

**Multicultural Guidelines: An Ecological Approach  
to Context, Identity, and Intersectionality, 2017**

*Prepared by the Task Force on Re-envisioning the Multicultural Guidelines  
for the 21st Century*

*Adopted by the APA Council of Representatives in August 2017*

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## Acknowledgements

***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.

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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-Gualdrón, & 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 it is 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 (Opatow, 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, cisgenderism, 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 (Íñiguez 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 (Breau & 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 setting, 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 (Stylianios & 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, Stylianios 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 & Robinson, 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 (NIDOC, 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, Burkner, & 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*

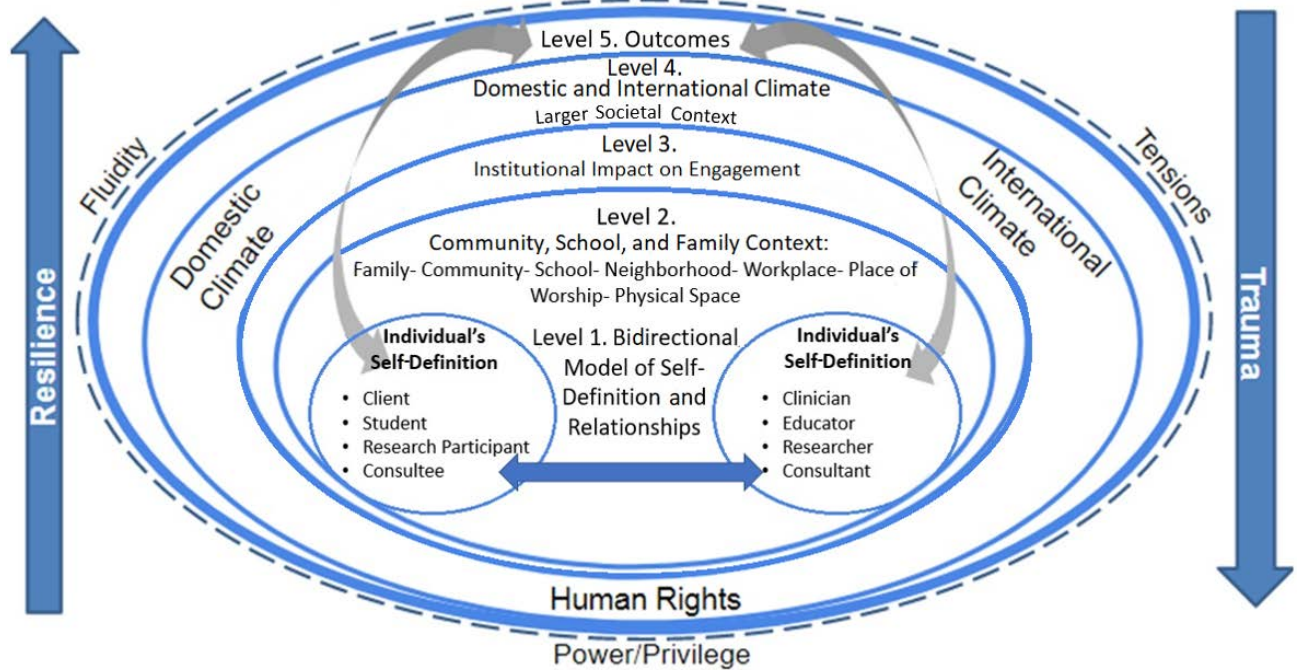
*Training* and *Case O. Lucy: Fear about a Marriage Ending*, that illustrate key concepts presented in Guideline 10.

## **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 lightning 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?

