to professional resources may contribute to the isolation of immigrant families and their systemic concealment of mental illness in family members (Dow, 2011).

Other factors related to underutilization. Fear of institutions can often limit the use of mental health services. About one third of refugees and asylees reported that they had both physical and mental health concerns, but many avoided public programs and assistance, despite eligibility, because of the fear that participation would affect their legal status (Edberg, Cleary, & Vyas, 2011). However, the underrepresentation of people of color in mental and behavioral health services cannot be solely explained by access. Even when economic factors are not a barrier to mental health service for people of color, differences in service utilization persist. For instance, clients from diverse racial and ethnic backgrounds with similar levels of health insurance still receive fewer services than their White/White American counterparts (Smedley, Stith, & Nelson, 2003). This disparity or disproportionality in service utilization has been explained by other variables: prior mistreatment in health settings resulting in cultural mistrust (Alegría et al., 2008; Whaley, 2001); linguistic difference between providers and clients (Kim et al., 2011); failure by the clinician to understand the needs of people of color (Breaux & Ryujin,

1999); underdetection by both providers and families (Alegría et al., 2008); clients' perceptions of their therapists' understanding of racial differences (Chang & Yoon, 2011); lack of psychoeducation for people of color about mental health as well as distrust of Western treatment (Li & Seidman, 2010); and lack of multicultural competence among clinicians (Daniel, Roysircar, Abeles, & Boyd, 2004; Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2015). It is also important to note that while there are many religious organizations serving refugees and asylum seekers, LGBTQ+ refugee and asylum seekers may not have their needs met through these organizations if their intersecting identities are not acknowledged and respected.

When those in a minority group do receive treatment, they are more likely to drop out in comparison to their White/White American counterparts (Owen, Imel, Adelson, & Rodolfa, 2012). Barriers of cultural disconnect may be apparent across domains of response from practitioner body language to the pursuit of inappropriate or inapplicable interventions. Interventions can focus on building trust into the accessibility of integrated mental and behavioral health services within communities. Such intervention can promote community psychoeducation to reduce service utilization limitations and seek to increase the cultural attunement of service providers (Dow, 2011).

With regard to misdiagnosis, cases of abuse have been either overlooked or wrongly emphasized as a result of language barriers, child-rearing norms, other cultural contexts, therapist bias, or therapist lack of knowledge (Aday, 2002). Practitioners' lack of ability to attune to cultural characteristics has led to the overpathologizing of psychotic symptoms, which in the context of certain cultures may present as within an appropriate range of stress responses (Dow, 2011). The prevalence of disparity in diagnoses confirms the Surgeon General's report on culture and mental health (USDHHS, 2001), that states, " . . . cultural misunderstanding or communication problems between clients and therapists may prevent minority group members from using services and receiving appropriate care" (p. 42).

Stigmatization by the dominant society about minority mental health (resulting in overdiagnosis or underdiagnosis), cultural stigmatization (shaming) by one's cultural group, and an individual's internalization of both dominant and minority societies' stigma interact with each other, resulting in underutilization. Research has shown, for instance, that immigrants from countries with high rates of political violence have a strong likelihood of trauma symptomology,

however Latino/Hispanic/Latinx men were less likely to seek treatment after political violence (Fortuna, Porche, & Alegría, 2008). Asian Indians were found to regard mental illness within the cultural views of karmic punishment, supernatural associations, or somato-medical explanations (Li & Seidman, 2010), and utilized services in ways unrelated to identified psychopathology (Kim, DeCoster, Huang, & Chiriboga, 2011). Similarly, Chinese immigrants were found to practice self-denial of need for services, fearing stigmatization by their society, as well as personal loss of self-respect or identity (Kung, 2003). Koreans between the ages of 60 and 74 were also likely to have stigmatized perceptions of mental illness and utilization of services (Park et al., 2015).

Acculturation issues. Acculturation has proven to be a significant variable in determining attitudes toward therapy, help-seeking behaviors, and utilization of help resources by Asian immigrant groups (Frey & Roysircar, 2006). Psychologists may find it facilitative to understand help-seeking attitudes of Asians/Asian Americans/Pacific Islanders that are determined by high versus low acculturation. When working with a less acculturated client, a psychologist can play the role of adviser, advocate, facilitator of indigenous support systems, and facilitator of indigenous healing systems (Atkinson, Thompson, & Grant, 1993). Even those with bicultural identities may have trouble relating under a fully Western framework, though they may have a stronger sense of self-assurance than less acculturated Asians/Asian Americans/Pacific Islanders (Omizo, Kim, & Abel, 2008; Roland, 2006; Roysircar-Sodowsky & Maestas, 2002).

Upon entering the United States, many immigrants face prejudice and discrimination based on both their immigrant status and ethnicity. U.S. citizens have expressed a fear that immigrants take jobs away from them, and there are pervasive negative stereotypes about immigrants being lazy and criminal in their conduct. In an effort to curb undocumented immigration, certain states have passed propositions that limit undocumented immigrants' access to health care, welfare, and higher education. Prejudicial attitudes like these create an unwelcoming environment for immigrants, both legal and undocumented, and add to their acculturation adaptation difficulties and psychological distress.

Nonmainstream religions. When health disparities are discussed, oftentimes religion is neglected. As a Western society, religion is typically not a part of current health practices. However, for many individuals, health can be very much entwined with their religious or spiritual leanings. Religion can give rise to different values and practices that intersect with other

social categories, such as race, gender, sexual orientation, gender identity, or class status. Furthermore, religion can often influence the ways in which individuals seek assistance for their illnesses (Padela & Curlin, 2013).

For example, many Muslims view illness as a “trial from God” (Mitchum, 2011; Padela, Gunter, & Killawi, 2011, p. 12). When conceptualized in this way, it is not appropriate to solely treat the underlying medical condition; spiritual healing is also needed. Conversely, some religions prohibit certain medical interventions. For instance, Muslims are not allowed to consume pork, but some vaccines and medicines are derived from pig products (Padela, et al., 2011; Mitchum, 2012). If a Muslim client presents with an illness, making sure that the agreed-upon medicine does not contain certain substances, like pig products, is needed. Having knowledge about what healthcare practices go with or against religious identity is important (Roysircar, 2003). In some cases, the individual may not know details about the medicine or treatment. Here the practitioner strives to be knowledgeable to best inform and care for their clients. This knowledge would likely improve the therapeutic relationship by creating honesty, dialogue, and trust (Roysircar, 2003).

Applications to Practice, Research, and Consultation

Practice. By incorporating a critical understanding of contextual factors, psychologists are likely to obtain a comprehensive understanding of clients’ concerns. With classroom and supervisory settings, psychologists as educators are encouraged to consider how issues of power and privilege affect clinical supervision and classroom dynamics, particularly as they relate to coursework focused on multicultural issues in psychology.

Psychologists might be mindful of Terrell and Terrell’s (1984) concept of cultural mistrust, which is the idea that targets of oppression bring a justifiable skepticism to medical, mental health, and research settings due to prior exploitation. Validating clients’ cultural mistrust and demonstrating cultural humility and a willingness to engage in open processing of racial issues can strengthen the therapeutic alliance and ultimately enhance treatment outcomes (Ward, 2002).

For many Asians/Asian Americans/Pacific Islanders and Hispanic/Latino/Latinx Americans, symptomology may need to be reframed as reactions to family or interpersonal issues. In certain collectivist cultures, well-being is tied to how well the family is functioning

and how committed the family is to health improvement. Within such a communal context, including families and addressing both the individual's and the family's motivation to continue treatment can be crucial to productive therapy (Li & Seidman, 2010). Attention is also needed for Latino/Hispanic/Latinx populations who would be using resources if not for limited English proficiency. Language assistance policies alone resulted in greater utilization in all Asian immigrant samples surveyed (Snowden, Masland, Peng, Lou, & Wallace 2011). In addition to the words being used, correct methods of verbal and nonverbal communication can be sought. Norms of address (titles, greetings) can be extremely important factors in a group setting and in couple or family therapy (Hudson, Adams, & Lauderdale, 2016).

It is recommended that diagnoses and assessment are culturally tailored and ecologically relevant. If a client refuses to talk about something in an interview, it could reflect how traumatizing that event was. However, if the topic in question is a subject that is not spoken of in this individual's culture (i.e., an issue of stigma), declining to talk about the subject might not be indicative of severe trauma. Rather, the avoidance might simply reflect a certain society's belief that speaking about a certain topic makes it worse. On the other hand, the inability to address a topic might result from it not being culturally appropriate to discuss as well as being extremely traumatizing (e.g., a type of "double trauma," as in the case of a Muslim woman who is raped). Here, not imposing the values of Western therapy, such as self-disclosure and implicit trust in the therapist (a stranger, a paid helper), on the client with an immigration experience is important.

In addition, being aware of the terminology that a particular culture uses (e.g., "fuku," a Dominican word for an intergenerational family curse; Roysircar & Pignatiello, 2015) can reduce potential confusion on the part of the practitioner or the client. Assessment includes pre-immigration vulnerabilities, such as religious persecution, torture, rape, flight, and relocation camps, as well as their exacerbation by post-immigration stressors, such as under- or unemployment, absence of network support, rejection by the host society, identity conflicts, and acculturative stress (Mawani, 2014; Roysircar, 2004a). It is important to realize that refugees who have been resettled are likely grieving multiple losses: loss of community, loss of an established role in that community, loss of supports, and the inability to use certain coping mechanisms that may have been helpful in the past. In addition to the personal loss experience, it is important to be aware of the potential intergenerational trauma that might be affecting the

individual. This may be particularly relevant for older immigrants who are valued as elders in their culture of origin but then marginalized in the United States. Increasing recognition of empowerment and social capital by providing specific resources such as support groups, language classes, and vocational training is critical to immigrants in the process of adapting to their host society (Agnew, 2009).

Research. Many studies on refugee and immigrant mental health focus on specialist services, like inpatient care, and do not address the whole range of service sectors where mental health care is provided. With regard to such research, methodological diversity is crucial. For example, investigators could complement quantitative methods with qualitative (Hill, et al., 2005), discovery-oriented (Smith, Flowers, & Larkin, 2009), and community-based participatory approaches (Mertens, 2014). Sue (1999) raised a crucial point that psychological research has emphasized internal validity of well-controlled studies over external validity (i.e., generalizable to varied populations and circumstances in the outside world), which has had negative implications for communities that have been excluded from many research studies of empirically supported treatments (cf., Wampold & Bhati, 2004). It will become increasingly important for researchers to establish relationships with community partners to collect and analyze data with and from those communities (Hill, Pace, & Robbins, 2010; Huynh & Roysircar, 2006).

Scholars have conceptualized the phenomenon of lateral violence, an interpersonal consequence of internalized oppression, whereby targets, unable to challenge oppressive systems, displace destructive feelings and actions onto members of their own or another underrepresented social group (Maracle, 1996). Research is needed to better understand the precise links between internalized forms of oppression and expressions of lateral violence. In the past and at present times, many refugees have been children, but there is very limited information on the help-seeking and service utilization of refugee and immigrant children. Research is also needed on how adult refugees and immigrants may be affected psychologically by the lack of recognition of their skill level (formerly they may have been doctors, educators, executives in the country of origin), and how unhealthy psychosocial and physical environments accompanying low-skill jobs have a negative impact on refugee well-being. Another area of research could be on how inequalities in exposure to environmental contaminants (e.g., lead, poor sanitation, crowded and unhygienic living conditions) can have long-term mental and

physical health consequences for farm laborers, refugees, and immigrants that are sometimes intergenerational.

Though meta-analysis has focused on developing a broad understanding of barriers to treatment for minority populations (cf., Griner & Smith, 2006), such research has not yet been established in the context of immigrant or refugee status minority groups. However, since the Surgeon General's report, more importance has been placed on documenting and understanding why disparities occur, such as this *Multicultural Guideline*'s objective (USHDDS, 2001) . Due to significant advances in research on mental health disparities for Latino/Hispanic/Latinx communities, encouraging developments have been made with regard to lessening disparities in mental health care for this particular ethnic group (Alegría et al., 2007). These same advances are necessary for the vast diversity of populations who have not received such focus in the clinical research domain.

Integrated health care. In the era of integrated health care, more focus is needed on the integrative aspects of health care, including the interface between mental and physical health services (Reiss-Brennan, et al., 2016). Such research could be dynamically focused on the multiple arenas of health care and service delivery, including access to and awareness of healthcare options; utilization of such options; sensitivity to multicultural differences in healthcare missions; immigrant and refugee perceptions on the quality of obtainable healthcare options; and healthcare treatment outcomes. Most studies have either exclusively focused on physical healthcare services (e.g., Avila & Bramlett, 2013; Alang, McCreedy, & McAlpine, 2015; Calvo & Hawkins, 2015; Kan, Choi, & Davis, 2016) or on mental healthcare services (e.g., Chong, Lee, & Victorino, 2014; Rousseau, Measham, & Nadeau, 2013), but not the integration of the two, as is becoming commonplace in a variety of community health centers, outpatient practices, and hospitals. Such a focus would help bridge the gap between physical health disparities and mental health disparities for immigrant and refugee populations, while also aiding in our considerations of stigma as it relates to specialty aspects of health care, such as mental health stigma.

Comparative research. The majority of the existing literature on immigrant mental health care focuses exclusively on target groups (Huang, Calzada, Cheng, & Brotman, 2012; Li & Seidman, 2010; Roberts, Mann, & Montgomery, 2016; Tsai & Thompson, 2013).

Comparative studies can be utilized to better understand the differences in mental health care that exist between dominant and nondominant help-seeking individuals. Similar studies have been conducted in international settings (e.g., Hollander, Bruce, Burstrom, & Ekblad, 2011), and significant findings from such studies uncover not only disparities of race or refugee status, but also, for example, disparities of gender, age, and socioeconomic status intersectionalities. These help identify unique demographic patterns that correlate with more notable mental health disparities than other demographic configurations.

Consultation. Psychologists can consult with nongovernmental organizations and community groups (e.g., Catholic Charities, Save the Children, Doctors Without Borders, and Partners in Health; ethnic community support groups of Cambodians, Vietnamese, Bhutanese, Korean church groups, and Islamic mosque groups; and human rights groups) to identify the specific problems to be solved that reflect inequitable access and then work with policymakers to develop policy options and alternatives. For instance, psychologists can consult with community and neighborhood health centers to increase access beyond hospital outpatient services.

Psychoeducation for clients, providers, and communities is a major intervention to reduce limitations on accessibility. Addressing stigma is central to increasing access for marginalized populations. Stigma that is addressed through talks on mental health by individuals who have mental disorders and through films could increase service utilization. Underutilization of treatment services warrants consultation on language matching, affordability, and location. Matching refugees and immigrants with providers of the same race or cultural background is possibly an advantage, but such matching also limits accessibility. Therefore, psychologists receiving education in a particular mental health problem, such as refugee trauma, is important. Self-reflection on social privilege is especially important in a group stetting, where a less-privileged individual in the group may be stereotyped. The psychologist consulting with a group that is having interpersonal difficulties can facilitate a discussion about the effects of a structurally imposed disparity, such as the educated middle class versus the working class or the powerful versus the disenfranchised, and facilitate consciousness of how group dynamics may reflect power dynamics in the larger society (Roysircar, 2008). Psychologists can help underrepresented groups and individuals find their voice, create cross-group relationships, and benefit from equity in resource allocations, in addition to experiencing equality.

Readers are encouraged to consult *Case I. Aiden: Struggling with Loss, Grief, and Inequity* in Appendix B, that illustrates key concepts presented in Guideline 5.

Guideline 6. Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

Introduction/Rationale

Psychologists endeavor to recognize that culture's relevance to mental health treatment, intervention, prevention, and service delivery is well established (Bernal & Sáez-Santiago, 2006). With this recognition comes the need to understand the multicultural aspects of personal and organizational experience. The term "culture-centered interventions" (APA, 2003; Pederson, 1997) refers to those intervention efforts that view the integration of culture and language as central to the delivery of services. Culture-centered interventions commonly exhibit an awareness of culture; knowledge concerning cultural aspects of an individual, group, couple, family, community, or organizational experience; an understanding of the difference between culture and pathology; and an ability to integrate the aforementioned points within the context of service delivery (Zayas, Torres, Malcolm, & DesRosiers, 1996).

Related work has considered the role of the culturally centered psychologist as a tool in the provision of culturally and linguistically relevant clinical services (Aldarondo, 2007; Hall, Ibaraki, Huang, Marti, & Stice, 2016); the development of rapport from a cross-cultural framework (Hays, 2016; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006); and social justice efforts to decrease health disparities through the provision of culturally centered service delivery and development of more culturally competent infrastructures. Perception and acceptance of help seeking is likely to vary across cultures. Research has found significant differences across communities in terms of access and utilization of services (USDHHS, 2001). The role of mental health stigma may be a factor that decreases help-seeking behavior. For instance, research has identified a relationship between stigma and low functioning among patients with bipolar disorder who were recruited from Latin America (Vázquez et al., 2011). Stigma can also affect the individual's decision to continue to engage in ongoing care.

Advocacy. Psychologists are encouraged to identify ways in which they may serve as advocates for system change. Systemic mental health advocacy refers to "a social movement that

seeks to change the disadvantageous policies and practices of legal, government, and health systems from within to develop a more inclusive community for people with mental disorders (also known as collective mental health advocacy; Stringfellow & Muscari, 2003)" (Gee, McGarty, & Banfield, 2015, p. 1). Several key advocacy movements include the United Kingdom's Consumer and Psychiatric Survivor Movement, the deinstitutionalization of mental health systems in the United States, Australia, and Canada during the 1960s and 1970s, and consumers and ex-consumers of mental health services prompting a change in services during the 1980s and 1990s (Gee et al., 2015).

Advocacy on behalf of persons from disadvantaged and discriminated populations has a long history in behavioral health. Since the early 1800s, systemic mental health advocacy has developed around the world through consumer-run organizations and groups, many receiving political recognition for consumer participation. Peer support specialists can talk about their experiences with mental health issues with those who face decisions about their own treatment (Stylianos & Kehyayan, 2012). Civil rights leaders have shared how their experiences in the Civil Rights Movement advocated for people with mental illnesses and underrepresented communities (Clauss-Ehlers & Parham, 2016; Parham & Clauss-Ehlers, 2016). Many of these efforts sought to address segregation practices influenced by referrals, residence, and insurance status (Smith, 2005).

Recent research has identified five critical themes that reflect the work of advocates and advocacy: "building consumer and career participation, voice and recognition for consumers and careers, influencing and improving mental health systems, effective collaboration and partnerships, and building organizational strength" (Gee et al., 2015, p. 1). These themes reflect a focus on involvement from constituencies that include people engaged in mental and behavioral health services and their caregivers. They also speak to the importance of having stronger systems of care for consumers and those involved with their care. Here psychologists act as part of a "cooperative community" working alongside consumers, colleagues, and other mental health professionals to promote mental health concerns as an important aspect of health (Gee et al., 2015, p. 2). In their model of advocacy, Stylianos and Kehyayan (2012) underscore the importance of "trust, empowerment, and choice" as factors that can influence and engage with services and may have an impact on outcomes (p. 117).

Areas of advocacy. While addressing the scope of advocacy that psychologists engage in globally is beyond the parameters of the *Multicultural Guidelines*, current literature demonstrates a range of advocacy areas in which psychologists are involved. These include, but are not limited to, advocacy efforts in response to risk behaviors such as substance abuse, sexual activity, and adolescent suicidal and homicidal ideation (Latkin, German, Vlahov, & Galea, 2013; Michael, et al., 2015); advocates for social justice in the school context (Espelage & Poteat, 2012); advocates for LGBT youth in school settings (McCabe & Rubinson, 2008); advocates for children living in foster care and their foster parents (Mainwaring, 2014); and responding to human rights issues (Kakkad, 2005). Two additional areas in which psychologists are involved include prevention and early intervention.

Prevention and early intervention. Multiculturally informed intervention and advocacy enhances prevention and early intervention services. Primary prevention efforts are of particular relevance to the psychologist because they are designed to prevent the development of issues. Prevention interventions have been developed to address specific issues such as school violence (Thakore et al., 2015); anxiety disorders among children and adolescents; and internalizing/externalizing mental health problems in response to divorce (Michael et al., 2015), among many other content areas. Community psychology has contributed to an understanding of prevention and early intervention through work that develops community partnerships to address service use disparities (Pickard, Kilgore, & Ingersoll, 2016). Psychologists are encouraged to be aware of the specific sociocultural context in which prevention programs are delivered. Effective prevention programs are informed by the contextual needs of the community they are designed to serve (Stanley, Ellis, Farrelly, Hollinghurst, & Downe, 2015). Early intervention (Shonkoff & Meisels, 2000) refers to:

> Multidisciplinary services provided for children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning. These goals are accomplished by providing individualized developmental, educational, and therapeutic services for children in conjunction with mutually planned support for their families (pp. xvii–xviii).

In their study of early interventionist's perceptions of family-centered care, cultural diversity, and cultural sensitivity, Gardiner and French (2011) found that, while interventionists understood family-centered care and early intervention, they were less able to conceptualize culturally sensitive intervention approaches appropriate for work with diverse families in terms of race, ethnicity, language, sexual orientation, socioeconomic status, couple and family composition, work, and religion. Rather, interventionists shared that they lacked training in cultural sensitivity and often did not have resources such as interpreters to address language barriers. The researchers concluded that training in cultural sensitivity is imperative for successful primary prevention and early intervention (Gardiner & French, 2011).

Applications to Practice, Research, and Consultation

Practice. Psychologists are encouraged to be aware of cultural differences in perceptions of mental health, stigma, and help-seeking behavior (Turner, et al., 2016). Psychologists strive to adapt their understanding of these terms in work with individuals, families, and groups so that interventions incorporate the perspective of those with whom they are working. By having an understanding of the differing worldviews through which individuals, families, and groups may approach mental health, stigma, and help seeking, it is thought that psychologists become more aware of barriers to access and utilization, providing better care as a result. Psychologists are encouraged to consult the science of prevention and intervention, especially with respect to evidence-based support for culture-centered interventions (Gardiner & French, 2011).

Psychologists also engage in advocacy efforts within the context of clinical practice. Relationship-centered advocacy is one approach used in clinical practice that emphasizes developing a mutually collaborative relationship based on a social justice framework (Weintraub & Goodman, 2010). Through advocacy efforts, psychologists participate in a "cooperative community" (Gee et al., 2015, p. 2) that seeks to improve the lives of those struggling with mental health issues.

Research. Psychologists who conduct research are encouraged to engage in efforts to foster the development of the science of culture-centered interventions. Psychologists strive to seek research participants who are diverse across multicultural variables so that findings reflect

the needs of specific populations. Psychologists can also respond to gaps in the literature by developing or applying research measures that address multicultural contexts (Gardiner & French, 2011). Testing and development of measures in different languages and among diverse cultures is critical to the development of the literature on culture-centered interventions and measures with culturally sound psychometric findings.

In addition, Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009) discuss how culture and context have critical influence across diagnosis and treatment. At the same time, they reiterate concerns about the fidelity of evidence-based treatments (EBTs) that may have been developed within a different cultural and linguistic context. Bernal et al. (2009) favor what they call "cultural compatibility and universalistic hypotheses (p. 362)." Increasingly, the application and adaptation of EBTs to culturally and linguistically diverse contexts and relevant outcomes are being documented in the literature (Bernal et al., 2009).

Consultation. Psychologists are encouraged to engage in consultation that furthers the development and implementation of culture-centered interventions (APA, 2003; Pederson, 1997). Consultation may focus on the development of culture-centered services, including prevention and early intervention, through the training of linguistically and culturally aware staff. Consultation may also involve conducting a needs assessment to determine that services reflect the diversity of the surrounding community in which they are offered. The psychologist as consultant can support systemic mental and behavioral health advocacy through efforts designed to support access to care, decrease stigma, and further develop a cultural-centered mental health infrastructure. Readers are encouraged to consult *Case J. Dr. Amy: Multiculturally Informed Advocacy* in Appendix B, that illustrates key concepts presented in Guideline 6.

D. Level 4: Domestic and International Climate

Connection to the model. The influences of Levels 1 to 3 come together in the model's fourth level, that considers the impact of domestic and international climates on client experiences. Technological and transportation advances lead to a more immediate connectivity on both the domestic front and also at the international level. The growing importance to clients of global events and context, including the increase within the United States of persons born in other countries, not only suggests that psychologists strive to understand their clients within an international context, it also emphasizes generational and cohort differences in experience. Two

areas to be addressed are: (1) the psychology profession's assumptions regarding work within an international context; and (2) the role of developmental stage within historical time. Guidelines 7 and 8 address these areas.

Guideline 7. Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.

Introduction/Rationale

Globalization, international geopolitics, and digital technologies have drawn the United States into a global satellite, where a complexity of social, business, and military encounters and ensuing intersectional identities are experienced at individual, local, and universal levels. A resultant dynamic interaction of local, national, and cross-national psychologies enhances understanding of indigenous, culture-specific, and common, as well as unique, aspects of behavior and identity development. Multilateral and horizontal dialogues among psychology professionals working collaboratively on cross-national projects can address the question of what it means to be human, universal, local, indigenous, communal, and individualistic so that psychology can be practiced broadly in global contexts. In addition, psychologists, as upholders of social justice, strive to develop coalition building with practitioners across nationalities to stop oppression, disempowerment, and crimes against humanity.

One traumatic event in one city in one part of the world, such as the violence of domestic terrorists in London or Paris, reverberates across the globe to the United States, and thus psychologists, while acting locally, aspire to think globally and understand human conditions in broad contexts. By recognizing that international psychology represents a postmodern form of consciousness, psychologists can theorize about universal conditions of trauma, resilience, oppression, empowerment, and human rights and dignity, while also operationalizing culture-specific manifestations of a universal experience.

At the present time, the U.S.' corporate and military power has much control of the world's economic, social, and political activities. United States' free trade policy, transactions, capital, and investment movements around the world have kept its economy open, dynamic, and

competitive, and have helped to ensure that the United States continues to be among the most profitable places in the world to do business (Office of the United States Trade Representative, 2016). However, the very quick connectivity of the world's economies, cultures, and Internet communications in the past 20 years has left imbalances and inequities for urban communities, manufacturers, and tradespeople within and outside the United States, causing vocational crises.

Despite recently closing hundreds of bases in Iraq and Afghanistan, the U.S. military covers 75% of the world's nations and is deployed in more than 150 countries, with over 130,000 active-duty personnel; other personnel deployed are part of peacekeeping missions, military attachés, or embassy and consulate security (Vine, 2015). The United States still maintains nearly 800 military bases in more than 70 countries and territories abroad (Time Magazine Graphics, 2016). The total cost of U.S. bases and troops in war zones is $160 to $200 billion (Vine, 2015). Britain, France, and Russia, by contrast, have approximately 30 foreign bases combined. The huge U.S. international engagement has heightened debates such as: What effect does the U.S. presence have socially, culturally, and environmentally around the world and on various worldviews of nations? What effects do U.S. international corporate powers and the Department of Homeland Security's "levels of threat" have on those living in the U.S.? Does the U.S. military presence after declaring The Global War on Terrorism make the United States and its allies safer? How are American Muslims affected by the U.S. travel ban on certain Muslim nations? Are hostile interactions with Syria and North Korea predictive of additional U.S. military engagements internationally? These debates are being held by social, political, peace, and trauma psychologists, policymakers, political scientists, economists, environmental scientists, sociologists, journalists, anthropologists, and U.S. citizens, among others.

U.S. wars (e.g., Operation Iraqi Freedom, Operation New Dawn in Iraq, and Operation Enduring Freedom) have made post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBIs) top-priority illnesses for the Department of Defense due to the thousands of soldiers and millions of family members who have been affected by the conflicts; moreover, billions of dollars have been spent each year for research and treatment of these disorders (Moore & Penk, 2011). Approximately 17% of active-duty soldiers had PTSD 3 to 6 months after deploying to Iraq and Afghanistan (Milliken, Auchterlonie, & Hoge, 2007). The prevalence of PTSD resulting from these two wars ranged from 4% to 45% (Shen, Arkes, Kwan, Tan, & Williams, 2010). Military suicide rates increased to the highest levels in history, soaring

to 29.7 deaths per 100,000, well above the rate of 25.1 per 100,000 for civilians (Luxton et al., 2010). Approximately 51% of United States Department of Veterans Affairs (VA)-enrolled service members have received one or more psychological diagnoses, the most common being PTSD (United States, 2015). Included in the stressors of war are the negative perceptions of many American soldiers, veterans, and civilians alike of Muslims societies outside and within the United States.

With regard to education, the number of international students at American colleges and universities grew by 7.1% to over one million in the 2015–2016 academic year. China was the largest sender of students to the U.S. during the 2015/16 academic year (e.g., 328,547); followed by India (e.g., 165,918); Saudi Arabia (e.g., 61,287); and South Korea (e.g., 61,007). Business, engineering, computer science, and math majors are among the most popular among international students, who report that they chose to study in the United States because of both access and the quality of its higher education (Open Doors, 2016). Meanwhile, the number of American students studying abroad for academic credit continues to increase. It is estimated that approximately 10% of all American undergraduates and approximately 15% of those studying for a bachelor’s degree (as opposed to an associate’s degree) study abroad at some point during their program (Open Doors, 2016).

International students coming from more than 200 countries contributed about $32.8 billion into the U.S. economy in 2015–2016 and supported more than 400,000 jobs (NAFSA: National Association of International Educators, 2016). The current chilling U.S. climate for foreign nationals may reduce the number of international students on university campuses in the near future. In the 21st century, as internationalization intensifies in its influence around the world, U.S. psychologists consulting with the military, businesses, and educational institutions are encouraged to move beyond White/White American-centric theories and simultaneously increase their understanding of psychology from the perspectives of other cultures (Pederson, Draguns, Lonner, & Trimble, 2008).

Psychologists are encouraged to be aware of their own cultural perspectives and avoid imposing them as this may have a negative impact on the well-being of clients from different nationalities. A lack of openness and accommodation can interfere with psychologists’ understanding of diverse experiences of the individuals with whom they may engage professionally. For instance, Fanon (1952) articulated the concept of double identity in the

context of colonial domination in Algeria. He contended that the colonized will often internalize the foreign ruler's idea of their own inferiority and emulate the colonizer through cultural assimilation, thus leading to alienation from their true identities (cf., David & Okazaki, 2006). As a result, myriad psychological troubles result from colonialism: misrecognition, dehumanization, depersonalization, inferiority, shame, helplessness, and a diminished sense of belonging (Fanon, 1952; Freire, 1970). In the new millennium, the impact of mass trauma has been experienced around the globe: terrorism, natural disasters, ethnic and religious cleansing, 9/11 trauma and the ensuing War on Terror, Syrian genocide and refugee crisis, continuing conflict in the Middle East, economic crises in Europe and North America, and globally, the trafficking of children, women, and child soldiers. These international events, made visible by media coverage, have great complexity and arouse confusion for many cultures grappling with their national challenges. Clearly, fast-paced and momentous events and transitions challenge psychologists' understanding of individual and mass trauma within systemic contexts, and their application of this understanding to inform research and practice (APA, 2012a; Roysircar, Podkova, & Pignatiello, 2013).

Clients, families, students, and their local communities and organizations across the globe, are likely to present stresses and illnesses in many ways. As such, proponents of psychological theories are encouraged to investigate conceptual holes in certain U.S. originating theories, fill these gaps with cultural constructs relevant to a particular population, and then adapt their theories to culture-specific representations, while also investigating the outcomes of such cultural adaptations (Hwang, 2016). Psychologists can also strive to examine their purpose, roles, and functions, be reflective about the consequence of uncritically exporting therapy models, and affirm the importance of respecting and incorporating local or culture-specific healing practices (Gerstein, Heppner, Aegisdottir, Leung, & Norsworthy, 2009). Miike (2012) recommends engaging in cultural humility and learning *from* cultures rather than learning *about* cultures.

Among the many cultural barriers for psychologists in international practice, the use of the English language is a complex issue. Draguns (2001) argued that a great many psychological ideas and knowledge of therapy methods are lost as a result of the dominance of English in the one-way flow of information (see also Hwang, 2016; Roysircar, 2013b). He thus suggested that psychologists listen to practitioners use their own languages and mental health terms, and seek to

become “receptive to the absorption of outside influences” (p. 1020), “avoid the pitfalls of encapsulation and homogenization,” and do all this “through communication and cooperation” (p. 1026).

Transnationalism can be experienced by U.S. expatriates living abroad, such as children of military families, missionaries, professionals, and business employees living overseas. Arnett (2002) suggested that globalization has an impact on social identity, with local identity losing salience. As adolescents develop into adults outside their birth country, they may favor a global identity. Furthermore, they may identify with more than one ethnic, racial, cultural, religious, and national identity, rendering complexity in social identity formation and in the cognitive-emotional processing of “Who am I.” Ethnic and racial identity has been a significant predictor of wellness among U.S. ethnic and racial minority adolescents, while governmental bureaucracy (e.g., census, passport, sojourner vs. native status, citizenship) demands single identification with one group. Such research and government approaches are based on the presupposition that a single ethnic, racial, or cultural identity is normative and positive.

It is important to note variations in experiences of transnationalism among immigrants, both legal and undocumented, in the United States. For example, transnational immigrants include people who as young adults migrated to the United States and then as older adults reside in their birth country and in the United States at different periods. They can also include older adults who relocate to the United States to help care for their grandchildren, but maintain their home in their birth country (APA, 2012a). A growing community of transnational immigrants includes “parachute kids.” This refers to children and adolescents who arrive without their parents or primary caregivers (Ying, 2001). They are known as parachute kids because they have been dropped off in a new country to live alone or with a caregiver. Undocumented children crossing the borders by foot or boat to enter the United States can be likened to parachute kids.

There are important differences between second-generation immigrant-origin youth and parachute kids, as the latter tend to live with relatives or family friends or attend boarding schools, or live in housing in groups without the supervision of adults (Chiang-Hom, 2004; Lee & Friedlander, 2014). These children and youth may be ill prepared for their international journey and adjustment to a foreign sociocultural context (Kuo & Roysircar, 2006). Further, they face the expectation of academic excellence in a new school and corresponding cultural and linguistic environments. Due to a lack of parental support and supervision, they may be at risk

for depression, substance abuse, gang involvement, and communication problems as well as interpersonal conflicts with family members (Kuo & Roysircar, 2006; Lee & Friedlander, 2014).

Transnationalism covers another child and youth population, Third Culture Kids (TCKs). In the current global economy, millions of U.S. children and adolescents are being raised in countries other than their passport country, which is referred to as their adoptive/second or amalgamated/expatriate third culture. Many TCKs will eventually return to their passport country either for school or when their parents complete employment overseas; however, a number will in many ways be citizens of the world because of their multiple experiences in international educational settings and temporary residences. Recognizing and understanding the causes of integration problems for TCKs who return to their birth/first culture may help reduce trauma from cultural marginalization pain, social isolation, relationship difficulties, low self-esteem, and work or school performance problems, as well as experiences of not identifying or interacting with the new home culture (Pollock & Van Reken, 2009). In anecdotes, many TCKs, upon returning to the United States, report feeling a profound sense of loss of their TCK lifestyle, culture, and sense of identity (Zilber, 2009). Pollock and Van Reken (2009) spoke of a delayed adolescence where once highly independent and mature TCK individuals resort back to more immature activities.

Living in a diaspora, foreign-born immigrants and refugees' transnational identities are distinguished by perpetual transformations determined by federal, state, and local institutions (green card status, asylum visa, driver's license, relocation settlements, English language requirements, deportation laws, and absence of citizenship privileges). Transnational identities of immigrants comprise both a personal agentic process (i.e., this is how I choose to identify myself) and structural institutional dynamics (i.e., this is how others, including the institution, identify me).

Psychologists strive to explain the complexities of transnational feminists by avoiding imposing U.S. women's narratives and assumptions on immigrants' lives and identities. Psychologists suggest caution when an immigrant is asked, "When did you last go home?" or "Have you gone home?" For immigrants, what is the meaning of home? Is it their birthplace? Where they grew up? Where their parents live? Where they currently live and work as adults? Who are an immigrant's community? Is home a geographic space, a historical space, an emotional space, or wherever the immigrant makes home in the second culture? How one

understands and defines home is a profoundly political question. An international student or new immigrant may not wish to be called a person of color, just as a Muslim woman may not wish to be unveiled because her hijab/burka or head covering is her femininity and not a result of societal oppression. Psychologists seek to understand that for immigrants, their home, community, and identity all fall somewhere between the histories they have inherited, their current choices, and access with regard to employment, community affiliations, neighborhoods, nonfamilial friendships, and English language acquisition.

Indeed, confronted by endless possibilities of communicating across the globe through the Internet, social networking sites allow people to continue in their pursuit of connections and attachments with "the other," so that the quest for discovery of new lands and people can easily shift from fantasy to reality and vice versa. Yet the growing need for interconnectedness between people around the world with regard to social, political, economic, technological, and cultural forms of exchange cannot be met solely via today's advanced technologies (e.g., social media). There is a need for both physically present engagement and the broader exposures that interactions with others across boundaries can happen while online. On the downside, the engagement with global diversity and the expectation that it can create a sense of closeness and intimacy with "the other" has led many to also be fearful and anxious of "the other."

Applications to Practice, Research, and Consultation

Practice. While U.S. psychologists have responded to trauma, PTSD, depression, anxiety, and other nomenclatures of psychopathology as health service providers, culture provides the context in which personality and mental disorders can be understood. Culture defines adaptation and maladaptation, resilience, vulnerability, and coping (Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017; Yamada & Marsella, 2013). The scoring and interpretation of assessments aims to reflect variables that are culturally important for the identification of problems in living (Dana, 2000). With regard to understanding psychological processes and behaviors, it is important for psychologists to seek to understand that individualism, self-reliance, self-efficacy, self-actualization, and self-care do not connote the only model in which human development and positive functioning can occur. In many cultures, self-psychology and group and interpersonal processes are interpreted differently (Roland, 2006).

Because of diverse nationalities' openness to Western understanding and practice, U.S. psychologists aspire to prevent the colonization of indigenous or culture-specific systems of health. They do this, first, by striving to learn to integrate Western and indigenous interventions. Second, they train local stakeholders and mental health workers to implement this Western culture-specific integrated model of care so they do not play the role of the primary interventionists (James, Noel, Favorite, & Jean, 2012). When engaged in therapy, psychologists are encouraged to export cultural empathy, described as ". . . the attitude and skill to bridge the cultural gap between the clinician and client," which is steeped in a sense of mutuality, openness, and deep empathic attunement (Dyche & Zayas, 2001, p. 246).

Hwang (2016) suggests that a surface structure strategy of providing culturally similar therapists, conducting therapy in the client's language, and creating office decorations that are culturally appropriate falls short of what he calls deep structure adaptations. Hwang (2016) referred to the former as a "top-down" psychotherapy adaptation and modification framework (PAMF). As a contrast, he developed a "bottom-up" formative method of adapting psychotherapy (FMAP). Hwang's work has been in Chinese communities in San Francisco that are culturally segregated and insular. His work involved a strong collaboration with stakeholders that were (a) Asian/Asian American/Pacific Islander-focused community health centers, (b) regular mental health providers, (c) traditional Chinese medicine practitioners, (d) Buddhist monks and nuns, and (e) local Taoist masters. Hwang (2016) recognized that Chinese-oriented practices and ideologies would be invaluable for informing mental health practice. The first step of the strategy was generating knowledge with the stakeholders of Chinese communities. The second step was integrating that knowledge with U.S. theoretical and empirical clinical knowledge. With the stakeholders, the third step was to create initial culturally adapted interventions. The fourth step was to test these interventions through evaluation studies. In the final step, the interventions were revised. Feedback, which Hwang (2016) considered as essential, was held off on until the clients gained more familiarity with what was going on.

An upfront psychiatric diagnosis carries with it the stigma of abnormality. Instead, Hwang (2016) placed psychological symptoms in one column on a chart and corresponding physical symptoms in another column, helping to foster a sense of balance of psychological-somatization presentation. Metaphors and Chinese proverbs were immensely helpful in communicating the relationship between symptoms and cognitive-behavioral treatment, and

Hwang's team was able to make the resulting interventions effective. When Hwang (2016) and his team assembled the final therapy manual, they searched through many *chengyu* or Chinese phrases. What they finally put on the cover of the manual was translated as, "If a mountain is obstructing your path, then find a way around it. If there is no road around it, then you need to find or make a path of your own. If you can't find a way around it or create a path, then you need to change the way you think and feel about the problem" (Hwang, 2016, p. 298).

Within the United States, it is anticipated that psychologists of the future will be asked to interact with clients from a potentially limitless range of immigrant backgrounds. For example, in 2012, two thirds of the students in New York City's public school system came from immigrant and underrepresented cultures. Consequently, psychologists in the average New York City public school are encouraged to be prepared to work with students whose parents have arrived in New York City from an estimated 40 nations across the globe (Roysircar, 2012). Exposure to the literature on practices in mental health, case conceptualization, and treatment in different cultures (cf., Moodley, Lengyell, Wu, & Geilen, 2015; Poyrazili & Thompson, 2013) is preparation for the central practice task of grasping what the world may look like from the vantage point of student-clients, as well as their extended families, neighborhood friends, and peers.

According to a study conducted by Whiteford and colleagues (2013) "Overall, mental and substance use disorders were the fifth leading disorder category of global DALYs" (e.g., disability-adjusted life years, p. 5); psychologists' behavioral health and psychosocial interventions will play a crucial part in preventing and treating these health problems worldwide (Council for Training in Evidence-Based Behavioral Health Practice, 2008). Partnerships between primary healthcare systems of other nations and U.S. behavioral health practices are needed for integrated treatment and increased human resources. Because hospital inpatient care is limited and costly in other nations, the demand for mental and behavioral health care in primary care medical facilities in different nations becomes critical (Souza, Yasuda, & Cristofani, 2009).

The need to proactively address the care-need gap from a practical approach has been repeatedly identified by the World Health Organization (World Health Organization [WHO], 2006). For instance, U.S. psychologists in international primary care settings can broadly address in a limited number of short sessions a wide array of problems that include medical,

physical, neurological, psychosomatic, relational, interpersonal, familial, financial, unemployed status, anxiety stressors, and culture-bound syndromes (Roysircar, et al., 2015). Research has also substantiated that it is feasible to deliver psychosocial/counseling interventions in nonspecialized, primary care healthcare settings in international locations (WHO, 2006).

Research. Research on the nature and status of the mental health professions in different countries can ask a series of questions with respect to the nature of a possible global helping paradigm that would link psychology, psychotherapy, and indigenous healing across national boundaries. Such questions include: How do perceptions of health and illness vary across cultures? How do help-seeking attitudes and behaviors vary across cultures? How does self-disclosure differ across cultures? How do models of helping vary across cultures? What is the relationship between indigenous healing and psychology? What constitutes ethical practice across cultures (Ruth, 2015)? While studies answering these questions will involve comparative cross-cultural research, within-group differences can be studied by applying the question to only one international setting and gaining in-depth knowledge of one society as a result.

Recent research has begun to address the relationship between structural forms of stigma and the impact on individual-level stigma processes. One particular example has focused on sexual orientation stigmatization across countries to determine the ways in which the combination of national legislation and social attitudes are linked to specific stigmatization processes at community and individual levels for sexual minority individuals. Results of a study (Pachankis et al., 2015) demonstrated that sexual minority men were more likely to conceal or hide their sexual orientation and/or gender identities in countries that were determined to have high levels of structural stigma as compared to those in low stigma countries.

With regard to the adaptation of transcultural adolescents, a question that psychologists may ask is: Are there interventions that may help reduce the severity or duration of integration difficulties in TCKs once they are detected? The answer may be found in research that compares findings on TCKs' adaptation to the new home society with research on immigrants adjusting to a new culture, as well as on sojourners or international students who are temporarily working, living, or studying in a country other than their own. Culturally appropriate skills in testing can take into consideration the English language in which a test has been normed and administered (AERA/APA/NCME, 2014). When administering a test in an international setting, a researcher is encouraged to consult with local language experts, healing practitioners, stakeholders, health

providers, and trained translators. Back translation that includes cultural translation is recommended for measures that are used for research. Internationally skilled psychologists, in addition to their expertise in traditional testing and its technical aspects, also strive to be aware of the cultural limitations of the tests they administer (AERA/APA/NCME, 2014).

Conducting research in nonindustrialized nations raises ethical concerns. Although U.S. psychologists obtain approval for their research from their institutions' human subject committee/institutional review board, the international communities in which they conduct their work may have no regulatory standards, even at the governmental level. Psychologists are encouraged to consult with local non-governmental organizations (NGOs), health clinics, and stakeholders to develop local regulatory standards for their research. In this way, psychologists can abide by both local and U.S. standards for research.

As an important example, transnational feminist researchers emphasize the importance of country and culture in the psychology of women. Three considerations are offered to argue for the value of the transnational feminist approach. First, evaluating a woman's well-being based on Western scholarship is not necessarily logical in its application to the rest of the world. Second, violence against women in the United States can be seen as a health issue that may reinforce internationally macro-level structures that perpetuate gender inequality. Third, a respectful discussion of strategies that draws on international knowledge rather than applying decisions made in the United States may be more empowering to the local sensibility. The effects of this intersectional approach, that seeks to strengthen local identity, may lead to respectful negotiations and improved use of funds for international research. A critical dialogue is posed by Grabe and Else-Quest (2012) to highlight the moral at hand for feminist scholars: "When we speak, write, and publish our findings, who are we accountable to? For us, our commitment is first and foremost to the women and girls with whom we work, whether in Nicaragua, Tanzania, California, or Philadelphia" (p. 161).

Consultation. Psychologists are encouraged to consult about accessible, equitable, and effective global mental and behavioral health care. Available mental healthcare resources are inequitably distributed, with low- and middle-income countries showing significantly fewer resources in comparison to high-income countries. Psychologists are encouraged to proactively address this care-need gap identified by WHO (2004). Given that there is currently no global practice blueprint to achieve universal mental and behavioral health care, psychologists are

encouraged to devise and consult on how to match effective strategies to a country's unique sociocultural, sociopolitical, and socioeconomic situation.

As an example, owing in part to the globalization of the manufacturing trade, members of the working class in the United States may have suffered unemployment, underemployment, or stagnant wages. Psychologists consulting on the impact of globalization are encouraged to be empathic about the painful reality of affected working class U.S. Americans' dispossession. They may be in a position to give voice to their pain in an effort to guide a leveling of the playing field. Psychologists in consultation regarding how to best understand a range of social and cultural experiences may also strive to identify ways that they can approach and discuss religion with their clients and students, and to assist others to consider how religion for many can be viewed as a vehicle for good, while recognizing that others may see it only as a representation of power (O'Grady & Orton, 2016; Pargament, Smith, Koenig, & Perez, 1998). Readers are encouraged to consult *Case K. Michael: Identity and Refugee Status,* that illustrates key concepts presented in Guideline 7.

Guideline 8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

Introduction/Rationale

The life cycle of individuals is heavily influenced not only by the immediate social and physical environment but also by current societal trends and the historical period. For example, wars and economic depressions affect the life cycle at all levels. The psychologist seeks ways to remain aware of how a client's personal experience and development has been influenced by these dynamic forces.

As discussed in several other guidelines, people often have multiple identifications. These identifications may have their own developmental cycles, as well as emerging and engaging across the full developmental cycle of the individuals psychologists consult with and treat. An individual who identified as a Black/African American/Black American activist and champion of the poor at one stage of life may transition into the Chief Executive Officer (CEO)

position of a large corporation at another. A multiracial person may identify with a singular, multiple, or no racial category (Rockquemore, Brunsma, & Delgado, 2009), and these identifications may change from childhood through older adulthood. A gay preadolescent with myotonic muscular dystrophy may transition to a community activist leading the fight for disability rights upon entry to adulthood. The historical period one lives through may also affect how individuals perceive themselves. Growing up during the Great Depression had a lifelong effect on the lives of those in later adolescence at the time, but only a minimal effect on those who were younger (Elder, 1974, 1998). Some historical periods have a lasting influence, such as the continuing impact of America's period of slavery and the infamous Tuskegee experiments. For these reasons, psychologists seek to develop and sustain an awareness of how an individual's identity has changed over time and how their identities, and the importance of each, are affected by the historical period, and the concurrent immediate developmental, social, and familial contexts in which the individual is situated.

To date, only minimal attention has been paid to considering intersectionality from the perspective of developmental stage and historical time, but the available literature supports the necessity of doing so. In a relatively early acknowledgment that identities are transformative and unique to the individual, Satcher (USDHHS, 2001) noted, "not all members that society groups into a given category will share the same culture. Many may identify with other social groups to which they feel a stronger cultural tie such as a Mexican American who identifies primarily as being Catholic, gay, Texan, or teenager" (p. 9). Implicit in Satcher's reference to the teenage developmental period as being a potentially critical aspect of identity is the relatively unexplored issue of how intersectional identities evolve. When does a child become aware that she is a Catholic, or Texan, or a teenager or lesbian; when does this identity begin to matter? For instance, a Mexican-born teenager may not appreciate the nature of one's identity and upbringing until moving to Boston and trying to fit in. Vespa (2009) notes that societal expectations of an individual are often based on a confluence of both gender and race, although depending on life stage, one or the other may be more influential in driving that individual's self-identity. Societal expectations may also change as a function of the historical period and immediate social context (Vespa, 2009).

Life cycle perspectives on behavioral problems. The psychologist dealing with diverse populations faces many challenges rarely anticipated in a homogenous caseload or research

project. The ten guidelines identified by this APA task force testify to the complexity of these challenges, and to the importance of understanding that clients comprise diverse intersectional identities, and present with characteristics and issues that can differ dramatically from those associated with middle- to upper-class non-Latino/Hispanic/Latinx, White/White American clients. Guideline 8 emphasizes the need to consider diverse clients within a developmental perspective, since their lives have proceeded along trajectories that reflect their unique confluence of culture, race, and social context. It is also important to avoid labeling departures from cisgendered, heteronormative, majority group behaviors or stages as reflecting cultural deviancy or deficits as opposed to variations that may result from the life experiences and cultural heritage of the client, research participant, or consultee (Jamil, Harper, & Bruce, 2013; McLoyd, 2006).

Before reviewing some of the unique characteristics of developmental stages and transitions experienced by racial/ethnic and other identity groups, it is important to recognize that the literature has identified characteristics of stages and transitions that represent general turning points and issues strongly influenced by the socioenvironmental context that may be expressed in unique ways . For instance, the developmental transition into retirement comes in many forms. Psychologists have long sought to understand how developmental stages, and indeed the entire life course, affect behavioral health. Each life stage has what Havighurst (1956; see also Seiffge-Krenke & Gelhaar, 2008) long ago referred to as “developmental tasks” and what Erikson (1950; Sokol, 2009) referred to as epigenetic psychosocial stages of development. Both theorists felt that how one deals with the tasks and challenges at each stage is a central issue. Struggling with one’s personal gender identity for example is part of the issue of identity versus ego diffusion described by Erikson, and the task of learning one’s gender role as described by Havighurst (1956). Important not only in general, but also to studies of identity groups, is that successful resolution of personal identity provides the individual with a greater advantage in facing the tasks of succeeding stages. In contrast, unsuccessful or only partially successful resolution can create potential problems not only in the present but also in the future. The timing and resolution of turning points may vary according to an individual’s intersectional identities and is a topic rarely addressed in the literature.

With respect to members from underrepresented groups, many of the latter face challenges atypical of the more advantaged even if the overall developmental task remains the

same, and may therefore face a greater chance of failure or have problems in resolution (Arnett, 2014; Cohler, & Michaels, 2012). Consider, for example, young male Hmong refugees who arrived in the United States without an education or employable skills, and who as a result faced unique challenges to developing a sense of personal autonomy and self-worth (Cerhan, 1990). Compounding the problem, economic stresses faced by minority parents can themselves have a lasting impact on a child's socioemotional development (McLoyd, 2006).

Successful resolution of each task or developmental stage has adaptive—or negative—implications for each successive life stage. In a study of over 7,000 persons followed over a 50-year period in England, Takizawa, Maughan, and Arseneault (2014) found that childhood experiences with bullying had effects on behavioral health that lasted for decades. As another example, for adolescents, one step toward achieving independence from parents is to obtain a driver's license. For the child of undocumented parents, or from economically challenged families, however, obtaining a driver's license may be difficult if not impossible.

In like manner, for an older person, the loss of driving privileges may pose challenges to personal autonomy, potentially making the individual not only more dependent on their immediate environment (see Guideline 4), including peers and family, but also leading to questions about self-worth and efficacy (Meuser, 2015). In dealing with clients and consultees across all stages—the psychologist would do well to consider the tasks and challenges facing individuals, their context, and their resolution of tasks in the past.

With regard to the LGBTQ+ community, D'Augelli (1994) noted that most conceptualizations of life span development are predicated on heterosexuality as the norm, and concluded that existing theories of development were inadequate when considering those with differing sexual identities. While few have worked on a revision or replacement for this model, there is at least a beginning. Roseborough (2004) studied conceptualizations of life span development among a small group of gay men. Applying Eriksonian stages to the study of LGBTQ+ adolescents transitioning into adulthood, Cohler and Michaels (2012) also examined how early life experiences influence progress along the life course. For both Roseborough (2004) and Cohler and Michaels (2012), the central point is that the developmental stages of diverse groups may vary widely in timing and critical points from what the psychologist may expect for clients of the same overt gender and age. Progress through stages may also exhibit

greater complexity. In a qualitative study of LGBTQ+ adolescents, for example, Jamil, Harper and Fernandez (2009) found that ethnic and sexual identities developed along dual tracks.

Applications to Practice, Research, and Consultation

Practice. When seeking to better understand a client, the psychologist may explore the developmental trajectory of the intersectional identities expressed by the client including factors that may have acted as barriers or those that promoted identity achievement. For example, scholars examining experiences of biracial identity and multiracial identity have adopted an ecological approach to racial identity by emphasizing that mixed-race people develop racial identities through interactions within multiple contexts and that there are no predictable stages of identity development or a single adaptive outcome or endpoint (Rockquemore & Laszloffy, 2003; Rockquemore et al., 2009). With regard to ethnic identity, Fuller-Rowell, Ong, and Phinney (2013) found that among Latino/Hispanic/Latinx college students, the progression toward a more mature ethnic identity may be negatively influenced by discrimination. In a small qualitative study, Vargas, Park-Taylor, Harris, and Ponterotto (2016) found that the developmental trajectories of boys from mother-only households reflected barriers and challenges not found in more traditional family units.

Another area that has received relatively little attention concerns issues faced by those in the deaf community (David & Werner, 2016; Humphries, 2014). In addition to race, gender, LGBTQ+ status and other identities, the psychologist may encounter other aspects of intersectional identity when working with clients from the deaf community. Several important statistics deserve special emphasis with such clients, students, organizations, and/or research participants as described by the National Institute on Deafness and Other Communication Disorders (NIDOCD, 2016). The first is that the majority of children with profound hearing loss are born to parents without hearing loss. Without exposure to information about the implications of this loss, a parent may not understand the needs of their hearing-impaired child. This includes, for example, awareness of the bicultural, bilingual nature of the deaf experience (e.g., Grosjean, 2010), and appreciation of American Sign Language as not only a language experience but a cultural experience as well (see Glickman, & Harvey, 2013).

The second statistic is that nearly 60,000 children in the United States had received cochlear implants by 2012. Such implants have been a point of controversy in the deaf

community, since many activists feel that a hearing "impairment" is not in fact an impairment or disability, and for this reason look unfavorably on implants (Sparrow, 2005). This can be a sensitive topic that the psychologist is encouraged to identify and understand.

The third statistic to consider is the role of generational differences in the life experiences of people with hearing loss. For example, a distinct deaf culture exists that may be of particular importance and meaningfulness, especially for older generations who have lived their entire lives as part of the deaf community. During the 20th century a vibrant deaf culture emerged, with deaf clubs, social gatherings, and a sense of community and shared experience (Burch, 2002; Holcomb, 2013). This culture has been threatened by the growing presence of technologies such as the previously mentioned cochlear implants, which are increasingly recommended for children and adults with profound hearing impairment. Differing opinions about technologies and the erosion of deaf culture across generations may generate conflict between parents and children (Sparrow, 2005).

Another factor the psychologist is encouraged to consider is that some individuals experience hearing loss only in later life. These are people who may not have had previous experience with hearing loss. Such individuals may have very different psychological issues to face than people with earlier onset. For example, many may feel that wearing a hearing aid is a stigma that sets them apart (David & Werner, 2016).

Research. Going beyond standard formulations of the life course, several researchers have studied identity formation in minority groups (e.g., Aboud, & Amato, 2001; Atkinson, Thompson, & Grant, 1993; Cross, 1978). Most of the work has focused on racial/ethnic groups, and therefore the implications for other identity groups, and especially those with complex intersectional identities, are unclear. One of the leaders in developmental studies of ethnic/racial identity, Phinney (1989), was influenced by Erickson's (1968) theory. Phinney (1989; 1993; Phinney, Ong, & Madden, 2000) proposed an ethnic identity status model with stages that reflect an individual's progress toward identity: unexamined ethnic identity that can include identity diffusion (marked by a relative lack of thought about ethnic identity) and identity foreclosure (marked by an uncritical acceptance of existing views about one's ethnic identity); ethnic identity search/moratorium (marked by active exploration of one's ethnic identity); and ethnic identity achievement (characterized by exploration and commitment to one's ethnic identity). The psychologist is encouraged to recognize various models of identity (e.g., Dirkes, Hughes,

Ramirez-Valles, Johnson, & Bostwick, 2016; Hamilton, Samek, Keyes, Mque, & Iacono, 2015). More research is clearly needed on the multidimensional aspects of ethnic identity, and developmental influences on individuals' intersectional identities (Smith & Silva, 2011).

In light of the generally underdeveloped nature of such research, psychologists may wish to incorporate qualitative research strategies as a means of discovering the full range of issues. Online strategies may have particular appeal since they have the potential to reach difficult to access populations (e.g., McInroy, 2016). It is also important that, when conducting research, psychologists seek to pay close attention to and inform themselves of the intersectional considerations participants present, and how these influence interpretations of findings regarding self, identity, group membership, and the consistency of presentation across groups of a psychological phenomenon or concept.

Consultation. Psychologists are encouraged to recognize the multiple and often unique factors underlying how well individuals thrive and meet goals during different stages of the life course. In addition to the historical period within which individuals develop, birth cohort and generation exert an influence (Baltes, Cornelius, & Nesselroade, 1979; Takizawa, Maughan, & Arseneault, 2014). The problem is compounded by what has been described as "invisible intersectionality," (see Purdie-Vaughns, & Eibach, 2008) that refers to the fact that often the various identities of an individual are not readily discernible to an uninformed observer. Moreover, intersectionality may create ambiguity for an individual when encountering prejudicial and discriminatory behavior, since it may be unclear which identities are eliciting the discriminatory behavior (Mohr & Purdie-Vaughns, 2015; Sedlovskaya, et al., 2013). For these reasons the psychologist strives to not take it for granted that problems arise only from the more obvious identity differences and ambiguities. Readers are encouraged to consult *Case L. Mary: A Focus on the Interpersonal Instead of the Contextual,* that illustrates key concepts presented in Guideline 8.

E. Level 5: Outcomes

Connection to the model. The influences of all levels of the model come together in the form of outcomes. As noted in the introduction, outcomes refer to the positive and negative consequences of activities engaged in by both clients and psychologists, and as influenced by forces in Levels 2–4. While psychologists are most often focused on behavioral health

problems, and how to attend to these problems from a multicultural framework, there are two general issues that can be addressed: (1) the ways in which to address and assess the various identities of participants, and (2) the enduring impact of disadvantage and associated trauma on what might be called the resilience of participants. The last two guidelines deal with these two general issues.

Guideline 9. Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the *Layered Ecological Model of the Multicultural Guidelines*.

Introduction/Rationale

The several levels of the model that inform the present guidelines all exert an influence on both the client and the psychologist. When dealing with clients and research participants who present with complex intersectional identities, these multiple lines of influence add to the usual challenges faced by the psychologist engaged in assessment, selection of appropriate intervention strategies, and research and consultation.

The psychologist therefore recognizes that assessment tools, and nearly all clinical interventions, have the potential to mischaracterize or even miss the behavioral health needs of racial/ethnic and other identity groups. The reasons include cultural and regional differences, stigma, literacy (including health literacy), the unique presentation of symptoms, explanations of psychological distress, distrust of providers and authority in general, and many other factors (Sue & Sue, 2016). When the fit of a particular therapy or assessment tool to a particular group is unclear, further research may be called for. In that case, focus groups and community involvement are forms of qualitative research that may be most helpful in the early stages of cultural adaptation (Hall, Yip, & Zárate, 2016; Ramos & Alegría, 2014).

The problem has not gone unnoticed. Since 2000 the U.S. Department of Health and Human Services, through its Office of Minority Health (2001, 2013), has published and subsequently revised a list of 15 standards designed to improve services for diverse groups in all realms, including behavioral health. Entitled the *Culturally and Linguistically Appropriate Services (CLAS*) standards (Office of Minority Health, 2013), they provide a blueprint for

appropriate care, research and evaluation. Psychologists working within hospitals may be interested in similar guidelines created by the Joint Commission (2010). Of the 15 standards, the first deals with the overarching need to deliver services appropriate to the individual's diverse needs. It states that health professionals (Office of Minority Health, 2013, p. 1): "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." Part of providing effective care and service is research into what represents appropriate client care. While randomized clinical trials (RCTs) are the gold standard in service research, they are costly and often fail to recruit the number from any specific identity group that would allow assessment of intervention effectiveness (Burlew, et al., 2011).

Psychologists also recognize that they do not work in isolation from the community: from an organizational perspective, there is a responsibility to ensure sufficient outreach to allow community feedback and monitoring of services, as well as to ensure that providers are well versed in the practice of multicultural competence, and that community members themselves have had educational opportunities designed to inform them of signs and symptoms of behavioral health problems and how to access services (Carrizales, Zahradnik, & Silverio, 2016; Chiriboga & Hernandez, 2015; Office of Minority Health, 2013).

Applications to Practice, Research, and Consultation

Practice. Psychologists are aware that members of diverse groups are less likely to seek help from mental health providers, just as they are less likely to participate in research and interventions. They are also less likely to continue in therapy or research once enrolled. Dropout rates among persons of color recruited for studies or participating in interventions are generally higher than those found among non-Latino/Hispanic/Latinx, White/White American clients and participants (e.g., Delphin-Rittmon, et al., 2015; Haan, Boon, Jong, Geluk, & Vermeiren, 2014; Jiang, et al., 2015; Thompson-Brenner et al., 2013).

Among the reasons are problems with the development of a therapeutic or research alliance, distrust, or a feeling that the intervention or research lacks relevance to the individual's life and circumstances (Griner & Smith, 2006). Others may be reluctant to participate in research or seek therapy due to their legal status, stigma associated with mental health disorders, gender identity, and unfamiliarity with the idea of research or with the healthcare system (Kim, et al.,

2011). The psychologist recognizes these barriers and seeks opportunities to improve rapport. Failure to do so may lead to therapeutic failure or systematic sample attrition. Compounding the problem is a lack of research on attrition in diverse groups other than those defined by race and ethnicity (Huey & Polo, 2008).

Yet another issue is fear of unequal treatment or mistreatment. The infamous Tuskegee study in which Black/African American/Black American men with syphilis were left untreated has helped create this perception. A lesser-known experiment conducted in Guatemala in the middle to late 1940s involved infecting men and women with syphilis without their consent or knowledge (Presidential Commission for the Study of Bioethical Issues, 2011). The historical period and generation can play a strong role in how members of diverse populations view researchers and practitioners, since societal views on individuals from diverse and discriminated groups change over time. Olson and colleagues (2015; see also Kimmel, Hinrichs, & Fisher, 2015) found that previous generations of children with a transgender identity were subjected to blatant discrimination, whereas during the past few years there has been growing acceptance of transgender and gender nonconforming identity, even in young children. Perhaps in consequence, Olson and colleagues (2015) found little evidence of distress in their recent national study of community-resident children.

Research. Given their reliance on primarily non-Latino/Hispanic/Latinx, White/White American samples, psychologists strive to recognize that the often-limited generalizability of randomized controlled trials (RCTs) may reduce the effectiveness of resulting evidence-based treatments (EBTs) with diverse groups (Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012). In a review of 79 articles dealing with interventions and trials related to serious mental illness (SMI), for example, Evans, Berkman, Brown, Gaynes, and Weber (2016) found that no study addressed efficacy with respect to persons who self-reported as LGBTQ+, or for whom English was a second language, and only one focused on older adults.

On the other hand, culturally adapted interventions have had demonstrated efficacy (Bernal & Domenech Rodríguez, 2012; Hall, Ibaraki, Huang, Marti, & Stice, 2016; Smith & Trimble, 2016; Zane, Kim, Bernal, & Gotuaco, 2016). One general conclusion: there is a need for establishing the effectiveness of EBTs for specific groups with a history of discrimination and systematic disadvantage. In short, the frequent mixing together of reference identity groups can lead to results that are not equally appropriate to all groups.

Choice of assessment tool can also be a problem when studying diverse populations. Applying standard tools can lead to erroneous conclusions when the individual client or participant belongs to a group or groups that face nonstandard problems or when there are errors in translation of instruments. For example, some populations, including Latino/Hispanic/Latinx elders in particular, but also older adults in general, are more likely to express somatic symptoms that are indicative of depression (Blazer, 2002; Liefland, Roberts, Ford, & Stevens, 2014). Assessment tools that omit somatic symptoms may therefore have the potential for underestimation of depression.

The psychologist seeks to understand that assessment tools may function very differently in different populations. For example, Chakawa, Butler and Shapiro (2015) found that only one of six items revealed different outcomes in a comparison of Black/African American/Black American and White/White American adults who completed a measure of ethnic identity. In contrast, Kim and colleagues (2009, 2011) found differential item functioning in 80% of items on a depression scale when comparing Mexican American and White/White American elders, but, like Chakawa and colleagues (2015), they found that 10% of items displayed differential responses when Blacks/African Americans/Black Americans and White/White Americans were compared. While the significance of differential item responses is ambiguous, the differences raise the possibility that instrument scores may not reflect underlying problems across different groups (Janssen, 2011). This is particularly true for less studied groups, such as the LGBTQ+ and refugee communities. Investigating prior use of the instrument with the target audience can be informative.

One strategy to deal with the potential misfit of RCTs and EBTs is to adapt them to the needs of the target population. The danger of EBT adaptation is that the resulting intervention is no longer evidence-based, unless additional research specific to the adaptation is conducted (Morales & Norcross, 2010). Hence the psychologist strives to review culturally adapted interventions for evidence of fidelity to the original approach. Critically, the psychologist strives to balance fidelity with fit of the intervention to the client's needs. It deserves mention that culturally adapted research and intervention is a hallmark of community-based participatory research (CBPR; Frerichs, Hassmiller Lich, Dave, & Corbie-Smith, 2015; Jernigan, Jacob, the Tribal Community Research Team, & Styne, 2016; Lichtveld, Goldstein, Grattan, & Mundorf, 2016). The latter is a form of community-engaged research (Perez et al., 2016; Santilli, Carroll-

Scott, & Ickovics, 2016). CBPR and other community-engaged research approaches, involve working closely with community members as partners and stakeholders, and have the potential to improve recruitment of diverse groups, resolve potential problems of trust or interest on the part of the community, reduce attrition, and improve cultural appropriateness.

Consultation. Glover and Friedman (2015) contend that when consulting with persons from diverse cultural groups, consulting psychologists are encouraged to check their "cultural baggage" (p. 149). At issue is viewing clients/organizations from their own perspective. This can be a challenge, since it requires psychologists to first understand their own culturally influenced perspectives and then consider how those perspectives influence how others are viewed (Sue & Sue, 2016). Despite the many problems associated with service to disadvantaged or discriminated groups there is an ethical responsibility to provide the most appropriate and effective care available (Sue & Sue, 2016; Trimble, Scharrón-del Río, & Hill, 2012). The psychologist recognizes that one cannot take the value and effectiveness of research or interventions for granted when working with clients and research participants from racial and ethnic minority and other minority groups. One barrier to effective consultation is the lack of data, especially data concerning individuals whose core identities may not be immediately evident, such as members of LGBTQ+ communities and other individuals with multiple sociocultural identities (Purdie-Vaughns & Eibach, 2008). Here, the consultant may wish to encourage the use of mixed methodologies that allow more qualitative strategies to inform investigators of the validity of more quantitative results (Del Toro & Yoshikawa, 2016).

Translation adequacy is another area where the consulting psychologist can make a difference—and an area that psychologists strive to consider when evaluating assessment tools. Since rigorous translations that achieve measurement equivalence require considerable time and effort (Bracken & Barona, 1991; Drasgow & Probst, 2005; Gile, Hansen, & Pokorn, 2010), the psychologist is encouraged to pay attention to the work that went into creating the translation, and the ongoing work that can be done. While many researchers employ an in-house "do it yourself" approach to translation, there is an informal gold standard that dates back to Brislin's (1970) early work on translation methodology. According to Brislin (1970; see also Koller, et al., 2007), it is critical to have different individuals prepare a translation from source material and to back translate the material into the language of the original source. It is also important to consider the target audience for which the translation was created, and whether the translation is

couched at the level of sophistication appropriate for that audience. The factorial structure of any translation can also be compared to that of the original, to help ensure that the translated version captures the original intent (Kim, Chiriboga, & Jang, 2009). Readers are encouraged to consult *Case M. Community-Based Research,* that illustrates key concepts presented in Guideline 9.

Guideline 10. Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

Introduction/Rationale

The Level 5 focus on outcomes as the ultimate component of the model encourages the psychologist to consider desired results in the context of the professional relationship. A strength-based approach seeks to consider and incorporate the positive attributes that diverse individuals, families, groups, and organizations bring to their experiences. This approach differs from more traditional models of practice that may have viewed deficits and pathology as the central focus (Clauss-Ehlers & Weist, 2004). With a strength-based approach, the psychologist operates from a perspective that acknowledges challenges while also identifying positive ways in which diverse individuals, families, groups, communities, and organizations address life experiences.

Resilience is one aspect of the strength-based approach. Resilience refers to the "process, capacity or outcome of successful adaptation despite challenges or threatening circumstances . . . good outcomes despite high risk status, sustained competence under threat and recovery from trauma" (Masten, Best, & Garmezy, 1990, p. 426). The concept of resilience has been deeply considered throughout the psychological literature (Masten, 2014), with a research and practice trajectory largely influenced by Rutter's study of how children cope with adversity (Cicchetti, 2013; Garmezy, 1991; Luthar, 2006; Rutter, 1985).

A focus on human strengths and resilience is found in positive psychology. Positive psychology is a framework that emphasizes mental health, adaptive functioning, and human strengths (Chang, Downey, Hirsch, & Lin, 2016). The focus shifts from exploring psychopathology to understanding how human beings achieve optimal well-being (Seligman &

Csikszentmihalyi, 2000). Positive psychology emphasizes individual qualities such as hope and optimism, capacity for love and vocation, perseverance, and courage over external and contextual sources of resilience. While it is important for psychologists to recognize the role of individual factors that determine resilience, psychologists are also encouraged to consider the role of contextual level factors and how they intersect with individual level factors in resilience.

In particular, although dispositional traits, such as the commitment to finding the meaning of life and a belief that one can influence the surroundings that are associated with pathways to resilience outcomes (Bonanno, 2004), resilience is also promoted by external resources, sociocultural factors, and affirming systems. In their study of first- and second-generation students who participated in a summer Educational Opportunity Fund (EOF) program to gain college entrance, Clauss-Ehlers and Wibrowski (2007) found the EOF academic institute acted as a resilience-promoting community that enhanced access to a college education. Hence, findings indicated that program participation related to significant increases in resilience and social support from peers and program staff among student participants. In another example, Theron, Theron, and Malindi (2012) studied South African adults' perceptions of a South African child's resilience. The adults reported a resilient South African child would show interrelated intrapersonal and interpersonal strengths. Intrapersonal strengths included a resilient personality, a future orientation, educational progress, value adherence, and equanimity. Interpersonal strengths included being actively supported in multiple systems. Theron et al. (2012) noted that the focus on intrapersonal and interpersonal strengths reflects the idea that resilience is a culturally congruent, bidirectional process between children and their environment.

More recent frameworks of resilience have considered a strength-based approach for understanding child and adolescent development, with attention to positive contextual, social, and individual factors that disrupt the negative effects of risk factors, and promote healthy development (Zimmerman & Brenner, 2010). Recent models have also incorporated sociocultural context into our understanding of resilience, and how social position factors such as race, gender, and social class can either promote or inhibit positive development (Clauss-Ehlers, 2008; García Coll & Marks, 2012; Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011; Suárez-Orozco, Suárez-Orozco, & Todorova, 2008). Many of these models consider how the larger sociocultural context influences resilience processes among diverse

communities. How cultural constructs dynamically influence coping and the ability to respond to adversity is also emphasized. The term cultural resilience refers to the extent to which the individual, family, group, or organization's culture promotes coping. The culturally focused resilient adaptation model has been described as "a dynamic, interactive process in which the individual negotiates stress through a combination of character traits, cultural background, cultural values, and facilitating factors in the sociocultural environment" (Clauss-Ehlers, 2004, p. 36).

Empirical evidence supports the notion that the sociocultural context be considered when examining resilience among diverse constituencies. Research has found, for instance, that cultural values, the relational context, and a sense of something larger than oneself promote resilience (Clauss-Ehlers, 2008). Consistent with ecological theory, responses of 131 Haitian children and adolescents, studied qualitatively and quantitatively in a complementary manner, indicated that resilience was derived from systems of home life and familial relationships, reflections on self-other interactions, interpersonal relationships, and connectedness with the natural and social environments, and that vulnerability was derived from living without external systemic support, placing a child at risk for an intrapersonal life of negative representation of self, self in relation to others, and personal-social attitudes (Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017).

In their study of 10- to 12-year-old Black/African American/Black American girls, Belgrave, Chase-Vaughn, Gray, Addison, and Cherry (2000) found that the girls who experienced a culture- and gender-specific intervention had significantly higher scores on a scale that measured Afrocentric values, racial identity, and physical appearance in comparison to the control group. In a study that examined the relationship between resilience and stress among a diverse group of college women, Clauss-Ehlers, Yang, and Chen (2006) found ethnic and gender identities were associated with greater resilience. In response to women who reported experiencing significant stressors, those who reported an androgynous gender identity (i.e., a gender identity that incorporated both feminine and masculine qualities) reported significantly higher resilience. Further, women who reported involvement in learning about their ethnic traditions also reported greater resilience.

Sociocultural considerations of resilience complement an expanding literature that seeks to understand the cultural underpinnings of trauma (Buse, Burker, & Bernacchio, 2013; Pole & Triffleman, 2010). Herman (1992) defines psychological trauma as:

> …an affiliation of the powerless. . . . Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. . . . Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe (p. 33).

Trauma is understood as a "global phenomenon" that characterizes the human condition (Buse et al., 2013, p. 15). While trauma is a universal experience, psychologists are encouraged to consider the cultural context in which traumatic events unfold (Wilson, 2007). Cultural considerations of trauma examine how the cultural context influences interpretation of and response to the traumatic event. For instance, the interpretation of and response to trauma may be shaped by cultural constructs such as societal norms focused on individualism versus collectivism (i.e., a focus on the individual vs. a focus on the group), religion and spirituality, body and mind (i.e., connections between the mind and the body), social roles, and overarching cultural values (Buse et al., 2013).

Understanding trauma from a multicultural perspective means that psychologists are aware that experiences and interpretations of traumatic events are influenced by the individual, couple, family, group, community, and organization's cultural perspectives. For instance, in their exploration of the applicability of cognitive processing therapy to post-traumatic stress disorder among Latino/Hispanic/Latinx and non-Latino/Hispanic/Latinx clients, Marques and colleagues (2016) found it was important for professionals to recognize how family, religion, violence exposure, and poverty shaped client beliefs and emotional responses to trauma. They conclude:

> We recognize that it can be challenging to talk with clients about their values and experiences with contextual factors, including marginalization and discrimination.

Nonetheless, talking with clients about these aspects of identity may help clients and clinicians identify and challenge stuck points, the central goal in CPT (p. 105).

Additionally, sociocultural context shapes how resilience is conceptualized and experienced in the face of traumatic stress. Harvey (2007) has argued that resilience is influenced by individuals' and communities' complex and dynamic contexts, and as such, resilience in the process of trauma recovery entails the negotiation of multiple domains of functioning (e.g., safety, attachment, self-cohesion) within these contexts. It is also important to recognize that resilience in the face of trauma is shaped by cultural beliefs and understandings (Tummala-Narra, 2007). Specifically, a behavior thought to reflect resilience in one cultural context may be considered undesirable in another cultural context. For example, survivors of intimate partner violence who view resilience as encompassing the ability to maintain a family unit and children's connections with parents may not consider the possibility of leaving an abusive partner or spouse. A different survivor of intimate partner violence, whose cultural beliefs emphasize the ability to secure independence from the abusive partner or spouse, may be more likely to consider leaving the partner or spouse.

Applications to Practice, Research, and Consultation

Practice. Culturally informed clinical and community-based interventions consider the role of historical and ongoing experiences of trauma and social injustice, as experienced and narrated by survivors (Brown, 2010; Bryant-Davis, 2007; Comas-Díaz, 2000). From a multicultural approach, practitioners recognize that resilience may be defined in distinct ways across sociocultural contexts, and that resilience and coping may be expressed in individual and collective forms (Clauss-Ehlers, 2008; Comas-Díaz, 2012; Franklin, 2004; Harvey & Tummala-Narra, 2007). Practitioners may be faced with dilemmas concerning the assessment of resilience and pathology in the aftermath of traumatic exposure. Often these dilemmas stem in part from the practitioner's cultural worldviews.

Attending to trauma and resilience in psychological practice further involves a consideration of traumatic exposure that is not currently recognized as a precipitant to PTSD in existing psychiatric diagnostic manuals. Specifically, traumatic stress rooted in exposure to violence based on sexism, racism, xenophobia, religious discrimination, poverty, heterosexism,

homophobia, transphobia, social class discrimination, and ableism, is conceptualized from a multicultural perspective as a key problem that negatively affects individuals' and communities' psychological well-being (Bryant-Davis, 2007; Comas-Díaz, 2000; Daniel, 2000; Franklin, 2004; Greene, 2013; Nagata & Cheng, 2003; Olkin, 2002; Smith, 2010; Tummala-Narra, 2005). There is ample research and clinical literature indicating that stress rooted in social injustice is associated with mental health issues, such as depression and anxiety (Bryant-Davis, 2007; Herman, 1992; Smith, 2010; Sue, 2009; Tummala-Narra, et al., 2012a). Psychologists in practice settings can inquire about individuals' and communities' experiences with social and political injustice and trauma, and their impact on psychological health and access to appropriate care and resources (Carter, 2007). Relatedly, psychologists can promote individual and collective resilience and coping in collaboration with individuals and communities such that core cultural beliefs and values are respected. It is also important to note that the role of traumatic stress is sometimes overlooked among individuals with serious mental illness.

Psychologists are encouraged to examine the sociopolitical contexts of traumatic experiences on a full range of mental health symptoms, and foster clients' understandings of the role of social injustice and trauma on their mental health. Traumatic experience and traumatic stress occur in the context of social injustice and violence, and trauma recovery occurs in the context of affirming communities and systems. Psychologists play a critical role in promoting resilience at the macro level by engaging in advocacy and collaboration with legal, medical, housing, educational, and other resources and systems of care that help survivors heal from injustices imposed on them (Goodman & Epstein, 2008; Harvey & Tummala-Narra, 2007; Herman, 1992).

Research. Exploration of resilience and trauma from a multicultural perspective has implications for empirical investigation. Research is needed on the local definitions of resilience, such as religious precepts (Roysircar, 2013a; 2013b) and political processes of nationalism and patriotism (Nuttman-Shwartz, Huss, & Altman, 2010) to provide evidence for the concept of cultural resilience. Here, research can encourage scientific inquiry to incorporate a strength-based approach. For instance, over 50% of Haitian children had higher resilience scores than vulnerability scores in their individual assessment profiles, despite continuous trauma experiences (Roysircar et al., 2015), a result that was consistent with the findings of researchers who have studied dispositional resilience (Seligman & Csikszentmihalyi, 2000), person-

environment interactional competency (Masten & Narayan, 2012), and cultural resilience (Clauss-Ehlers, Yang, & Chen, 2006; Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006). Girls and women experience many systemic and relational forms of oppression, but it is important to note that findings about sex and gender differences in children's reactions to mass trauma are mixed (Kerig, Chaplo, Bennett, & Modrowski, 2016). Gender and sex roles may vary in cultures with different religions and culture-specific experiences of social disorder.

Researchers are encouraged to be familiar with gender and sex roles in a culture to understand nuanced resilience and vulnerability responses of boys and girls, as well as men and women, in that culture, particularly with regard to the type of adversity (e.g., natural disasters, human-made disasters, political or religious violence, or a combination of all three ecological crises; Cohen-Louck & Ben-David, 2017; Tekin et al., 2016). While existing research provides important knowledge about understanding trauma and resilience from a multicultural perspective, additional study is needed to build upon the evidence base (Marques et al., 2016). Future research can also incorporate samples that represent diverse demographic and developmental variables. The application of qualitative and quantitative approaches will present diverse ways to explore relevant constructs (Chang et al., 2016). Additionally, research can explore the cumulative effects of various factors across the ecological context and in response to social injustice to better understand the complexity of trauma, mental health, and resilience (Harvey, 2007; Zimmerman & Brenner, 2010).

Research can also consider the development of appropriate measures of trauma and resilience that integrate a multicultural context (Clauss-Ehlers, 2008). Recent assessment measures have explored the concept of resilience from a sociocultural perspective. Other efforts have assessed resilience in the aftermath of traumatic exposure (Harvey, 2007). Instruments that examine resilience and trauma from a multicultural perspective can provide helpful tools for researchers and clinicians to assess strengths and challenges associated with resilience and trauma. Additional work is needed to develop assessment measures that incorporate larger contextual factors (e.g., race, ethnicity, language, gender, social class, sexual orientation, disability) in the measurement of trauma and resilience. Such scales will also benefit from psychometric data based on diverse samples.

Consultation. Consultation across research, practice, and educational settings can integrate existing knowledge concerning the role of sociocultural issues in resilience and trauma.

Specifically, research and practice consultants can help individuals and organizations consider the impact of historical and ongoing violence experienced by vulnerable populations (e.g., women and men coping with sexual violence; survivors of intimate partner violence; older adults enduring a lifetime of neighborhood violence; children coping with physical, sexual, and/or emotional abuse and neglect; and survivors of political violence, racial violence, hate-based violence, and terrorism) on individuals' psychological well-being and intergroup relations. They can also encourage individuals and organizations to assess resilience among individuals and communities as defined along unique sociocultural contexts (Tummala-Narra, 2013). Psychologists involved with training and education are encouraged to include sociocultural understandings of trauma, traumatic stress, resilience, and coping in their curricula.

Further, clinical supervisors often hold key roles in how knowledge concerning multicultural conceptualizations of trauma and resilience are translated to practice. It is important that graduate-level psychology students are exposed to research and applications related to trauma and resilience that provide an opportunity to examine and discuss the influence of sociocultural issues in conducting research and implementing interventions with trauma survivors from diverse sociocultural backgrounds. Consultation also encompasses attention to secondary traumatic stress and vicarious traumatization as experienced by researchers, practitioners, and educators (Baird & Kracen, 2006; Yassen, 1995). This is particularly important as psychologists at any phase of their training and careers may experience stress from either a personal history of trauma or repeated exposure to traumatic material that may have a negative impact on their work and ultimately, on the well-being of clients, students, research participants, and consultees.

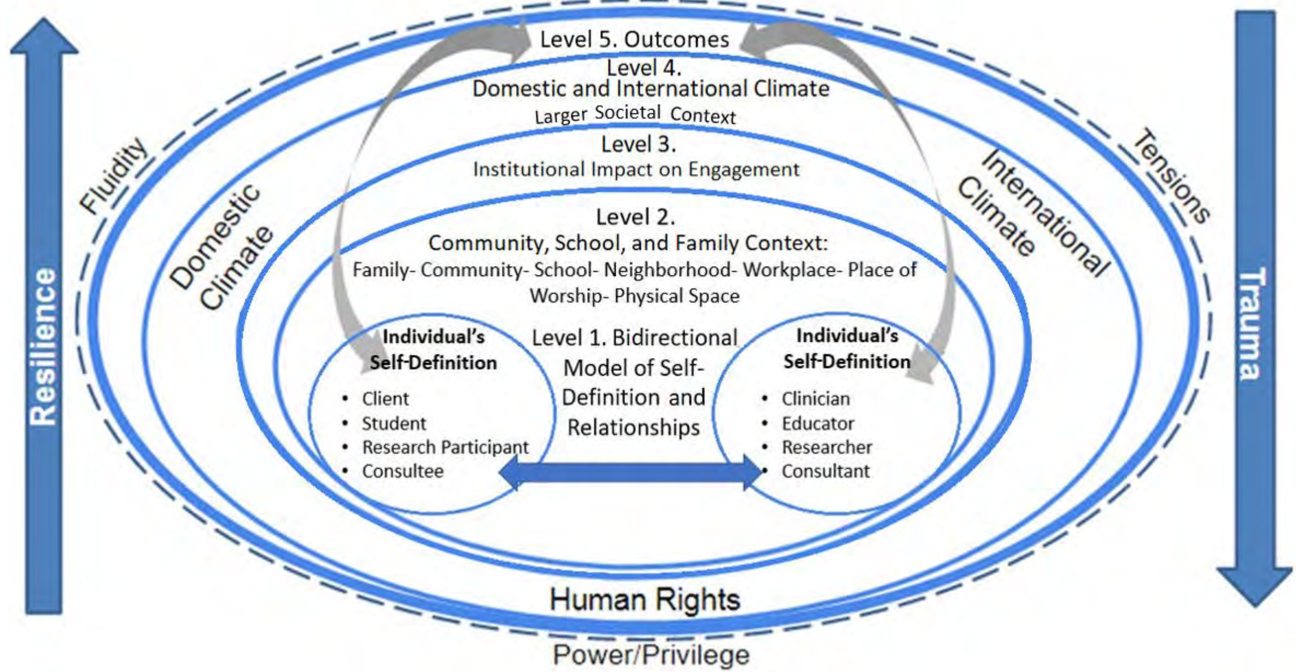
Knowledge of individual and community trauma and resilience has implications for policymakers serving vulnerable communities. Resilience appears to be the outcome of how a person's attitudes/skills interact productively with family, natural, physical, economic, cultural, religious, and social environments. The wider people's reach for resources and the greater the security and nurturance of their environment, the more resilience outcomes they will manifest. Systemic factors of resilience would include larger societal interventions, such as reductions of disparity in health and psychological care. Readers are encouraged to consult *Case N. The Oregano Family: Working with Mental Health and Faith-Based Communities in Clinical*

Training and *Case O. Lucy: Fear about a Marriage Ending,* that illustrate key concepts presented in Guideline 10.

Conclusion

The goal of the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality, 2017* is to present practice guidelines to help the practitioner, educator, researcher, and consultant strive to identify, understand, and respond to multicultural content in a helpful, professional way. The *Layered Ecological Model of the Multicultural Guidelines* presents a framework to understand multiculturally focused practice, education, research, and consultation. The model's five layers, Bidirectional Model of Self-Definition and Relationships, Community, School, and Family Context, Institutional Impact on Engagement, Domestic and International Climate, and Outcomes, present an ecological framework from which psychologists can consider and apply the *Multicultural Guidelines*.

Figure 1. Layered Ecological Model of the Multicultural Guidelines



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Appendix A: Definitions

Advocacy: Refers to the psychologists' role in promoting mental and behavioral health and well-being among those with whom they work. Advocacy in mental health extends beyond individual and group counseling into systems-level change and may involve policy work on local, state, federal, and international levels. Psychologists who serve as advocates become part of a cooperative community, working with clients, colleagues, mental health professionals, and interested supportive others to promote systems of care.

Culture: Belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care-taking practices, media, educational systems) and organizations (media, educational systems). Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group.

Disparities: Differences in domains such as health, wealth, income, education, incarceration, employment, and housing, across social identity groups. Health disparities refer to differences in access, utilization, and quality of care. Disparities are linked to structural forms of oppression and may exist with regard to racial or ethnic group, gender, sexual orientation, gender identity, or other identifying considerations, both across and within social groups.

Disproportionalities: Over- or underrepresentation of a given population that may be defined by racial and ethnic background, socioeconomic status, national origin, English proficiency, sexual orientation, and educational needs, among other variables, in a specific category.

Diversity: The definition of diversity is complex, given the array of contexts in which the word is used. It is, within the realm of psychology (and sociopolitical and legal consideration), most often associated with a recognition of a range of identities and personal attributes, across the population of individuals inhabiting a particular setting or environment, such as an educational program, or a country's citizenry, or when discussing the world at large. To be diverse is to be made up of a broad range of individuals representing the multitude of races, creeds, religious or social identifiers, or genders that comprise humanity (or the array of potential identifiers associated with an attribute of nature). It is strongly associated with the concepts of difference, tolerance, and multicultural engagement.

Human rights: The United Nations defines human rights as universal legal rights that protect individuals and groups from those behaviors that interfere with freedom and human dignity (Min, n.d..). Key aspects of human rights are that they are recognized internationally, legally protected, and concerned with human dignity; are universal and

interdependent; cannot be taken away; protect individuals and groups; and are obligations of the State and State leaders (Min, n.d.).

Implicit racism: Implicit racism refers to an individual's utilization of unconscious biased attitudes when making judgments about people from different racial and ethnic groups. Implicit racism is an automatic negative reaction when a person is faced with race-related triggers, including phenotypic, cultural, class, and/or speech/accent differences. Since this type of racism lies beyond the awareness of individuals, they may report that they do not hold racist ideologies and yet display implicit racism in their everyday interactions. Implicit attitudes influence "responses that are more difficult to monitor and control… [e.g., eye movements, blinking] or responses that people do not view as an indication of their attitude and thus do not try to control" (Dovidio, Kawakami, & Gaertner, 2002, p. 62).

Internationalization of psychology: A process by which psychologists demonstrate awareness of the globalization of psychology. Psychologists recognize that their assumptions, values, and biases reference their national history and culture. Internationalization entails recognizing and appreciating global variations in human behaviors, norms, explanatory systems, thought processes, religion, spirituality, and styles of social communication and interaction.

Intersectionality: A paradigm that addresses the multiple dimensions of identity and social systems as they intersect with one another and relate to inequality, such as racism, genderism, heterosexism, ageism, and classism, among other variables. Intersectionality is organized around the location of self within a set of co-constructed social identities (e.g., Black/African American/Black American, gay, older adult, male), and proposes ways to identify, challenge, and resist various forms of oppression. The study of intersectionality has been a significant paradigm within women's studies and is becoming a focus for psychologists who do research and engage in activism regarding historical and contemporary social injustices.

Language: Those symbols, both verbal and nonverbal, that an individual uses to express their ideas and knowledge. Language embodies culture; a society's language reflects its cultural values. For instance, in Spanish the word "I" is "yo," and is written in lowercase rather than uppercase as is found in North America (Clauss-Ehlers, 2006). This reflects the collective aspect of many Latin American countries where the group is more important than the individual.

Macroaggressions: Best defined as potential large-scale or overt acts of aggression and disrespect that are directed toward those of a different race, culture, gender, religion, or other sociocultural identity. Macroaggressions include direct and indirect acts of bias that are broadly engaged toward diverse individuals or groups, and are typically readily identifiable given their presentation. One example of a macroaggression would be recent actions taken to diminish the power in the statement "Black Lives Matter," through

efforts to dismiss clear differences in actions taken by political and legal structures against one group specifically (e.g., the promotion of the campaign stating "All Lives Matter," where specific and necessary efforts to emphasize the importance of speaking out in support of African Americans and their challenges within the historical and current culture are challenged by statements made by predominantly White/White Americans that no one group of individuals is due any greater regard than any other, thereby attempting to negate the consideration of aggressions toward a specific group as important and necessary). Macroaggressions can be contrasted with microaggressions, which are perhaps more covert and insidious.

Microaggressions: Lately, the discourse on racism has shifted from overt exo-level manifestations like legal segregation or Jim Crow laws to subtle or indirect discriminatory behaviors and expressions of bias at the interpersonal level, called microaggressions. Microaggressions are: "Brief and commonplace daily, verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273). Microaggressions are likely to emerge not when behavior would look prejudicial, but when other rationales could be offered. Many microaggressions have become conditioned, with people not realizing that they are engaging in them. In this interpersonal dilemma of unintentional and/or invisible prejudice, there is a question as to whether a racial incident actually happened, resulting in a clash of realities for the actor and the target.

Multicultural: The coexistence of diverse cultures that reflect varying reference group identities. Multicultural can embody the coexistence of cultures within an individual, family, group, or organization.

Prevention: Efforts that aim to avert the development of a challenge, disease, or concern related to mental health, health, or safety, among other areas. Prevention is often divided into three categories: primary prevention seeks to restrict or diminish the onset of an issue or disease through reduction of risk; secondary prevention aims to reduce or end disease progression through the identification and treatment of a condition before it becomes symptomatic; tertiary prevention refers to efforts that decrease the impact of a disease or concern once it has been treated. In education policy, early intervention refers to services provided for children from birth to age 3. These services seek to promote health and well-being, respond to any existing developmental delays, decrease developmental delays, enhance educational skills and competence, and support the parental role.

Privilege: Unearned special rights, immunities, and societal advantages that are granted on the basis of membership in a dominant social identity group. Privilege represents an expression of power. Through cultural norms and values, privilege oftentimes is invisible to those who possess it.

Oppression: Superiority exercised by the dominant group over other groups through laws, policies, cultural norms, and everyday practices that produce and reproduce societal inequities. Structural forms of oppression inhibit the ability to develop one's full potential and may result in negative physical, psychological, and social outcomes.

Resilience: The ability to overcome structural and individual challenges through a combination of character traits, cultural background, cultural values, and environmental supports. As such, resilience is considered an ability to overcome challenges given both individual and contextual strengths.

Self-definition: An individual's description of one's identity and identifications with one or more cultural groups or communities. A person's self-definition can shift across time, context, and life transitions, and has implications for identity labels. Self-definition is linked to a sense of agency and control over one's own life. Due to internalized forms of oppression, self-definition might reflect distorted perceptions of cultural groups produced through stereotypes and prejudice.

Social justice: Full and equal participation of all groups in a society that is mutually shaped to meet their needs. Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure (Bell, 1997).

Stereotypes: Fixed, overgeneralized beliefs about a group or community. These beliefs can relate to different aspects of diversity such as age, gender, race, ethnicity, national origin, sexual orientation, ability status, language, religion, and social class. Stereotypes shape attitudes and behaviors toward various sociocultural groups and contribute to discrimination.

Strength-based approach: Focuses psychological practice toward recognition of the inherent strengths of individuals, families, groups, and organizations. It developed as a response to more traditional deficit-based models of pathology and intervention, and instead guides professionals in assisting clients and consultees to use personal strengths as a means of attaining recovery and empowerment. This approach views health and well-being holistically, by engaging assets to identify and achieve positive outcomes.

Trauma: Experiences of extraordinary, terrifying events such as accidents, natural disasters, interpersonal violence, political violence, and war. Recent conceptualizations of traumatic experiences include hate-based victimization (e.g., violence against racial groups and LGBTQ+ communities). Responses to traumatic events involve an array of psychological and physical concerns such as nightmares, flashbacks, hypervigilance,

difficulty regulating affect, headaches, difficulty concentrating on tasks, loss of trust in others, and relational challenges.

Appendix B: Case Studies That Illustrate the *Layered Ecological Model of the Multicultural Guidelines**

Case studies are presented to help illustrate the applied aspect of *Re-envisioning the Multicultural Guidelines*. Cases represent clinical, educational, research, and consultation scenarios. Please note that while cases strive to reflect intersectionality across a range of diverse backgrounds and experiences, it is beyond the scope of this project to portray all dimensions of diversity. As such, case studies seek to address a range of multicultural scenarios that might be found in clinical, educational, research, and consultative arenas. Case studies can be used as teaching and training tools.

* Names and identifying data have been changed to protect confidentiality. Some cases are composite cases, incorporating various experiences; others are fictional.

Level 1 Case Illustrations: Bidirectional Model of Self-Definition and Relationships

Guideline 1. Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

A. Tuan: Identity Transformation and Intersectionality over the Life Span

Tuan is a 48-year-old cisgender Vietnamese American bilingual man who has sought help from a psychologist to address his depressed mood and isolation. In the initial session of psychotherapy, Tuan told the therapist that he identifies as Vietnamese American. When asked by the therapist about whether he was in a relationship, he responded, "I'm not in a relationship. I'm not sure what my sexual orientation is."

Tuan was born in a large city in Vietnam and arrived to a rural area in the United States with his parents when he was 10 years old. While in Vietnam, his family faced financial struggles and had hoped for improved living conditions in the United States. He reported growing up in a middle-class home with parents who worked hard in a small business. He lived in a neighborhood and attended school where there was little racial and cultural diversity. At home, he spoke Vietnamese with his parents, and outside of home, he spoke English. He often felt different and "on the outside" at school, but did develop a few close friendships. In describing his school experiences, Tuan spoke about how he had always thought he felt different due to his racial and ethnic backgrounds, but that in recent years, he realized that he also felt different because of his sexual orientation. Tuan recalled that he was attracted to boys and girls while in school and college, but never believed he could talk openly with anyone about his feelings.

Tuan later married a second-generation Vietnamese American heterosexual woman. The marriage ended after 3 years, when he disclosed to his wife that he was sexually attracted

to both men and women. Following their divorce, Tuan began exploring his attraction to men but dated infrequently. About one year prior to seeking psychotherapy, Tuan disclosed his sexual orientation to his parents. To his disappointment, Tuan's parents said he was "dishonorable" and they would not accept his sexual orientation. Tuan had few supports and confided in one friend. His friend, while sympathetic to Tuan's painful experience of coming out, was unsure of how to support him. Tuan increasingly felt like a burden to his friend and parents, and wished that he no longer had to feel the pain and anguish of living a secret life. He felt as though no one could understand his conflicts. He coped with his sadness through working more hours and staying isolated.

Over time and as he explored his sexual orientation, Tuan felt more disconnected with his Vietnamese heritage and language. In psychotherapy, Tuan struggled with how to come to terms with what he has known about himself for a long time, and how others can accept his sexual identity. He reported feeling as though he could not be the "right type" of Vietnamese person in his parents' view, nor could he be the "out" bisexual man to non-Vietnamese American and non-Asian American friends who did not understand why he couldn't just "be himself." Tuan told his therapist that he could not fully be himself in any situation, always having to hide some aspect of self to connect with others.

Questions for Discussion:

1. Are there aspects of Tuan's identity that feel difficult to address in psychotherapy or counseling? Do you have a sense of why?
2. For what reasons might Tuan feel uncomfortable or reluctant to describe his challenges within and outside of his family with a therapist?
3. How can therapists help clients explore the multiple dimensions and fluidity of their identities?
4. How might you explore the complex nature of Tuan's identity in an empirical study?

B. An Example of Inclusive Research

A research team at Alphabeta University developed a study of sleep and cognition that ultimately involved the assessment of over 1,000 children between the ages of 7 and 9 years of age, who were recruited from urban and suburban communities in two U.S. cities. The goals of the study were to assess the impact of snoring and sleep disordered breathing (SDB) on the youths' cognitive and behavioral development. Given concerns about the role that racial and cultural factors may play in the interaction between development and this medical condition, the researchers made a decision to emphasize a predominantly underserved population across a range of socioeconomic and cultural backgrounds consistent with the cities being used for the study (i.e., Chicago, Illinois, and Chapel Hill, North Carolina), as well as the general population of children and their families being seen in respective sleep clinics.

Children who participated were evaluated across a number of variables addressing their sleep status and the arousals they experienced secondary to their SDB. This was done

using standardized approaches to sleep assessment, including completion of a polysomnographic study while the child slept overnight (with a parent accompanying them) in the clinical research laboratory. The children also underwent comprehensive assessments of their cognitive and behavioral status, including completion of a set of neuropsychological measures such as IQ and educational attainment, but also attention, problem solving, and memory tasks; parent reports about their development and sleep profiles; questionnaires regarding emotional and behavioral regulation; and an assessment of their sleep efficiency.

The study aimed to apply specific theoretical approaches to address the potential relationships between SDB and cognitive inefficiency, as well as behavioral difficulties that are often seen as a result of sleep problems and sometimes misdiagnosed as a disorder such as Attention-Deficit/Hyperactivity Disorder (ADHD). Because substantial prior research has focused most directly on children representative of a White/White American suburban middle-class background, the research team determined that, with their approach, the study required being more directly inclusive of a wider range of children across cultures and socioeconomic status backgrounds.

The principal investigators expressed a particular concern about the possible variability that might be found, given educational differences across cultural and racial groups, socioeconomic differences the families experience, and differences secondary to gender that all contribute to health challenges that underlie snoring and SDB. As a result, they developed the study as a comparison across groups recruited both within and across the settings in which recruitment took place (e.g., families coming to an urban hospital that was situated within a more diverse section of the city, such that Latino/Hispanic/Latinx and Black/African American/Black American children were readily able to be included, versus children from a setting that was more suburban and less diverse in terms of socioeconomic and cultural groups recruited).

The researchers discussed with their statistician the need to focus on multiple potential moderating variables, including race and ethnicity, but also parental education and income, type of educational setting, availability of physical activities for recreation, and resources such as a local grocery store with an affordable range of healthy food choices. One particular consideration for the research team was potential vulnerability to SDB; the study's Principal Investigator (PI) in particular was concerned that, based on previous studies, it was known that obesity contributes to a greater likelihood of developing SDB, and children of Latino/Hispanic/Latinx and Black/African American/Black American backgrounds were more prone to being identified as obese.

Results from the study were particularly informative; they highlighted a number of potential effects, such as the strong influence of SDB on neuropsychological profiles in the attention and executive functioning domains, and less successful grade profiles. More importantly, however, the researchers identified that differences in socioeconomic background were a significant moderator of these effects. Specifically, children with lower available financial resources appeared to show a greater impact of SDB on their learning and skill development. To better address these concerns, the team turned to their

statistician to utilize a set of analytic approaches to the data. These approaches more effectively allowed for matching subjects across the range of variables identified as showing cultural and racial differences to better explore and address these important factors. They also felt that this allowed for a greater emphasis on multicultural factors in the onset and expression of a challenging health concern. In turn, it was thought that this approach would more effectively engage the public and guide physicians to pay closer attention to sleep in their patients.

Questions for Discussion:

1. When addressing the prevalence and impact of sleep disordered breathing in their subject populations, what were the important factors requiring attention, given differences regarding a range of cultural and racial/ethnic factors?
2. When conducting research regarding the interaction between physical and psychological concerns, like sleep and cognition, what would you highlight as an important set of considerations to develop an appropriate study sample and ensure appropriate statistical considerations?
3. Because factors such as race and sociocultural status intersect, how can a research team effectively parse the potential impact of these factors on study design and analysis?

Guideline 2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

C. Marcus: Exploring Stereotypes and Microaggressions

Marcus is a 40-year-old cisgender, heterosexual African American man who has been coping with anxiety and panic attacks since he was in his early 20s. He worked with a therapist previously for a few sessions, but did not find this experience helpful. He reported that his previous therapist appeared uncomfortable and unsympathetic with his concerns about the challenges he faced at his workplace. As the intensity of his anxiety symptoms increased over the past year, he decided to seek help from another therapist. In his first session with this new therapist, Marcus disclosed that he felt overwhelmed by work-related pressures, and that he felt as though he was always looking over his shoulder to be sure that he could maintain his position.

Marcus grew up in a low-income neighborhood where he struggled with traumatic events on a regular basis. He described his relationship with his parents and his older sister as close, but reported that the family coped with stress related to long work hours for his parents, and with ongoing violence in their neighborhood and schools. Marcus would frequently hear shots being fired or learn about people being robbed.

Marcus received scholarships to attend a high school far away from home, and subsequently to college, where he studied engineering. He described his experience of leaving home as “confusing and difficult,” as he missed his family and friends, and the predominantly White institutions he attended felt unfamiliar. Marcus’s focus and drive to excel academically brought new economic opportunities, and he was able to help his family financially. However, Marcus remained feeling “like an outsider” at school and later at work. He has also dreaded being around extended family since he left for college as several family members have commented that he acts as though he “is above them.” Marcus noted that he had experienced anxiety throughout his life, first due to the violence near his home, and later due to a lack of safety and belonging when living away from his family home.

Marcus shared with the therapist that he continues to feel as though he constantly has to work harder than anyone in his workplace to maintain the managerial level position he has achieved. Marcus also told his therapist that his co-workers, none of whom are African American, assume that he has always been wealthy given his educational opportunities, and yet, on the other hand, project stereotypes about African American men as being lazy and aggressive. He struggles with others’ perceptions of him, feeling as if they “box” him into ideas about who he should be, rather than reflecting who he really is. Marcus indicates to the therapist that he does not want to be put in a “box” or category. His experience of being stereotyped and categorized has taken a significant toll on Marcus’s psychological well-being, as evidenced in his anxiety and panic attacks. Sometimes, he even wonders if his success is due to affirmative action rather than his own ability, and whether or not he can continue to be successful.

Questions for Discussion:

1. What reactions and feelings come up for you as you read about Marcus and his therapist? How might these feelings influence the way you might interact with Marcus?
2. How does your current knowledge or understanding of African American men’s racial and social class experiences inform how you might conceptualize Marcus’s concerns?
3. Have you had the experience of feeling “boxed in” or categorized by others based on their understanding of people from racial or sociocultural backgrounds with whom you identify?
4. How have you tried to help clients cope with isolation related to stereotyping or discrimination? What types of resources outside of counseling or psychotherapy have been helpful to your clients in addressing stereotyping and discrimination?

D. Melissa: Training Experiences as a Practicum Student

A 22-year-old, gender non-conforming psychology practicum student training on an inpatient unit shadowed a male psychologist. Dr. Samuel, an older, cisgender, heterosexual person, was a practicing evangelical Christian who integrated his deeply held beliefs with his approach to clinical and professional practice.

Shortly after beginning practicum, Melissa, who requested the pronoun “they”/”them” rather than “she”/”her” when others referred to Melissa, had a conversation with Dr. Samuel, who discussed Biblical verses to frame a point being made. For instance, Dr. Samuel presented Melissa with a video to watch that discussed the importance of a Biblical framework for explaining human nature, and Melissa hesitantly obliged. However, Melissa identified as secular and feminist, and in actuality felt offended by Dr. Samuel’s request. Given the power differential and role of a practicum student on an inpatient unit, Melissa felt obligated to converse with Dr. Samuel about his Christian beliefs and values within the context of his supervision of their work.

While Melissa never witnessed Dr. Samuel discussing his religion with his clients, they observed several ways in which they believed his religious orientation influenced how he dealt with female versus male patients on the unit. It appeared to Melissa that Dr. Samuel was often more dismissive toward his female patients by having shorter meetings with them and being more directive regarding how to progress with treatment, in comparison with their observations of his interactions with male patients. They also observed that Dr. Samuel would address his White patients differently than patients of color and those who spoke a primary language other than English. They noticed that Dr. Samuel was quick to diagnose patients of color and those less proficient in English, and he was often more dismissive of their communications with him. On the other hand, he appeared to spend more time trying to understand his White, English-speaking patients of different ethnicities and cultures. Melissa soon got the impression that many of the female patients and patients of color would rather work with the other psychologists on the unit.

Aside from patient-therapist interactions, Melissa also noticed that Dr. Samuel interacted differently with his coworkers. Notably, most of the professionals on the unit were women, and Dr. Samuel never shook hands with or made direct eye contact with these female colleagues; this was quite different from his interactions with male colleagues on the unit. Dr. Samuel’s behaviors with both his colleagues and his patients made an impact on how he was often viewed by women coworkers on the unit, and Melissa overheard many conversations between staff members sharing the viewpoint that Dr. Samuel was disrespectful with them.

Questions for Discussion:

1. Discuss how stereotypes can be held by almost all individuals, no matter their ethnic, racial, religious, age, sexual orientation, and gender identity statuses, and the intersectionality of these backgrounds.
2. Discuss how unconscious beliefs and attitudes of both psychologists and student trainees can have an impact on clinical relationships with clients as well as coworkers. While clinicians and trainees may not intentionally react to clients and fellow professionals in a harmful or stereotypical way, discuss how they may hold implicit biases that drive reactions to clients or coworkers.
3. Could the given case be superimposed on a professional who is a fundamentalist Muslim; a conservative Brahman Hindu; a traditional Catholic; or an Orthodox Jew? Could the case be superimposed on a psychology practicum trainee of diverse self-definitions and identities, such as an international student, an immigrant, someone with

refugee status, someone whose second language was English; someone with a gay, lesbian, or bisexual orientation; someone with a non-Western religious or spiritual affiliation; or someone from an upper socioeconomic class?

4. What are your views about "color-blind democracy" in the theory, research, and practice of psychology?

Level 2 Case Illustrations: Community, School, and Family Context

Guideline 3. Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

E. Dr. Enrique: Culturally and Linguistically Responsive Consultation

Dr. Enrique is a licensed Latino/Hispanic/Latinx male psychologist who has been contacted by the principal of a local Catholic school to consult with them about parent involvement. The school serves students in the elementary school years and is located in a low-resource neighborhood in the heart of a large metropolitan city. The student body is primarily Latino/Hispanic/Latinx with most children speaking Spanish at home. While instruction at the school is primarily taught in English, most of the students' parents are monolingual Spanish speakers.

When the principal contacts Dr. Enrique, she says that the teachers are very concerned about the lack of parent involvement. The school staff shares the belief that parent involvement is critical to the academic success of their students. Further, while the school has reached out and invited parents to events, the turnout has been low. The principal explains how the teachers interpret the lack of parent involvement as parents not caring about their children's academic success. Teachers are frustrated with the lack of response on behalf of the parents. The principal senses low morale among teachers and is concerned that this will have a negative effect on interactions between the school and students/families.

Dr. Enrique is motivated to learn more about the current situation and how to respond. First, Dr. Enrique reaches out to the teachers. He hears their concerns about the lack of parental involvement and participation. Dr. Enrique inquires about the events with no parent participation. He learns that they were advertised in English because the school did not have a translator. He also learns that the events were scheduled during the day at a time when many parents may have been working or taking care of young children.

Dr. Enrique suggests that the school plan another event. He reaches out to the principal, stating the invitation must come from the head of the school, and then trickle down through the teachers. Flyers are sent home in Spanish. The event is scheduled during the evening in hopes that parents will not be working. The flyer clearly states that child care will be offered and refreshments served. The flyer is sent out two weeks prior to the

event, and then subsequently sent home in children's backpacks once a week for the following two weeks.

The night of the event approaches. Teachers and the principal are present, as are other administrators. Volunteers help watch the children as needed and a buffet dinner has been organized. Slowly parents begin to circle into the main hallway where the event is held. The room begins to fill to the point that there are more parents than teachers. Dr. Enrique opens the conversation in Spanish and English—welcoming everyone to the event.

As the conversation continues, he shares that the school invites parents to be more involved in the day-to-day life of the school. Teachers talk about specific ways that parents can come to school and participate in various activities. Parents share that their lack of engagement reflected their sense that it would be disrespectful to the school, specifically to the teachers, if they came in. They share that in their cultures, *respeto*, or having a sense of respect for others, is of utmost importance. Not participating in the life of the school is born out of concern that their participation would be viewed as a lack of *respeto*. Parents didn't want their children's teachers to think that they did not respect their role by being present at the school. They shared that in their cultures, parents tend not to get involved as an indication that they have the utmost trust in the teachers and their decisions.

Through communication of the two perspectives, the teachers can clearly share with the parents that they want them to be involved in the life of the school. They talk about how their school in the United States truly wants to build working partnerships with parents. Hearing the invitation, parents commit to greater involvement. It is as though having the teachers' permission prompts them to feel more comfortable with participating more fully.

Questions for Discussion:

1. What is your view of the consultant's role within a multicultural context?
2. How can the consultant understand and incorporate cultural values and perspectives in work with organizations?
3. How did Dr. Enrique respond to each of the constituencies involved in the school? How did his response encourage collaboration among constituencies?
4. How does Dr. Enrique's example inform your own work as an organizational consultant working within a multicultural context?

Guideline 4. Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

F. Yasmin: Bridging Different Worlds

Yasmin is a 28-year-old Muslim, immigrant, cisgender woman from Pakistan. She continues to experience the loss of her husband who was killed in the September 11, 2001 collapse of the World Trade Center, where he worked in a small business. Yasmin has experienced numerous acts of racially motivated verbal and physical aggression since 9/11. She has also experienced the challenging demands of raising her son who was born with multiple disabilities.

After her husband's death, Yasmin's parents and parents-in-law came from Pakistan, taking turns living with her, supporting her, and helping her with child care. Their eventual departure was very difficult for her. For the past 5 years Yasmin has lived by herself.

Yasmin mourned for her husband for several years. She eventually entered into a relationship with another Pakistani man. This relationship helped Yasmin express herself in ways that helped her to be less conservative than previously. While romantic, this was not a sexual relationship. However, due to disagreements about the care of her son, Yasmin decided to end the relationship.

Yasmin was very close to her father until he passed away a few years ago. Between her father, husband, and former male companion, she always had a strong male figure in her life. When Yasmin decided to end the relationship with her companion, it was the first time that she was without close male guidance. Yasmin had to live independently. She struggled to pursue a career in retail, take care of herself, and meet the particularly challenging demands of her son who was completely dependent on her. Yasmin chose to stop wearing her hijab (a veil/head covering that often covers the head and chest) partly for her own protection from being stared or shouted at in public transportation, or in large stores. Nonetheless, she continues to face prejudice because of her accent and speech, physical appearance, behavioral differences, and gender practices. However, Yasmin has made friends, Pakistani as well as American, who have helped her in ways that she needed following the passing of her husband. However, Yasmin does not have the familial and communal support that she would have if she were in Pakistan. Despite these challenges, Yasmin is taking online courses to improve her career standing. Her perseverance through struggles attests to her resilience.

Yasmin is now dating a White/White American male whom she met at work. While this man is good to her son and Yasmin likes many aspects of an egalitarian relationship, she is bothered by his sexual advances. She likens his amorous behaviors to sexual assault and believes she is at risk for rape. Because of her Muslim faith and cultural gender role, Yasmin believes that intercourse should occur only after marriage. She feels immodest, thinking she is sexually provocative. Sometimes she thinks she is a sinner. Yasmin is filled with shame, thinking that she is letting down her mother, sisters, and mother-in-law, who had advised her to return home to them in Pakistan for her protection, sexual purity, and for the preservation of her conservative values and practices. Yasmin also feels guilt, thinking she will be unfaithful to her dead husband if she has sex.

Questions for Discussion:

1. Describe practitioners’ self-reflections about a dominant society’s use of oppression, privilege, and power over religious minority groups and individuals; their reflective self-examination of their own biases and stereotypes about Islam and its followers; their ever-present awareness of their multiple social identities as well as those of others; the biases that exist because of such identities; and how their interactions with others are based on these identities.
2. How would a psychologist incorporate trauma and resilience when working with a culturally diverse person who has suffered continuous life stressors including racism, discrimination, and societal hatred? How would a psychologist evaluate theoretical adaptations to demonstrate evidence-based practice?
3. Discuss practitioners’ need to understand Islamic tenets and the differences between Muslim culture and that of the United States. Discuss an understanding of how much a particular Muslim immigrant is committed to such ideals and how difficult it may be to remain committed to one’s faith in the United States; how it might be common for Muslim women living in the United States to struggle with the difference in women’s roles in the United States versus those in an Islamic culture; and how such underlying gender roles may make clients uncomfortable with a practitioner.
4. How would Yasmin define self, community, and their relationship with each other?
5. Describe Yasmin’s challenges as she adapts to life in a highly individualistic environment as opposed to the collectivist family culture she was used to.

G. Anthony: Having an Identity That Extends Beyond One’s Disability

Anthony, a 25-year-old, cisgender, biracial/multi-ethnic (Black/African American/Black American, White/White American, Latino/Hispanic/Latinx) male, was referred for individual psychotherapy in conjunction with his participation in ongoing vocational rehabilitation programming. He presented with a history of mild intellectual disability that was acquired secondary to a traumatic brain injury (TBI) he sustained during early adolescence when he was in a motor vehicle accident with his family. Of note, Anthony and his brother were the only members of their family to survive the accident, and both sustained significant TBI’s.

Anthony was fifteen at the time of the accident, and he had been highly functioning prior to his TBI. Before sustaining his injury, Anthony had been enrolled in a college prep high school program and was active in both athletics and extracurricular activities, including chess and computer design clubs. He and his brother, who is three years younger than Anthony, were the middle children in a large family of six boys and two girls. Anthony lost both his parents and two of his siblings in the accident. Two older siblings (males), both of whom were adults and living on their own at the time of the accident, now serve as guardians for Anthony and his brother. The two youngest siblings (one male, one female), were also not in the car at the time of the accident. Subsequent to the accident they were raised by an aunt who lived in a nearby city. Anthony visits these two younger siblings during the holidays and at family gatherings.

Anthony's case manager, when discussing current concerns with the psychologist, indicated that Anthony had been struggling of late with impulse control, particularly around select peers, both male and female. This led to difficulties both at his residence, a group home program for young men who have neurodevelopmental challenges, and in the sheltered employment program Anthony participates in weekly. The case manager indicated that she suspected some of his impulsivity, which has included inappropriate language and touching, was related to Anthony's desire to be more like his typical peers who are in relationships. She shared that she and the staff working with Anthony were seeking guidance on how to best support him in making better behavioral choices, particularly around his romantic and sexual feelings. The case manager also shared that they were looking to provide Anthony with an opportunity to more directly address his feelings of difference that appear to have an impact on his mood.

At first, therapeutic work with Anthony focused on helping him share his current experience of himself as a man with an acquired neurodevelopmental disorder as well as to gain an understanding of how his viewpoint about himself had changed. This work was done in a context of Anthony's awareness of who he had been prior to the accident and what was different for him as a consequence of his injuries and the loss of some capabilities. It was clear from early on that Anthony's tendency to act and speak impulsively were primary consequences of his TBI. He sustained injuries to his developing executive skills, such that challenges were noted with flexibility, thinking strategically, and impulsivity, including saying inappropriate things as they came to mind. It also became evident that Anthony's recent behavioral difficulties, where he impulsively sought out more intimate interactions with male and female peers, were associated with efforts to be "more of who I used to be, someone who went on dates and had friends, who had people in my life who wanted to be around me."

Anthony shared that he often felt dismayed that he was now seen as "ugly" and "stupid" by other men and women he saw daily. He brought in a photo of himself, taken during adolescence and prior to his accident. Anthony actively compared what was different for him then with now; he focused specifically on the scar he had because of his neurosurgeries for his TBI; his loss of gross and fine motor skill, such as his inability to ambulate independently; and his altered growth, that made him much shorter than peers. Anthony began to talk more directly about what he had lost cognitively and emotionally because of the accident; sharing that he had been a budding wrestler and a good student before his TBI, and that he had many friends then too. Since then, his path had changed significantly, with many associated losses in terms of opportunities and expected outcomes. Anthony shared that he was most often reminded of these losses, including the fact that he had just been able to start dating shortly before the car accident, when he saw perceived neurotypical peers outside of his program and residence.

Anthony experienced significant and understandable sadness about these losses. He was able to identify that this led him to want to "change stuff" by making his life "normal." However, Anthony also admitted that some things could not easily be changed, like his inability to ambulate without a walker, and that he needed to use a wheelchair when

required to go long distances. Anthony shared how this was a substantial limitation on his ability to ask a peer out on a date, or to spend time with a peer without adult supervision.

As treatment continued, discussions focused on Anthony's experience of these losses and their impact on his ability to see the possibility of a life that was more layered and optimistic. With regard to his impulsive actions, the therapist helped Anthony better understand his range of feelings regarding intimacy and sexuality. The therapist and Anthony took into account that he had physical and cognitive differences secondary to his TBI that affected how Anthony could share, verbally and through touch, his attraction to someone. As a man who was hampered in his mobility and capacity for physical contact across a variety of situations and settings, it was important for the therapist to help Anthony and his support team address how he, a young man with many typical wishes and desires both in terms of love and physical interest, could address these within home and work environments.

One important step forward occurred when Anthony was able to meet a wider range of peers, both for friendship and potential dating, and to work directly on how to discriminate between an interest in intimacy and frank sexual desires. Therapy additionally helped Anthony become more comfortable with how he could express and address his physical desires. This was accomplished in part through a better understanding of his own body and learning how to address feelings in a socially appropriate manner. Social scripts were developed, with coaching provided within treatment as well as with the teams at work and in the residence. This allowed Anthony to more effectively inhibit immediate wishes to connect through touching, that were often perceived as intrusive and inappropriate. Instead Anthony could work toward initiating interactions verbally, allowing boundaries to be established.

Anthony worked to recognize himself as not only someone with a disability, but also as a member of a wider array of communities, where his strengths and differences could be better appreciated. His beliefs of himself as "damaged" and "ugly" were challenged through opportunities to ask both how others perceived him, and through frank discussions about how this allied with and differed from his own expectations and perceptions. Anthony was supported in more directly mourning the trauma and losses he experienced, so that he could begin to conceptualize himself as both a survivor and as resilient. This led to two important changes: One, Anthony began to see himself as moving forward on a new trajectory, which, while different from his path prior to the accident, was still valid and open to many successes. Two, Anthony came to recognize that he himself could play a more active role in decision making. These changes led Anthony to seek out new opportunities within his vocational program and to open himself up to the interest a fellow peer had expressed with regard to dating him.

Questions for Discussion:

1. Describe practitioners' considerations regarding cognitive and physical disability, and how these are conceptualized within the dominant society's continued emphasis on privilege, oppression, and capability.

2. How would psychologists adapt trauma theory to address the challenges experienced by Anthony, a biracial/multi-ethnic man, who has lost both family and his experience of himself as a functional member of the community? How would they evaluate theoretical adaptations to demonstrate evidence-based practice?
3. What is required of practitioners so they can have an understanding of how disability is experienced within the United States? What can promote an understanding of how individuals with cognitive and physical challenges experience daily life that can subsequently facilitate more effective problem solving within supportive treatments?
4. How can a therapist consider disability across multiple levels of identity? What are the implications of these considerations for understanding intersectionality?

H. Jung: Access to Culturally Relevant Treatment

Jung is a 70-year-old Korean woman who married an American soldier and came back to the United States with him when he left the service. They lived in a rural area of northern Maine, where her husband was a fisherman until his death five years ago. Jung's English proficiency is minimal and she suffers from left-sided paralysis secondary to a stroke. Since her husband's death, Jung has become increasingly depressed because there are no Koreans living nearby and her disability limits travel. Jung has become increasingly isolated, her only social contact being a friendly postman and the grocery store clerk who delivers her food.

Jung's primary care doctor realizes there is a problem but Jung's limited ability to speak English and reticence to talk about mental health issues interfere with any care beyond medication. A search of local mental health providers revealed there is no one within 100 miles who speaks even limited Korean. Jung shuts down when the doctor encourages her to try a telephone interpreting service. In desperation, the doctor contacted the Korean Consulate and spoke with staffers working in a facility in Nova Scotia, the closest to Jung's home. The consulate arranged for a psychologist fluent in the Korean language to speak with Jung via the Internet on a monthly basis while she is at the doctor's office.

Questions for Discussion:

1. How could Jung's relationships with the delivery person and the grocery clerk be incorporated into achieving her treatment goals to help her feel less isolated?
2. How could local resources, in addition to the postman and clerk, help in providing a more beneficial environment for Jung?

Level 3 Case Illustrations: Institutional Impact on Engagement

Guideline 5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to

address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

I. Aiden: Struggling with Loss, Grief, and Inequity

Aiden is a 10-year-old, White/White American boy of Irish descent, who was referred to a psychologist by his school counselor. Aiden has been struggling with completing his schoolwork and concentrating on tasks. According to his teachers, he has been disruptive in class and unable to complete homework on a regular basis. His grades have declined over the course of several marking periods. While the school recommended an evaluation, the process was delayed due to Aiden's father's hesitancy to engage in the testing process. Rather, Aiden's father repeatedly shared that his son didn't have psychological issues, stating that his behavior was just reflective of his being a kid. He continued to encourage Aiden to focus on his schoolwork and not let feelings "get in the way" of academic success.

It was when Aiden's grades dropped substantially that his father finally agreed to the evaluation process. Aiden was evaluated for a learning disability. Testing results indicated that he did not have a learning disability, but rather, issues of grief and loss were affecting his academic life. The evaluator recommended that Aiden be referred for psychotherapy.

After some hesitation, Aiden's father agreed; however, the start of therapy was further delayed by the family's lack of health insurance coverage for treatment. The school was eventually able to connect the family with a community-based mental health center that could work with Aiden at a reduced fee. Aiden lives with his father, who works long hours in two different grocery stores to support his family. Aiden's mother died of ovarian cancer when he was 7 years old. Aiden and his father were devastated by her illness, which progressed quite quickly and led to her death just 7 months after initial diagnosis. No other family members were living near Aiden and his father. Aiden's father had struggled with maintaining stable employment, and was overwhelmed with grief over his wife's death. Aiden's mother was also the primary household earner and her death resulted in additional economic challenges for her husband and son, who lost their health insurance.

While Aiden's father eventually agreed to therapy for his son at the community-based mental health center, he underestimated the impact of their traumatic loss on both of them. He also doubted whether someone he considered to be a "professional person" would be able to understand the loss and poverty that he and his son were experiencing. Aiden's father feels unable to fully support his son emotionally, given his tremendous responsibilities securing money for food and rent. A salient source of support became the Catholic Church that Aiden and his father attended on most Sundays. A few people from the church offered emotional support but later expressed their feelings of inadequacy related to providing academic support.

Questions for Discussion:

1. How does the role of stigma affect Aiden's access to treatment?
2. How does a lack of resources influence the family's access to treatment and health care?
3. What role does cultural mistrust play in Aiden's father's willingness to have his son engage in treatment?
4. In your role as a psychologist, how have you engaged in trauma-informed practice?

Guideline 6. Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

J. Dr. Amy: Multiculturally Informed Advocacy

Dr. Amy has been asked to consult with a community advocacy group to help develop and implement a parenting program for families with young children. The advocacy group is very connected to the diverse community in which it is housed. As such, there is a history of relationships between the organization and the surrounding neighborhood. Dr. Amy's task is to help staff plan, market, and implement a parenting program for parents with young children from birth to age 3. The group's decision to develop such a program stems from an awareness of the increasing number of young families moving into the neighborhood along with the number of parents referred to the clinic by child protective services.

The parenting program's advocacy goal is to provide parents of infants and toddlers a place to go—at no cost—where they can learn parenting skills and interact with one another. The parenting program is geared primarily toward early intervention, since eligible parents must have children from birth to age 3. The preventive aspect of the program aims to encourage learning and parent interactions before a crisis occurs, rather than during or afterwards.

To ensure the program reflects the community's demographic composition, Dr. Amy and parenting center staff walk throughout the neighborhood to talk with parents about their interest. Through these informal conversations, they learn that many parents have felt isolated since having a child. Several mothers share that they are the only parent raising their child. They talk about the lack of a social support network and feeling that they lack a voice in their communities. Some parents talk about being depressed since the birth of their child. They talk about feeling overwhelmed to the point of waking up in the morning wondering how they are going to live up to their parental responsibilities throughout the day. These conversations help Dr. Amy and her colleagues recognize that the parent program should be a safe haven where parents can interact with one another in addition to staff.

A series of workshops are organized that aim to be responsive to the struggles shared by the parents with whom they spoke. Topics such as "father involvement," "post-partum depression," "parenting style," "work/family balance," and "stress management" are all key concerns. Workshops are also responsive to the neighborhood's linguistic and cultural diversity. Written information and workshops are presented in the languages spoken within the surrounding community. The program also works to develop collaborative relationships with parents in the community. As parents enroll, they are encouraged to recommend topics of discussion that reflect what they are experiencing. Parents enjoy coming in with their babies and toddlers. They learn about community resources and talk about shared challenges. Over time, the number of referrals from child protective services decreases.

Questions for Discussion:

1. How did Dr. Amy effectively engage in advocacy efforts that supported the community?
2. In what culturally responsive ways can psychologists engage in advocacy efforts?
3. What are some of the barriers to effective community-based advocacy? How can these barriers be addressed?
4. In your role as a practicing psychologist, are there ways that prevention and early intervention can promote positive outcomes?

Level 4 Case Illustrations: Domestic and International Climate

Guideline 7. Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.

K. Michael: Identity and Refugee Status

Michael is a 24-year-old African refugee in the United States who was born and raised in Ethiopia. He identifies as cisgender male, heterosexual, and being poor. Michael came to the United States via Uganda where he took part in a struggle to overthrow a post-colonial military regime. Michael traveled to the United States on a student visa; however, the visa was a means of escape from Africa and he was not registered as a student in the United States. This visa has long expired and he is presently undocumented. While Michael was not his birth name; it was the name of his Ugandan friend who arranged for Michael to travel to the United States in his place. The issue of names and identity is central to Michael's life.

One of Michael's first acts upon leaving Ethiopia was to abandon his thirteen names, each taken from a preceding generation in his family. With this symbolic erasure of his past, Michael believed that he had entered the world with a blank slate, and could define his identity anew. Michael found Uganda in the midst of its own nationalistic identity

crisis, trying to fill the void left by British colonists. This country, with its abundance of revolutionary sentiment, was the perfect place for Michael to redefine himself. Michael and his friend, the original Michael, organized groups at a university where they were both pretending to be students, to protest human rights violations by the military government. However, the activism became armed revolution, and Michael felt lost and conflicted. He believed in liberation but could not be the violent radical that a nationalistic context now esteemed.

Some time later, Michael travelled to a Midwestern college town in the United States where he encountered a new set of dynamics around identity. In Uganda, Michael was an outsider enamored with a revolution but not willing to kill. In the United States, as an African, he was expected to accept his social position as a second-class, invisible person of color. Two different structural systems invited two opposing identities. The result was that Michael saw himself as a traitor, abandoning his African compatriots and beloved friends, including his namesake, who lost his life fighting for freedom. At the same time, Michael experienced himself as a maladjusted acquiescent person who accepted a subordinate identity enforced by a racist and classist society.

Questions for Discussion:

1. What are some practitioners' self-reflections regarding their values, beliefs, and assumptions about refugees coming to the United States from countries with civil strife; and about their knowledge of political uprisings, dictatorships, and religious and ethnic cleansing in African, Arabic, and/or Middle Eastern nations?
2. How would a psychologist do a structured intake on personal and family history with Michael, who is a reticent and distrusting interviewee?
3. Describe Michael's various cultural and social identities and their intersectionality. Which are dictated externally and have developed into an existential problem of a lack of self-knowledge?
4. Describe a community-based intervention that may help Michael incorporate and internalize a revolutionary aspect into his identity.

Guideline 8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

L. Mary: A Focus on the Interpersonal Instead of the Contextual

Mary is a 17-year-old Japanese American–born teenager raised in the United States. She is currently facing the prospect of taking the SAT and other national exams required to apply for college. While a bright student with a straight A average in high school, Mary has become increasingly anxious about taking the exams. As a result, she refuses to take the step of actually signing up to take them. Her parents, who were born in Japan, are bewildered about her refusal and anxiety, and what they increasingly see as self-destructive behavior.

Since early childhood, Mary's parents have enrolled her in afterschool educational support activities, similar to the *juku*, or private educational organizations that provide additional academic experiences outside the school setting in Japan. Mary's mother stopped working after she was born so she could devote herself to her daughter's development.

On some level, she feels that Mary's current struggles must reflect a failure on her part. On another level, Mary's mother feels frustrated that the sacrifice she made with regard to giving up her career to raise her daughter has not been rewarded by a motivation on her daughter's part to attend college.

After consultation with Mary's pediatrician, her parents have taken the step of having her see a psychologist. The latter is a non-Latino/Hispanic/Latinx White/White American professional who views Mary's behavior as simply acting out and resisting parental authority. He is unaware of the significance with which national exams are often viewed in Japan. He is also unaware of the trend to engage children in outside academic activities starting at a very young age that is a tradition for this family. Mary's parents tell the psychologist that they are devastated by what they perceive as a lack of motivation, especially given the overarching importance they have placed on these exams throughout her adolescence. The psychologist continues to frame the issue as one that reflects adolescent development and resistance to authority. As a result, he employs a CBT approach designed to address parent-child relations and issues of adolescent development instead of the generational and cultural conflict at play.

Questions for Discussion:

1. In what ways can the psychologist incorporate a multicultural framework in working with Mary and her family?
2. What are some of the intergenerational issues that affect family relationships and functioning?
3. As a psychologist taking a systemic approach, in what ways can you be responsive to the concerns of both Mary and her parents?
4. What are some of the developmental issues that may currently have an impact on Mary's experience, as well as that of her parents?

Level 5 Case Illustrations: Outcomes

Guideline 9. Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the **Layered Ecological Model of the Multicultural Guidelines**.

M. Community-Based Research

A research psychologist new to the local university was interested in assessing depressive symptomatology among American Indian residents of a nearby tribal reservation. She approached the local tribal council and asked for their help in recruiting subjects. After a week of deliberation, the council firmly refused to grant her request. When the disappointed psychologist asked for an explanation, the head of the council initially said that it didn't seem like the project would benefit local members of his tribe. When pressed, he admitted that her university had a long history of doing research in the town without informing anyone of the results or working with the community. As a result, community leaders had become united in rejecting any proposed research by university faculty.

The psychologist expressed her disappointment but said she understood the concerns and would do her best to demonstrate her commitment to the community. For the next three years she worked closely with the town's tribal council on a number of projects that they initiated and participated in several activities designed to assist tribal members. When she finally revisited the possibility of research on depression, the council members wrote letters of support and actively assisted in recruitment.

Questions for Discussion:

1. As psychologists conducting community-based research, what are some considerations for building relationships in the community?
2. How can research psychologists be aware of the experiences of the communities in which they are conducting research?
3. How does this case reflect your own experiences conducting community-based research?
4. In what ways can research psychologists give back to the communities where their research is being conducted?

Guideline 10. Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

N. The Oregano Family: Working with Mental Health and Faith-Based Communities in Clinical Training

Six weeks prior to being seen at the university counseling center, the Oregano family suffered a devastating tragedy when Mr. Oregano, the husband and father of three children, was in a fatal plane crash. Traveling back home on a consumer airline, sudden lightening caused an electrical outage that led to the crash. Mrs. Oregano and her three

children, ages 4, 10, and 16, come to counseling presenting symptoms of post-traumatic stress. Understandably, the 4-year-old continues to ask when his father is going to return home.

The service provider is a doctoral student who is supervised by a licensed psychologist. The doctoral student is working with the Oregano family as part of a clinical practicum experience. From the beginning of their work together, Mrs. Oregano has expressed concern about the status of her late husband's afterlife. A devout Roman Catholic, she shares that the family has no body to bury, something profoundly important to someone whose faith believes in resurrection of the body. She expresses her concern to the trainee, sharing that a formal burial will help the family and future generations remember her late husband, while also respecting the saints. She shares with the trainee the teachings of her priest and is overwhelmed with grief related not only to loss, but also to concerns about her late husband's afterlife.

The trainee focuses on the symptoms Mrs. Oregano and her children are experiencing. Uncertain how to address the role of religion for this family, the trainee avoids it, minimizing family concerns in this area, focusing solely on the post-traumatic stress symptoms. The family begins to attend psychotherapy sporadically, which the trainee interprets as resistance to dealing with the loss.

The supervisor encourages the trainee to ask the family about their faith and the concerns the lack of a burial presents. Treatment seems to shift as Mrs. Oregano and her oldest child talk about their visits with their priest and the solace they get from the church. The supervisor increasingly encourages the trainee to incorporate the "voice" of the priest in sessions. In other words, the trainee is to ask about what the priest would say in response to current struggles and stresses. In this way, the supervisor invites the trainee to consider the importance of both mental health and faith. The Oregano family can approach their loss through an integration of both perspectives, rather than feeling they have to choose one over the other.

Questions for Discussion:

1. What does the supervisor encourage the trainee to understand when taking a culturally informed approach to education and training?
2. What are the goals of supervision that takes a culturally informed approach?
3. What are some of the challenges that might emerge for supervisor and supervisee in the context of supervision that takes this approach?
4. How can using an awareness of internal and contextual biases reduce or remove potential tensions in supervision?

O. Lucy: Fear about a Marriage Ending

Lucy is a 36-year-old White/White American transgender woman who has sought help from a psychologist to cope with her anxiety related to her relationship with her wife. Lucy has been employed in a pharmaceutical company for over eight years. She has grown increasingly anxious about the stability of her marriage, as she suspects that her

wife may be romantically involved with someone else. Lucy sometimes experiences panic symptoms, and feels overwhelmed by the prospect of her marriage ending.

Lucy grew up in a home in a rural area of the United States with her two siblings, parents, and grandparents. She describes her parents as “progressive and accepting,” and as supportive when, in her teens, she told them that she was a girl. Her parents encouraged Lucy to work with a therapist at this time, which was an important source of support for her. However, Lucy was severely bullied by peers who verbally and physically attacked her in and out of school. She coped with these traumatic experiences through the use of substances such as alcohol and marijuana. Lucy described this time of her life as “most painful and depressing” and often thought of ending her life. She decided to attend college in a city far from her family home to escape the trauma she endured as an adolescent. While Lucy had not worked with a therapist since high school, she connected with a transgender community in college, and continued to form friendships with people she experienced as supportive and caring toward her. Soon after college, she met a cisgender woman whom she dated for several years and later married. Lucy feels that her wife has been a central figure in her life and someone who has advocated for her. This has been especially important in circumstances at work when Lucy has faced transphobic and heterosexist comments from coworkers.

Lucy has done hormone replacement therapy for several years, and more recently, has been considering sexual reassignment surgery (SRS). However, she feels confused about whether to pursue this, as her wife is against the idea of surgery, and has told Lucy that she “passes” as a woman without it. Lucy has felt hurt by these comments and wonders whether her wife truly understands what it means for her to be a transgender woman. At the same time, Lucy believes that her wife has been the one person she has relied on to help her cope with hostility based on her gender identity and sexual orientation. Their tension has escalated over the past year, and increasingly, Lucy has suspected that her wife is losing interest in being with her. Lucy worries that these conflicts may lead to separation or divorce. She is terrified of this potential loss and worries that she may cope with her anxiety by using substances or hurting herself in some other way.

Questions for Discussion:

1. What reactions do you have after reading about Lucy’s experiences? What experience have you had in working with transgender clients?
2. How would you conceptualize the role of trauma in Lucy’s life?
3. How would you approach helping Lucy with her anxiety, considering her past history of substance use, depression, and suicidal ideation?
4. In what ways do others’ perceptions of Lucy’s gender identity and sexual orientation affect her identity and relationships?

Appendix B: Case Studies That Illustrate the *Layered Ecological Model of the Multicultural Guidelines**

Case studies are presented to help illustrate the applied aspect of *Re-envisioning the Multicultural Guidelines*. Cases represent clinical, educational, research, and consultation scenarios. Please note that while cases strive to reflect intersectionality across a range of diverse backgrounds and experiences, it is beyond the scope of this project to portray all dimensions of diversity. As such, case studies seek to address a range of multicultural scenarios that might be found in clinical, educational, research, and consultative arenas. Case studies can be used as teaching and training tools.

* Names and identifying data have been changed to protect confidentiality. Some cases are composite cases, incorporating various experiences; others are fictional.

Level 1 Case Illustrations: Bidirectional Model of Self-Definition and Relationships

Guideline 1. Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

A. Tuan: Identity Transformation and Intersectionality over the Life Span

Tuan is a 48-year-old cisgender Vietnamese American bilingual man who has sought help from a psychologist to address his depressed mood and isolation. In the initial session of psychotherapy, Tuan told the therapist that he identifies as Vietnamese American. When asked by the therapist about whether he was in a relationship, he responded, "I'm not in a relationship. I'm not sure what my sexual orientation is."

Tuan was born in a large city in Vietnam and arrived to a rural area in the United States with his parents when he was 10 years old. While in Vietnam, his family faced financial struggles and had hoped for improved living conditions in the United States. He reported growing up in a middle-class home with parents who worked hard in a small business. He lived in a neighborhood and attended school where there was little racial and cultural diversity. At home, he spoke Vietnamese with his parents, and outside of home, he spoke English. He often felt different and "on the outside" at school, but did develop a few close friendships. In describing his school experiences, Tuan spoke about how he had always thought he felt different due to his racial and ethnic backgrounds, but that in recent years, he realized that he also felt different because of his sexual orientation. Tuan recalled that he was attracted to boys and girls while in school and college, but never believed he could talk openly with anyone about his feelings.

Tuan later married a second-generation Vietnamese American heterosexual woman. The marriage ended after 3 years, when he disclosed to his wife that he was sexually attracted to both men and women. Following their divorce, Tuan began exploring his attraction to men but dated infrequently. About one year prior to seeking psychotherapy, Tuan

disclosed his sexual orientation to his parents. To his disappointment, Tuan's parents said he was "dishonorable" and they would not accept his sexual orientation. Tuan had few supports and confided in one friend. His friend, while sympathetic to Tuan's painful experience of coming out, was unsure of how to support him. Tuan increasingly felt like a burden to his friend and parents, and wished that he no longer had to feel the pain and anguish of living a secret life. He felt as though no one could understand his conflicts. He coped with his sadness through working more hours and staying isolated.

Over time and as he explored his sexual orientation, Tuan felt more disconnected with his Vietnamese heritage and language. In psychotherapy, Tuan struggled with how to come to terms with what he has known about himself for a long time, and how others can accept his sexual identity. He reported feeling as though he could not be the "right type" of Vietnamese person in his parents' view, nor could he be the "out" bisexual man to non-Vietnamese American and non-Asian American friends who did not understand why he couldn't just "be himself." Tuan told his therapist that he could not fully be himself in any situation, always having to hide some aspect of self to connect with others.

Questions for Discussion:

5. Are there aspects of Tuan's identity that feel difficult to address in psychotherapy or counseling? Do you have a sense of why?
6. For what reasons might Tuan feel uncomfortable or reluctant to describe his challenges within and outside of his family with a therapist?
7. How can therapists help clients explore the multiple dimensions and fluidity of their identities?
8. How might you explore the complex nature of Tuan's identity in an empirical study?

C. An Example of Inclusive Research

A research team at Alphabeta University developed a study of sleep and cognition that ultimately involved the assessment of over 1,000 children between the ages of 7 and 9 years of age, who were recruited from urban and suburban communities in two U.S. cities. The goals of the study were to assess the impact of snoring and sleep disordered breathing (SDB) on the youths' cognitive and behavioral development. Given concerns about the role that racial and cultural factors may play in the interaction between development and this medical condition, the researchers made a decision to emphasize a predominantly underserved population across a range of socioeconomic and cultural backgrounds consistent with the cities being used for the study (i.e., Chicago, Illinois, and Chapel Hill, North Carolina), as well as the general population of children and their families being seen in respective sleep clinics.

Children who participated were evaluated across a number of variables addressing their sleep status and the arousals they experienced secondary to their SDB. This was done using standardized approaches to sleep assessment, including completion of a polysomnographic study while the child slept overnight (with a parent accompanying

them) in the clinical research laboratory. The children also underwent comprehensive assessments of their cognitive and behavioral status, including completion of a set of neuropsychological measures such as IQ and educational attainment, but also attention, problem solving, and memory tasks; parent reports about their development and sleep profiles; questionnaires regarding emotional and behavioral regulation; and an assessment of their sleep efficiency.

The study aimed to apply specific theoretical approaches to address the potential relationships between SDB and cognitive inefficiency, as well as behavioral difficulties that are often seen as a result of sleep problems and sometimes misdiagnosed as a disorder such as Attention-Deficit/Hyperactivity Disorder (ADHD). Because substantial prior research has focused most directly on children representative of a White/White American suburban middle-class background, the research team determined that, with their approach, the study required being more directly inclusive of a wider range of children across cultures and socioeconomic status backgrounds.

The principal investigators expressed a particular concern about the possible variability that might be found, given educational differences across cultural and racial groups, socioeconomic differences the families experience, and differences secondary to gender that all contribute to health challenges that underlie snoring and SDB. As a result, they developed the study as a comparison across groups recruited both within and across the settings in which recruitment took place (e.g., families coming to an urban hospital that was situated within a more diverse section of the city, such that Latino/Hispanic/Latinx and Black/African American/Black American children were readily able to be included, versus children from a setting that was more suburban and less diverse in terms of socioeconomic and cultural groups recruited).

The researchers discussed with their statistician the need to focus on multiple potential moderating variables, including race and ethnicity, but also parental education and income, type of educational setting, availability of physical activities for recreation, and resources such as a local grocery store with an affordable range of healthy food choices. One particular consideration for the research team was potential vulnerability to SDB; the study’s Principal Investigator (PI) in particular was concerned that, based on previous studies, it was known that obesity contributes to a greater likelihood of developing SDB, and children of Latino/Hispanic/Latinx and Black/African American/Black American backgrounds were more prone to being identified as obese.

Results from the study were particularly informative; they highlighted a number of potential effects, such as the strong influence of SDB on neuropsychological profiles in the attention and executive functioning domains, and less successful grade profiles. More importantly, however, the researchers identified that differences in socioeconomic background were a significant moderator of these effects. Specifically, children with lower available financial resources appeared to show a greater impact of SDB on their learning and skill development. To better address these concerns, the team turned to their statistician to utilize a set of analytic approaches to the data. These approaches more effectively allowed for matching subjects across the range of variables identified as

showing cultural and racial differences to better explore and address these important factors. They also felt that this allowed for a greater emphasis on multicultural factors in the onset and expression of a challenging health concern. In turn, it was thought that this approach would more effectively engage the public and guide physicians to pay closer attention to sleep in their patients.

Questions for Discussion:

4. When addressing the prevalence and impact of sleep disordered breathing in their subject populations, what were the important factors requiring attention, given differences regarding a range of cultural and racial/ethnic factors?
5. When conducting research regarding the interaction between physical and psychological concerns, like sleep and cognition, what would you highlight as an important set of considerations to develop an appropriate study sample and ensure appropriate statistical considerations?
6. Because factors such as race and sociocultural status intersect, how can a research team effectively parse the potential impact of these factors on study design and analysis?

Guideline 2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

C. Marcus: Exploring Stereotypes and Microaggressions

Marcus is a 40-year-old cisgender, heterosexual African American man who has been coping with anxiety and panic attacks since he was in his early 20s. He worked with a therapist previously for a few sessions, but did not find this experience helpful. He reported that his previous therapist appeared uncomfortable and unsympathetic with his concerns about the challenges he faced at his workplace. As the intensity of his anxiety symptoms increased over the past year, he decided to seek help from another therapist. In his first session with this new therapist, Marcus disclosed that he felt overwhelmed by work-related pressures, and that he felt as though he was always looking over his shoulder to be sure that he could maintain his position.

Marcus grew up in a low-income neighborhood where he struggled with traumatic events on a regular basis. He described his relationship with his parents and his older sister as close, but reported that the family coped with stress related to long work hours for his parents, and with ongoing violence in their neighborhood and schools. Marcus would frequently hear shots being fired or learn about people being robbed.

Marcus received scholarships to attend a high school far away from home, and subsequently to college, where he studied engineering. He described his experience of

leaving home as “confusing and difficult,” as he missed his family and friends, and the predominantly White institutions he attended felt unfamiliar. Marcus’s focus and drive to excel academically brought new economic opportunities, and he was able to help his family financially. However, Marcus remained feeling “like an outsider” at school and later at work. He has also dreaded being around extended family since he left for college as several family members have commented that he acts as though he “is above them.” Marcus noted that he had experienced anxiety throughout his life, first due to the violence near his home, and later due to a lack of safety and belonging when living away from his family home.

Marcus shared with the therapist that he continues to feel as though he constantly has to work harder than anyone in his workplace to maintain the managerial level position he has achieved. Marcus also told his therapist that his co-workers, none of whom are African American, assume that he has always been wealthy given his educational opportunities, and yet, on the other hand, project stereotypes about African American men as being lazy and aggressive. He struggles with others’ perceptions of him, feeling as if they “box” him into ideas about who he should be, rather than reflecting who he really is. Marcus indicates to the therapist that he does not want to be put in a “box” or category. His experience of being stereotyped and categorized has taken a significant toll on Marcus’s psychological well-being, as evidenced in his anxiety and panic attacks. Sometimes, he even wonders if his success is due to affirmative action rather than his own ability, and whether or not he can continue to be successful.

Questions for Discussion:

5. What reactions and feelings come up for you as you read about Marcus and his therapist? How might these feelings influence the way you might interact with Marcus?
6. How does your current knowledge or understanding of African American men’s racial and social class experiences inform how you might conceptualize Marcus’s concerns?
7. Have you had the experience of feeling “boxed in” or categorized by others based on their understanding of people from racial or sociocultural backgrounds with whom you identify?
8. How have you tried to help clients cope with isolation related to stereotyping or discrimination? What types of resources outside of counseling or psychotherapy have been helpful to your clients in addressing stereotyping and discrimination?

D. Melissa: Training Experiences as a Practicum Student

A 22-year-old, gender non-conforming psychology practicum student training on an inpatient unit shadowed a male psychologist. Dr. Samuel, an older, cisgender, heterosexual person, was a practicing evangelical Christian who integrated his deeply held beliefs with his approach to clinical and professional practice.

Shortly after beginning practicum, Melissa, who requested the pronoun “they”/”them” rather than “she”/”her” when others referred to Melissa, had a conversation with Dr.

Samuel, who discussed Biblical verses to frame a point being made. For instance, Dr. Samuel presented Melissa with a video to watch that discussed the importance of a Biblical framework for explaining human nature, and Melissa hesitantly obliged. However, Melissa identified as secular and feminist, and in actuality felt offended by Dr. Samuel's request. Given the power differential and role of a practicum student on an inpatient unit, Melissa felt obligated to converse with Dr. Samuel about his Christian beliefs and values within the context of his supervision of their work.

While Melissa never witnessed Dr. Samuel discussing his religion with his clients, they observed several ways in which they believed his religious orientation influenced how he dealt with female versus male patients on the unit. It appeared to Melissa that Dr. Samuel was often more dismissive toward his female patients by having shorter meetings with them and being more directive regarding how to progress with treatment, in comparison with their observations of his interactions with male patients. They also observed that Dr. Samuel would address his White patients differently than patients of color and those who spoke a primary language other than English. They noticed that Dr. Samuel was quick to diagnose patients of color and those less proficient in English, and he was often more dismissive of their communications with him. On the other hand, he appeared to spend more time trying to understand his White, English-speaking patients of different ethnicities and cultures. Melissa soon got the impression that many of the female patients and patients of color would rather work with the other psychologists on the unit.

Aside from patient-therapist interactions, Melissa also noticed that Dr. Samuel interacted differently with his coworkers. Notably, most of the professionals on the unit were women, and Dr. Samuel never shook hands with or made direct eye contact with these female colleagues; this was quite different from his interactions with male colleagues on the unit. Dr. Samuel's behaviors with both his colleagues and his patients made an impact on how he was often viewed by women coworkers on the unit, and Melissa overheard many conversations between staff members sharing the viewpoint that Dr. Samuel was disrespectful with them.

Questions for Discussion:

5. Discuss how stereotypes can be held by almost all individuals, no matter their ethnic, racial, religious, age, sexual orientation, and gender identity statuses, and the intersectionality of these backgrounds.
6. Discuss how unconscious beliefs and attitudes of both psychologists and student trainees can have an impact on clinical relationships with clients as well as coworkers. While clinicians and trainees may not intentionally react to clients and fellow professionals in a harmful or stereotypical way, discuss how they may hold implicit biases that drive reactions to clients or coworkers.
7. Could the given case be superimposed on a professional who is a fundamentalist Muslim; a conservative Brahman Hindu; a traditional Catholic; or an Orthodox Jew? Could the case be superimposed on a psychology practicum trainee of diverse self-definitions and identities, such as an international student, an immigrant, someone with refugee status, someone whose second language was English; someone with a gay, lesbian, or bisexual orientation; someone with a non-Western religious or spiritual

affiliation; or someone from an upper socioeconomic class?
8. What are your views about "color-blind democracy" in the theory, research, and practice of psychology?

Level 2 Case Illustrations: Community, School, and Family Context

Guideline 3. Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

E. Dr. Enrique: Culturally and Linguistically Responsive Consultation

Dr. Enrique is a licensed Latino/Hispanic/Latinx male psychologist who has been contacted by the principal of a local Catholic school to consult with them about parent involvement. The school serves students in the elementary school years and is located in a low-resource neighborhood in the heart of a large metropolitan city. The student body is primarily Latino/Hispanic/Latinx with most children speaking Spanish at home. While instruction at the school is primarily taught in English, most of the students' parents are monolingual Spanish speakers.

When the principal contacts Dr. Enrique, she says that the teachers are very concerned about the lack of parent involvement. The school staff shares the belief that parent involvement is critical to the academic success of their students. Further, while the school has reached out and invited parents to events, the turnout has been low. The principal explains how the teachers interpret the lack of parent involvement as parents not caring about their children's academic success. Teachers are frustrated with the lack of response on behalf of the parents. The principal senses low morale among teachers and is concerned that this will have a negative effect on interactions between the school and students/families.

Dr. Enrique is motivated to learn more about the current situation and how to respond. First, Dr. Enrique reaches out to the teachers. He hears their concerns about the lack of parental involvement and participation. Dr. Enrique inquires about the events with no parent participation. He learns that they were advertised in English because the school did not have a translator. He also learns that the events were scheduled during the day at a time when many parents may have been working or taking care of young children.

Dr. Enrique suggests that the school plan another event. He reaches out to the principal, stating the invitation must come from the head of the school, and then trickle down through the teachers. Flyers are sent home in Spanish. The event is scheduled during the evening in hopes that parents will not be working. The flyer clearly states that child care will be offered and refreshments served. The flyer is sent out two weeks prior to the event, and then subsequently sent home in children's backpacks once a week for the following two weeks.

The night of the event approaches. Teachers and the principal are present, as are other administrators. Volunteers help watch the children as needed and a buffet dinner has been organized. Slowly parents begin to circle into the main hallway where the event is held. The room begins to fill to the point that there are more parents than teachers. Dr. Enrique opens the conversation in Spanish and English—welcoming everyone to the event.

As the conversation continues, he shares that the school invites parents to be more involved in the day-to-day life of the school. Teachers talk about specific ways that parents can come to school and participate in various activities. Parents share that their lack of engagement reflected their sense that it would be disrespectful to the school, specifically to the teachers, if they came in. They share that in their cultures, *respeto*, or having a sense of respect for others, is of utmost importance. Not participating in the life of the school is born out of concern that their participation would be viewed as a lack of *respeto*. Parents didn't want their children's teachers to think that they did not respect their role by being present at the school. They shared that in their cultures, parents tend not to get involved as an indication that they have the utmost trust in the teachers and their decisions.

Through communication of the two perspectives, the teachers can clearly share with the parents that they want them to be involved in the life of the school. They talk about how their school in the United States truly wants to build working partnerships with parents. Hearing the invitation, parents commit to greater involvement. It is as though having the teachers' permission prompts them to feel more comfortable with participating more fully.

Questions for Discussion:

5. What is your view of the consultant's role within a multicultural context?
6. How can the consultant understand and incorporate cultural values and perspectives in work with organizations?
7. How did Dr. Enrique respond to each of the constituencies involved in the school? How did his response encourage collaboration among constituencies?
8. How does Dr. Enrique's example inform your own work as an organizational consultant working within a multicultural context?

Guideline 4. Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

F. Yasmin: Bridging Different Worlds

Yasmin is a 28-year-old Muslim, immigrant, cisgender woman from Pakistan. She continues to experience the loss of her husband who was killed in the September 11,

2001 collapse of the World Trade Center, where he worked in a small business. Yasmin has experienced numerous acts of racially motivated verbal and physical aggression since 9/11. She has also experienced the challenging demands of raising her son who was born with multiple disabilities.

After her husband's death, Yasmin's parents and parents-in-law came from Pakistan, taking turns living with her, supporting her, and helping her with child care. Their eventual departure was very difficult for her. For the past 5 years Yasmin has lived by herself.

Yasmin mourned for her husband for several years. She eventually entered into a relationship with another Pakistani man. This relationship helped Yasmin express herself in ways that helped her to be less conservative than previously. While romantic, this was not a sexual relationship. However, due to disagreements about the care of her son, Yasmin decided to end the relationship.

Yasmin was very close to her father until he passed away a few years ago. Between her father, husband, and former male companion, she always had a strong male figure in her life. When Yasmin decided to end the relationship with her companion, it was the first time that she was without close male guidance. Yasmin had to live independently. She struggled to pursue a career in retail, take care of herself, and meet the particularly challenging demands of her son who was completely dependent on her. Yasmin chose to stop wearing her hijab (a veil/head covering that often covers the head and chest) partly for her own protection from being stared or shouted at in public transportation, or in large stores. Nonetheless, she continues to face prejudice because of her accent and speech, physical appearance, behavioral differences, and gender practices. However, Yasmin has made friends, Pakistani as well as American, who have helped her in ways that she needed following the passing of her husband. However, Yasmin does not have the familial and communal support that she would have if she were in Pakistan. Despite these challenges, Yasmin is taking online courses to improve her career standing. Her perseverance through struggles attests to her resilience.

Yasmin is now dating a White/White American male whom she met at work. While this man is good to her son and Yasmin likes many aspects of an egalitarian relationship, she is bothered by his sexual advances. She likens his amorous behaviors to sexual assault and believes she is at risk for rape. Because of her Muslim faith and cultural gender role, Yasmin believes that intercourse should occur only after marriage. She feels immodest, thinking she is sexually provocative. Sometimes she thinks she is a sinner. Yasmin is filled with shame, thinking that she is letting down her mother, sisters, and mother-in-law, who had advised her to return home to them in Pakistan for her protection, sexual purity, and for the preservation of her conservative values and practices. Yasmin also feels guilt, thinking she will be unfaithful to her dead husband if she has sex.

Questions for Discussion:

6. Describe practitioners' self-reflections about a dominant society's use of oppression, privilege, and power over religious minority groups and individuals; their

reflective self-examination of their own biases and stereotypes about Islam and its followers; their ever-present awareness of their multiple social identities as well as those of others; the biases that exist because of such identities; and how their interactions with others are based on these identities.

7. How would a psychologist incorporate trauma and resilience when working with a culturally diverse person who has suffered continuous life stressors including racism, discrimination, and societal hatred? How would a psychologist evaluate theoretical adaptations to demonstrate evidence-based practice?

8. Discuss practitioners' need to understand Islamic tenets and the differences between Muslim culture and that of the United States. Discuss an understanding of how much a particular Muslim immigrant is committed to such ideals and how difficult it may be to remain committed to one's faith in the United States; how it might be common for Muslim women living in the United States to struggle with the difference in women's roles in the United States versus those in an Islamic culture; and how such underlying gender roles may make clients uncomfortable with a practitioner.

9. How would Yasmin define self, community, and their relationship with each other?

10. Describe Yasmin's challenges as she adapts to life in a highly individualistic environment as opposed to the collectivist family culture she was used to.

N. Anthony: Having an Identity That Extends Beyond One's Disability

Anthony, a 25-year-old, cisgender, biracial/multi-ethnic (Black/African American/Black American, White/White American, Latino/Hispanic/Latinx) male, was referred for individual psychotherapy in conjunction with his participation in ongoing vocational rehabilitation programming. He presented with a history of mild intellectual disability that was acquired secondary to a traumatic brain injury (TBI) he sustained during early adolescence when he was in a motor vehicle accident with his family. Of note, Anthony and his brother were the only members of their family to survive the accident, and both sustained significant TBI's.

Anthony was fifteen at the time of the accident, and he had been highly functioning prior to his TBI. Before sustaining his injury, Anthony had been enrolled in a college prep high school program and was active in both athletics and extracurricular activities, including chess and computer design clubs. He and his brother, who is three years younger than Anthony, were the middle children in a large family of six boys and two girls. Anthony lost both his parents and two of his siblings in the accident. Two older siblings (males), both of whom were adults and living on their own at the time of the accident, now serve as guardians for Anthony and his brother. The two youngest siblings (one male, one female), were also not in the car at the time of the accident. Subsequent to the accident they were raised by an aunt who lived in a nearby city. Anthony visits these two younger siblings during the holidays and at family gatherings.

Anthony's case manager, when discussing current concerns with the psychologist, indicated that Anthony had been struggling of late with impulse control, particularly around select peers, both male and female. This led to difficulties both at his residence, a

group home program for young men who have neurodevelopmental challenges, and in the sheltered employment program Anthony participates in weekly. The case manager indicated that she suspected some of his impulsivity, which has included inappropriate language and touching, was related to Anthony's desire to be more like his typical peers who are in relationships. She shared that she and the staff working with Anthony were seeking guidance on how to best support him in making better behavioral choices, particularly around his romantic and sexual feelings. The case manager also shared that they were looking to provide Anthony with an opportunity to more directly address his feelings of difference that appear to have an impact on his mood.

At first, therapeutic work with Anthony focused on helping him share his current experience of himself as a man with an acquired neurodevelopmental disorder as well as to gain an understanding of how his viewpoint about himself had changed. This work was done in a context of Anthony's awareness of who he had been prior to the accident and what was different for him as a consequence of his injuries and the loss of some capabilities. It was clear from early on that Anthony's tendency to act and speak impulsively were primary consequences of his TBI. He sustained injuries to his developing executive skills, such that challenges were noted with flexibility, thinking strategically, and impulsivity, including saying inappropriate things as they came to mind. It also became evident that Anthony's recent behavioral difficulties, where he impulsively sought out more intimate interactions with male and female peers, were associated with efforts to be "more of who I used to be, someone who went on dates and had friends, who had people in my life who wanted to be around me."

Anthony shared that he often felt dismayed that he was now seen as "ugly" and "stupid" by other men and women he saw daily. He brought in a photo of himself, taken during adolescence and prior to his accident. Anthony actively compared what was different for him then with now; he focused specifically on the scar he had because of his neurosurgeries for his TBI; his loss of gross and fine motor skill, such as his inability to ambulate independently; and his altered growth, that made him much shorter than peers. Anthony began to talk more directly about what he had lost cognitively and emotionally because of the accident; sharing that he had been a budding wrestler and a good student before his TBI, and that he had many friends then too. Since then, his path had changed significantly, with many associated losses in terms of opportunities and expected outcomes. Anthony shared that he was most often reminded of these losses, including the fact that he had just been able to start dating shortly before the car accident, when he saw perceived neurotypical peers outside of his program and residence.

Anthony experienced significant and understandable sadness about these losses. He was able to identify that this led him to want to "change stuff" by making his life "normal." However, Anthony also admitted that some things could not easily be changed, like his inability to ambulate without a walker, and that he needed to use a wheelchair when required to go long distances. Anthony shared how this was a substantial limitation on his ability to ask a peer out on a date, or to spend time with a peer without adult supervision.

As treatment continued, discussions focused on Anthony's experience of these losses and their impact on his ability to see the possibility of a life that was more layered and optimistic. With regard to his impulsive actions, the therapist helped Anthony better understand his range of feelings regarding intimacy and sexuality. The therapist and Anthony took into account that he had physical and cognitive differences secondary to his TBI that affected how Anthony could share, verbally and through touch, his attraction to someone. As a man who was hampered in his mobility and capacity for physical contact across a variety of situations and settings, it was important for the therapist to help Anthony and his support team address how he, a young man with many typical wishes and desires both in terms of love and physical interest, could address these within home and work environments.

One important step forward occurred when Anthony was able to meet a wider range of peers, both for friendship and potential dating, and to work directly on how to discriminate between an interest in intimacy and frank sexual desires. Therapy additionally helped Anthony become more comfortable with how he could express and address his physical desires. This was accomplished in part through a better understanding of his own body and learning how to address feelings in a socially appropriate manner. Social scripts were developed, with coaching provided within treatment as well as with the teams at work and in the residence. This allowed Anthony to more effectively inhibit immediate wishes to connect through touching, that were often perceived as intrusive and inappropriate. Instead Anthony could work toward initiating interactions verbally, allowing boundaries to be established.

Anthony worked to recognize himself as not only someone with a disability, but also as a member of a wider array of communities, where his strengths and differences could be better appreciated. His beliefs of himself as "damaged" and "ugly" were challenged through opportunities to ask both how others perceived him, and through frank discussions about how this allied with and differed from his own expectations and perceptions. Anthony was supported in more directly mourning the trauma and losses he experienced, so that he could begin to conceptualize himself as both a survivor and as resilient. This led to two important changes: One, Anthony began to see himself as moving forward on a new trajectory, which, while different from his path prior to the accident, was still valid and open to many successes. Two, Anthony came to recognize that he himself could play a more active role in decision making. These changes led Anthony to seek out new opportunities within his vocational program and to open himself up to the interest a fellow peer had expressed with regard to dating him.

Questions for Discussion:

1. Describe practitioners' considerations regarding cognitive and physical disability, and how these are conceptualized within the dominant society's continued emphasis on privilege, oppression, and capability.
2. How would psychologists adapt trauma theory to address the challenges experienced by Anthony, a biracial/multi-ethnic man, who has lost both family and his

experience of himself as a functional member of the community? How would they evaluate theoretical adaptations to demonstrate evidence-based practice?

3. What is required of practitioners so they can have an understanding of how disability is experienced within the United States? What can promote an understanding of how individuals with cognitive and physical challenges experience daily life that can subsequently facilitate more effective problem solving within supportive treatments?

4. How can a therapist consider disability across multiple levels of identity? What are the implications of these considerations for understanding intersectionality?

O. Jung: Access to Culturally Relevant Treatment

Jung is a 70-year-old Korean woman who married an American soldier and came back to the United States with him when he left the service. They lived in a rural area of northern Maine, where her husband was a fisherman until his death five years ago. Jung's English proficiency is minimal and she suffers from left-sided paralysis secondary to a stroke. Since her husband's death, Jung has become increasingly depressed because there are no Koreans living nearby and her disability limits travel. Jung has become increasingly isolated, her only social contact being a friendly postman and the grocery store clerk who delivers her food.

Jung's primary care doctor realizes there is a problem but Jung's limited ability to speak English and reticence to talk about mental health issues interfere with any care beyond medication. A search of local mental health providers revealed there is no one within 100 miles who speaks even limited Korean. Jung shuts down when the doctor encourages her to try a telephone interpreting service. In desperation, the doctor contacted the Korean Consulate and spoke with staffers working in a facility in Nova Scotia, the closest to Jung's home. The consulate arranged for a psychologist fluent in the Korean language to speak with Jung via the Internet on a monthly basis while she is at the doctor's office.

Questions for Discussion:

3. How could Jung's relationships with the delivery person and the grocery clerk be incorporated into achieving her treatment goals to help her feel less isolated?

4. How could local resources, in addition to the postman and clerk, help in providing a more beneficial environment for Jung?

Level 3 Case Illustrations: Institutional Impact on Engagement

Guideline 5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental

health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

P. Aiden: Struggling with Loss, Grief, and Inequity

Aiden is a 10-year-old, White/White American boy of Irish descent, who was referred to a psychologist by his school counselor. Aiden has been struggling with completing his schoolwork and concentrating on tasks. According to his teachers, he has been disruptive in class and unable to complete homework on a regular basis. His grades have declined over the course of several marking periods. While the school recommended an evaluation, the process was delayed due to Aiden's father's hesitancy to engage in the testing process. Rather, Aiden's father repeatedly shared that his son didn't have psychological issues, stating that his behavior was just reflective of his being a kid. He continued to encourage Aiden to focus on his schoolwork and not let feelings "get in the way" of academic success.

It was when Aiden's grades dropped substantially that his father finally agreed to the evaluation process. Aiden was evaluated for a learning disability. Testing results indicated that he did not have a learning disability, but rather, issues of grief and loss were affecting his academic life. The evaluator recommended that Aiden be referred for psychotherapy.

After some hesitation, Aiden's father agreed; however, the start of therapy was further delayed by the family's lack of health insurance coverage for treatment. The school was eventually able to connect the family with a community-based mental health center that could work with Aiden at a reduced fee. Aiden lives with his father, who works long hours in two different grocery stores to support his family. Aiden's mother died of ovarian cancer when he was 7 years old. Aiden and his father were devastated by her illness, which progressed quite quickly and led to her death just 7 months after initial diagnosis. No other family members were living near Aiden and his father. Aiden's father had struggled with maintaining stable employment, and was overwhelmed with grief over his wife's death. Aiden's mother was also the primary household earner and her death resulted in additional economic challenges for her husband and son, who lost their health insurance.

While Aiden's father eventually agreed to therapy for his son at the community-based mental health center, he underestimated the impact of their traumatic loss on both of them. He also doubted whether someone he considered to be a "professional person" would be able to understand the loss and poverty that he and his son were experiencing. Aiden's father feels unable to fully support his son emotionally, given his tremendous responsibilities securing money for food and rent. A salient source of support became the Catholic Church that Aiden and his father attended on most Sundays. A few people from the church offered emotional support but later expressed their feelings of inadequacy related to providing academic support.

Questions for Discussion:

5. How does the role of stigma affect Aiden's access to treatment?
6. How does a lack of resources influence the family's access to treatment and health care?
7. What role does cultural mistrust play in Aiden's father's willingness to have his son engage in treatment?
8. In your role as a psychologist, how have you engaged in trauma-informed practice?

Guideline 6. Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

Q. Dr. Amy: Multiculturally Informed Advocacy

Dr. Amy has been asked to consult with a community advocacy group to help develop and implement a parenting program for families with young children. The advocacy group is very connected to the diverse community in which it is housed. As such, there is a history of relationships between the organization and the surrounding neighborhood. Dr. Amy's task is to help staff plan, market, and implement a parenting program for parents with young children from birth to age 3. The group's decision to develop such a program stems from an awareness of the increasing number of young families moving into the neighborhood along with the number of parents referred to the clinic by child protective services.

The parenting program's advocacy goal is to provide parents of infants and toddlers a place to go—at no cost—where they can learn parenting skills and interact with one another. The parenting program is geared primarily toward early intervention, since eligible parents must have children from birth to age 3. The preventive aspect of the program aims to encourage learning and parent interactions before a crisis occurs, rather than during or afterwards.

To ensure the program reflects the community's demographic composition, Dr. Amy and parenting center staff walk throughout the neighborhood to talk with parents about their interest. Through these informal conversations, they learn that many parents have felt isolated since having a child. Several mothers share that they are the only parent raising their child. They talk about the lack of a social support network and feeling that they lack a voice in their communities. Some parents talk about being depressed since the birth of their child. They talk about feeling overwhelmed to the point of waking up in the morning wondering how they are going to live up to their parental responsibilities throughout the day. These conversations help Dr. Amy and her colleagues recognize that the parent program should be a safe haven where parents can interact with one another in addition to staff.

A series of workshops are organized that aim to be responsive to the struggles shared by the parents with whom they spoke. Topics such as “father involvement,” “post-partum depression,” “parenting style,” “work/family balance,” and “stress management” are all key concerns. Workshops are also responsive to the neighborhood’s linguistic and cultural diversity. Written information and workshops are presented in the languages spoken within the surrounding community. The program also works to develop collaborative relationships with parents in the community. As parents enroll, they are encouraged to recommend topics of discussion that reflect what they are experiencing. Parents enjoy coming in with their babies and toddlers. They learn about community resources and talk about shared challenges. Over time, the number of referrals from child protective services decreases.

Questions for Discussion:

5. How did Dr. Amy effectively engage in advocacy efforts that supported the community?
6. In what culturally responsive ways can psychologists engage in advocacy efforts?
7. What are some of the barriers to effective community-based advocacy? How can these barriers be addressed?
8. In your role as a practicing psychologist, are there ways that prevention and early intervention can promote positive outcomes?

Level 4 Case Illustrations: Domestic and International Climate

Guideline 7. Psychologists endeavor to examine the profession’s assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist’s self-definition, purpose, role, and function.

R. Michael: Identity and Refugee Status

Michael is a 24-year-old African refugee in the United States who was born and raised in Ethiopia. He identifies as cisgender male, heterosexual, and being poor. Michael came to the United States via Uganda where he took part in a struggle to overthrow a post-colonial military regime. Michael traveled to the United States on a student visa; however, the visa was a means of escape from Africa and he was not registered as a student in the United States. This visa has long expired and he is presently undocumented. While Michael was not his birth name; it was the name of his Ugandan friend who arranged for Michael to travel to the United States in his place. The issue of names and identity is central to Michael’s life.

One of Michael’s first acts upon leaving Ethiopia was to abandon his thirteen names, each taken from a preceding generation in his family. With this symbolic erasure of his past, Michael believed that he had entered the world with a blank slate, and could define his identity anew. Michael found Uganda in the midst of its own nationalistic identity crisis, trying to fill the void left by British colonists. This country, with its abundance of

revolutionary sentiment, was the perfect place for Michael to redefine himself. Michael and his friend, the original Michael, organized groups at a university where they were both pretending to be students, to protest human rights violations by the military government. However, the activism became armed revolution, and Michael felt lost and conflicted. He believed in liberation but could not be the violent radical that a nationalistic context now esteemed.

Some time later, Michael travelled to a Midwestern college town in the United States where he encountered a new set of dynamics around identity. In Uganda, Michael was an outsider enamored with a revolution but not willing to kill. In the United States, as an African, he was expected to accept his social position as a second-class, invisible person of color. Two different structural systems invited two opposing identities. The result was that Michael saw himself as a traitor, abandoning his African compatriots and beloved friends, including his namesake, who lost his life fighting for freedom. At the same time, Michael experienced himself as a maladjusted acquiescent person who accepted a subordinate identity enforced by a racist and classist society.

Questions for Discussion:

5. What are some practitioners' self-reflections regarding their values, beliefs, and assumptions about refugees coming to the United States from countries with civil strife; and about their knowledge of political uprisings, dictatorships, and religious and ethnic cleansing in African, Arabic, and/or Middle Eastern nations?
6. How would a psychologist do a structured intake on personal and family history with Michael, who is a reticent and distrusting interviewee?
7. Describe Michael's various cultural and social identities and their intersectionality. Which are dictated externally and have developed into an existential problem of a lack of self-knowledge?
8. Describe a community-based intervention that may help Michael incorporate and internalize a revolutionary aspect into his identity.

Guideline 8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

S. Mary: A Focus on the Interpersonal Instead of the Contextual

Mary is a 17-year-old Japanese American–born teenager raised in the United States. She is currently facing the prospect of taking the SAT and other national exams required to apply for college. While a bright student with a straight A average in high school, Mary has become increasingly anxious about taking the exams. As a result, she refuses to take the step of actually signing up to take them. Her parents, who were born in Japan, are bewildered about her refusal and anxiety, and what they increasingly see as self-destructive behavior.

Since early childhood, Mary's parents have enrolled her in afterschool educational support activities, similar to the *juku*, or private educational organizations that provide additional academic experiences outside the school setting in Japan. Mary's mother stopped working after she was born so she could devote herself to her daughter's development.

On some level, she feels that Mary's current struggles must reflect a failure on her part. On another level, Mary's mother feels frustrated that the sacrifice she made with regard to giving up her career to raise her daughter has not been rewarded by a motivation on her daughter's part to attend college.

After consultation with Mary's pediatrician, her parents have taken the step of having her see a psychologist. The latter is a non-Latino/Hispanic/Latinx White/White American professional who views Mary's behavior as simply acting out and resisting parental authority. He is unaware of the significance with which national exams are often viewed in Japan. He is also unaware of the trend to engage children in outside academic activities starting at a very young age that is a tradition for this family. Mary's parents tell the psychologist that they are devastated by what they perceive as a lack of motivation, especially given the overarching importance they have placed on these exams throughout her adolescence. The psychologist continues to frame the issue as one that reflects adolescent development and resistance to authority. As a result, he employs a CBT approach designed to address parent-child relations and issues of adolescent development instead of the generational and cultural conflict at play.

Questions for Discussion:

5. In what ways can the psychologist incorporate a multicultural framework in working with Mary and her family?
6. What are some of the intergenerational issues that affect family relationships and functioning?
7. As a psychologist taking a systemic approach, in what ways can you be responsive to the concerns of both Mary and her parents?
8. What are some of the developmental issues that may currently have an impact on Mary's experience, as well as that of her parents?

Level 5 Case Illustrations: Outcomes

Guideline 9. Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis,

dissemination, and evaluation of efficacy as they address the first four levels of the **Layered Ecological Model of the Multicultural Guidelines**.

T. Community-Based Research

A research psychologist new to the local university was interested in assessing depressive symptomatology among American Indian residents of a nearby tribal reservation. She approached the local tribal council and asked for their help in recruiting subjects. After a week of deliberation, the council firmly refused to grant her request. When the disappointed psychologist asked for an explanation, the head of the council initially said that it didn't seem like the project would benefit local members of his tribe. When pressed, he admitted that her university had a long history of doing research in the town without informing anyone of the results or working with the community. As a result, community leaders had become united in rejecting any proposed research by university faculty.

The psychologist expressed her disappointment but said she understood the concerns and would do her best to demonstrate her commitment to the community. For the next three years she worked closely with the town's tribal council on a number of projects that they initiated and participated in several activities designed to assist tribal members. When she finally revisited the possibility of research on depression, the council members wrote letters of support and actively assisted in recruitment.

Questions for Discussion:

5. As psychologists conducting community-based research, what are some considerations for building relationships in the community?
6. How can research psychologists be aware of the experiences of the communities in which they are conducting research?
7. How does this case reflect your own experiences conducting community-based research?
8. In what ways can research psychologists give back to the communities where their research is being conducted?

Guideline 10. Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

N. The Oregano Family: Working with Mental Health and Faith-Based Communities in Clinical Training

Six weeks prior to being seen at the university counseling center, the Oregano family suffered a devastating tragedy when Mr. Oregano, the husband and father of three children, was in a fatal plane crash. Traveling back home on a consumer airline, sudden lightening caused an electrical outage that led to the crash. Mrs. Oregano and her three children, ages 4, 10, and 16, come to counseling presenting symptoms of post-traumatic

stress. Understandably, the 4-year-old continues to ask when his father is going to return home.

The service provider is a doctoral student who is supervised by a licensed psychologist. The doctoral student is working with the Oregano family as part of a clinical practicum experience. From the beginning of their work together, Mrs. Oregano has expressed concern about the status of her late husband's afterlife. A devout Roman Catholic, she shares that the family has no body to bury, something profoundly important to someone whose faith believes in resurrection of the body. She expresses her concern to the trainee, sharing that a formal burial will help the family and future generations remember her late husband, while also respecting the saints. She shares with the trainee the teachings of her priest and is overwhelmed with grief related not only to loss, but also to concerns about her late husband's afterlife.

The trainee focuses on the symptoms Mrs. Oregano and her children are experiencing. Uncertain how to address the role of religion for this family, the trainee avoids it, minimizing family concerns in this area, focusing solely on the post-traumatic stress symptoms. The family begins to attend psychotherapy sporadically, which the trainee interprets as resistance to dealing with the loss.

The supervisor encourages the trainee to ask the family about their faith and the concerns the lack of a burial presents. Treatment seems to shift as Mrs. Oregano and her oldest child talk about their visits with their priest and the solace they get from the church. The supervisor increasingly encourages the trainee to incorporate the "voice" of the priest in sessions. In other words, the trainee is to ask about what the priest would say in response to current struggles and stresses. In this way, the supervisor invites the trainee to consider the importance of both mental health and faith. The Oregano family can approach their loss through an integration of both perspectives, rather than feeling they have to choose one over the other.

Questions for Discussion:

5. What does the supervisor encourage the trainee to understand when taking a culturally informed approach to education and training?
6. What are the goals of supervision that takes a culturally informed approach?
7. What are some of the challenges that might emerge for supervisor and supervisee in the context of supervision that takes this approach?
8. How can using an awareness of internal and contextual biases reduce or remove potential tensions in supervision?

O. Lucy: Fear about a Marriage Ending

Lucy is a 36-year-old White/White American transgender woman who has sought help from a psychologist to cope with her anxiety related to her relationship with her wife. Lucy has been employed in a pharmaceutical company for over eight years. She has grown increasingly anxious about the stability of her marriage, as she suspects that her

wife may be romantically involved with someone else. Lucy sometimes experiences panic symptoms, and feels overwhelmed by the prospect of her marriage ending.

Lucy grew up in a home in a rural area of the United States with her two siblings, parents, and grandparents. She describes her parents as "progressive and accepting," and as supportive when, in her teens, she told them that she was a girl. Her parents encouraged Lucy to work with a therapist at this time, which was an important source of support for her. However, Lucy was severely bullied by peers who verbally and physically attacked her in and out of school. She coped with these traumatic experiences through the use of substances such as alcohol and marijuana. Lucy described this time of her life as "most painful and depressing" and often thought of ending her life. She decided to attend college in a city far from her family home to escape the trauma she endured as an adolescent. While Lucy had not worked with a therapist since high school, she connected with a transgender community in college, and continued to form friendships with people she experienced as supportive and caring toward her. Soon after college, she met a cisgender woman whom she dated for several years and later married. Lucy feels that her wife has been a central figure in her life and someone who has advocated for her. This has been especially important in circumstances at work when Lucy has faced transphobic and heterosexist comments from coworkers.

Lucy has done hormone replacement therapy for several years, and more recently, has been considering sexual reassignment surgery (SRS). However, she feels confused about whether to pursue this, as her wife is against the idea of surgery, and has told Lucy that she "passes" as a woman without it. Lucy has felt hurt by these comments and wonders whether her wife truly understands what it means for her to be a transgender woman. At the same time, Lucy believes that her wife has been the one person she has relied on to help her cope with hostility based on her gender identity and sexual orientation. Their tension has escalated over the past year, and increasingly, Lucy has suspected that her wife is losing interest in being with her. Lucy worries that these conflicts may lead to separation or divorce. She is terrified of this potential loss and worries that she may cope with her anxiety by using substances or hurting herself in some other way.

Questions for Discussion:

5. What reactions do you have after reading about Lucy's experiences? What experience have you had in working with transgender clients?
6. How would you conceptualize the role of trauma in Lucy's life?
7. How would you approach helping Lucy with her anxiety, considering her past history of substance use, depression, and suicidal ideation?
8. In what ways do others' perceptions of Lucy's gender identity and sexual orientation affect her identity and relationships

American Psychological Association

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

Adopted August 21, 2002
Effective June 1, 2003
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to Introduction and Applicability
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ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

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AMENDMENTS TO THE 2002 "ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT" IN 2010 AND 2016

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INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A-E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The American Psychological Association's Council of Representatives adopted this version of the APA Ethics Code during its meeting on August 21, 2002. The Code became effective on June 1, 2003. The Council of Representatives amended this version of the Ethics Code on February 20, 2010, effective June 1, 2010, and on August 3, 2016, effective January 1, 2017. (see p. 16 of this pamphlet). Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Office of Ethics, American Psychological Association, 750 First St. NE, Washington, DC 20002-4242. This Ethics Code and information regarding the Code can be found on the APA website, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code, or amendments thereto, as follows:

American Psychological Association. (1953). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist, 14*, 279-282.

American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist, 18*, 56-60.

American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist, 23*, 357-361.

American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor*, 22-23.

American Psychological Association. (1979). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist, 36*, 633-638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist, 45*, 390-395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.

American Psychological Association. (2010). 2010 amendments to the 2002 *"Ethical Principles of Psychologists and Code of Conduct." American Psychologist, 65*, 493.

American Psychological Association. (2016). Revision of ethical standard 3.04 of the *"Ethical Principles of Psychologists and Code of Conduct"* (2002, as amended 2010). *American Psychologist, 71*, 900.

Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First St. NE, Washington, DC 20002-4242, or phone (202) 336-5510.

The modifiers used in some of the standards of this Ethics Code (*e.g., reasonably, appropriate, potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of

psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating with Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04a.

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter with Clients/Patients; 7.07, Sexual Relationships with Students and Supervisees; 10.05, Sexual Intima-

cies with Current Therapy Clients/Patients; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients.)

3.09 Cooperation with Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission,

they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter with Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals.)

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships with Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expect-

ed duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing with Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter with Clients/Patients.)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on informa-

tion and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies with Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

AMENDMENTS TO THE 2002 "ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT" IN 2010 AND 2016

2010 Amendments

Introduction and Applicability

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority~~ in keeping with basic principles of human rights.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.~~ Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and ~~to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.~~ take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

2016 Amendment

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04a.

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Chapter 36 of Title 54.1 of the Code of Virginia

Psychology

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§ 54.1-3600. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Applied psychologist" means an individual licensed to practice applied psychology.

"Board" means the Board of Psychology.

"Certified sex offender treatment provider" means a person who is certified to provide treatment to sex offenders and who provides such services in accordance with the provisions of §§ 54.1-2924.1, 54.1-3005, 54.1-3505, 54.1-3611, and 54.1-3705 and the regulations promulgated pursuant to these provisions.

"Clinical psychologist" means an individual licensed to practice clinical psychology.

"Practice of applied psychology" means application of the principles and methods of psychology to improvement of organizational function, personnel selection and evaluation, program planning and implementation, individual motivation, development and behavioral adjustment, as well as consultation on teaching and research.

"Practice of clinical psychology" includes, but is not limited to:

1. "Testing and measuring" which consists of the psychological evaluation or assessment of personal characteristics such as intelligence, abilities, interests, aptitudes, achievements, motives, personality dynamics, psychoeducational processes, neuropsychological functioning, or other psychological attributes of individuals or groups.

2. "Diagnosis and treatment of mental and emotional disorders" which consists of the appropriate diagnosis of mental disorders according to standards of the profession and the ordering or providing of treatments according to need. Treatment includes providing counseling, psychotherapy, marital/family therapy, group therapy, behavior therapy, psychoanalysis, hypnosis, biofeedback, and other psychological interventions with the objective of modification of perception, adjustment, attitudes, feelings, values, self-concept, personality or personal goals, the treatment of alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, pain, injury or disability.

3. "Psychological consulting" which consists of interpreting or reporting on scientific theory or research in psychology, rendering expert psychological or clinical psychological opinion, evaluation, or engaging in applied psychological research, program or organizational development, administration, supervision or evaluation of psychological services.

"Practice of psychology" means the practice of applied psychology, clinical psychology or school psychology.

The "practice of school psychology" means:

1. "Testing and measuring" which consists of psychological assessment, evaluation and diagnosis relative to the assessment of intellectual ability, aptitudes, achievement, adjustment, motivation, personality or any other psychological attribute of persons as individuals or in groups that directly relates to learning or behavioral problems that impact education.

2. "Counseling" which consists of professional advisement and interpretive services with children or adults for amelioration or prevention of problems that impact education.

Counseling services relative to the practice of school psychology include but are not limited to the procedures of verbal interaction, interviewing, behavior modification, environmental manipulation and group processes.

3. "Consultation" which consists of educational or vocational consultation or direct educational services to schools, agencies, organizations or individuals. Psychological consulting as herein defined is directly related to learning problems and related adjustments.

4. Development of programs such as designing more efficient and psychologically sound classroom situations and acting as a catalyst for teacher involvement in adaptations and innovations.

"Psychologist" means a person licensed to practice school, applied or clinical psychology.

"School psychologist" means a person licensed by the Board of Psychology to practice school psychology.

(1976, c. 608, § 54-936; 1987, cc. 522, 543; 1988, c. 765; 1994, c. 778; 1996, cc. 937, 980; 2004, c. 11.)

§ 54.1-3601. Exemption from requirements of licensure.

The requirements for licensure provided for in this chapter shall not be applicable to:

1. Persons who render services that are like or similar to those falling within the scope of the classifications or categories in this chapter, so long as the recipients or beneficiaries of such services are not subject to any charge or fee, or any financial requirement, actual or implied, and the person rendering such service is not held out, by himself or otherwise, as a licensed practitioner or a provider of clinical or school psychology services.

2. The activities or services of a student pursuing a course of study in psychology in an institution accredited by an accrediting agency recognized by the Board or under the supervision of a practitioner licensed or certified under this chapter, if such activities or services constitute a part of his course of study and are adequately supervised.

3. The activities of rabbis, priests, ministers or clergymen of any religious denomination or sect when such activities are within the scope of the performance of their regular or specialized ministerial duties, and no separate charge is made or when such activities are performed, whether

with or without charge, for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination or sect, and the person rendering service remains accountable to its established authority.

4. Persons employed as salaried employees or volunteers of the federal government, the Commonwealth, a locality, or any agency established or funded, in whole or part, by any such governmental entity or of a private, nonprofit organization or agency sponsored or funded, in whole or part, by a community-based citizen group or organization, except that any such person who renders psychological services, as defined in this chapter, shall be (i) supervised by a licensed psychologist or clinical psychologist; (ii) licensed by the Department of Education as a school psychologist; or (iii) employed by a school for students with disabilities which is certified by the Board of Education. Any person who, in addition to the above enumerated employment, engages in an independent private practice shall not be exempt from the licensure requirements.

5. Persons regularly employed by private business firms as personnel managers, deputies or assistants so long as their counseling activities relate only to employees of their employer and in respect to their employment.

6. Any psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction consulting with licensed psychologists in this Commonwealth.

7. Any psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction when in Virginia temporarily and such psychologist has been issued a temporary license by the Board to participate in continuing education programs or rendering psychological services without compensation to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

8. The performance of the duties of any commissioned or contract clinical psychologist in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States while such individual is so commissioned or serving.

9. Any person performing services in the lawful conduct of his particular profession or business under state law.

10. Any person duly licensed as a psychologist in another state or the District of Columbia who testifies as a treating psychologist or who is employed as an expert for the purpose of possibly testifying as an expert witness.

(1976, c. 608, § 54-944; 1986, c. 581; 1988, c. 765; 1996, cc. 937, 980; 2000, c. 462.)

§ 54.1-3602. Administration or prescription of drugs not permitted.

This chapter shall not be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine as defined in Chapter 29 (§ 54.1-2900 et seq.) of this title.

(1976, c. 608, § 54-945; 1988, c. 765.)

§ 54.1-3603. Board of Psychology; membership.

The Board of Psychology shall regulate the practice of psychology. The membership of the Board shall be representative of the practices of psychology and shall consist of nine members as follows: five persons who are licensed as clinical psychologists, one person licensed as a school psychologist, one person licensed as an applied psychologist and two citizen members. At least one of the seven psychologist members of the Board shall be a member of the faculty at an accredited college or university in this Commonwealth actively engaged in teaching psychology. The terms of the members of the Board shall be four years.

(1976, c. 608, § 54-937; 1981, c. 447; 1982, c. 165; 1985, c. 159; 1986, cc. 464, 510; 1988, cc. 42, 765; 1996, cc. 937, 980.)

§ 54.1-3604. Nominations.

Nominations for professional members may be made from a list of at least three names for each vacancy submitted to the Governor by the Virginia Psychological Association, the Virginia Academy of Clinical Psychologists, the Virginia Applied Psychology Academy and the Virginia Academy of School Psychologists. The Governor may notify such organizations of any professional vacancy other than by expiration. In no case shall the Governor be bound to make any appointment from among the nominees.

(1986, c. 464, § 54-937.1; 1988, c. 765; 1996, cc. 937, 980.)

§ 54.1-3605. Powers and duties of the Board.

In addition to the powers granted in other provisions of this title, the Board shall have the following specific powers and duties:

1. To cooperate with and maintain a close liaison with other professional boards and the community to ensure that regulatory systems stay abreast of community and professional needs.

2. To conduct inspections to ensure that licensees conduct their practices in a competent manner and in conformance with the relevant regulations.

3. To designate specialties within the profession.

4. To issue a temporary license for such periods as the Board may prescribe to practice psychology to persons who are engaged in a residency or pursuant to subdivision 7 of § 54.1-3601.

5. To promulgate regulations for the voluntary certification of licensees as sex offender treatment providers.

6. To administer the mandatory certification of sex offender treatment providers for those professionals who are otherwise exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 and to promulgate regulations governing such mandatory certification. The regulations shall include provisions for fees for application processing, certification qualifications, certification issuance and renewal and disciplinary action.

7. To promulgate regulations establishing the requirements for licensure of clinical psychologists that shall include appropriate emphasis in the diagnosis and treatment of persons with moderate and severe mental disorders.

(1976, c. 608, §§ 54-929, 54-931; 1983, c. 115; 1986, cc. 64, 100, 464; 1988, c. 765; 1993, c. 767; 1994, c. 778; 1996, cc. 937, 980; 1997, c. 556; 1999, c. 630; 2001, cc. 186, 198; 2004, c. 11.)

§ 54.1-3606. License required.

A. In order to engage in the practice of applied psychology, school psychology, or clinical psychology, it shall be necessary to hold a license.

B. Notwithstanding the provisions of subdivision 4 of § 54.1-3601 or any Board regulation, the Board of Psychology shall license, as school psychologists-limited, persons licensed by the Board of Education with an endorsement in psychology and a master's degree in psychology. The Board of Psychology shall issue licenses to such persons without examination, upon review of credentials and payment of an application fee in accordance with regulations of the Board for school psychologists-limited.

Persons holding such licenses as school psychologists-limited shall practice solely in public school divisions; holding a license as a school psychologist-limited pursuant to this subsection shall not authorize such persons to practice outside the school setting or in any setting other than the public schools of the Commonwealth, unless such individuals are licensed by the Board of Psychology to offer to the public the services defined in § 54.1-3600.

The Board shall issue persons, holding licenses from the Board of Education with an endorsement in psychology and a license as a school psychologist-limited from the Board of Psychology, a license which notes the limitations on practice set forth in this section.

Persons who hold licenses as psychologists issued by the Board of Psychology without these limitations shall be exempt from the requirements of this section.

(1979, c. 408, § 54-939.1; 1988, c. 765; 1996, cc. 937, 980; 1999, cc. 967, 1005.)

§ 54.1-3606.1. Continuing education.

A. The Board shall promulgate regulations governing continuing education requirements for psychologists licensed by the Board. Such regulations shall require the completion of the equivalent of 14 hours annually in Board-approved continuing education courses for any license renewal or reinstatement after the effective date.

B. The Board shall include in its regulations governing continuing education requirements for licensees a provision allowing a licensee who completes continuing education hours in excess of the hours required by subsection A to carry up to seven hours of continuing education credit forward to meet the requirements of subsection A for the next annual renewal cycle.

C. The Board shall approve criteria for continuing education courses that are directly related to the respective license and scope of practice of school psychology, applied psychology and clinical psychology. Approved continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment and care of patients with moderate and severe mental disorders. Any licensed hospital, accredited institution of higher education, or national, state or local health, medical, psychological or mental health association or organization may submit applications to the Board for approval as a provider of continuing education courses satisfying the requirements of the Board's regulations. Approved course providers may be required to register continuing education courses with the Board pursuant to Board regulations. Only courses meeting criteria approved by the Board and offered by a Board-approved provider of continuing education courses may be designated by the Board as qualifying for continuing education course credit.

D. All course providers shall furnish written certification to licensed psychologists attending and completing respective courses, indicating the satisfactory completion of an approved continuing education course. Each course provider shall retain records of all persons attending and those persons satisfactorily completing such continuing education courses for a period of four years following each course. Applicants for renewal or reinstatement of licenses issued pursuant to this article shall retain for a period of four years the written certification issued by any course provider. The Board may require course providers or licensees to submit copies of such records or certification, as it deems necessary to ensure compliance with continuing education requirements.

E. The Board shall have the authority to grant exemptions or waivers or to reduce the number of continuing education hours required in cases of certified illness or undue hardship.
2000, c. 83; 2015, c. 359.

§ 54.1-3607. .

Repealed by Acts 1996, cc. 937 and 980.

§ 54.1-3608. .

Repealed by Acts 2001, cc. 186 and 198.

§§ 54.1-3609. , 54.1-3610.

Repealed by Acts 2004, c. 11.

§ 54.1-3611. Restriction of practice; use of titles.

No person, including licensees of the Boards of Counseling; Medicine; Nursing; Psychology; or Social Work, shall claim to be a certified sex offender treatment provider unless he has been so certified. No person who is exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 shall hold himself out as a provider of sex offender treatment services unless he is certified as a sex offender treatment provider by the Board of Psychology.

(1994, c. 778; 1999, c. 630; 2000, c. 473.)

§ 54.1-3612. .

Repealed by Acts 1997, c. 698.

§ 54.1-3613. .

Repealed by Acts 2004, cc. 40 and 68.

§ 54.1-3614. Delegation to unlicensed persons.

Any licensed psychologist may delegate to unlicensed personnel supervised by him such activities or functions as are nondiscretionary and do not require the exercise of professional judgment for their performance and which are usually or customarily delegated to such persons by psychologists, if such activities or functions are authorized by and performed for such psychologist and responsibility for such activities or functions is assumed by such psychologist.

(1996, cc. 937, 980.)

§ 54.1-3615. .

Repealed by Acts 2004, c. 64.

§ 54.1-3616. Use of title "Doctor.".

No person regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in advertising in connection with his practice unless he simultaneously uses a clarifying title, initials, abbreviation or designation or language that identifies the type of practice for which he is licensed.

(1996, cc. 937, 980.)

Chapter 36 of Title 54.1 of the Code of Virginia

Psychology

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§ 54.1-3600. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Applied psychologist" means an individual licensed to practice applied psychology.

"Board" means the Board of Psychology.

"Certified sex offender treatment provider" means a person who is certified to provide treatment to sex offenders and who provides such services in accordance with the provisions of §§ 54.1-2924.1, 54.1-3005, 54.1-3505, 54.1-3611, and 54.1-3705 and the regulations promulgated pursuant to these provisions.

"Clinical psychologist" means an individual licensed to practice clinical psychology.

"Practice of applied psychology" means application of the principles and methods of psychology to improvement of organizational function, personnel selection and evaluation, program planning and implementation, individual motivation, development and behavioral adjustment, as well as consultation on teaching and research.

"Practice of clinical psychology" includes, but is not limited to:

1. "Testing and measuring" which consists of the psychological evaluation or assessment of personal characteristics such as intelligence, abilities, interests, aptitudes, achievements, motives, personality dynamics, psychoeducational processes, neuropsychological functioning, or other psychological attributes of individuals or groups.

2. "Diagnosis and treatment of mental and emotional disorders" which consists of the appropriate diagnosis of mental disorders according to standards of the profession and the ordering or providing of treatments according to need. Treatment includes providing counseling, psychotherapy, marital/family therapy, group therapy, behavior therapy, psychoanalysis, hypnosis, biofeedback, and other psychological interventions with the objective of modification of perception, adjustment, attitudes, feelings, values, self-concept, personality or personal goals, the treatment of alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, pain, injury or disability.

3. "Psychological consulting" which consists of interpreting or reporting on scientific theory or research in psychology, rendering expert psychological or clinical psychological opinion, evaluation, or engaging in applied psychological research, program or organizational development, administration, supervision or evaluation of psychological services.

"Practice of psychology" means the practice of applied psychology, clinical psychology or school psychology.

The "practice of school psychology" means:

1. "Testing and measuring" which consists of psychological assessment, evaluation and diagnosis relative to the assessment of intellectual ability, aptitudes, achievement, adjustment, motivation, personality or any other psychological attribute of persons as individuals or in groups that directly relates to learning or behavioral problems that impact education.

2. "Counseling" which consists of professional advisement and interpretive services with children or adults for amelioration or prevention of problems that impact education.

Counseling services relative to the practice of school psychology include but are not limited to the procedures of verbal interaction, interviewing, behavior modification, environmental manipulation and group processes.

3. "Consultation" which consists of educational or vocational consultation or direct educational services to schools, agencies, organizations or individuals. Psychological consulting as herein defined is directly related to learning problems and related adjustments.

4. Development of programs such as designing more efficient and psychologically sound classroom situations and acting as a catalyst for teacher involvement in adaptations and innovations.

"Psychologist" means a person licensed to practice school, applied or clinical psychology.

"School psychologist" means a person licensed by the Board of Psychology to practice school psychology.

(1976, c. 608, § 54-936; 1987, cc. 522, 543; 1988, c. 765; 1994, c. 778; 1996, cc. 937, 980; 2004, c. 11.)

§ 54.1-3601. Exemption from requirements of licensure.

The requirements for licensure provided for in this chapter shall not be applicable to:

1. Persons who render services that are like or similar to those falling within the scope of the classifications or categories in this chapter, so long as the recipients or beneficiaries of such services are not subject to any charge or fee, or any financial requirement, actual or implied, and the person rendering such service is not held out, by himself or otherwise, as a licensed practitioner or a provider of clinical or school psychology services.

2. The activities or services of a student pursuing a course of study in psychology in an institution accredited by an accrediting agency recognized by the Board or under the supervision of a practitioner licensed or certified under this chapter, if such activities or services constitute a part of his course of study and are adequately supervised.

3. The activities of rabbis, priests, ministers or clergymen of any religious denomination or sect when such activities are within the scope of the performance of their regular or specialized ministerial duties, and no separate charge is made or when such activities are performed, whether

with or without charge, for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination or sect, and the person rendering service remains accountable to its established authority.

4. Persons employed as salaried employees or volunteers of the federal government, the Commonwealth, a locality, or any agency established or funded, in whole or part, by any such governmental entity or of a private, nonprofit organization or agency sponsored or funded, in whole or part, by a community-based citizen group or organization, except that any such person who renders psychological services, as defined in this chapter, shall be (i) supervised by a licensed psychologist or clinical psychologist; (ii) licensed by the Department of Education as a school psychologist; or (iii) employed by a school for students with disabilities which is certified by the Board of Education. Any person who, in addition to the above-enumerated employment, engages in an independent private practice shall not be exempt from the licensure requirements.

5. Persons regularly employed by private business firms as personnel managers, deputies or assistants so long as their counseling activities relate only to employees of their employer and in respect to their employment.

6. Any psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction consulting with licensed psychologists in this Commonwealth.

7. Any psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction when in Virginia temporarily and such psychologist has been issued a temporary license by the Board to participate in continuing education programs or rendering psychological services without compensation to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

8. The performance of the duties of any commissioned or contract clinical psychologist in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States while such individual is so commissioned or serving.

9. Any person performing services in the lawful conduct of his particular profession or business under state law.

10. Any person duly licensed as a psychologist in another state or the District of Columbia who testifies as a treating psychologist or who is employed as an expert for the purpose of possibly testifying as an expert witness.

11. Any psychologist who is licensed in another state, the District of Columbia, or a United States territory or possession and who is in good standing with the applicable regulatory agency in that state, the District of Columbia, or that United States territory or possession who provides behavioral health services, as defined in § 37.2-100, to a patient located in the Commonwealth when (i) such practice is for the purpose of providing continuity of care through the use of telemedicine services as defined in § 38.2-3418.16 and (ii) the psychologist has previously

established a practitioner-patient relationship with the patient. A psychologist who provides behavioral health services to a patient located in the Commonwealth through use of telemedicine services pursuant to this subdivision may provide such services for a period of no more than one year from the date on which the psychologist began providing such services to such patient.

1976, c. 608, § 54-944; 1986, c. 581; 1988, c. 765; 1996, cc. 937, 980; 2000, c. 462; 2022, c. 275.

§ 54.1-3602. Administration or prescription of drugs not permitted.

This chapter shall not be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine as defined in Chapter 29 (§ 54.1-2900 et seq.) of this title.

(1976, c. 608, § 54-945; 1988, c. 765.)

§ 54.1-3603. Board of Psychology; membership.

The Board of Psychology shall regulate the practice of psychology. The membership of the Board shall be representative of the practices of psychology and shall consist of nine members as follows: five persons who are licensed as clinical psychologists, one person licensed as a school psychologist, one person licensed in any category of psychology, and two citizen members. At least one of the seven psychologist members of the Board shall be a member of the faculty at an accredited institution of higher education in the Commonwealth actively engaged in teaching psychology. The terms of the members of the Board shall be four years.

1976, c. 608, § 54-937; 1981, c. 447; 1982, c. 165; 1985, c. 159; 1986, cc. 464, 510; 1988, cc. 42, 765; 1996, cc. 937, 980; 2019, c. 169.

§ 54.1-3604. Nominations.

Nominations for professional members may be made from a list of at least three names for each vacancy submitted to the Governor by the Virginia Psychological Association, the Virginia Academy of Clinical Psychologists, the Virginia Applied Psychology Academy and the Virginia Academy of School Psychologists. The Governor may notify such organizations of any professional vacancy other than by expiration. In no case shall the Governor be bound to make any appointment from among the nominees.

(1986, c. 464, § 54-937.1; 1988, c. 765; 1996, cc. 937, 980.)

§ 54.1-3605. Powers and duties of the Board.

In addition to the powers granted in other provisions of this title, the Board shall have the following specific powers and duties:

1. To cooperate with and maintain a close liaison with other professional boards and the community to ensure that regulatory systems stay abreast of community and professional needs.

2. To conduct inspections to ensure that licensees conduct their practices in a competent manner and in conformance with the relevant regulations.

3. To designate specialties within the profession.

4. To issue a temporary license for such periods as the Board may prescribe to practice psychology to persons who are engaged in a residency or pursuant to subdivision 7 of § 54.1-3601.

5. To promulgate regulations for the voluntary certification of licensees as sex offender treatment providers.

6. To administer the mandatory certification of sex offender treatment providers for those professionals who are otherwise exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 and to promulgate regulations governing such mandatory certification. The regulations shall include provisions for fees for application processing, certification qualifications, certification issuance and renewal and disciplinary action.

7. To promulgate regulations establishing the requirements for licensure of clinical psychologists that shall include appropriate emphasis in the diagnosis and treatment of persons with moderate and severe mental disorders.

(1976, c. 608, §§ 54-929, 54-931; 1983, c. 115; 1986, cc. 64, 100, 464; 1988, c. 765; 1993, c. 767; 1994, c. 778; 1996, cc. 937, 980; 1997, c. 556; 1999, c. 630; 2001, cc. 186, 198; 2004, c. 11.)

§ 54.1-3606. License required.

A. In order to engage in the practice of applied psychology, school psychology, or clinical psychology, it shall be necessary to hold a license.

B. Notwithstanding the provisions of subdivision 4 of § 54.1-3601 or any Board regulation, the Board of Psychology shall license, as school psychologists-limited, persons licensed by the Board of Education with an endorsement in psychology and a master's degree in psychology. The Board of Psychology shall issue licenses to such persons without examination, upon review of credentials and payment of an application fee in accordance with regulations of the Board for school psychologists-limited.

Persons holding such licenses as school psychologists-limited shall practice solely in public school divisions; holding a license as a school psychologist-limited pursuant to this subsection shall not authorize such persons to practice outside the school setting or in any setting other than the public schools of the Commonwealth, unless such individuals are licensed by the Board of Psychology to offer to the public the services defined in § 54.1-3600.

The Board shall issue persons, holding licenses from the Board of Education with an endorsement in psychology and a license as a school psychologist-limited from the Board of Psychology, a license which notes the limitations on practice set forth in this section.

Persons who hold licenses as psychologists issued by the Board of Psychology without these limitations shall be exempt from the requirements of this section.

(1979, c. 408, § 54-939.1; 1988, c. 765; 1996, cc. 937, 980; 1999, cc. 967, 1005.)

§ 54.1-3606.1. Continuing education.

A. The Board shall promulgate regulations governing continuing education requirements for psychologists licensed by the Board. Such regulations shall require the completion of the equivalent of 14 hours annually in Board-approved continuing education courses for any license renewal or reinstatement after the effective date.

B. The Board shall include in its regulations governing continuing education requirements for licensees a provision allowing a licensee who completes continuing education hours in excess of the hours required by subsection A to carry up to seven hours of continuing education credit forward to meet the requirements of subsection A for the next annual renewal cycle.

C. The Board shall approve criteria for continuing education courses that are directly related to the respective license and scope of practice of school psychology, applied psychology and clinical psychology. Approved continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment and care of patients with moderate and severe mental disorders. Any licensed hospital, accredited institution of higher education, or national, state or local health, medical, psychological or mental health association or organization may submit applications to the Board for approval as a provider of continuing education courses satisfying the requirements of the Board's regulations. Approved course providers may be required to register continuing education courses with the Board pursuant to Board regulations. Only courses meeting criteria approved by the Board and offered by a Board-approved provider of continuing education courses may be designated by the Board as qualifying for continuing education course credit.

D. All course providers shall furnish written certification to licensed psychologists attending and completing respective courses, indicating the satisfactory completion of an approved continuing education course. Each course provider shall retain records of all persons attending and those persons satisfactorily completing such continuing education courses for a period of four years following each course. Applicants for renewal or reinstatement of licenses issued pursuant to this article shall retain for a period of four years the written certification issued by any course provider. The Board may require course providers or licensees to submit copies of such records or certification, as it deems necessary to ensure compliance with continuing education requirements.

E. The Board shall have the authority to grant exemptions or waivers or to reduce the number of continuing education hours required in cases of certified illness or undue hardship.

2000, c. 83; 2015, c. 359.

§ 54.1-3606.2. (Effective January 1, 2021) Psychology Interjurisdictional Compact.

Article I. Purpose.

Whereas, states license psychologists, in order to protect the public through verification of education, training, and experience and ensure accountability for professional practice; and

Whereas, this Compact is intended to regulate the day-to-day practice of telepsychology (i.e., the provision of psychological services using telecommunication technologies) by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for 30 days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to authorize State Psychology Regulatory Authorities to afford legal recognition, in a manner consistent with the terms of the Compact, to psychologists licensed in another state; and

Whereas, this Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety; and

Whereas, this Compact does not apply when a psychologist is licensed in both the Home and Receiving States; and

Whereas, this Compact does not apply to permanent in-person, face-to-face practice, it does allow for authorization of temporary psychological practice.

Consistent with these principles, this Compact is designed to achieve the following purposes and objectives:

1. Increase public access to professional psychological services by allowing for telepsychological practice across state lines, as well as temporary in-person, face-to-face services into a state in which the psychologist is not licensed to practice psychology;

2. Enhance the states' ability to protect the public's health and safety, especially client/patient safety;

3. Encourage the cooperation of Compact States in the areas of psychology licensure and regulation;

4. Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history;

5. Promote compliance with the laws governing psychological practice in each Compact State; and

6. Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

Article II. Definitions.

A. "Adverse Action" means any action taken by a State Psychology Regulatory Authority that finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

B. "Association of State and Provincial Psychology Boards" (ASPPB) means the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

C. "Authority to Practice Interjurisdictional Telepsychology" means a licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

D. "Bylaws" means those bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to Article X for its governance, or for directing and controlling its actions and conduct.

E. "Client/Patient" means the recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

F. "Commissioner" means the voting representative appointed by each State Psychology Regulatory Authority pursuant to Article X.

G. "Compact State" means a state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to Article XIII, Section C or been terminated pursuant to Article XII, Section B.

H. "Coordinated Licensure Information System," also referred to as "Coordinated Database," means an integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

I. "Confidentiality" means the principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

J. "Day" means any part of a day in which psychological work is performed.

K. "Distant State" means the Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

L. "E.Passport" means a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

M. "Executive Board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

N. "Home State" means a Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

O. "Identity History Summary" means: a summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

P. "In-Person, Face-to-Face" means interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

Q. "Interjurisdictional Practice Certificate (IPC)" means a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily, and verification of one's qualifications for such practice.

R. "License" means authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

S. "Non-Compact State" means any State which is not at the time a Compact State.

T. "Psychologist" means an individual licensed for the independent practice of psychology.

U. "Psychology Interjurisdictional Compact Commission" also referred to as "Commission" means the national administration of which all Compact States are members.

V. "Receiving State" means a Compact State where the client/patient is physically located when the telepsychological services are delivered.

W. "Rule" means a written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to Article XI of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal or suspension of an existing rule.

X. "Significant Investigatory Information" means:

1. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

2. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

Y. "State" means a state, commonwealth, territory, or possession of the United States.

Z. "State Psychology Regulatory Authority" means the Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

AA. "Telepsychology" means the provision of psychological services using telecommunication technologies.

BB. "Temporary Authorization to Practice" means a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

CC. "Temporary In-Person, Face-to-Face Practice" means where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

Article III. Home State Licensure.

A. The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

B. A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

C. Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

D. Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

E. A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

1. Currently requires the psychologist to hold an active E.Passport;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

5. Complies with the Bylaws and Rules of the Commission.

F. A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

1. Currently requires the psychologist to hold an active IPC;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the FBI, or other designee with similar authority, no later than 10 years after activation of the Compact; and

5. Complies with the Bylaws and Rules of the Commission.

Article IV. Compact Privilege to Practice Telepsychology.

A. Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

B. To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to 1 a by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

2. Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree; and

j. The program includes an acceptable residency as defined by the Rules of the Commission;

3. Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

4. Have no history of adverse action that violate the Rules of the Commission;

5. Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

6. Possess a current, active E.Passport;

7. Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology; criminal background; and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

D. A psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State, is restricted, suspended or otherwise limited, the E.Passport shall be revoked and therefore the psychologist shall not be

eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

Article V. Compact Temporary Authorization to Practice.

A. Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

B. To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, OR authorized by Provincial Statute or Royal Charter to grant doctoral degrees; OR

b. A foreign college or university deemed to be equivalent to 1 a above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; AND

2. Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full- time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

j. The program includes an acceptable residency as defined by the Rules of the Commission;

3. Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

4. No history of adverse action that violate the Rules of the Commission;

5. No criminal record history that violates the Rules of the Commission;

6. Possess a current, active IPC;

7. Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

D. A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State, is restricted, suspended or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

Article VI. Conditions of Telepsychology Practice in a Receiving State.

A. A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

1. The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State;

2. Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

Article VII. Adverse Actions.

A. A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

B. A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

C. If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

1. All Home State disciplinary orders that impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

2. In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

3. Other actions may be imposed as determined by the Rules promulgated by the Commission.

D. A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

E. A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice that occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

F. Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

G. No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection C.

Article VIII. Additional Authorities Invested in a Compact State's Psychology Regulatory Authority.

A. In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

1. Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's

Psychology Regulatory Authority for the attendance and testimony of witnesses, and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

2. Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

B. During the course of any investigation, a psychologist may not change his Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

Article IX. Coordinated Licensure Information System.

A. The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists individuals to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

B. Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against a psychologist's license;

5. An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;

6. Non-confidential information related to alternative program participation information;

7. Any denial of application for licensure, and the reasons for such denial; and

8. Other information that may facilitate the administration of this Compact, as determined by the Rules of the Commission.

C. The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

D. Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

E. Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

Article X. Establishment of the Psychology Interjurisdictional Compact Commission.

A. The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

1. The Commission is a body politic and an instrumentality of the Compact States.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings.

1. The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; OR

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

2. Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

3. Each Commissioner shall be entitled to one (1) vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

4. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

5. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article XI.

6. The Commission may convene in a closed, non-public meeting if the Commission must discuss:

a. Non-compliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline or other personnel matters, or practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law-enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

7. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

8. The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compact States;

9. The Commission shall maintain its financial records in accordance with the Bylaws; and

10. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

D. The Commission shall have the following powers:

1. The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rule shall have the force and effect of law and shall be binding in all Compact States;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compact State;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property real, personal or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees comprised of Members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

E. The Executive Board.

1. The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact. The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission;

b. One ex-officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

2. The ex-officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

3. The Commission may remove any member of the Executive Board as provided in Bylaws.

4. The Executive Board shall meet at least annually.

5. The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, fees paid by Compact States such as annual dues, and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

F. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State. 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified Immunity, Defense, and Indemnification.

1. The members, officers, Executive Director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, Executive Director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful or wanton misconduct of that person.

Article XI. Rulemaking.

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission; and

2. On the website of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons who submit comments independently of each other;

2. A governmental subdivision or agency; or

3. A duly-appointed person in an association that has having at least 25 members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not fewer than five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Compact State funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Article XII. Oversight, Dispute Resolution and Enforcement.

A. Oversight.

1. The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

B. Default, Technical Assistance, and Termination.

1. If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States, and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be

submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

4. A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

5. The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution.

1. Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States. 2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the commission.

D. Enforcement.

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Article XIII. Date of Implementation of the Psychology Interjurisdictional Compact Commission and Associated Rules, Withdrawal, and Amendments.

A. The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

1. A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

E. This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

Article XIV. Construction and Severability.

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States.

§ 54.1-3607. .

Repealed by Acts 1996, cc. 937 and 980.

§ 54.1-3608. .

Repealed by Acts 2001, cc. 186 and 198.

§§ 54.1-3609. , 54.1-3610.

Repealed by Acts 2004, c. 11.

§ 54.1-3611. Restriction of practice; use of titles.

No person, including licensees of the Boards of Counseling; Medicine; Nursing; Psychology; or Social Work, shall claim to be a certified sex offender treatment provider unless he has been so certified. No person who is exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 shall hold himself out as a provider of sex offender treatment services unless he is certified as a sex offender treatment provider by the Board of Psychology.

(1994, c. 778; 1999, c. 630; 2000, c. 473.)

§ 54.1-3612. .

Repealed by Acts 1997, c. 698.

§ 54.1-3613. .

Repealed by Acts 2004, cc. 40 and 68.

§ 54.1-3614. Delegation to unlicensed persons.

Any licensed psychologist may delegate to unlicensed personnel supervised by him such activities or functions as are nondiscretionary and do not require the exercise of professional judgment for their performance and which are usually or customarily delegated to such persons by psychologists, if such activities or functions are authorized by and performed for such psychologist and responsibility for such activities or functions is assumed by such psychologist.

(1996, cc. 937, 980.)

§ 54.1-3615. .

Repealed by Acts 2004, c. 64.

§ 54.1-3616. Use of title "Doctor.".

No person regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in advertising in connection with his practice unless he simultaneously uses a

clarifying title, initials, abbreviation or designation or language that identifies the type of practice for which he is licensed.

(1996, cc. 937, 980.)

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF PSYCHOLOGY

VIRGINIA BOARD OF PSYCHOLOGY

Title of Regulations: 18 VAC 125-20-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 36 of Title 54.1 of the *Code of Virginia*

Revised Date: December 21, 2022

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Part I
General Provisions

18VAC125-20-10. Definitions.

The following words and terms, in addition to the words and terms defined in §§ 54.1-3600 and 54.1-3606.2 of the Code of Virginia, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"APA" means the American Psychological Association.

"APPIC" means the Association of Psychology Postdoctoral and Internship Centers.

"ASPPB" means the Association of State and Provincial Psychology Boards.

"Board" means the Virginia Board of Psychology.

"CAEP" means Council for the Accreditation of Educator Preparation.

"Compact" means the Psychology Interjurisdictional Compact.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"CPA" means Canadian Psychological Association.

"Demonstrable areas of competence" means those therapeutic and assessment methods and techniques for the populations served and for which one can document adequate graduate training, workshops, or appropriate supervised experience.

"E.Passport" means a certificate issued by ASPPB that authorizes telepsychology services in a compact state.

"Face-to-face" means in person.

"Intern" means an individual who is enrolled in a professional psychology program internship.

"Internship" means an ongoing, supervised, and organized practical experience obtained in an integrated training program identified as a psychology internship. Other supervised experience or on-the-job training does not constitute an internship.

"IPC" means an interjurisdictional practice certificate issued by ASPPB that grants temporary authority to practice in a compact state.

"NASP" means the National Association of School Psychologists.

"Practicum" means the pre-internship clinical experience that is part of a graduate educational program.

"Practicum student" means an individual who is enrolled in a professional psychology program and is receiving pre-internship training and seeing clients.

"Professional psychology program" means an integrated program of doctoral study in clinical or counseling psychology or a master's degree or higher program in school psychology designed to train professional psychologists to deliver services in psychology.

"Regional accrediting agency" means one of the six regional accrediting agencies recognized by the U.S. Secretary of Education established to accredit senior institutions of higher education.

"Residency" means a post-internship, post-terminal degree, supervised experience approved by the board.

"Resident" means an individual who has received a doctoral degree in a clinical or counseling psychology program or a master's degree or higher in school psychology and is completing a board-approved residency.

"School psychologist-limited" means a person licensed pursuant to § 54.1-3606 of the Code of Virginia to provide school psychology services solely in public school divisions.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual consultation, guidance, and instruction with respect to the skills and competencies of the person supervised.

"Supervisor" means an individual who assumes responsibility for the education and training activities of a person under supervision and for the care of such person's clients and who provides supervision consistent with the training and experience of both the supervisor and the person under supervision and with the type of services being provided.

18VAC125-20-20. (Repealed.)

18VAC125-20-30. Fees required by the board.

A. The board has established fees for the following:

	Applied psychologists, Clinical psychologists, School psychologists	School psychologists-limited
1. Registration of residency (per residency request)	$50	- -
2. Add or change supervisor	$25	- -
3. Application processing and initial licensure	$200	$85
4. Annual renewal of active license	$140	$70
5. Annual renewal of inactive license	$70	$35
6. Late renewal	$50	$25
7. Verification of license to another jurisdiction	$25	$25
8. Duplicate license	$5	$5
9. Additional or replacement wall certificate	$15	$15
10. Handling fee for returned check or dishonored credit card or debit card	$50	$50
11. Reinstatement of a lapsed license	$270	$125
12. Reinstatement following revocation or suspension	$500	$500

B. Fees shall be made payable to the Treasurer of Virginia and forwarded to the board. All fees are nonrefundable.

C. Between May 1, 2020, and June 30, 2020, the following renewal fees shall be in effect:

1. For annual renewal of an active license as a clinical, applied, or school psychologist, it shall be $100. For an inactive license as a clinical, applied, or school psychologist, it shall be $50.

2. For annual renewal of an active license as a school psychologist-limited, it shall be $50. For an inactive license as a school psychologist-limited, it shall be $25.

18VAC125-20-35. Change of name or address.

Licensees or registrants shall notify the board in writing within 60 days of:

1. Any legal name change; or

2. Any change of address of record or of the licensee's or registrant's public address if different from the address of record.

Part II
Requirements for Licensure

18VAC125-20-40. General requirements for licensure.

Individuals licensed in one licensure category who wish to practice in another licensure category shall submit an application for the additional licensure category in which the licensee seeks to practice.

18VAC125-20-41. Requirements for licensure by examination.

A. Every applicant for licensure by examination shall:

1. Meet the education requirements prescribed in 18VAC125-20-54, 18VAC125-20-55, or 18VAC125-20-56 and the experience requirement prescribed in 18VAC125-20-65 as applicable for the particular license sought; and

2. Submit the following:

a. A completed application on forms provided by the board;

b. A completed residency agreement or documentation of having fulfilled the experience requirements of 18VAC125-20-65;

c. The application processing fee prescribed by the board;

d. Official transcripts documenting the graduate work completed and the degree awarded; transcripts previously submitted for registration of supervision do not have to be resubmitted unless additional coursework was subsequently obtained. Applicants who are graduates of institutions that are not regionally accredited shall submit documentation from an accrediting agency acceptable to the board that their education meets the requirements set forth in 18VAC125-20-54, 18VAC125-20-55, or 18VAC125-20-56;

e. A current report from the National Practitioner Data Bank; and

f. Verification of any other health or mental health professional license, certificate, or registration ever held in Virginia or another jurisdiction. The applicant shall not have surrendered a license, certificate, or registration while

under investigation and shall have no unresolved action against a license, certificate, or registration.

B. In addition to fulfillment of the education and experience requirements, each applicant for licensure by examination must achieve a passing score on all parts of the Examination for Professional Practice of Psychology required at the time the applicant took the examination.

C. Every applicant shall attest to having read and agreed to comply with the current standards of practice and laws governing the practice of psychology in Virginia.

18VAC125-20-42. Prerequisites for licensure by endorsement.

Every applicant for licensure by endorsement shall submit:

1. A completed application;

2. The application processing fee prescribed by the board;

3. An attestation of having read and agreed to comply with the current Standards of Practice and laws governing the practice of psychology in Virginia;

4. Verification of all other health and mental health professional licenses, certificates, or registrations ever held in Virginia or any jurisdiction of the United States or Canada. In order to qualify for endorsement, the applicant shall not have surrendered a license, certificate, or registration while under investigation and shall have no unresolved action against a license, certificate, or registration;

5. A current report from the National Practitioner Data Bank; and

6. Further documentation of one of the following:

a. A current credential issued by the National Register of Health Service Psychologists;

b. Current diplomate status in good standing with the American Board of Professional Psychology in a category comparable to the one in which licensure is sought;

c. A Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards;

d. Five years of active licensure in a category comparable to the one in which licensure is sought with at least 24 months of active practice within the last 60 months immediately preceding licensure application; or

e. If less than five years of active licensure or less than 24 months of active practice within the last 60 months, documentation of current psychologist

licensure in good standing obtained by standards substantially equivalent to the education, experience, and examination requirements set forth in this chapter for the category in which licensure is sought as verified by a certified copy of the original application submitted directly from the out-of-state licensing agency or a copy of the regulations in effect at the time of initial licensure and the following: (1) Verification of a passing score on all parts of the Examination for Professional Practice of Psychology that were required at the time of original licensure; and (2) Official transcripts documenting the graduate work completed and the degree awarded in the category in which licensure is sought.

18VAC125-20-43. Requirements for licensure as a school psychologist-limited.

A. Every applicant for licensure as a school psychologist-limited shall submit to the board:

1. A copy of a current license issued by the Board of Education showing an endorsement in psychology.

2. An official transcript showing completion of a master's degree in psychology.

3. A completed Employment Verification Form of current employment by a school system under the Virginia Department of Education.

4. The application fee.

B. At the time of licensure renewal, school psychologists-limited shall be required to submit an updated Employment Verification Form if there has been a change in school district in which the licensee is currently employed.

18VAC125-20-50. (Repealed.)

18VAC125-20-51. (Repealed.)

18VAC125-20-54. Education requirements for clinical psychologists.

A. Beginning June 23, 2028, an applicant shall hold a doctorate in clinical or counseling psychology from a professional psychology program in a regionally accredited university that was accredited at the time the applicant graduated from the program by the APA, CPA, or an accrediting body acceptable to the board. Graduates of programs that are not within the United States or Canada shall provide documentation from an acceptable credential evaluation service that provides information verifying that the program is substantially equivalent to an APA-accredited program.

B. Prior to June 23, 2028, an applicant shall either hold a doctorate from an accredited program, as specified in subsection A of this section, or shall hold a doctorate from a professional psychology program that documents that the program offers education and training that prepares individuals for the practice of clinical psychology as defined in § 54.1-3600 of the Code of Virginia and meets the following criteria:

1. The program is within an institution of higher education accredited by an accrediting agency recognized by the U.S. Department of Education or publicly recognized by the Association of Universities and Colleges of Canada as a member in good standing. Graduates of programs that are not within the United States or Canada must provide documentation from an acceptable credential evaluation service that provides information that allows the board to determine if the program meets the requirements set forth in this chapter.

2. The program shall be recognizable as an organized entity within the institution.

3. The program shall be an integrated, organized sequence of study with an identifiable psychology faculty and a psychologist directly responsible for the program and shall have an identifiable body of students who are matriculated in that program for a degree. The faculty shall be accessible to students and provide them with guidance and supervision. The faculty shall provide appropriate professional role models and engage in actions that promote the student's acquisition of knowledge, skills, and competencies consistent with the program's training goals.

4. The program shall encompass a minimum of three academic years of full-time graduate study or the equivalent thereof.

5. The program shall include a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in each of the following substantive content areas:

a. Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy).

b. Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion).

c. Social bases of behavior (e.g., social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues).

d. Psychological measurement.

e. Research methodology.

f. Techniques of data analysis.

g. Professional standards and ethics.

6. The program shall include a minimum of at least three or more graduate semester credit hours or five or more graduate quarter hours in each of the following clinical psychology content areas:

a. Individual differences in behavior (e.g., personality theory, cultural difference and diversity).

b. Human development (e.g., child, adolescent, geriatric psychology).

c. Dysfunctional behavior, abnormal behavior, or psychopathology.

d. Theories and methods of intellectual assessment and diagnosis.

e. Theories and methods of personality assessment and diagnosis including its practical application.

f. Effective interventions and evaluating the efficacy of interventions.

C. Applicants shall submit documentation of having successfully completed practicum experiences involving assessment, diagnosis, and psychological interventions. The practicum experiences shall include a minimum of nine graduate semester hours or 15 or more graduate quarter hours or equivalent in appropriate settings to ensure a wide range of supervised training and educational experiences.

D. An applicant shall graduate from an educational program in clinical psychology that includes an appropriate emphasis on and experience in the diagnosis and treatment of persons with moderate to severe mental disorders.

E. Candidates for clinical psychologist licensure shall have successfully completed an internship in a program that is either accredited by APA or CPA, or is a member of APPIC, or the Association of State and Provincial Psychology Boards/National Register of Health Service Psychologists, or one that meets equivalent standards. If the internship was obtained in an educational program outside of the United States or Canada, a credentialing service approved by the board shall verify equivalency to an internship in an APA-accredited program.

F. An applicant for a clinical license may fulfill the residency requirement of 1,500 hours, or some part thereof, as required for licensure in 18VAC125-20-65, in the doctoral practicum supervised experience, which occurs prior to the internship, and that meets the following standards:

1. The supervised professional experience shall be part of an organized sequence of training within the applicant's doctoral program that meets the criteria specified in this section.

2. The supervised experience shall include face-to-face direct client services, service-related activities, and supporting activities.

a. "Face-to-face direct client services" means treatment or intervention, assessment, and interviewing of clients.

b. "Service-related activities" means scoring, reporting or treatment note writing, and consultation related to face-to-face direct services.

c. "Supporting activities" means time spent under supervision of face-to-face direct services and service-related activities provided onsite or in the trainee's academic department, as well as didactic experiences, such as laboratories or seminars, directly related to such services or activities.

3. In order for pre-doctoral practicum hours to fulfill all or part of the residency requirement, the following shall apply:

a. Not less than one-quarter of the hours shall be spent in providing face-to-face direct client services;

b. Not less than one-half of the hours shall be in a combination of face-to-face direct service hours and hours spent in service-related activities; and

c. The remainder of the hours may be spent in a combination of face-to-face direct services, service-related activities, and supporting activities.

4. A minimum of one hour of individual face-to-face supervision shall be provided for every eight hours of supervised professional experience spent in direct client contact and service-related activities.

5. Two hours of group supervision with up to five practicum students may be substituted for one hour of individual supervision. In no case shall the hours of individual supervision be less than one-half of the total hours of supervision.

6. The hours of pre-doctoral supervised experience reported by an applicant shall be certified by the program's director of clinical training on a form provided by the board.

7. If the supervised experience hours completed in a series of practicum experiences do not total 1,500 hours or if a candidate is deficient in any of the categories of hours, a candidate shall fulfill the remainder of the hours by meeting requirements specified in 18VAC125-20-65.

18VAC125-20-55. Education requirements for applied psychologists.

A. The applicant shall hold a doctorate from a professional psychology program from a regionally accredited university that meets the following criteria:

1. The program is within an institution of higher education accredited by an accrediting agency recognized by the U.S. Department of Education or publicly recognized by the Association of Universities and Colleges of Canada as a member in good standing. Graduates of programs that are not within the United States or Canada must provide documentation from a credential evaluation service acceptable to the board that demonstrates that the program meets the requirements set forth in this chapter.

2. The program shall be recognizable as an organized entity within the institution.

3. The program shall be an integrated, organized sequence of study with an identifiable psychology faculty and a psychologist directly responsible for the program and shall have an identifiable body of students who are matriculated in that program for a degree. The faculty shall be accessible to students and provide them with guidance and supervision. The faculty shall provide appropriate professional role models and engage in actions that promote the student's acquisition of knowledge, skills, and competencies consistent with the program's training goals.

4. The program shall encompass a minimum of three academic years of full-time graduate study or the equivalent thereof.

5. The program shall include a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in each of the following substantive content areas:

a. Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy).

b. Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion).

c. Social bases of behavior (e.g., social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues).

d. Psychological measurement.

e. Research methodology.

f. Techniques of data analysis.

g. Professional standards and ethics.

B. Demonstration of competence in applied psychology shall be met by including a minimum of at least 18 semester hours or 30 quarter hours in a concentrated program of study in an identified area of psychology, for example, developmental, social, cognitive, motivation, applied behavioral analysis, industrial/organizational, human factors, personnel selection and evaluation, program planning and evaluation, teaching, research or consultation.

18VAC125-20-56. Education requirements for school psychologists.

A. The applicant shall hold at least a master's degree in school psychology, with a minimum of at least 60 semester credit hours or 90 quarter hours, from a college or university accredited by a regional accrediting agency, which was accredited by the APA or CAEP or was approved by NASP, or shall meet the requirements of subsection B of this section.

B. If the applicant does not hold a master's degree in school psychology from a program accredited by the APA or CAEP or approved by NASP, the applicant shall have a master's degree from a psychology program that offers education and training to prepare individuals for the practice of school psychology as defined in § 54.1-3600 of the Code of Virginia and that meets the following criteria:

1. The program is within an institution of higher education accredited by an accrediting agency recognized by the U.S. Department of Education or publicly recognized by the Association of Universities and Colleges of Canada as a member in good standing. Graduates of programs that are not within the United States or Canada must provide documentation from a credential evaluation service acceptable to the board that demonstrates that the program meets the requirements set forth in this chapter.

2. The program shall be recognizable as an organized entity within the institution.

3. The program shall be an integrated, organized sequence of study with an identifiable psychology faculty and a psychologist directly responsible for the program and shall have an identifiable body of students who are matriculated in that program for a degree. The faculty shall be accessible to students and provide them with guidance and supervision. The faculty shall provide appropriate professional role models and engage in actions that promote the student's acquisition of knowledge, skills, and competencies consistent with the program's training goals.

4. The program shall encompass a minimum of two academic years of full-time graduate study or the equivalent thereof.

5. The program shall include a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in each of the following substantive content areas:

a. Psychological foundations (e.g., biological bases of behavior, human learning, social and cultural bases of behavior, child and adolescent development, individual differences).

b. Educational foundations (e.g., instructional design, organization and operation of schools).

c. Interventions/problem-solving (e.g., assessment, direct interventions, both individual and group, indirect interventions).

d. Statistics and research methodologies (e.g., research and evaluation methods, statistics, measurement).

e. Professional school psychology (e.g., history and foundations of school psychology, legal and ethical issues, professional issues and standards, alternative models for the delivery of school psychological services, emergent technologies, roles and functions of the school psychologist).

6. The program shall be committed to practicum experiences that shall include:

a. Orientation to the educational process;

b. Assessment for intervention;

c. Direct intervention, including counseling and behavior management; and

d. Indirect intervention, including consultation.

C. Candidates for school psychologist licensure shall have successfully completed an internship in a program accredited by APA or CAEP, or approved by NASP, or is a member of APPIC or one that meets equivalent standards.

18VAC125-20-60. (Repealed.)

18VAC125-20-65. Residency.

A. Candidates for clinical or school psychologist licensure shall have successfully completed a residency consisting of a minimum of 1,500 hours of supervised experience in the delivery of clinical or school psychology services acceptable to the board.

1. For clinical psychology candidates, the hours of supervised practicum experiences in a doctoral program may be counted toward the residency hours, as specified in 18VAC125-20-54. Hours acquired during the required internship shall not be

counted toward the 1,500 residency hours. If the supervised experience hours completed in a practicum do not total 1,500 hours or if a candidate is deficient in any of the categories of hours, a candidate may fulfill the remainder of the hours by meeting requirements specified in subsection B of this section.

2. School psychologist candidates shall complete all the residency requirements after receipt of their final school psychology degree.

B. Residency requirements.

1. Candidates for clinical or school psychologist licensure shall have successfully completed a residency consisting of a minimum of 1,500 hours in a period of not less than 12 months and not to exceed three years of supervised experience in the delivery of clinical or school psychology services acceptable to the board, or the applicant may request approval to extend a residency if there were extenuating circumstances that precluded completion within three years.

2. Supervised experience obtained in Virginia without prior written board approval will not be accepted toward licensure. Candidates shall not begin the residency until after completion of the required degree as set forth in 18VAC125-20-54 or 18VAC125-20-56.

3. In order to have the residency accepted for licensure, an individual who proposes to obtain supervised post-degree experience in Virginia shall register with the board prior to the onset of such supervision by submission of:

a. A supervisory contract along with the application package;

b. The registration of supervision fee set forth in 18VAC125-20-30; and

c. An official transcript documenting completion of educational requirements as set forth in 18VAC125-20-54 or 18VAC125-20-56 as applicable.

4. If board approval was required for supervised experience obtained in another United States jurisdiction or Canada in which residency hours were obtained, a candidate shall provide evidence of board approval from such jurisdiction.

5. There shall be a minimum of two hours of individual supervision per 40 hours of supervised experience. Group supervision of up to five residents may be substituted for one of the two hours on the basis that two hours of group supervision equals one hour of individual supervision, but in no case shall the resident receive less than one hour of individual supervision per 40 hours.

6. Supervision shall be provided by a psychologist who holds a current, unrestricted license in the jurisdiction in which supervision is being provided and who is licensed to practice in the licensure category in which the resident is seeking licensure.

7. The supervisor shall not provide supervision for activities beyond the supervisor's demonstrable areas of competence nor for activities for which the applicant has not had appropriate education and training.

8. The supervising psychologist shall maintain records of supervision performed and shall regularly review and co-sign case notes written by the supervised resident during the residency period. At the end of the residency training period, the supervisor shall submit to the board a written evaluation of the applicant's performance.

9. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervisors.

C. Residents shall not refer to or identify themselves as clinical psychologists or school psychologists, independently solicit clients, bill directly for services, or in any way represent themselves as licensed psychologists. Notwithstanding, this does not preclude supervisors or employing institutions from billing for the services of an appropriately identified resident. During the residency period, residents shall use their names, the initials of their degree, and the title "Resident in Psychology" in the licensure category in which licensure is sought.

18VAC125-20-70. (Repealed.)

Part III
Examinations

18VAC125-20-80. General examination requirements.

A. A candidate shall achieve a passing score on the final step of the national examination within two years immediately preceding licensure. A candidate may request an extension of the two-year limitation for extenuating circumstances. If the candidate has not taken the examination by the end of the two-year period, the applicant shall reapply according to the requirements of the regulations in effect at that time.

B. The board shall establish passing scores on all steps of the examination.

18VAC125-20-90. (Repealed.)

Part IV
Licensure [Repealed]

18VAC125-20-110. (Repealed.)

Part V
Licensure Renewal; Reinstatement

18VAC125-20-120. Annual renewal of licensure.

Every license issued by the board shall expire each year on June 30.

1. Every licensee who intends to continue to practice shall, on or before the expiration date of the license, submit to the board a license renewal form supplied by the board and the renewal fee prescribed in 18VAC125-20-30.

2. Licensees who wish to maintain an active license shall pay the appropriate fee and verify on the renewal form compliance with the continuing education requirements prescribed in 18VAC125-20-121. First-time licensees by examination are not required to verify continuing education on the first renewal date following initial licensure.

3. A licensee who wishes to place his license in inactive status may do so upon payment of the fee prescribed in 18VAC125-20-30. A person with an inactive license is not authorized to practice; no person shall practice psychology in Virginia without a current active license. An inactive licensee may activate a license by fulfilling the reactivation requirements set forth in 18VAC125-20-130.

4. Failure of a licensee to receive a renewal notice and application forms from the board shall not excuse the licensee from the renewal requirement.

18VAC125-20-121. Continuing education course requirements for renewal of an active license.

A. Licensees shall be required to complete a minimum of 14 hours of board-approved continuing education courses each year for annual licensure renewal. A minimum of 1.5 of these hours shall be in courses that emphasize the ethics, laws, and regulations governing the profession of psychology, including the standards of practice set out in 18VAC125-20-150. A licensee who completes continuing education hours in excess of the 14 hours may carry up to seven hours of continuing education credit forward to meet the requirements for the next annual renewal cycle.

B. For the purpose of this section, "course" means an organized program of study, classroom experience, or similar educational experience that is directly related to the practice of psychology and is provided by a board-approved provider that meets the criteria specified in 18VAC125-20-122.

1. At least six of the required hours shall be earned in face-to-face or real-time interactive educational experiences. Real-time interactive shall include a course in

which the learner has the opportunity to interact with the presenter during the time of the presentation.

2. The board may approve up to four hours per renewal cycle for each of the following specific educational experiences:

a. Preparation for and presentation of a continuing education program, seminar, workshop, or academic course offered by an approved provider and directly related to the practice of psychology. Hours may only be credited one time, regardless of the number of times the presentation is given, and may not be credited toward the face-to-face requirement.

b. Publication of an article or book in a recognized publication directly related to the practice of psychology. Hours may only be credited one time, regardless of the number of times the writing is published, and may not be credited toward the face-to-face requirement.

c. Serving at least six months as editor or associate editor of a national or international, professional, peer-reviewed journal directly related to the practice of psychology.

3. Ten hours will be accepted for one or more three-credit-hour academic courses completed at a regionally accredited institution of higher education that are directly related to the practice of psychology.

4. The board may approve up to two hours per renewal cycle for membership on a state licensing board in psychology.

C. Courses must be directly related to the scope of practice in the category of licensure held. Continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment, and care of patients with moderate and severe mental disorders.

D. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

E. The board may grant an exemption for all or part of the continuing education requirements for one renewal cycle due to circumstances determined by the board to be beyond the control of the licensee.

F. Up to two of the 14 continuing education hours required for renewal may be satisfied through delivery of psychological services, without compensation, to low-income individuals receiving mental health services through a local health department or a free

clinic organized in whole or primarily for the delivery of those health services as verified by the department or clinic. Three hours of volunteer service is required for one hour of continuing education credit.

18VAC125-20-122. Continuing education providers.

A. The following organizations, associations, or institutions are approved by the board to provide continuing education:

1. Any psychological association recognized by the profession or providers approved by such an association.

2. Any association or organization of mental health, health, or psychoeducational providers recognized by the profession or providers approved by such an association or organization.

3. Any regionally accredited institution of higher learning.

4. Any governmental agency or facility that offers mental health, health, or psychoeducational services.

5. Any licensed hospital or facility that offers mental health, health, or psychoeducational services.

6. Any association or organization that has been approved as a continuing education provider by a psychology board in another state or jurisdiction.

B. Continuing education providers approved under subsection A of this section shall:

1. Maintain documentation of the course titles and objectives and of licensee attendance and completion of courses for a period of four years.

2. Monitor attendance at classroom or similar face-to-face educational experiences.

3. Provide a certificate of completion for licensees who successfully complete a course. The certificate shall indicate the number of continuing education hours for the course and shall indicate hours that may be designated as ethics, laws, or regulations governing the profession, if any.

18VAC125-20-123. Documenting compliance with continuing education requirements.

A. All licensees in active status are required to maintain original documentation for a period of four years.

B. After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.

C. Upon request, a licensee shall provide documentation as follows:

1. Official transcripts showing credit hours earned from an accredited institution; or

2. Certificates of completion from approved providers.

D. Compliance with continuing education requirements, including the maintenance of records and the relevance of the courses to the category of licensure, is the responsibility of the licensee. The board may request additional information if such compliance is not clear from the transcripts or certificates.

E. Continuing education hours required by disciplinary order shall not be used to satisfy renewal requirements.

18VAC125-20-130. Late renewal; reinstatement; reactivation.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late fee prescribed in 18VAC125-20-30 and the license renewal fee for the year the license was not renewed and by completing the continuing education requirements specified in 18VAC125-20-121 for that year.

B. A person whose license has not been renewed for one year or more and who wishes to resume practice shall:

1. Present evidence to the board of having met all applicable continuing education requirements equal to the number of years the license has been expired, not to exceed four years;

2. Pay the reinstatement fee as prescribed in 18VAC125-20-30; and

3. Submit verification of any professional certification or licensure obtained in any other jurisdiction subsequent to the initial application for licensure.

C. A psychologist wishing to reactivate an inactive license shall submit the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and document completion of continued education hours equal to the number of years the license has been inactive, not to exceed four years.

18VAC125-20-140. (Repealed.)

Part VI
Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement

18VAC125-20-150. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Psychologists respect the rights, dignity, and worth of all people and are mindful of individual differences. Regardless of the delivery method, whether face-to-face or by use of technology, these standards shall apply to the practice of psychology.

B. Persons regulated by the board and persons practicing in Virginia with an E.Passport or an IPC shall:

1. Provide and supervise only those services and use only those techniques for which they are qualified by education, training, and appropriate experience;

2. Delegate to persons under their supervision only those responsibilities such persons can be expected to perform competently by education, training, and experience;

3. Maintain current competency in the areas of practices through continuing education, consultation, or other procedures consistent with current standards of scientific and professional knowledge;

4. Accurately represent their areas of competence, education, training, experience, professional affiliations, credentials, and published findings to ensure that such statements are neither fraudulent nor misleading;

5. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services. Make appropriate consultations and referrals consistent with the law and based on the interest of patients or clients;

6. Refrain from undertaking any activity in which their personal problems are likely to lead to inadequate or harmful services;

7. Avoid harming, exploiting, misusing influence, or misleading patients or clients, research participants, students, and others for whom they provide professional services and minimize harm when it is foreseeable and unavoidable;

8. Not engage in, direct, or facilitate torture, which is defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that causes harm;

9. Withdraw from, avoid, adjust, or clarify conflicting roles with due regard for the best interest of the affected party and maximal compliance with these standards;

10. Make arrangements for another professional to deal with emergency needs of clients during periods of foreseeable absences from professional availability and provide for continuity of care when services must be terminated;

11. Conduct financial responsibilities to clients in an ethical and honest manner by:

a. Informing clients of fees for professional services and billing arrangements as soon as is feasible;

b. Informing clients prior to the use of collection agencies or legal measures to collect fees and provide opportunity for prompt payment;

c. Obtaining written consent for fees that deviate from the practitioner's usual and customary fees for services;

d. Participating in bartering only if it is not clinically contraindicated and is not exploitative; and

e. Not obtaining, attempting to obtain, or cooperating with others in obtaining payment for services by misrepresenting services provided, dates of service, or status of treatment.

12. Be able to justify all services rendered to clients as necessary for diagnostic or therapeutic purposes;

13. Construct, maintain, administer, interpret, and report testing and diagnostic services in a manner and for purposes that are current and appropriate;

14. Design, conduct, and report research in accordance with recognized standards of scientific competence and research ethics. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as participants in human research, with the exception of retrospective chart reviews;

15. Report to the board known or suspected violations of the laws and regulations governing the practice of psychology;

16. Accurately inform a client or a client's legally authorized representative of the client's diagnoses, prognosis, and intended treatment or plan of care. A psychologist shall present information about the risks and benefits of the recommended treatments in understandable terms and encourage participation in the decisions regarding the patient's care. When obtaining informed consent treatment for which generally recognized techniques and procedures have not been established, a psychologist shall inform clients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation;

17. Clearly document at the outset of service delivery what party the psychologist considers to be the client and what, if any, responsibilities the psychologist has to all related parties;

18. Determine whether a client is receiving services from another mental health service provider, and if so, document efforts to coordinate care;

19. Document the reasons for and steps taken if it becomes necessary to terminate a therapeutic relationship (e.g., when it becomes clear that the client is not benefiting from the relationship or when the psychologist feels endangered). Document assistance provided in making arrangements for the continuation of treatment for clients, if necessary, following termination of a therapeutic relationship; and

20. Not engage in conversion therapy with any person younger than 18 years of age.

C. In regard to confidentiality, persons regulated by the board shall:

1. Keep confidential their professional relationships with patients or clients and disclose client information to others only with written consent except as required or permitted by law. Psychologists shall inform clients of legal limits to confidentiality;

2. Protect the confidentiality in the usage of client information and clinical materials by obtaining informed consent from the client or the client's legally authorized representative before (i) videotaping, (ii) audio recording, (iii) permitting third party observation, or (iv) using clinical information in teaching, writing, or public presentations; and

3. Not willfully or negligently breach the confidentiality between a practitioner and a client. A disclosure that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

D. In regard to client records, persons regulated by the board shall:

1. Maintain timely, accurate, legible, and complete written or electronic records for each client. For a psychologist practicing in an institutional setting, the recordkeeping shall follow the policies of the institution or public facility. For a psychologist practicing in a noninstitutional setting, the record shall include:

a. The name of the client and other identifying information;

b. The presenting problem, purpose, or diagnosis;

c. Documentation of the fee arrangement;

d. The date and clinical summary of each service provided;

e. Any test results, including raw data, or other evaluative results obtained;

f. Notation and results of formal consults with other providers; and

g. Any releases by the client;

2. Maintain client records securely, inform all employees of the requirements of confidentiality and dispose of written, electronic, and other records in such a manner as to ensure their confidentiality; and

3. Maintain client records for a minimum of five years or as otherwise required by law from the last date of service, with the following exceptions:

a. At minimum, records of a minor child shall be maintained for five years after attaining 18 years of age;

b. Records that are required by contractual obligation or federal law to be maintained for a longer period of time; or

c. Records that have been transferred pursuant to § 54.1-2405 of the Code of Virginia pertaining to closure, sale, or change of location of one's practice.

E. In regard to dual relationships, persons regulated by the board shall:

1. Not engage in a dual relationship with a person under supervision that could impair professional judgment or increase the risk of exploitation or harm. Psychologists shall take appropriate professional precautions when a dual relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs;

2. Not engage in sexual intimacies or a romantic relationship with a student, supervisee, resident, intern, therapy patient, client, or those included in collateral therapeutic services (such as a parent, spouse, or significant other of the client) while providing professional services. For at least five years after cessation or termination of professional services, not engage in sexual intimacies or a romantic relationship with a therapy patient, client, or those included in collateral therapeutic services. Consent to, initiation of, or participation in sexual behavior or romantic involvement with a psychologist does not change the exploitative nature of the conduct nor lift the prohibition. Because sexual or romantic relationships are potentially exploitative, psychologists shall bear the burden of demonstrating that there has been no exploitation, based on factors such as duration of therapy, amount of time since therapy, termination circumstances, client's personal history and mental status, and adverse impact on the client;

3. Not engage in a personal relationship with a former client in which there is a risk of exploitation or potential harm or if the former client continues to relate to the psychologist in his professional capacity; and

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

F. Upon learning of evidence that indicates a reasonable probability that another mental health provider is or may be guilty of a violation of standards of conduct as defined in statute or regulation, persons licensed by the board shall advise their clients of their right to report such misconduct to the Department of Health Professions in accordance with § 54.1-2400.4 of the Code of Virginia.

18VAC125-20-160. Grounds for disciplinary action or denial of licensure.

The board may take disciplinary action or deny a license or registration for any of the following causes:

1. Conviction of a felony, or a misdemeanor involving moral turpitude (i.e., relating to lying, cheating, or stealing);

2. Procuring or attempting to procure or maintaining a license or registration by fraud or misrepresentation;

3. Conducting practice in such a manner so as to make it a danger to the health and welfare of clients or to the public;

4. Engaging in intentional or negligent conduct that causes or is likely to cause injury to a client;

5. Performing functions outside areas of competency;

6. Demonstrating an inability to practice psychology with reasonable skill and safety to clients by reason of illness or substance misuse, or as a result of any mental, emotional, or physical condition;

7. Failing to comply with the continuing education requirements set forth in this chapter;

8. Violating or aiding and abetting another to violate any statute applicable to the practice of the profession, including § 32.1-127.1:03 of the Code of Virginia relating to health records;

9. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

10. Performing an act or making statements that are likely to deceive, defraud, or harm the public;

11. Having a disciplinary action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction or surrendering such a license, certification, or registration in lieu of disciplinary action;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation;

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia, or abuse of aged and incapacitated adults as required in § 63.2-1606 of the Code of Virginia; or

14. Violating any provisions of this chapter, including practice standards set forth in 18VAC125-20-150.

18VAC125-20-170. Reinstatement following disciplinary action.

A. Any person whose license has been revoked by the board under the provisions of 18VAC125-20-160 may, three years subsequent to such board action, submit a new application to the board for reinstatement of licensure. The board in its discretion may, after a hearing, grant the reinstatement.

B. The applicant for such reinstatement, if approved, shall be licensed upon payment of the appropriate fee applicable at the time of reinstatement.