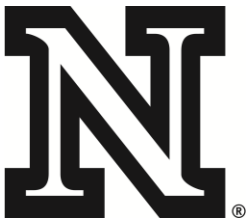
Nebraska Internship Consortium in Professional Psychology

NICPP Intern Handbook

2019-2020



University of Nebraska–Lincoln

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Nebraska Internship Consortium in Professional Psychology

List of NICPP Interns 2019-2020

SITE	FIRST	LAST
NMPD PC	Andrew Johnson	Ahrendt
MMI BPIC	Sarah	Brenner
MMI RICN	Megan	Carter
MMI BPIC	Margaret Rose	Christie
MMI RICN	Meghan	Coleman
MMI BPIC	Emily Rodgers	DeFouw
MMI RICN	Samantha	Eastberg
MMI BPIC	Morgan Ann	Eldridge
MMI BPIC	Aria	Fiat
BT Outp	Kristin Chelsea	Gallaway
NMPD HP	Kristina	Harper
MMI CASD	Kristin Leigh	Hathaway
BT Outp	Katherine	Havlik
MMI CASD	Jessika Renee	Hurts
MMI CASD	Chathuri Ranmali	Illapperuma
BT Outp	Natalie Marie	Jensen
BT GI	Brian	Johnson
MMI BPIC	Phoebe	Jordan
MMI BPIC	Elizabeth (Lissy)	Kane
MMI BPIC	Julia	Lockyer
CSS	Kaleb	Long
QLI	Jacob	Lowe
MMI BPIC	Rachel	Mathews
MMI BPIC	Paige	McArdle
CHC	Jenna	Medlin
BT AD	Christina	Monachino
BT Outp	Elizabeth (Lisa)	Moore
MMI BPIC	Jenna	Mullarkey
MMI BPIC	Madison	Paff
BT Outp	Philip	Richard III
BT GI	Janna Mae	Sanders
CHC	Mary	Schenkenfelder
MMI BPIC	Maryia Marie	Schneider
MMI BPIC	Katie	Slusher
MMI RICW	Phillip Anthony	Suess
MMI BPIC	Hannah Morgan	West
BT Outp	Daniel Parsons	Wilkie
DHHS	Jessica	Withers

Nebraska Internship Consortium in Professional Psychology

Comprehensive Seminar
2019-2020

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akushner2@unl.edu

Overview

Welcome to the Nebraska Internship Consortium in Professional Psychology (NICPP)! The ***major goal*** of the Consortium is to provide an integrated, individually tailored, and coordinated series of learning experiences that will serve interns with opportunities to: (a) practice and expand on previously held knowledge and learned skills, (b) develop new skills and knowledge, and (c) experience personal and professional growth and development, thus contributing to the emergence of a competent, scientist-practitioner professional psychologist. Interns across Consortium sites serve populations across the lifespan, including children and adolescents, families, care providers who regularly interact with children and families (e.g., parents, teachers, others), and adults struggling with various psychological or medical conditions.

In your internship training, a sequential, graded, and cumulative series of learning experiences are provided. Through your daily activities and monthly consortium seminar meetings, it is hoped that you will have opportunities to achieve the following ***training objectives:*** (a) apply ethical decision making to complex clinical and research activities; (b) develop knowledge and skills in delivering services within primary care settings and collaborate across settings and care-providers; (c) develop and demonstrate a commitment to evidence-based intervention procedures; (d) receive exposure to a diversity of psychological and mental health services within broad community contexts and across a breadth of treatment facilities; (e) demonstrate a commitment to diversity and individual differences; (f) develop an appreciation for and commitment to research, including scientific practices and/or research activities; (g) generate research questions related to your work with clients and answer those questions; and (h) develop competencies to evaluate the efficacy of your work with diverse clients and systems.

Purpose of the Monthly Seminars

The primary purpose of the seminar is to support and enhance the training objectives of the NICPP. In addition to complementing and furthering the goals and objectives of the Consortium as a whole, the purposes of the seminar meetings are to:

1. provide a common core of experiences among all the Consortium interns,
2. facilitate interns' relationships with each other,
3. increase interns' knowledge of psychology science and practice across many settings, and
4. increase knowledge of the breadth and depth of lifespan psychology.

Content

The seminar has at least four components that are integrated throughout the year. Ethical practice and scientific investigation are emphasized throughout each component.

1. Diversity: Multicultural issues in assessment and intervention, development of world views, guidelines for delivery of services to ethnically and linguistically diverse clients, issues in racial acculturation. Ideally, issues of diversity are infused throughout all topics and presentations.

2. Intervention: Intervention with substance abuse, health issues, system level intervention, family therapy, child psychopathology, supervision, consultation, crisis intervention.

3. Professional Issues: Staff from each site discuss the role of psychology in diverse agencies including family medicine, inpatient psychiatric hospitals, private practice, residential facilities for developmentally disabled clients, schools, and universities. In addition, specific presentations regarding ethics and issues related to managed care are explored.

4. Assessment: Behavioral, psychometric issues/research, neuropsychology, family, infant, personality/emotional, custody, and vocational.

Schedule

The seminar is scheduled monthly from 8:30 am to 5:00 pm. Lunch is on your own unless otherwise specified in the agenda.

Its location rotates across the Consortium sites (See schedule below.). In addition to presentations by Consortium faculty and area experts, interns present professional case presentations. A social event is arranged by the intern social coordinators during lunch or at the end of each monthly seminar.

Internship Requirements

A minimum of 2,000 hours are required during a year long, 12-month period (at least 50 working weeks), documented in monthly logs submitted to the NICPP coordinator. A minimum of 500 hours must be direct client contact. Extended leave (as defined by your site) will be agreed upon and drafted prior to the dates of leave in an agreement and formal document between training director, intern, and NICPP administration. Paid time off is outlined by your NICPP site and timing is approved based on agency need. Participate in a minimum of 2 hours per week in individual supervision, plus an addition 2 hours of training activities. The NICPP and your site must have all of your completed/approved paperwork and documentation to issue your Certificate of Internship Completion.

Interns are required to attend and participate in all of the monthly NICPP seminars. Plan on these seminars lasting from 8:45am until 5:00pm. Director and Site Training Director approval is required to miss a seminar day, which is only approved in unusual circumstances. Interns missing a seminar day will be expected to review training materials such as recordings and slide presentations of seminar day didactics on their own time. If missed, you are still required to complete feedback to seminar presentations. Interns are responsible for their travel expenses unless otherwise arranged by their site. Travel time on seminar days to locations other than an intern's placement is logged as "Other" on the intern log. For any internship placement within 200 miles of Lincoln, interns are required to attend all consortium days in person. Outside that radius, interns must attend at least four in person, including orientation and the June seminar day, and two of the intern's choice. With site approval, interns outside the 200-mile radius may attend more than four seminar days face-to-face. All seminar days not attended face-to-face will be attended by teleconference arranged by interns site

One presentation at a Consortium seminar day. This is a case presentation focused on a theme, and following all of the case presentations for the day, there will be a discussion in which presenters respond to questions.

Two Psychology Intern Evaluations, one midyear, one yearend, completed by the primary supervisor, with comments and signatures of the supervisor and the intern, and the signature of the UNL director. The evaluation form is found in the "Intern Goals" section of this handbook. Interns need to average 4 or above in **each** area summary on their year-end evaluation to successfully complete internship.

Supervisors will evaluate three competency areas via live supervision and incorporate the feedback into your Evaluation. One of these competencies will be Teaching/Presenting using your case presentation during seminar days. The second will be Assessment, by directly observing you conduct an intake assessment. On this competency, the criteria is at or exceeding 70% of the items outlined on the Assessment tool. The third assessment area is Supervision.

Three Goal Attainment Scaling (GAS) forms, initial, midyear, and yearend, reviewed and signed by the intern, supervisor, and UNL co-director. At the beginning of the year, interns work with their supervisors to establish specific professional goals for their training year in the initial GAS form. Interns assess and score their progress on the goals at midyear and again at yearend, reviewing their progress with their supervisors. Goals may be revised as necessary. These ratings are essential for interns to develop self-awareness associated with the development of competencies. We encourage interns to review the form regularly and to use it in supervision. This will enhance skill development and autonomy.

Two site visit (and site visit evaluations) are required; please submit the evaluations to the NICPP administrative assistant as soon as a site visit is complete. To arrange a site visit, follow the process outlined for each individual site. Site visits are intended to expand your experience beyond your home site. Site visits are also vital to socialization and broad training components outlined by APA.

Interns are required to submit a monthly Activity Log by the 5th of the following month. These are to be emailed to the NICPP administrative assistant. If the administrative assistant does not receive your log by that date an email will be sent to you and all the training directors reminding you to submit your logs. This is your professional responsibility. Please be diligent. Remember that Logs could delay your internship completion date. We need all information before sending out completion certificates.

Interns are expected to maintain their own Professional Liability Coverage. Insurance is available through the APA Insurance Trust for approximately $30/year (http://www.apait.org/apait/products/studentliability/).

Peer Support Development

Socialization with peer colleagues outside of your site is an important component of APA training. In order to facilitate this socialization, we have intern social chairs that will organize social hours after seminar days. Although we recognize travel issues of interns, we feel that attendance of as many social hours is important for professional development. We will also randomize seating orders of interns during seminar days. Interns will be prompted to discuss professional and personal topics at the beginning of each seminar to further socialize interns across sites. Given the diverse sites, orientations and disciplines within the consortium, it is very important to learn and expand your knowledge outside of your area of specialization. This goal is also consistent with APA's requirement to enhance interns' broad and general knowledge and experiences.

Grievance and Due Process Procedures

Periodically concerns arise among interns or their supervisors that address performance or supervision. The NICPP considers such issues to be critically important and works hard to support the continued development of interns as a priority. Thus, structured policies around grievance and due process procedures have been developed and are provided at the outset of the internship year. A remediation plan and document will be completed in coordination with the intern, site Training Director, and NICPP administration. It is strongly encouraged that concerns, complaints, or questions be dealt with directly, immediately, and collaboratively. The Director of the Consortium, Dr. Michael Scheel, and Associate Directors, Drs. Grennan and Haugen are available and willing to help on an informal or formal basis.

Intern Support Services

A variety of intern support services are available through the Consortium and individual agencies to facilitate progress through the internship. First, supervisors engage in ongoing formal (structured) and informal (semi-structured) performance evaluations to monitor progress and provide additional experiences and support as necessary. Second, Drs. Scheel, Haugen and Grennan as Director and Associate Co-Directors are available to interns to acknowledge and address intern concerns and to provide feedback. Third, formal evaluation procedures are in place to provide structure around the growth and performance of interns. ***Policies related to the formal performance monitoring of interns' center around the provision of guidance, structure and support for their professional development, rather than the delivery of punitive or punishing consequences.*** Finally, one or two intern representatives serve on the Board each year to support fellow interns and ensure the intern's viewpoint is shared at Board and policy levels. Additionally, two or three intern representatives serve as social liaisons to the Consortium. These interns help coordinate social activities for the Consortium. We also involve at least one intern in our efforts to provide a systematic and long-term efforts to recruit and retain diverse interns and staff. We strongly believe that interns views are important in our continued growth as a consortium.

Preparation for and Integration of Seminar Information

Specific readings, advance organizers, and discussion questions may be provided each month. It is expected that interns read and become proficient in the following guidelines and principles regarding service delivery, published by the APA:

American Psychological Association. (1990). *Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations.* Washington, DC: Author.

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct.* Washington, DC: Author.

American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*. Washington, DC: Author.

Using the Library at the University of Nebraska (Lincoln and Omaha)

The University Library is available for your use. You will be given a card for Criss Library (University of Nebraska at Omaha), Love Library (University of Nebraska–Lincoln) or both, depending on your placement. You may also access materials the libraries make available online. When checking out materials, you may be asked to provide photo ID.

Student Membership in APA Divisions

We strongly encourage our NICPP interns to become members of professional organizations in psychology. If you are not already a member of your respective divisions in APA (Clinical – 12; Counseling – 17; School – 16), we encourage you to sign up for these divisions. Additionally, other divisions that reflect interests across the NICPP are: 7, 13, 25, 29, 37, 38, 40, 45, 52, 53 and 54 (to name a few). Most divisions offer discounted student membership. For more information, please log onto:

Division 12 (Clinical): http://www.div12.org/membership

Division 16 (School): http://www.apa.org/about/division/div16.aspx

Division 17 (Counseling): http://www.apa.org/about/division/div17.aspx

Division 22 (Rehabilitation Psychology): http://www.apadivisions.org/division-22/

Division 38 (Health Psychology):
http://www.apa.org/about/division/div38.aspx

Division 53 (Clinical Child and Adolescent Psychology):
http://www.clinicalchildpsychology.org/

Division 54 (Society of Pediatric Psychology):
https://www.societyofpediatricpsychology.org/

American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*. Washington, DC: Author.

Intern File Retention

Intern files will be kept ten (10) years. Before files are shredded, information on each intern will be added to the spreadsheet of former interns, including name, site, start and end dates, evidence of completion, and names of supervisors completing mid-year and year-end evaluation. Letters of completion and/or copies of signed certificates of completion, if available, will be pulled from the files and kept in a folder together with a printout of the spreadsheet.

Interns Receiving Scholarships in Addition to NICPP Stipend

Interns are allowed to receive scholarships in addition to intern stipend.

Board of Supervisors Structure

The UNL Director position will rotate between the UNL Clinical, Counseling, and School Psychology programs, along with two Associate Directors from the consortium sites determined by the board. Term of office is flexible, with the preference that a new director start at least two years before an APA self-study/site-visit year. There will be two non-voting board members from the training programs at UNL not holding the director position. The non- voting board members will attend the November, April, and August board meetings.

Final Comments

Your internship training in the NICPP is a collaborative effort among the intern, his/her supervisor, agency staff, and the Consortium Director and Associate Directors. Communication is VITAL. Electronic mail is used extensively, and it is ultimately the intern's responsibility to ensure that he/she shares appropriate communication channels. Please check the NICPP website regularly (http://cehs.unl.edu/nicpp/). Please consider becoming a member of the NICPP Facebook group, Nebraska Internship Consortium in Professional Psychology, and following our Twitter feed, @NICPP_UNL. We hope to use our Facebook page for networking between current and past interns and supervisors. Ultimately, successful completion of the internship requires a great deal of careful decision making on the intern's part. We are here to help you. Your feedback is valued. Keep your priorities clear. Always remember that ***your training needs are most important.***

NICPP INTERN MONTHLY ACTIVITY LOG 2019-2020

E-mail logs to Alisa Kushner (akushner2@unl.edu) by the 5th of each month for the preceding month!

Save document as: Lastname_Firstname_Month_Log Ex: Kushner_ Alisa_July_Log

NAME: 0 SITE: 0

Starting and ending dates:	Week 1 7/1/19 - 7/5/19	Week 2 7/8/19 - 7/12/19	Week 3 7/15/19 - 7/19/19	Week 4 7/22/19 - 7/26/19	Week 5 7/29/19 - 8/2/19	Monthly Total
Direct face-to-face Supervision						0
Other Supervision						0
Total Supervision Hours	**0**	**0**	**0**	**0**	**0**	**0**
# of scheduled clients (SC)						0
# of SC who were no shows/canceled						0
Total Hours of Individual Therapy						0
Total Hours of Group Therapy						0
Total Hours of Family Therapy						0
Total Hours of Couples Therapy						0
Assessment (Admin/Feedback)						0
Training/Supervising Others						0
Teaching (Lecture/Rounds)						0
Consultation/Collaboration						0
Outreach						0
Walk-in/Crisis						0
Total Direct Hours	0	0	0	0	0	0
Professional Development						0
Didactics						0
Clinical Preparation						0
Supervision Preparation						0
Reports/Documentation						0
Research Professional Reading						0
Staff/Administrative Meetings						0
Other						0
Total Indirect Hours	0	0	0	0	0	0
Total hours/week	0	0	0	0	0	0
Running Totals for Year	**Running Direct Hours**		0	**Running Total Hours**		0

Put an X in the box that best corresponds to your behavior this month.

This month I completed my Intern Log:	1 At the end of the month	2 Twice during the month	3 At the end of each week	4 A few times during the week	5 At the end of each day

NICPP Intern Log Operational Definitions

Record all activities in 15-minute increments. If an activity lasted less than 15 minutes, round up to the next 15-minute increment (i.e., .25 hr, .5 hr, .75 hr, 1 hr).

Supervision Received

Direct face-to-face supervision:

- This category includes any supervision received in person by a *licensed psychologist*.
  - Two hours of weekly, face-to-face, individual supervision is required. This can be facilitated by a primary or secondary supervisor.
    - *Rural sites may use visual telecommunication technology in unusual circumstances and when face-to-face supervision is impractical, but must demonstrate that such technology provides sufficient oversight. (https://www.appic.org/Joining-APPIC/Internship-Membership-Criteria)*
  - This category includes any supervision that occurred during scheduled meetings as well as spontaneous face-to-face supervision.

Other supervision:

- This category includes any supervision that occurred via any mode other than individual, face-to-face, including group supervision (i.e. supervision of supervision, peer supervision). This category includes supervision received from your university advisor or other supervisors over the phone.

Face to Face Psychological Services (Direct Service)

Number of scheduled therapy hours:

- This category includes all therapy hours (individual, group, family) scheduled for the week, whether the appointments were held or not.

Number of scheduled therapy hours that were no shows/canceled:

- This category includes the number of hours where the clients who did not attend their appointment, whether they canceled the appointment or simply did not show up.

Total hours of individual therapy:

- This category includes the total time spent providing individual therapy services for the week. Round therapy appointments to .5-hour or 1-hour increments.

Total hours of group therapy:

- This category includes the total time spent in group therapy for the week. Round therapy appointments to .5-hour or 1-hour increments.

Total hours of family therapy:

- This category includes the total time spent in family therapy for the week. Round therapy appointments to .5-hour or 1-hour increments.

Total hours of couples therapy:

- This category includes the total time spent in couples therapy for the week. Round therapy appointments to .5-hour or 1-hour increments.

Assessment (admin/feedback):

- This category includes time spent conducting assessments, including intake assessments, and specific diagnostic, achievement, and/or cognitive assessments with any type of informal or standardized assessment instruments. This category also includes time spent delivering the assessment results to the client and/or guardian, caseworker, administrative staff, etc.

Training/supervising others:

- This category includes activities related to the intern providing training or supervision to others. This category includes time spent providing peer supervision.

Teaching (lecture/rounds):

- This category includes time spent engaged in the activity of teaching. This category includes presentations given to community members or the public when conducted as a responsibility of your intern training program. When conducted as a private endeavor, this time is not recorded on the NICPP Intern Log.

Consultation/collaboration:

- This category includes time spent *directly providing* consultation to others or collaborating with others on assessment, treatment, or evaluation. This includes treatment team meetings, case conferences, school meetings (IEPs, MDTs, SATs) and consultation to others including, but not limited to: case workers, probation officers, in-home service providers, outpatient therapists, etc.

Outreach:

- This category includes activities related to community outreach, including volunteering at events directly involving your training site. If an intern elects to participate in outreach or volunteer activities not associated with the training site and outside of clinical hours, do not count this time.

Walk-in/crisis:

- This category refers to time spent in managing crisis situations or walk-in appointments. It includes time spent managing emergency calls.

Other (Non-Direct Service)

Professional development:

- This category includes time spent attending a formal workshop or conference. This does not include time spent traveling or overnight hours. Travel may be recorded under the Other category.

Didactics:

- This category includes time spent in training sessions at your training site or sessions attended while on a site visit. This also includes training sessions attended on monthly consortium days. This category includes time spent preparing for didactics by reading assigned literature or completing other assigned preparatory activities.

Clinical preparation:

- This category includes time spent preparing for clinic sessions. Preparation may include review of file information, reading articles, or using other resources to develop or refine interventions.

Supervision preparation:

- This category includes time spent preparing for supervision including reviewing tape, reading notes, and preparing for supervision (either receiving or providing). This category applies to any time spent related to receiving or providing supervision.

Reports, documentation:

- This category includes time spent on documentation. Documentation includes written, typed, or electronic work, as well as dictation. This category includes, but is not limited to: initial clinical assessments, therapy notes, standardized assessments or psychological testing reports, treatment plan documents, caseworker/court letters, physician letters, correspondence with clients/legal guardians, etc.

Research/professional reading:

- This category includes time spent conducting research activities (including dissertation), including conducting literature reviews; developing research designs; meeting with research team members; collecting, analyzing, and reporting data; and writing up research activities. This category does not include reading for clinical preparation. Time spent reading for clinical preparation is included under the Clinical Preparation category. Dissertation-related or other research-related activities conducted during leave/vacation time, or outside of paid work hours is eligible to log under this category.

Staff/Administrative meetings :

- This category includes time spent participating in non-clinical meetings. This often includes meetings in which administrative matters are the primary focus.

Other:

- This category includes any other activities that are not included in any other category.

NICPP Hours Requirements

A minimum of 2,000 hours completed during a 12-month period (at least 50 working weeks). A minimum of 25% of hours (500) in face-to-face psychological services to patients and clients. A minimum of 2 hours per week in individual supervision.

Site Visits in the Nebraska Internship Consortium in Professional Psychology

The unifying perspective of psychological practice across the Consortium sites is ecological developmental theory. Individuals are continually developing in the context of reciprocal interactions with the environment. Change is possible from multiple sources, including environmental, psychological, and biological factors. Psychological and behavioral interventions occur at all levels and through diverse activities. The various sites within the Consortium provide opportunities for interns to develop knowledge and skills in providing services within primary care settings and collaborating across settings and care-providers.

Unique to the Nebraska Internship Consortium in Professional Psychology is the geographic locale within which it is situated. Through the inclusion of agencies in urban (e.g., Omaha), regional (e.g., Lincoln), and rural (e.g., Beatrice) settings, interns gain exposure to differences in psychological and mental health services across broad community contexts. Further, the availability of sites such as schools, hospitals, out-patient clinics, and residential agencies adds to the breadth of treatment facilities to which interns are introduced.

In order to facilitate the exposure to the diversity of psychological services and treatment within the consortium, the training directors are committed to introducing interns to the breadth of experiences across the various sites. To achieve this goal, interns are required to conduct **two** site visits during their internship year (the visits are best scheduled between September and December). Interns may choose to visit any site within the consortium. Site visits are ½ day to a full day in length, depending on the site, and may be arranged through the training director at the site. Additionally, the interns at the respective sites throughout the consortium aid in the site visit process. Schedule site visits early in the training year! After completing a site visit, please email your completed Site Visit Evaluation Form to the NICPP administrative assistant.

Information regarding the various sites in NICPP can be found at http://cehs.unl.edu/nicpp/. You are responsible for your own meals at site visits unless otherwise announced.

PLEASE DO THESE ALL ON QUALTRICS
(This is only an example of the questions on the form)

Nebraska Internship Consortium in Professional Psychology

Site Visit Evaluation Form 2019-2020

*** Must conduct two site visits during internship year****
Best time to schedule visits is between September and December

Name:_____ **Date:** _____

1. Where did you complete your site visit? (check the box):

□ DHHS
□ Boys Town (Location: Omaha or Grand Island)
□ CHC – Creighton University
□ CSS
□ Munroe-Meyer Institute (Clinic/Program_____)
□ Nebraska Medicine Psychology Department
□ QLI

Please use the following 6-point Likert scale when responding to the following item:

1 =	Extremely Dissatisfied	4 =	Somewhat Satisfied
2 =	Mostly Dissatisfied	5 =	Mostly Satisfied
3 =	Somewhat Dissatisfied	6 =	Extremely Satisfied

2. How satisfied were you with the site visit?

1 2 3 4 5 6

3. General comments about the site visit process:

Department of Health and Human Services of Nebraska

Tessa Svoboda, PsyD
402.239.2947
tessa.svoboda@nebraska.gov

Kelly Jensen, PsyD
402.806.7462
kelly.jensen@nebraska.gov

Site Visit Description

- Contact Tessa Svoboda, PsyD and/or Kelly Jensen, PsyD by phone or email. Please give at least two weeks' notice when scheduling.
- Best day would be Thursdays, though individual arrangements may be made for any day.
- If visiting on Thursday morning, interns would attend the weekly Department meeting and Behavior Support Review Committee meetings, tour BSDC, and be given a presentation/discussion regarding behavioral programming for and/or assessment of clients demonstrating intellectual and developmental disabilities as done at BSDC.
- Visitors would get some exposure to persons with intellectual and developmental disabilities residing at an Intermediate Care Facility.
- Visitors would be exposed to practical aspects of behavior management.
- Depending on the day of the visit, visitors might get to attend an Interdisciplinary Team (IDT) meeting.

Boys Town Site Visit
Boys Town (Omaha), Nebraska

Kimberly Haugen, Ph.D.
531.355.3106
kimberly.haugen@boystown.org

Site Visit Description

Trainees who visit Boys Town for a site visit will have the opportunity to learn about Boys Town and to better understand interns' role within the organization. Visitors will learn about the organization's continuum of care, meet direct care staff, tour a family home in the residential program, and participate in a training.

To Schedule a Site Visit:

- Email Kimberly Haugen, Boys Town Training Director
- Schedule the visit at least 1 week in advance

Site visits are scheduled from 8am – 12pm on these days:

- Monday, September 16, 2019
- Monday, October 7, 2019

Schedule:

8:00 - 8:45	Meet with Kim Haugen: overview of Boys Town
9:00 - 10:00	Tour of a home in the residential program
10:15 – 11:00	Meet with current interns
11:00 – 12:00	Participate in Training
	9/16 Training Topic: Engaging Families in Treatment
	10/7 Training Topic: Exposure Principles in Treatment

Directions: Boys Town Center for Behavioral Health
13460 Walsh Drive, Boys Town NE 68010
Conference Room 149
Clinic Number if you are lost: (531) 355-3358

- From the intersection of 132nd Street and Dodge, go south on 132nd street
- Turn west onto Walsh Drive (first stop light south of the intersection)
- Proceed until you see the Behavioral Health Clinic sign and turn right
  This is your second right once you are on Walsh Drive
  It is a 3-story brick building with large pillars in the front
- Park in the lot in front of the building and check in with the receptionists on the first floor

Boys Town Central Nebraska Site Visit
Grand Island, Nebraska

Carley D Starling, PsyD.
308-381-8853
carley.starling@boystown.org

Site Visit Description

Trainees who visit Boys Town Central Nebraska for a site visit will have the opportunity to learn about Boys Town - Central Nebraska and to better understand interns' role within the organization. Visitors will learn about the organization's continuum of care, meet direct care staff, meet with current interns, and participate in a training.

To Schedule a Site Visit:

- Email Carley Starling, Director Boys Town BHC Central Nebraska
- Schedule the visit at least 1 week in advance
- Site visits are scheduled from 8am – 12pm on the following days:
    - Friday, October 11, 2019
    - Friday, November 1, 2019

Schedule:

8:00-8:50 am	Meet with Carley Starling: Overview of Boys Town
9:00-9:50 am	Meet with Current Interns
10:00-11:00 am	Discussion regarding difference between Campus & Central Nebraska BHC
11:00-12:00	Participate in Training

Catholic Social Services Site Visit

Peter Martin, Ph.D.
3700 Sheridan Blvd
Lincoln, NE
402.489.1834
pmartin@cssisus.org

Site Visit Description

Catholic Social Services of Southern Nebraska welcomes interns from other sites to visit our program* during their year of training. We offer a unique perspective to the provision of mental health services by striving to integrate the Catholic faith into all aspects of our agency.

To Schedule a Site Visit

To schedule, please contact Peter Martin at the above email address at least 1-2 weeks in advance.
Site visits will be conducted on the following first Fridays of the month:

- **09/6/2019**
- **11/1/2019**
- **03/6/2020**

Typical Schedule

10:00 – 12:00	Attend Clinical Staff Meeting (General organizational issues, Applied spiritual reflection and faith-integrated discussion, Case Consultation)
12:00 – 12:30	Mass (attendance not required)
12:30 – 1:15	Lunch
1:15 – 3:15	Attend Faith-Integrated Didactic Training
3:00 – 4:00	Meet with Training Director and/or Intern(s) to review the site visit. An overview of the structure and mission of the agency as well as the philosophy of integrating the Catholic faith with psychology can be discussed at this time.

There are numerous restaurants approximately a mile away from our facility for lunch (e.g., Subway, Jimmy John's, Braeda, Runza, McDonald's, Burger King, Wendy's, Freddy's, Ramos Pizza, etc.). Depending on company scheduling issues, CSS may provide a pot-luck lunch for interns during the site visit! I will let you know if lunch will be provided.

*Please do not drive to the CSS Social Services branch located at 2241 "O" Street. **The Site Visit will be held at 3700 Sheridan Blvd, Ste. 1, Lincoln, NE 68506**

Creighton University Site Visit
Student Counseling Services

Rebecka Tompkins, Psy.D. L.P.
Markoe Hall
2439 Burt St,
Omaha, NE 68178
402.280.2735
rebeckatompkins@creighton.edu

Site Visit Description

- Site Visits will be scheduled in September and March, typically the first Wednesday of the month.

- Interns should arrange the Site Visit by contacting Dr. Rebecka Tompkins at rebeckatompkins@creighton.edu or calling 402.280.2735.

- The Site Visit will be scheduled on Wednesdays, 10:00 am – 2:30 pm.

- Two weeks' notice will be required in scheduling all Site Visits.

- Visiting Interns will learn about the duties of an Intern in a University counseling service, attend a consultation with a University administrator, and participate in case conference.

- The case conference will involve a clinical staff discussion of difficult therapy/assessment cases.

- Visiting Interns can expect to have lunch on campus.

Munroe-Meyer Institute Site Visit

University of Nebraska Medical Center
Allison Grennan, Ph.D.
402.559.4427
allison.grennan@unmc.edu

Site Visit Options

Children's Behavioral Sleep Disorder Clinic – This program is an interdisciplinary clinic that specializes in diagnosing and treating children with behavioral sleep disorders. One intern can visit on Tuesdays. Email Dr. Brett Kuhn (brkuhn@unmc.edu) to arrange the specific date.

PDD Clinic – This is an interdisciplinary clinic involving psychology and developmental medicine providing clinical services (no assessment) to children and families with Autism Spectrum Disorders. 1-2 visitors can be accommodated from 8:30-11:30 on the 2nd Wednesday of each month. Contact Dr. Keith Allen (kdallen@unmc.edu) to arrange to attend.

Autism Early Intervention Clinic – This is a program that provides specialized services based on the principles of Applied Behavior Analysis to children between the ages of 2 and 10 with an Autism Spectrum Disorder diagnosis. We can accommodate 1-3 visitors on any given day. Observations must be scheduled at least 1 month in advance. Contact Amanda Zangrillo (Amanda.zangrillo@unmc.edu).

Autism Diagnostic Clinic – This clinic focuses on the diagnostic assessment of autism spectrum disorder. A child's appointment with this clinic includes: (1) a diagnostic interview, (2) the Autism Diagnostic Observation Schedule-2, and (3) a speech and language evaluation.
At the end of the appointment the multi-disciplinary team reviews each case, arrives at diagnostic conclusions, and develops appropriate referrals. This clinic meets each Tuesday from 8:00 am to 3:00 pm. Observations must be scheduled at least 1 month in advance. Contact Amanda Zangrillo (amanda.zangrillo@unmc.edu) to arrange a visit.

Severe Behavior and Pediatric Feeding Disorders Programs – The Severe Behavior Disorders Program focuses on assessment and intervention of severe behavior disorders. Common diagnoses seen in the clinic include autism spectrum disorder, ADHD, ODD, pica, disruptive behavior disorder, and stereotypic movement disorder. The most common behavior problems include aggression, self-injurious behavior, disruptive behavior, pica, and elopement. The Pediatric Feeding Disorders Program provides specialized services based on the principles of Applied Behavior Analysis to children between the ages of 6 months and 12 years diagnosed with a feeding disorder (e.g., failure to thrive, food refusal, G-tube dependence, food selectivity). We can accommodate 1-3 visitors on a given day. Observations must be scheduled at least 1 month in advance. Contact Amanda Zangrillo (amanda.zangrillo@unmc.edu) to arrange a visit.

Village Pointe Pediatrics –This clinic is one of MMI's Outreach clinics where psychologists are integrated into primary care practice with pediatricians. Psychology provides outpatient behavioral health services for children and adolescents in this primary care setting. One intern can attend on a Wednesday or Thursday, 12:30-5pm. Contact Rachel Valleley at 402.559.2401 to schedule a day.

Cardiac Follow-up Clinic – This clinic involves evaluations of preschool and school-age children who have undergone surgery for complex congenital heart disease. Psychology participates with Developmental Medicine and Nursing staff. One doctoral intern can be accommodated at the clinic, which is held the 1st and 4th Fridays of each month from 9am to 12pm. Contact Dr. Holly Roberts to arrange a specific date to attend, 402.559.5762 or hroberts@unmc.edu.

Kearney Behavioral Health Clinic – This MMI Outreach Clinic is integrated into the Children's Physicians-Kearney clinic. Psychologists collaborate with pediatricians and primary care physicians to provide outpatient behavioral health services for children and adolescents with a variety of presenting concerns. Interns can attend clinic on Tuesdays or Wednesdays from 9:00am-5:00pm. Contact Dr. Nancy Foster at 402-980-3133 or nlfoster@unmc.edu.

Genetics Clinic – MMI provides outreach genetics clinic in Kearney and North Platte. Psychologists work with pediatricians, geneticists, genetic counselors, and nursing staff to meet the behavioral health and medical needs of children and adolescents with a variety of genetic disorders. The dates of the clinic vary. Interested interns should contact Dr. Nancy Foster at 402-980-3133 or nlfoster@unmc.edu to schedule.

Autism Care for Toddlers (ACT) Clinic: The Autism Care for Toddlers (ACT) Clinic is a community outreach program located in the Autism Center of Nebraska at the intersection of 90th and Q streets. The clinic provides early intervention services using applied behavior analysis (ABA), offering one-on-one services for toddlers with autism and a caregiver-training program.

Please contact Hanna Beck (hanna.beck@unmc.edu) or Dr. Regina Carroll (regina.carroll@unmc.edu) to schedule.

Behavioral and Developmental Pediatrics: This clinic is an outpatient psychology/behavioral pediatrics clinic located in the developmental pediatrics department at Munroe-Meyer Institute. Site visits can be scheduled with the psychologist, Katy Menousek, PhD, to observe either outpatient behavioral health or autism diagnostic services. Contact Dr. Menousek at katy.menousek@unmc.edu to schedule a visit.

Val Verde Outreach Behavioral Health: This clinic is one of MMI's Outreach clinics where psychologists are integrated into primary care practice with pediatricians. Psychology provides outpatient behavioral health services for children and adolescents in this primary care setting. One intern can attend on a Wednesday between 9am-12pm or 1-4pm. Contact Tara Sjuts (tara.sjuts@unmc.edu) to schedule a day.

Nebraska Medicine Psychology Department

Cecilia Poon, Ph.D.
402.559.5031
cepoon@nebraskamed.com

Site Visit Description

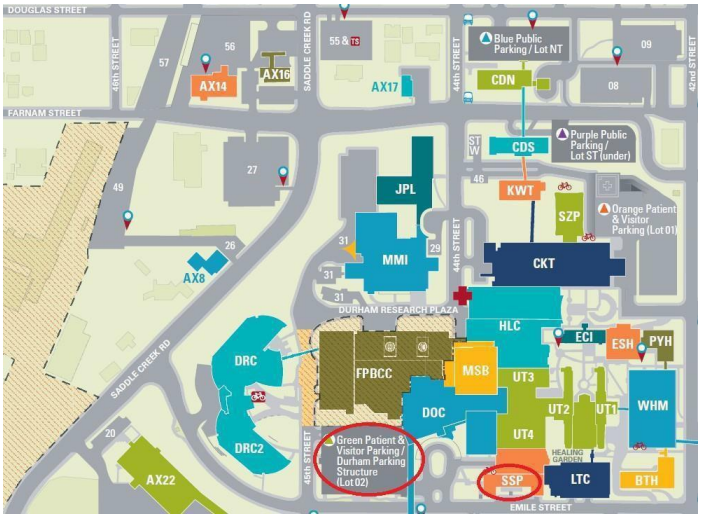
Visiting interns will have the opportunity to learn more about Nebraska Medicine/University of Nebraska Medical Center and health psychologists' role within the organization. The visit will include meetings with the training director and intern, as well as other staff members from specific interdisciplinary teams depending on availability and interest. Visiting interns will have the opportunity to attend the psychology journal club at noon and complete a campus tour that highlights the integration of psychological services within various inpatient and outpatient settings.

To Schedule a Site Visit:

- Email Dr. Cecilia Poon at cepoon@nebraskamed.com
- To arrange a site visit, please contact us **at least 1 month** in advance
- Site visits can be scheduled on the 4th Friday of the month of September (9/27/2019), October (10/25/2019), November (11/22/2019), and March (3/27/2020). Additionally, arrangements on alternative days may be available under unusual circumstances.

Directions:

Park at the Green Visitor's parking at 45th/Emile Street. Walk across the circle drive to SSP. Take the elevator to the 5th Floor. Walk to the end of the hallway and check in with the Psychology front desk. If you have trouble finding us, please call: 402.559.5031



QLI Site Visit

QLI
6404 N 70th Pl.
Omaha NE 68104

Jeff Snell, Ph.D.
402.573.2162
jeff.snell@qliomaha.com

Interns' visits to QLI are typically scheduled on a Friday for the opportunity to observe the team process for initial assessment staffing and clinical updates. Visits on other days are available by request. Most visits will be approximately three-quarters of a day (9AM-3PM), but we are also flexible in that regard. In keeping with our philosophy to provide a real-life, functional and applied model of experience and learning, we are interested in providing experiences that are personally and professionally valuable for you!

Visits will include interaction with QLI psychology staff and a review of their duties and responsibilities within the clinical team, as well as interaction with members of other professional disciplines within the clinical team. A tour of the facilities and time to observe the rehabilitation and information exchange process will be provided.

We are also open to experiences that an intern specifically requests if we can provide them. We're only limited by the creativity that you and we have. The process is most efficient if an intern or group contacts Dr. Snell first to talk about the day, and then a collaborative decision can be made as to what schedule will work best for that particular person or group. We typically limit the number of visitors on a single day to four, so if you are planning to visit as a group, please keep this number in mind as you coordinate with your peers. Please call Dr. Snell at least one week prior to your requested date of visitation.

2019-2020 NICPP Seminar Schedule

Date	Event	Host, Location	Proposed Presenter/Topic
Friday, 8/16/19	NICPP Orientation	UNL, Lincoln	• Allison Grennan – NICPP • Kim Haugen – Clinical Supervision • Alison Delizza – Self-Care
Friday, 9/20/19	NICPP Seminar	Nebraska Medicine, Omaha	• David Cates – Suicide
Friday, 10/18/19	NICPP Seminar	DHHS, Beatrice	• Allison Grennan – Job Talk • Understanding the Court Process
Friday, 11/15/19	NICPP Seminar	Catholic Social Services, Lincoln	• Dennis McChargue – Motivational Interviewing • Peter Martin – Faith Integration
Friday, 12/13/19	NICPP Seminar	Creighton, Omaha	• Alana Schriver - Refugees
Fridays, 1/3/20 & 1/10/20	NICPP Interviews	Boys Town, Omaha	
Friday, 2/21/20	NICPP Seminar	MMI, Omaha	• Brett Kuhn – Pediatric Sleep
Friday, 3/20/20	NICPP Seminar	MMI Rural, Kearney	• Nancy Foster – Integrated Behavioral Health
Friday, 4/17/20	NICPP Seminar	Quality Living, Omaha	• Jeff Snell - Pain
Friday, 5/15/20	NICPP Seminar	UNL, Lincoln	• Justin Weeks - Anxiety
Friday, 6/19/20	NICPP Seminar	Boys Town, Omaha	• Donna Stewart – Multicultural Diversity & Awareness

Case Presentation Requirements

The purposes of the case presentations are as follows:

1) Encourage interns to maintain scientist-practitioner model in everyday clinical work.
2) Practice presentation skills.
3) Improve clinical skills.
4) Respond professionally to questions and feedback.

When presenting cases or clinical topics, keep in mind that the unifying perspective across Consortium sites is an ecological developmental orientation. This perspective embraces the concept that people are continually developing and in reciprocal transactions with the environment. Emphasis is on the conditions in a client's environment/context/setting as a source of change. A case presentation might also target a system or staff and show how changing that system affects an individual client or client outcomes. Each trainee will have 20 minutes for the case presentation. After all of the case presentations, one of the Training staff will facilitate approximately 15 minutes of panel discussion. During this time, the Training staff will direct questions about the topic to the presenters. The presentations will be organized by theme. You will sign up for a date based on the designated topic for the seminar day. Email presentation slides to the NICPP administrative assistant the Tuesday before the presentation for electronic distribution.

Presentation Guidelines

Relevant Client Characteristics:

- Age, gender, grade, sexual identity and orientation, ethnicity
- Critical development and medical history
- Critical family history
- Diversity issues – GRAACES (gender, religion, age, ability, class, ethnicity, sexuality) and rural/urban cultural differences,and their implications for service delivery and treatment.

Presenting Problem:

- Operationally define the presenting concern
- How was the problem assessed?
- DSM-5 diagnoses?
- What data were or will be collected (records, direct observation, self-report, parent report, questionnaires, standardized measures, etc).
- Any problems or potential problems with data collection?
- How were/will these data used to make a clinical decision?

Previous Research:

- What is the empirical basis for treatment? Briefly discuss research studies and data that support your selected treatment. Provide selected references.

Treatment:

- Describe the treatment components (or components that you will utilize).
- Was the treatment an empirically supported treatment?
- Treatment integrity – How did you ensure that treatment was actually implemented?
- If changes were made in treatment, how were data used to help you make decisions?
- What were ethical and diversity considerations with this treatment?

Evaluation:

- How were or will progress be evaluated in an objective manner?

Case/Clinical Topic Presentation Feedback Form-SUPERVISOR

Intern: _____ Date: _____

Presentation Topic: _____

Start Time: _____ End Time: _____

Name of Supervisor Giving Feedback: _____

Presentation addressed the following issues (√):

Each competency area is described with a list of specific behaviors. Some competencies also request information regarding context or population. The degree of competence for specific behaviors may be rated using the numerical scale from 1 to 3 described below. The scores on the specific behaviors listed in an area are averaged for the area summary rating. **Please circle the appropriate number after each summary and make comments as necessary.**

Competency Scale 1-3

1 = Doesn't meet expectations
2 = Meets expectations
3 = Exceeds expectations

___ (a) Presenting problem
___ (b) Presentation included pre-treatment assessment data
___ (c) Relevant client characteristics (i.e., mental/psychological, medical, other conditions; DSM-5 diagnoses.)

Note: For clinical topic presentation on a medical condition, include relevant DSM-5 diagnoses as appropriate, e.g., major depressive disorder in the context of multiple sclerosis; habit reversal therapy for Tourette's disorder. Also include data on the prevalence of the condition among specific/special populations.

1 2 3

___ Presentation included a discussion of previous research on treatment options (with references)

Note: For clinical topic presentation, focus on psychological treatment first.

1 2 3

___ Presentation included a discussion of treatment (how this approach exemplifies "best practice") and goals

1 2 3

___ Presentation included consideration of culturally responsive service delivery (considering GRAACES – gender, religion, age, ability, class, ethnicity, sexuality – and rural/urban cultural differences, for example) and how culture may impact treatment/outcomes

Note: For clinical topic presentation, broadly describe how these elements influence treatment.

1 2 3

___ Presentation utilized data-based decision-making for evaluation of treatment

Note: For clinical topic presentation, broadly describe data one should obtain/assess.

1 2 3

___ Presentation included ethical considerations/dilemmas

1 2 3

___ Presentation was conducted professionally (delivery, appearance, attire, handouts) and was completed in time allowed (20 minutes + 5 minutes Q&A and discussion)

1 2 3

___ Presenter offered items for discussion

1 2 3

Presentation Style:

Rating of Presentation style 1 2 3

- **Comments** (professionalism, knowledge and fluency with material, pace, effective use of nonverbals/gestures, engagement/interaction with audience):

- Strengths of presenter:

- Growth Areas:

Overall Rating: 1 2 3

Case Presentation Feedback

Intern:_____Date:_____

Presentation Topic: _____

Start Time:_____End Time: _____

Presentation addressed the following areas (√):

_____Relevant Client Characteristics:
- Age, gender, grade, sexual identity and orientation, ethnicity
- Critical development and medical history
- Critical family history
- Diversity issues – GRAACES (gender, religion, age, ability, class, ethnicity, sexuality) and rural/urban cultural differences,and their implications for service delivery and treatment.

_____Presenting Problem:
- Operationally define the presenting concern
- How was the problem assessed?
- DSM-5 diagnoses?
- What data were or will be collected (records, direct observation, self-report, parent report, questionnaires, standardized measures, etc).
- Any problems or potential problems with data collection?
- How were/will these data used to make a clinical decision?

_____Previous Research:
- What is the empirical basis for treatment? Briefly discuss research studies and data that support your selected treatment. Provide selected references.

_____Treatment:
- Describe the treatment components (or components that you will utilize).
- Was the treatment an empirically supported treatment?
- Treatment integrity – How did you ensure that treatment was actually implemented?
- If changes were made in treatment, how were data used to help you make decisions?
- What were ethical and diversity considerations with this treatment?

_____Evaluation of Treatment Outcomes:
- How were treatment outcomes evaluation in an objective manner?

_____Professionalism
- Dressed professionally, language use, met time requirement

_____Discussion:
- Actively participated in group discussion related to treatment topic

Comments (professionalism, knowledge and fluency with material, pace, effective use of non-verbals/gestures, use of fillers, engagement/interaction with audience, etc.):

Strengths:

Growth Areas:

Case Presentation Sign-up

Date	Topic & Discussion Facilitator	Host, Location	Presenter
Friday, 8/16/19	n/a	UNL, Lincoln	n/a
Friday, 9/20/19	Behavior Management, Cecilia Poon	Nebraska Medicine, Omaha	1. Kristin Hathaway 2. Chathuri Illapperuma 3. Jessika Hurts 4. Jessica Withers 5. Meghan Coleman
Friday, 10/18/19	Behavior Management across the Lifespan, Tessa Svoboda	DHHS, Beatrice	1. Emily DeFouw 2. Megan Carter 3.
Friday, 11/15/19	Social Stressors, Peter Martin	Catholic Social Services, Lincoln	1. Phoebe Jordan 2. Jenna Mullarkey 3. Kaleb Long 4. 5.
Friday, 12/13/19	Multicultural/Trauma Considerations, Rebecka Tompkins	Creighton, Omaha	1. Mary Schenkenfelder 2. Jenna Medlin 3. Katherine Havlik 4. Kristin Gallaway 5. Daniel Wilkie
Fridays, 1/3/20 & 1/10/20	n/a	Boys Town, Omaha	n/a
Friday, 2/21/20	Neurodevelopmental or School-Based Concerns, Allison Grennan	MMI, Omaha	1. Madison Paff 2. Philip Richard 3. Katie Slusher 4. Maryia Schneider 5. Aria Fiat
Friday, 3/20/20	Rural Behavioral Health Considerations, Nancy Foster	MMI Rural, Kearney	1. Samantha Eastberg 2. Janna Sanders 3. Brian Johnson 4. Phillip Suess 5.
Friday, 4/17/20	Health Psychology, Jeff Snell	Quality Living, Omaha	1. Jacob Lowe 2. Andrew Ahrendt 3. Kristina Harper 4. Julia Lockyer 5.
Friday, 5/15/20	Mood/Anxiety Disorders, Mike Scheel	UNL, Lincoln	1. Hannah West 2. Paige McArdle 3. Christina Monachino 4. Margaret Christie 5. Rachel Mathews
Friday, 6/19/20	Pediatric Concerns, Kim Haugen	Boys Town, Omaha	1. Morgan Eldridge 2. Sarah Brenner 3. Natalie Jensen 4. Lisa Moore 5. Lissy Kane

NICPP Intern Goals and Evaluations

The training goals of the Nebraska Internship Consortium in Professional Psychology are diverse and represent the far-reaching nature of training in a scientist-practitioner approach to psychology. Specifically, when completing an internship through the NICPP, we expect prospective psychologists to gain experiences and competencies in:

- applying ethical decision making to complex clinical and research activities
- developing knowledge and skills in delivering services within primary care settings and collaborating across settings and care-providers
- developing and demonstrating a commitment to evidence-based intervention procedures
- receiving exposure to a diversity of psychological and mental health services within broad community contexts and across a breadth of treatment facilities
- demonstrating a commitment to diversity and individual differences
- developing an appreciation for and commitment to research, including scientific practices and/or research activities
- developing research questions related to their work with clients and answering those questions
- developing competencies to evaluate the efficacy of their work with diverse clients and systems

Supervisors formally evaluate the progress of interns toward competence using the Psychology Intern Evaluation. Interns develop specific, objective goals using the GAS form and rate their own progress on each goal. In addition, interns are encouraged to complete the Intern Evaluation of Supervisor and evaluate the quality of the supervision they are receiving and how effective their supervisor is in helping them to achieve their goals and develop competency.

Psychology Intern Evaluation

Formal evaluation forms are completed twice in the intern's program. Specifically, a midyear evaluation is conducted, wherein each intern's performance and goals are reviewed, with recommendations for subsequent activities and actions articulated. Likewise, a summative, yearend evaluation is completed to provide an appraisal of the intern's competencies at the completion of his/her internship experience. Supervisors review these assessments and offer recommendations in individualized meetings with the interns. Supervisors and interns comment on the evaluation and each signs the evaluation before forwarding it to the UNL Co-Director.

These evaluations should be based on actual observation and/or reports of supervising psychologists, clients, and others concerned with clients and their treatment. The format includes eight basic competency areas and a general summary section. Competencies which are irrelevant to a particular site may be marked NA. Relevant competencies which are not listed may be addressed in the general summary.

Competency Scale 1-6

1 = Pre-internship/Deficient **4 = Yearend Competency Minimum**
2 = Beginning Internship **5 = Yearend Competent**
3 = Midyear Competency Minimum **6 = Post-internship/Excellent**

Each competency area is described with a list of specific behaviors. Some competencies also request information regarding context or population. The degree of competence for specific behaviors may be rated using the numerical scale from 1 to 6 described above. The scores on the specific behaviors listed in an area are averaged for the area summary rating.

Note that the competency scale of 1 to 6 is intended to represent the typical range and course of development during the internship year. It is expected that for most interns in most areas ratings will be between 2 and 5, 2-3 at the beginning of internship and moving, as competencies develop, to 3-4 at midyear and 4-5 at the conclusion of the internship. Supervisors are asked to explain specifically in the comments any ratings that fall in the 1-2 pre-internship/deficient and/or 5-6 post-internship/exceptional ranges of the scale. As indicated by the scale, all students need to average 4 or above in each area summary to successfully complete internship.

Goal Attainment Scaling (GAS) Form

An important aspect of preparing for and completing your doctoral internship is establishing professional goals and monitoring their attainment over time. Interns are required to work with their supervisors and develop goals for their training. These will be established at the beginning of the year, assessed midpoint, and revised as necessary. They will be evaluated again at the end of the year using Goal Attainment Scaling.

When developing goals, please be as specific and objective as possible. Goals should be reasonable, attainable, constructive, and measurable. They should also indicate a timeline by which they will be accomplished. Please follow the format provided when developing and submitting your goals. Establish and review your goals with your site supervisor. He/she should sign off on your goals form before you submit it. The forms should be submitted to Dr. Scheel **at the September, December, and June seminars.**

Suggested Reading:

Kiresuk, T.J., Smith, A., Cardillo, J.E. (1994). *Goal attainment scaling: Applications, theory, and measurement*. Hillsdale, NJ: Lawrence Erlbaum Associates.

http://betterevaluation.org/evaluation-options/GoalAttainmentScales

http://personalresearchandevaluation.com/documents/goal_attainment/ColinSHARP-Paper-Workshop2-GAS.pdf

Intern Evaluation of Supervisor

Interns are encouraged, but not required, to complete evaluations of their supervisors at midyear and yearend. Ideally, the evaluation will be an opportunity for candid feedback and will be discussed with the supervisor before being sent to the NICPP administrative assistant. However, interns also have the option of requesting confidentiality and sharing the evaluation only with the UNL Director.

NEBRASKA INTERNSHIP CONSORTIUM IN PROFESSIONAL PSYCHOLOGY
Psychology Intern Evaluation 2019-2020

Intern Name: _____ **Dates Covered:** _____

Supervisor/Training Director: _____ **Site:** _____

This evaluation should be based on actual observation and/or reports of supervising psychologists, clients, and others concerned with clients and their treatment. The format includes eight basic competency areas and a general summary section. Competencies which are irrelevant to a particular site may be marked NA. Relevant competencies which are not listed may be addressed in the general summary.

Each competency area is described with a list of specific behaviors. Some competencies also request information regarding context or population. The degree of competence for specific behaviors may be rated using the numerical scale from 1 to 6 described below. The scores on the specific behaviors listed in an area are averaged for the area summary rating.

If directly observed or audio taped observed, please describe which component(s) of the Area was/were observed in your comments to the intern.

Competency Scale 1-6

1 = Pre-internship/Deficient	**4 = Yearend Competency Minimum**
2 = Beginning Internship	**5 = Yearend Competent**
3 = Midyear Competency Minimum	**6 = Post-internship/Exceptional**

Note: The competency scale of 1 to 6 is intended to represent the typical range and course of development during the internship year. It is expected that for <u>most</u> interns in <u>most</u> areas ratings will be between 2 and 5, 2-3 at the beginning of internship and moving, as competencies develop, to 3-4 at midyear and 4-5 at the conclusion of the internship. Please <u>explain specifically in the comments</u> any ratings that fall in the 1-2 pre-internship/deficient and/or 5-6 post-internship/exceptional ranges of the scale. As indicated by the scale, all students need to average 4 or above in each area summary at the conclusion of the internship year to successfully complete internship.

AREA 1 INTERVENTION/THERAPY TREATMENT

Indicate modality (Y/N):	Indicate populations (Y/N):
_____ Individual therapy	_____ Child
_____ Couples therapy	_____ Adolescent
_____ Family therapy	_____ College Student
_____ Group therapy	_____ Adult
_____ Other	_____ Geriatric
	_____ Other

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Grasp the presenting problem
_____ Clarify client's expectations
_____ Conceptualize the case
_____ Establish a therapeutic relationship
_____ Engage client in setting appropriate goals
_____ Utilize knowledge of the literature
_____ Employ effective interventions
_____ Follow up on plans
_____ Adapt to client's progress
_____ Recognize and manage transference/countertransference dynamics
_____ Manage referral, transfer, or termination processes

Area 1 Summary _____

Area 1 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 2 CONSULTATION/COLLABORATION

Indicate agency/organizational settings (list):

Indicate professional disciplines participating (list):

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Recognize the need for consultation
_____ Involve appropriate sources
_____ Communicate with referral sources
_____ Communicate with family or caregivers
_____ Communicate with other service providers
_____ Address relevant issues
_____ Follow up on plans

Area 2 Summary _____

Area 2 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 3 ASSESSMENT/EVALUATION/TESTING

Indicate type of assessments done (Y/N):

_____ Intake Assessment
_____ Diagnostic Interviewing
_____ Behavioral Observation
_____ Intelligence
_____ Personality
_____ Abilities
_____ Interests
_____ Educational/Academic Evaluation
_____ Psycho-physiological Functioning
_____ Neuropsychological Functioning
_____ Other

Indicate populations assessed (Y/N):

_____ Child
_____ Adolescent
_____ College Student
_____ Adult (parents, caregivers, etc.)
_____ Geriatric
_____ Other

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Discern need for assessment
_____ Explain rationale to clients
_____ Select appropriate instruments
_____ Adhere to administration standards
_____ Interpret and integrate results
_____ Develop relevant recommendations
_____ Present findings

Area 3 Summary _____

Area 3 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 4 TEACHING/PRESENTING/SUPERVISING OTHERS

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Select appropriate subject matter
_____ Prepare adequately
_____ Establish rapport
_____ Adapt to the needs of the audience
_____ Communicate information
_____ Provide feedback

Area 4 Summary _____

Area 1 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 5 RESEARCH/PROGRAM EVALUATION

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Conceptualize the question
_____ Use existing resources
_____ Collect and analyze data
_____ Identify meaningful findings
_____ Present useful recommendations

Area 5 Summary _____

Area 5 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 6 ETHICAL/LEGAL/CULTURAL AWARENESS

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Demonstrate sensitivity to cultural differences
_____ Recognize issues with ethical and/or legal implications
_____ Understand relevant standards and regulations
_____ Comply with the spirit of such standards and regulations
_____ Consult with other professionals when appropriate

Area 6 Summary _____

Area 6 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 7 PROFESSIONAL/INTERPERSONAL CONDUCT

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Maintain prompt and regular attendance
_____ Carry fair workload
_____ Use time effectively
_____ Know and observe organization's operating procedures
_____ Manage service logistics (e.g., scheduling, billing)
_____ Keep up-to-date records
_____ Complete written work
_____ Demonstrate professional appearance and deportment

Area 7 Summary _____

Area 7 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

AREA 8 SUPERVISION/PROFESSIONAL DEVELOPMENT

On the competency scale of 1 to 6, to what degree of competence does intern:

_____ Demonstrate capacity for self-awareness
_____ Take responsibility for supervision agenda
_____ Recognize supervision needs
_____ Invite feedback
_____ Accept criticism
_____ Try new approaches
_____ Self identify as professional vs. student
_____ Participate in professional activities

Area 8 Summary _____

Area 8 Observation
Was this:

Directly observed (video/in-person)
Audio taped
Not directly observed

Supervisor: Comment on any concerns or accomplishments not included above and summarize intern's overall progress, addressing established strengths, current areas of active growth, and priorities for future development:

Intern: Comment on perceived accuracy of evaluation, additional observations, and any new goals contemplated in response to this evaluation.

Supervisor Signature	Date
Intern Signature	Date
NICPP Co-Director Signature	Date

Name:_____ Signature of Intern: _____
NICPP Site: _____ Signature of Primary Site Supervisor: _____
Date: _____ Signature of Consortium Director: _____

Nebraska Internship Consortium in Professional Psychology Intern Goals

(Goal Attainment Scaling)

Training Objectives	**Actions to be Taken to Meet Objectives**	Timeline	Date Completed	**Rating** **-2 = Significantly Worse** **-1 = Somewhat Worse** **0 = No Progress** **+1 = Goal Partially Met** **+2 = Goal Fully Met**	
				Midyear	**Yearend**
Apply ethical decision making to complex clinical and research activities					
Develop and demonstrate knowledge and skills in delivering services and collaborating across settings and care-providers (consultation)					
Develop and demonstrate a commitment to evidence-based intervention procedures					

Demonstrate a commitment to, appreciation of, and respect for diversity and individual differences					
Develop and demonstrate an appreciation for and commitment to research, including scientific practices and/or research activities					
Develop research questions/skills related to your work with clients					
Develop and demonstrate competencies to evaluate the efficacy of your work with diverse clients and systems					
Conduct formal and informal assessment for the purpose of designing interventions and creating recommendations					
Develop and demonstrate awareness of supervision needs and set goals for supervision process					

Administrative Tasks and Professional Behavior (i.e., complete and turn in paperwork by due dates, show up on time, dress and behave in a professional manner)					

NICPP
INTERN EVALUATION OF SUPERVISOR
(On Qualtrics)

PLEASE NOTE: This form is optional and may be modified to better fit certain Consortium sites. If, for some reason, an intern is not comfortable presenting candid feedback to his/her supervisor, the intern may discuss this evaluation with Dr. McChargue.

Supervisor_____ Semester_____

Intern_____ Date of Report_____

Importance of Anonymity:
_____High – I do NOT want my supervisor to know I wrote this evaluation.
_____Low – I am comfortable with my supervisor knowing I wrote this evaluation.

Please choose a rating which best reflects your experiences with this supervisor.

6 Strongly Agree
5 Mostly Agree
4 Somewhat Agree
3 Somewhat Disagree
2 Mostly Disagree
1 Strongly Disagree
NA Not Applicable

A. Supervisory Relationship – focus on my supervisor as a person, and the climatein which we worked.

MY SUPERVISOR

1. Shows a high level of empathy toward me.	6	5	4	3	2	1	NA
2. Communicates respect and concern for me.	6	5	4	3	2	1	NA
3. Promotes a learning environment which is supportive and safe.	6	5	4	3	2	1	NA
4. Encourages independent thinking and responsible action.	6	5	4	3	2	1	NA

5. Makes me feel appreciated as a professional.	6	5	4	3	2	1	NA
6. Is a model of ethical behavior.	6	5	4	3	2	1	NA
7. Is open to feedback on supervisory behavior.	6	5	4	3	2	1	NA

B. Structure of supervision – focus on goals, objectives and boundaries of mysupervision.

MY SUPERVISOR

8. Schedules and maintains sufficient time for supervision.	6	5	4	3	2	1	NA
9. Provides extra time as requested.	6	5	4	3	2	1	NA
10. Addresses my learning needs and agenda.	6	5	4	3	2	1	NA
11. States own objectives for supervision.	6	5	4	3	2	1	NA
12. Sets and maintains appropriate boundaries in supervision.	6	5	4	3	2	1	NA
13. Helps me set and revise my learning goals.	6	5	4	3	2	1	NA
14. Gives focused and specific feedback.	6	5	4	3	2	1	NA
15. Confronts me constructively.	6	5	4	3	2	1	NA
16. Uses positive reinforcement.	6	5	4	3	2	1	NA
17. Selects effective aids in supervision (i.e., role-playing) to meet goals.	6	5	4	3	2	1	NA
18. Encourages or assigns readings							

related to casework.	6	5	4	3	2	1	NA
19. Provides timely, ongoing feedback.	6	5	4	3	2	1	NA

C. Development of Counseling Skills – focus on conceptualization of the case, treatment, and termination of brief therapy.

MY SUPERVISOR

20. Assesses my basic counseling skills.	6	5	4	3	2	1	NA
21. Promotes accurate use of assessment techniques when appropriate.	6	5	4	3	2	1	NA
22. Suggests alternative assessment.	6	5	4	3	2	1	NA
23. Assists in case conceptualization.	6	5	4	3	2	1	NA
24. Helps develop client and treatment goals.	6	5	4	3	2	1	NA
25. Provides insight into client dynamics.	6	5	4	3	2	1	NA
26. Offers general strategies for treatment.	6	5	4	3	2	1	NA
27. Provides specific suggestions and responses for sessions.	6	5	4	3	2	1	NA
28. Assists in planning and implementing termination.	6	5	4	3	2	1	NA
29. Focuses on counseling content and process.	6	5	4	3	2	1	NA
30. Assists me in appraising my counseling skills.	6	5	4	3	2	1	NA

D. Global Evaluations of Supervisor's Behavior

31. Overall skill in setting relationship (Items 1-7).	6	5	4	3	2	1	NA
32. Overall skill in structure of supervision (Items 8-19).	6	5	4	3	2	1	NA
33. Overall skill in furthering development of my counseling skills (Items 20-30)	6	5	4	3	2	1	NA

34. **Comments**: In particular, you might address your supervisor's major strengths as well as areas for possible improvement.

Assessment Competency Area

Each intern is expected to demonstrate at least a 70% criteria score (of the rated areas). Your supervisor may rate some area(s) as Not Applicable, depending upon the type of assessment that you are conducting. This data needs to be incorporated into the intern's NICPP evaluation, in Area #3 - Assessment.

In each of these competency areas, rate the intern using these anchors:
Yes = Intern demonstrated the skill, as operationally defined under each competency
No = Intern did not demonstrate the skill
N/A = The skill is not relevant to the context of the observation.

Supervisor Observation and Evaluation of Clinical Activity of a Trainee (Assessment) Revised 7/16

Trainee _____ Date _____
Supervisor _____ Site: _____

Type of Clinical Activity

- ☐ Outpatient Psychological Evaluation
- ☐ Crisis Evaluation
- ☐ Warm Hand-off
- ☐ Outpatient Psychological/Neuropsychological Evaluation with Testing
- ☐ Other: _____

Rapport and Agenda Setting

Rapport	**Yes**	**No**	**N/A**
Smiles, introduces self to patient and other social support present			
Shows "listening" body position and eye contact			
Looks at patient when talking or listening			
Notes patient clues to their affect and responds with pauses, listening and empathy behaviors, including appropriate matching of affect/use of humor			
Responds well to any communication strains through interview			
Demonstrates sensitivity to ethnicity, family culture, community culture, sexual orientation, or cognitive/physical impairment			
Learns about patient's life and circumstances as well as current medical issues			
Agenda Setting	**Yes**	**No**	**N/A**
Verifies patient identity, clarifies trainee status and supervisor name			
Orients patient to purpose of the meeting including structure/goals/time of the session			
Gets input/agreement from patient about the agenda for the meeting and priorities			
Introduces computer, typing into patient's record, note-taking			
Discusses issues about confidentiality/Patient Services Agreement			
If applicable, elicits circumstances of the referral and main concern			

Rating in this Category (Rapport and Agenda Setting)

☐ Satisfactory (Meets expectation) ☐ Unsatisfactory (Needs improvement)

Comments:

Assessment

Preparation	**Yes**	**No**	**N/A**
Reviews medical record & other relevant records			
Discusses case with PCP prior to meeting with patient			
Key Aspects of Assessment	**Yes**	**No**	**N/A**
Guides patient through interview with appropriate balance of structure and flexibility			
Asks high number of open ended questions, followed by focused probes for detail			
Elicits patient's perspective on main concerns, what helps, expectations for the evaluation and/or treatment			
Elicits information to assess patient's safety (i.e., suicidality and abuse/neglect)			
Elicits information to assess biological influences (specific medical illness, medication, other treatments, etc.)			
Elicits information about school functioning (academic information and behavior) for pediatric patients			
Elicits information about family functioning (problems, family psychiatric history, and stressors as well as strengths that may help with treatment plan)			
Responds well to challenging patient behavior (e.g. tangential, limited disclosure, distractible behavior, etc.) to maintain good time and relationship management			
Selection/administration/and scoring of behavioral questionnaires or psychological tests (if applicable)			
Manages time well so that important agenda items are sufficiently addressed			

Rating in this Category (Assessment)

☐ Satisfactory (Meets expectation) ☐ Unsatisfactory (Needs improvement)

Comments:

Biopsychosocial Case Conceptualization

Integrative Conceptualization and Diagnosis	**Yes**	**No**	**N/A**
Identifies the most important or central problems/concerns			
Identifies strengths			
Accurately understands biological influences on behavior (medical illnesses, prescription drugs, sleep problems), or seeks out needed information			
Appropriately considers all relevant information/data, even when it may not easily fit in with other sources of information; integrates into cohesive conceptualization			
Selects appropriate diagnosis(es)			

Rating in this Category (Biopsychosocial Case Conceptualization)

☐ Satisfactory (Meets expectation) ☐ Unsatisfactory (Needs improvement)

Comments:

Communication with Others: Documentation and Collaborative Care

Documentation	**Yes**	**No**	**N/A**
Enters important information accurately into Medical Record			
Completes psychological assessment report within designated time			
Collaborative care	**Yes**	**No**	**N/A**
Copies notes to PCP			
Communicates key issues with PCP			

Rating in this Category (Communication with Others)

☐ Satisfactory (Meets expectation) ☐ Unsatisfactory (Needs improvement)

Comments:
Percentage of items rated yes:
Yes/Total # of rated items (eliminate N/A ratings)

Areas of strength:

Areas for growth:

Other comments:

_____ _____

Signature of Supervisor/Date Signature of Trainee/Date

Supervision Competency Area

Each intern is expected to demonstrate competency providing Clinical Supervision. The format of this will vary across sites. The following Supervision competency areas need to be evaluated and incorporated into your NICPP evaluation under Area 8.

Address the following supervision competencies in the first NICPP evaluation:

1) Multicultural and/or Diversity Considerations:
   Identify cultural and/or diversity factors by discussing personal expectations, values, biases, prejudice, stereotyping, worldviews, etc.

2) Legal Considerations:
   Identify and discuss any potential legal factors that may affect decision-making

3) Ethical Practice:
   Identify and discuss any potential ethical factors that may affect decision-making

Address the following supervision competencies in the second NICPP evaluation:

1) Demonstrates knowledge:
   Verbalize knowledge of evidence-based treatment related to a presenting situation

2) Self-Care:
   Identify stressors that may impact service provision, brainstorm self-care strategies, discuss options for engaging in self-care

SUPERVISION, EVALUATION, AND DUE PROCESS: POLICIES AND PROCEDURES

Nebraska Internship Consortium in Professional Psychology

Introductory Statements

The Nebraska Internship Consortium in Professional Psychology is committed to maintaining an internship program that facilitates learning and professional growth for interns. The training staff places a high premium on creating a work environment that is professionally stimulating, open to change, supportive of diversity, and sufficiently flexible to accommodate individual needs and requirements. Fundamental to a successful training experience is the provision of ongoing feedback to interns that facilitates professional and personal growth.

The training program recognizes that developmental stressors are inherent both in the transition from graduate school to an internship setting and during the course of the internship. During the internship, interns are exposed to full-time clinical practice, typically involving a full and challenging caseload as well as responding to client crises and agency requirements. Furthermore, intern supervision is often very intense, concentrated and frequent, which may increase the intern's sense of personal and professional vulnerability. Thus, while the internship represents a critical professional opportunity when interns can learn and refine skills, gain a greater sense of professional confidence, and develop a greater sense of professional identity, it is also a time of increased stress and vulnerability.

Since trainees make significant development transitions during the internship and may need special types of assistance during this time, it is the responsibility of the training program to provide activities, procedures, and opportunities that can facilitate growth and minimize stress. Such measures include, but are not limited to, extensive orientation meetings, individualized programs, clear and realistic expectations, clear and timely evaluations which include suggestions for positive change, contact with support individuals (e.g., supervisors) and/or groups (e.g., other graduate trainees, former interns, etc.), seminars specifically addressing expected stressors and transitions, and staff attention to the gradual increase in both the number and severity of clients.

This document outlines the rights and responsibilities of interns in the training process. It also outlines the supervision, evaluation, and due process procedures.

Intern Rights and Responsibilities

<u>Intern Rights</u>

1. The right to a clear statement of general rights and responsibilities upon entry into the internship, including a clear statement of goals and parameters of the training experience.
2. The right to be trained by professionals who behave in accordance with the APA ethical guidelines.
3. The right to be treated with professional respect, that recognizes the training and experience the intern brings with him/her.
4. The right to ongoing evaluation that is specific, respectful, and pertinent.
5. The right to engage in an ongoing evaluation of the training program experience.
6. The right to initiate an informal resolution of problems that might arise in the training experience (supervision assignments, etc.) through discussion or request letter to the staff member concerned and/or to the NICPP Director and Associate Directors.
7. The right to due process and appeal to the Consortium Director and Associate Directors to deal with problems after informal resolution has failed or to determine when rights have been infringed upon.
8. The right to respect for one's personal privacy.

Intern Responsibilities

1. The responsibility to read, understand, and clarify, if necessary, the statement of rights and responsibilities. It is assumed that these responsibilities will be exercised and their implementation is viewed as a function of competence.
2. The responsibility to maintain behavior within the scope of the APA ethical guidelines.
3. The responsibility to behave within the principles set forth by the statutes and regulations of the American Psychological Association, the University of Nebraska–Lincoln, and the respective Consortium agency. These Principles are set forth in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (http://www.apa.org/ethics/code/index.aspx) and the University of Nebraska–Lincoln's Student Code of Conduct(http://stuafs.unl.edu/dos/code).
4. The responsibility to be open to professionally appropriate feedback from supervisors, professional staff, and agency personnel.
5. The responsibility to behave in a manner that promotes professional interactions and is in accordance with the standards and expectations of the University of Nebraska–Lincoln and the respective Consortium agency.
6. The responsibility to give constructive feedback that evaluates the training experience or other experiences in the Consortium.
7. The responsibility to conduct oneself in a professionally appropriate manner if due process is initiated.
8. The responsibility to actively participate in the training, clinical services, and the overall activities of the Consortium. This includes requirements of completing contracts in a timely manner, attending monthly seminars as set by the Board of Supervisors, completing and submitting logs to the Consortium office each month, and providing information to the Consortium office as requested for completion of all informational reports.
9. The responsibility to meet training expectations by developing competency in (1) assessment skills, (2) psychotherapy skills, (3) outreach and consultation skills, and (4) other areas as delineated in the intern evaluation forms.

Supervision

Good supervision by appropriately credentialed and experienced psychologists is one of the most critical aspects of an internship experience in professional psychology. Psychology interns must have psychologists available as their primary mentoring models. In this way, interns can see how psychologists work in a variety of settings, with particular populations, and with a wide array of remedial and preventive interventions and assessment procedures.

All interns in the Consortium are guaranteed two hours of face-to-face supervision from their supervisors and an additional two hours of supervision in other modalities (e.g., case conferences, staffing, multidisciplinary teams, grand rounds) every week. These hours form an important core of training. The frequent and easy access to psychologist supervisors may, however, be even more important than formally scheduled supervision sessions. For this reason, the Consortium Board of Supervisors affirm a policy on supervision that matches good training practices, not simply the bare minimums required by state law or our national accrediting agency. All interns will receive site- specific didactics on supervision expectations for that site.

The best internship experiences will be possible in agencies that have full-time psychology staff. This staff will be committed to quality mentoring activities with interns and be responsible for providing feedback and support as the interns become socialized to their work and gain competence in the many tasks and roles played by psychologists. Interns will have a clear understanding of the lines of authority among their supervisors and agency administrators so their concerns and needs can be dealt with in a timely manner. The best supervisors are skilled in their own work and have enough influence on the agency environment so they can oversee the responsibilities and opportunities offered to the interns.

Psychology interns can learn very important information and skills from non-psychologist supervisors. These individuals (e.g., psychiatrists, social workers, psychiatric nurses, speech and language experts, rehabilitation experts, physicians, teachers, and other non-doctoral mental health practitioners) play an important, but secondary, role in the training of psychologists. If some portion of an intern's learning depends on interaction with other related professionals (this should be the case), the primary psychologist supervisor must gain cooperation and commitment from these individuals to take on a training and mentoring role with the interns.

The Evaluation Process

The NICPP continually assesses each intern's performance. Feedback from the assessments facilitates interns' professional growth by acknowledging strengths and identifying performance areas that need improvement. Formative evaluations occur on a regular basis to provide ongoing input and feedback regarding an intern's performance and support the continual development of interns' skills and competencies. Formal evaluation forms are completed twice in the intern's program. Specifically, a midyear evaluation is conducted, wherein each intern's performance and goals are reviewed, with recommendations for subsequent activities and actions articulated. Likewise, a summative, end of year evaluation is completed to provide an appraisal of the intern's competencies at the completion of his/her internship experience. Supervisors review these assessments and offer recommendations in individualized meetings with the interns. In the meetings, differences between interns' and supervisors' appraisals are expected to surface and, in most cases, be resolved. After meeting, the supervisor and intern sign the written evaluation and forward it to the UNL Director and/or Associate Directors.

Communication with Interns' Home Graduate Programs

The NICPP Directorship are responsible for communicating with each intern's sponsoring graduate program about the intern's activities and progress. Early in the year, the home graduate program receives information about the intern's training activities. At the end of the internship year, the home program receives copies of supervisors' evaluations of the intern's skills, professionalism, and personal functioning, along with a brief summary evaluation indicating whether the intern successfully completed the internship.

At any time, if problems arise that seem serious enough to cast doubt on an intern's ability to successfully complete the internship program, the NICPP Director and/or Associate Directors will inform the sponsoring graduate program. The home program will be encouraged to provide input to assist in resolving the problems.

Due Process in Evaluation and Remediation

The NICPP follows due process guidelines to ensure that decisions about interns are not arbitrary or personally based. The program uses the same procedures to evaluate all interns, and it has appeal procedures that permit any intern to challenge program decisions. The due process guidelines include the following:

1. All interns receive a written statement of program expectations for professional functioning.
2. Evaluation procedures are clearly stipulated, including when and how evaluations will be conducted.
3. The procedures and actions for making decisions about impairment are outlined in written statements given to all interns.
4. Graduate programs are informed about any suspected difficulties with interns.
5. Remediation plans are instituted for identified inadequacies, and they include time frames for remediation and specify consequences for failure to rectify the inadequacies.
6. All interns receive a written description of procedures they may use to appeal the program's actions.
7. Interns are given sufficient time to respond to any action taken by the program.
8. Decisions or recommendations regarding the interns' performance are based on input from multiple professional sources.
9. Program actions and their rationale are documented in writing to all relevant parties.

Definitions

Among professionals in training, "problem behaviors" are expected and may be common in the ongoing process of developing and refining professional skills. Problem behaviors are said to be present when supervisors perceive that a trainee's behaviors, attitudes, or characteristics are disrupting the quality of his or her clinical services; his or her relationships with peers, supervisors, or other staff; or his or her ability to comply with appropriate standards of professional behavior. It is a matter of professional judgment as to when an intern's problem behaviors are serious enough to constitute an impairment rather than merely being problems.

The NICPP has adopted a clear definition of impairment that facilitates accurate identification of significant problematic performance. Intern impairment is defined as an interference in professional functioning that renders the intern

- unable and/or unwilling to acquire and integrate professional standards into his/her repertoire of professional behavior;
- unable to acquire professional skills that reach an acceptable level of competency; or
- unable to control personal stress which leads to dysfunctional emotional reactions and behaviors that disrupt professional functioning.

More specifically, problem behaviors typically become identified as impairments when they include one or more of the following characteristics:

1. The intern does not acknowledge, understand, or address the problem when it is identified.
2. The problem is not merely a reflection of a skill deficit that can be rectified by academic or didactic training.
3. The quality of services delivered by the intern is significantly negatively affected.
4. The problem is not restricted to one area of professional functioning.
5. A disproportionate amount of attention by training personnel is required.
6. The intern's behavior does not change as a function of feedback, remediation efforts, and/or time.

Procedural Guidelines

Under usual circumstances the progress of students through the internship program will be monitored and adjusted according to the needs of the intern. If at any time, however, the intern is identified as having an impairment as defined above, the preferred action is for the intern and his or her supervisory team to consider the intern's progress in light of these difficulties. If repeated attempts to remediate the intern's deficits have been unsuccessful, a process for considering further action will be initiated. These procedures have been developed to protect student rights and the integrity of the internship program.

Step 1

When a determination is made that an educational or professional problem exists, the student and his or her agency training director/supervisor will discuss the problem and outline ways to correct or rectify the problem. This interaction process should allow for ample communication opportunities for the student to react to the information presented regarding a potential problem area. Utilize the Due Process Documentation template to document the concern(s), action plan, and resolution. This documentation needs to be provided to the site’s Training Director and Dr. Scheel .

Step 2

If the problem continues, the supervisor will again discuss the nature of the problem with the intern. The intern will have the opportunity to discuss the problem in detail with his or her supervisor. If this second meeting with the agency supervisor is unsuccessful in resolving the intern's difficulties, a meeting will then be held with the intern, agency supervisor, and the Consortium Director(s). The intern will be informed of the meeting at least one week prior to the date and will have the opportunity to provide additional evidence to the Consortium Director(s) and agency supervisor to consider at that meeting. Associate Directors will recuse themselves from decisions at the Director level if it is associated with their sites.

The purpose of this meeting will be to develop additional intervention plans, decide whether the current contract should stay in force, or if a subset of the Supervisory Board should be convened to address the intern's difficulties.

Step 3

When the outcome of Step 2 results in a conclusion that an intern's skills, professionalism, or personal functioning are inadequate for an intern in training, the Supervisory Board (comprised of a subset of at least 4 members representing different Consortium agencies), with input from other relevant supervisory staff, initiates the following procedures:

1. The negative evaluations will be reviewed formally and a determination made as to what action needs to be taken to address the problems identified. The intern will be notified in writing that such a review is occurring and that the Supervisory Board is prepared to receive any information or statement that the intern wishes to provide with reference to the identified problems.
2. The intern will be informed at least one week prior to the meeting.
3. After reviewing all available information, the Supervisory Board may adopt one or more of the following steps, or take other appropriate action.

    - The committee may elect to take no further action.
    - The committee may issue an Acknowledgement Notice which formally states that (a) the committee is aware of and concerned about the negative evaluation; (b) the evaluation has been brought to the intern's attention and the board or other supervisors will work with the intern to rectify the problem within a specified time frame; and (c) the behaviors associated with the negative evaluation are not significant enough to warrant more serious action at the time.

Step 4

If the Supervisory Board deems that the behaviors associated with the negative evaluation are significant enough to warrant more serious attention, the Board may issue a Probation Notice. Probationary status specifies that the board, through the supervisors and NICPP Directors, will actively and systematically monitor for a specific length of time, the degree to which the intern addresses, changes, and/or otherwise improves the problem behaviors. The Probation Notice is a written statement to the intern that includes the following items:

- A description of the problematic behavior.
- Specific recommendations for rectifying the problems.
- Criteria for ending the probationary status and procedures to assess whether the problem has been appropriately rectified.
- A time frame for the probation during which the problem is expected to be ameliorated.
- A summary of options available to the intern.

If the Board deems that remedial action is required, the identified impairment must be systematically addressed by the site. Possible remedial steps include (but are not limited to) the following:

- Increased supervision, either with the same or other supervisors.

- Change in the format, emphasis, and/or focus of supervision.
- A recommendation and/or requirement that personal therapy be undertaken with a clear statement about the manner in which such therapy contacts will be used in the intern evaluation process.
- Recommendation of a leave of absence and/or a second internship.

Following the delivery of an Acknowledgment Notice or Probation Notice, the NICPP Director(s) will meet with the intern to review the required remedial steps. The intern may elect to accept the conditions or may challenge the committee's actions as outlined below. In either case, the Director(s) will inform the intern's sponsoring university, and indicate the nature of the inadequacy and the steps taken by the Supervisory Board. The intern shall receive a copy of the letter to the sponsoring university.

Once an Acknowledgement Notice has been issued by the Supervisory Board, the problem's status will be reviewed within three months, or the next formal evaluation, whichever comes first. In the case of a Probation Notice, the problem's status will be reviewed within the time frame set by the notice.

Failure to Correct Problems

When a combination of interventions does not rectify the impairment within a reasonable period of time, or when the intern seems unable or unwilling to alter his or her behavior, the training program may need to take more formal action. If an intern on probation has not improved sufficiently to rectify the problems under the conditions stipulated by the Probation Notice, the Supervisory Board will conduct a formal review and then inform the intern in writing that the conditions for revoking the probation have not been met. The committee may then elect to take any of the following steps, or other appropriate action.

1. It may continue the probation for a specified time period.
2. It may issue a suspension, whereby the intern is not allowed to continue engaging in certain professional activities until there is evidence that the problem behaviors in question have been rectified.
3. It may inform the intern, the intern's sponsoring university, the Consortium Directors, and the agency Training Director and supervisors, that the intern will not successfully complete the internship if his/her behavior does not change. If by the end of the training year, the intern has not successfully completed the training requirements, the Board may give the intern only limited certification, or no certification at all. The Board may specify those settings in which the intern can or cannot function adequately. The intern and the intern's home department will be informed that the intern has not successfully completed the internship.
4. It may inform the intern that the Board is recommending to the intern's sponsoring university, the Consortium Directors, and the agency Training Director and supervisors that the intern be terminated immediately from the internship program, and with the Directors' and agency Training Director's approval, move to terminate the intern.
5. When the Board's deliberations lead to the conclusion that an intern is not suited for a career in professional clinical practice, it may recommend and assist in implementing a career shift for the intern.

All the above steps will be appropriately documented and implemented in ways that are consistent with due process procedures, including opportunities for interns to initiate grievance proceedings to challenge Supervisory Board decisions. The intern will be informed of meetings at least one week prior to their occurrence and have the opportunity to provide evidence for consideration. If the decision has been to terminate the intern, the intern, the full Supervisory Board, and the intern's academic training director will be notified within ten days. The intern and academic training director will be given an opportunity to respond orally and/or in writing to this decision. The Supervisory Board will consider this input prior to reaching a final decision.

Intern Challenge and Grievance Procedures

Interns who receive an Acknowledgment Notice or Probation Notice, or who otherwise disagree with any Supervisory Board decision regarding their status in the program, are entitled to challenge the Board's actions by initiating a grievance procedure. Within 5 working days of receipt the Board's notice or other decision, the intern

must inform the NICPP Director(s) in writing that he or she is challenging the Board's action. The intern then has 5 additional days to provide the NICPP Director(s) with information as to why the intern believes the Board's action is unwarranted. Failure to provide such information will constitute a withdrawal of the challenge. Following receipt of the intern's challenge, the following actions will be taken.

1. The NICPP Director(s) will convene a Review Panel consisting of two staff members selected by the NICPP Director(s) and two staff members selected by the intern. These will be members of the NICPP who did not serve on the Supervisory Board. The intern retains the right to hear all facts and the opportunity to dispute or explain his or her behavior.
2. The NICPP Director(s) will conduct and chair a review hearing in which the intern's challenge is heard and the evidence presented. The Review Panel's decisions will be made by majority vote. Within 10 days of completion of the review hearing, the Review Panel will prepare a report on its decisions and recommendations and will inform the intern of its decisions. The Review Panel will then submit its report to the intern's sponsoring university, the Consortium NICPP Directors, and the agency Training Director and supervisors.
3. Once the Review Panel has informed the intern and submitted its report, the intern has 5 working days within which to seek a further review of his or her grievance by submitting a written request for further review. The intern's request must contain brief explanations of the grievance and of the desired settlement he or she is seeking, and it must also specify which policies, rules, or regulations have been violated, misinterpreted, or misapplied.
4. The Chairperson of the Department of Educational Psychology of UNL will convene an independent ad hoc committee charged with conducting a review of all documents submitted and render a written decision. They will render their decision within 15 working days of receipt of the Review Panel's report, and within 10 working days of receipt of an intern's request for further review if such request was submitted. The Chairperson and ad hoc committee may accept the Review Panel's action, reject the Review Panel's action and provide an alternative, or refer the matter back to the Review Panel for further deliberation. The panel will report back to the Chairperson and ad hoc committee within 10 working days of the request for further deliberation. The Chairperson and independent committee will then make a final decision regarding actions to be taken. This decision shall be final and binding.
5. Once a final and binding decision has been made, the intern, sponsoring university, and other appropriate individuals will be informed in writing of the action taken.

Staff Allegation of Intern Violations of Standards

Any staff member of the NICPP, UNL, or cooperating agencies may file a written grievance against an intern for the following reasons: (a) unethical or legal violations of professional standards or laws; (b) failure to satisfy professional obligations that thereby violate the rights, privileges, or responsibilities of others.

1. The NICPP Director(s) will review the grievance with other members of the Supervisory Board and determine if there is reason to go further or whether the behavior in question is being rectified.
2. If the Director(s) and other Board members determine that the alleged behavior cited in the complaint, if proven, would not constitute a serious violation, the Director(s) shall inform the staff member, who may be allowed to renew the complaint if additional information is provided.
3. When a decision has been made by the Director(s) and other Board members that there is probable cause for deliberation by a Review Panel, the Director(s) shall notify the staff member and request permission to inform the intern. The staff member shall have 5 days to respond to the request and shall be informed that failure to grant permission may preclude further action. If no response is received within 5 days, or permission to inform the intern is denied, the Director(s) and the other Board members shall decide whether to proceed with the matter.
4. If the intern is informed of the complaint, a Review Panel is convened consisting of the Director(s), two members selected by the staff member who filed the allegation, and two members selected by the intern. The Review Panel receives any relevant information from the intern, the staff member, or both, that bears on its deliberations.

5. The Review Panel, chaired by the Director(s), will hold a review hearing in which the complaint is heard and evidence presented. Within 10 days of completing the review hearing, the Review Panel shall communicate its recommendation to the intern and to the intern's sponsoring university, the Consortium Director(s), and the agency Training Director and supervisors.
6. Once the Review Panel has communicated its recommendation to the intern and to the intern's sponsoring university, the Consortium Director(s), and the agency Training Director and supervisors, the intern has 5 working days within which to submit a written request for further review. The request should include relevant information, explanations, and viewpoints that may challenge, refute, or otherwise call for modification of the Review Panel's decisions and recommendations. The request should also specify policies, rules, or regulations that may have been violated, misinterpreted, or misapplied.
7. Once a final and binding decision has been made, the intern, sponsoring university, and other appropriate individuals will be informed in writing of the action taken.
8. The Chairperson of the Department of Educational Psychology at UNL will then convene an independent ad hoc committee and conduct a review of all documents submitted and render a written decision. They will render their decision within 15 working days of receipt of the Review Panel's report, and within 10 working days of receipt of an intern's request for further review if such request was submitted. The Chairperson and ad hoc committee will then make a final decision regarding actions to be taken.
9. Once a final and binding decision has been made, the intern, sponsoring university, and other appropriate individuals will be informed in writing of the action taken.

Interns' Procedures for Registering Concerns or Complaints

During the twelve-month internship, interns may experience a concern about some element of the internship. Procedures for dealing with concerns are outlined below.

Step 1

When an intern experiences problems or concerns at his/her agency, he/she should schedule a meeting with his/her direct supervisor to discuss the concern. Most complaints or concerns of interns can be handled informally by speaking with the direct supervisor. Most often the outcome of such a meeting is an agreement on a plan that satisfies the concern. In some cases, it may be helpful to develop a written document summarizing the details of the agreement or plan to address the concern. A time frame of up to 14 days should be specified within which the plan should be implemented and concerns allayed.

If the discussion between the intern and supervisor is not agreeable to the intern or if after fourteen days there has been no improvement, the intern should inform the supervisor that the next higher supervisor will be contacted. This may be another psychologist, an agency administrator, or another individual in a supervisory position. The intern is advised to inquire as to the agency guidelines for handling complaints. The human resources department at the agency may help identify the most appropriate individual.

If the concern involves the direct supervisor and the intern is not comfortable speaking with him or her, the intern is advised to discuss the matters with an individual who is superior to the supervisor. Additionally, the intern may contact either of the Directors of the Consortium with a concern about the supervisor.

Almost all complaints and concerns can be addressed by the informal collaboration of intern, supervisor, agency supervisor, and in some cases, the Consortium Director(s). This additional consultation with agency administrator/supervisor and/or the Consortium Director(s) should take no more than an additional 14 working days.

Step 2

If the intern is not satisfied with informal procedures or the responses received to verbal complaints, a formal grievance should be written to the supervisor. The supervisor will respond in writing within seven calendar days of

receiving the written document. The written complaint and supervisor's response should be copied and sent to the agency supervisor and to the Consortium Director(s). A meeting among all concerned parties should be held to attempt a resolution. Such a meeting should take place within seven working days of receipt of the supervisor's written response. The purpose of this meeting is to engage in collaborative problem-solving and make efforts to identify solutions to the concern.

Step 3

If the first two steps have not resulted in a satisfactory resolution, the Consortium Director(s) should be contacted in writing. Details of procedures initiated in Steps 1 and 2 and outcomes of these actions should be specified clearly. The Director(s) will convene the Board of Supervisors or a subset of the Board to develop a plan to resolve the ongoing difficulties.

This process will take no more than approximately two weeks. The Board of Supervisors is the final step in decision making. However, the intern may enlist assistance from the program director at the intern's home institution. The Board welcomes such involvement.

Interns' Rights during Due Process & Grievances

The intern has several rights during the problem-solving/grievance process. Specifically, the intern is entitled to several safeguards designed to support and assist him/her. The intern:

- may have a non-participating observer present at any point in the process;
- can ask others to assist in defining or providing more evidence about the concern;
- may ask the supervisor's supervisor or the Consortium Director(s) to attend any problem solving meetings that occur;
- may elect to confer with agency experts in Personnel or Human Resources Departments if the matter pertains to that area;
- may enlist the help of the designated personnel at the agency or at the University of Nebraska–Lincoln if the concern is discrimination or harassment;
- may contact the academic program advisor or the American Psychological Association for advice and counsel;
- has the right to file grievances and to fully use this procedure with no fear of harassment or reprisal. Harassment or reprisal of any kind is in itself a grievous offense.

The Consortium faculty and staff are committed to the education and professional development of interns. Any issue brought to the attention of supervisors and/or the Directors and/or Board will be taken seriously and honest attempts will be made toward its resolution. The APA Ethical Principles of Psychologists and Code of Conduct (2010) will be followed by all participants including the supervisor, Directors, Board, and intern. Confidentiality will be safeguarded to the fullest extent possible.

Due Process Documentation

Meeting Date:

Meeting Time:

Intern:

Supervisor:

Concern:

Action Plan:

Intern

Supervisor

Follow-Up Meeting Date & Time:

_____ _____

Intern Date Supervisor Date

Due Process Documentation – Follow-Up

Meeting Date:

Meeting Time:

Resolution Summary:

_____		_____	
Intern	Date	Supervisor	Date

University of Nebraska
Nebraska Internship Consortium in Professional Psychology

DIVERSITY PLAN

Preface

Diversity is the multiplicity of people, cultures, and ideas that contribute to the richness and variety of life. Diversity broadly encompasses the mixture of similarities and differences along several dimensions: race, national origin, ability, religion, sexual orientation, age, and gender. It includes values, cultures, concepts, learning styles, and perceptions that individuals possess. By its very nature, diversity fosters inclusiveness, encourages the exchange of new ideas, improves decision making, and broadens the scope of problem solving.

Diversity in all its dimensions must be valued. Where there is diversity, there is evidence of openness, emergence of inclusiveness, and a respect and appreciation for differences. Where diversity exists, there is indeed an enriched environment.

Diversity is about creating an equitable, hospitable, appreciative, safe, and inclusive campus environment – one that embraces the full spectrum of all community members' contributions. We must respond with effort and vigor to issues of diversity. We commit ourselves to enhancing the quality of experience for all members of the Consortium community by enhancing our diversity.

We believe that diversity in interns and supervisors:

- Enriches the educational experience. We learn from those whose experiences, beliefs, and perspectives are different from our own, and these lessons can be taught best in a richly diverse intellectual and social environment.
- Promotes personal growth and a healthy society. Diversity challenges stereotyped perspectives, encourages critical thinking, and helps students learn to communicate effectively with people of varied backgrounds.
- Strengthens communities and the workplace. Education within a diverse setting prepares students to become good citizens in an increasingly complex pluralistic society, fosters mutual respect and teamwork, and helps build communities whose members are judged by the quality of their character and their contributions.
- Enhances Americans' economic competitiveness. Sustaining the nation's prosperity in the twenty-first century will require us to make effective use of the talents and abilities of all our citizens in work settings that bring together individuals from diverse backgrounds and cultures.

Achieving diversity within the NICPP does not require quotas; nor does diversity warrant admission of unqualified applicants. However, the diversity we seek does require that we continue to be able to reach out and make a conscious effort to build healthy and diverse learning

environments appropriate for their missions. The success of the Consortium and the strength of our democracy depend on it.

An interagency consortium composed of increasing numbers of interns, faculty, and supervisors of diverse cultural, racial, and ethnic backgrounds makes the NICPP both more exciting and more complex. The Consortium must prepare our interns for the wider world beyond the state's borders, since it is the world that will impact their adult lives. When they come to the Consortium, they must learn to negotiate differences and to function in new situations. Learning opportunities in the NICPP that reflect the diversity of the larger society are vital for interns' ability to feel comfortable interacting with people different from themselves. They will become more aware of societal and individual diversity, and also more likely to promote racial understanding. Our efforts to improve the quality of professional training of the NICPP remain our top priority. The pursuit to achieve a Consortium community reflective and supportive of diversity complements and enhances those efforts.

Given the aforementioned belief statement, the NICPP endorses the following goals related to equity, diversity, and multiculturalism.

GOAL 1:
Establish and encourage a clear commitment to the value of diversity on the part of all members of the Consortium community.

There should be a clear and continuous commitment from all members of the Consortium community. The supervisors, staff, and interns are all key to achieving demonstrable progress toward inclusion and participation for every member of the NICPP community. The example they set is crucial to the development of an institutional commitment to diversity. NICPP supervisors should not only state their commitment clearly and continuously, but should exhibit that commitment through their actions. When the commitment to the value of diversity is clearly demonstrated by these leaders, the actions of the entire Consortium community will parallel the standards they set.

GOAL 2:
Establish a system of accountability to measure progress toward achieving the recommendations set forth above.

1. The Board of Supervisors should be responsible for implementing an equity plan. Uniform reporting methods should be established in order to provide meaningful Consortium-wide analysis.
2. Performance evaluations at every level should address demonstrated implementation of equity policies.
3. Each site should report annually to the Board of Supervisors regarding the status of diversity concerns and progress made.
4. Exit interviews, or other methods of gathering information, should be established in order to determine whether equity issues have been addressed.

GOAL 3:
Establish effective methods of recruitment and retention designed to achieve multicultural representation among staff and interns.

1. Staff and interns are crucial role models. Incentives for active and successful affirmative action participation should be established. Establishment of vitae banks, use of minority directories, and personal networking within fields of study and consortiums are recommended recruiting tools.
2. Candidates for site employment and internships should be made to feel welcome at Consortium sites and within local communities. Sincere and meaningful efforts should be made by the sites to cooperate with local communities to develop and maintain the receptive social climate for all people, particularly those within the Consortium family.
3. Mentoring and professional development opportunities for people should be encouraged and reviewed for effectiveness.
4. The reasons why people have declined offers of site employment and internship positions should be determined and addressed.
5. Recruiting interns nationally should be implemented, but not to the exclusion of enhancing recruitment efforts aimed toward multicultural residents of Nebraska. Effective formal and informal social support systems should be in place to improve intern prospects for success and retention once in the Consortium.
6. Intern recruiting methods that are meaningful for bilingual interns and staff will be developed and implemented.

GOAL 4:
Create and maintain a climate conducive to success for all peoples.

1. Unfair, illegal, and irrational discrimination should not be tolerated in any form within the Nebraska Internship Consortium. Appropriate steps to eliminate this type of discrimination should be swift and effective.
2. Every effort should be made to create a Consortium climate in which all staff and interns feel respected and comfortable and in which success is possible and obtainable. Seemingly simple information is greatly appreciated: is there a grocery store nearby that stocks cultural foods or products; where can an intern who is culturally diverse purchase personal grooming or health products; does the community have a cultural center. Highly visible programs are valuable, but thoughtful courtesy is priceless.
3. Every effort should be made within NICPP to dispel the ignorance or anxiety associated with multicultural experiences. The multicultural experience is not to be feared or dismissed; the experience should be viewed and shared by each site as an important step toward maturity, balance, equity, social justice, and racial harmony.

GOAL 5:
Support and encourage a training experience which manifests diversity as a sign of equality.

Inclusion of diversity within the training program is desirable to properly prepare interns for a successful career upon the completion of the internship experience. In training programs and experiences, the consideration of diversity issues is encouraged.

Consortium faculty are encouraged to evaluate training plans and curricula to insure that they accurately evidence a balanced reflection of the contribution of all people, regardless of culture, race, or ethnicity.

GOAL 6:
Achieve a meaningful improvement in awareness and sensitivity to diversity issues.

1. A program and atmosphere designed to raise awareness of diversity issues, increase sensitivity in general, offer thoughtful approaches to the acceptance of diversity, and recognize the value of diversity should be available for all Consortium staff.
2. A similar program to achieve the goals and objectives as described above should be developed and implemented for interns in the Consortium in areas apart from the training environment. Successful participation and interaction in this program as it is developed in various ways should be considered a desirable part of the internship experience.
3. Consortium-sponsored/supported and community-based workshops, seminars, speakers, forums, and festivals on cultural diversity for interns, staff, and Directors should be attended, supported, and held with regularity.

Excerpted with modifications from the University of Nebraska Board of Regents Policy Goals Pertaining to Equity for People of Color (Originally issued February, 1993; re-confirmed February, 1997), the Comprehensive Diversity Plan for the University of Nebraska–Lincoln, May 5, 2000, and the 2006-2011 Strategic Plan for Diversity for the University of Nebraska–Lincoln.

It is the policy of the University of Nebraska–Lincoln not to discriminate based upon age, race, ethnicity, color, national origin, gender, sex, pregnancy, disability, sexual orientation, genetic information, veteran's status, marital status, religion or political affiliation.

NICPP Policy Statement on Interns Who Experience Conflicts Working with Diverse Clients/Patients:

In our APA-accredited program we are committed to a training process that ensures that interns develop the knowledge, skills, and attitudes to work effectively with members of the public who embody intersecting demographics, attitudes, beliefs, and values. When interns' attitudes, beliefs, or values create tensions that negatively impact the training process or their ability to effectively treat members of the public, the program faculty and supervisors are committed to a developmental training approach that is designed to support the acquisition of professional competence. We support interns in finding a belief- or value-congruent path that allows them to work in a professionally competent manner with all clients/patients.

For some interns, integrating personal beliefs or values with professional competence in working with all clients/patients may require additional time and faculty support. Ultimately though, to complete our internship program successfully, all interns must be able to work with any client placed in their care in a beneficial and noninjurious manner. Professional competencies are determined by the profession for the benefit and protection of the public; consequently, interns do not have the option to avoid working with particular client populations or refuse to develop professional competencies because of conflicts with their attitudes, beliefs, or values.

Our training clinics are committed to providing an inclusive and welcoming environment for all members of our community. Consistent with this principle, Consortium policy requires that supervisors and interns do not discriminate on the basis of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status in the services provided at the training clinics.

In some cases, tensions may arise for an intern due to differences in beliefs or values with clients. Because the interns will have to navigate these sorts of clinical situations in their future practice careers, the program has a responsibility to prepare interns to do so in a safe and ethical manner. NICPP will respectfully work with interns as they learn how to effectively practice with a broad range of clients. Thus, interns should expect to be assigned clients that may present challenges for them at some point in training. If interns do not feel comfortable or capable of providing competent services to a client because it conflicts with the intern's beliefs or values, it is the intern's responsibility to bring this issue to the attention of his/her supervisor. Because client welfare and safety are always the first priority, decisions about client assignment and reassignment are the responsibility of the faculty/supervisors.

Adopted April 13, 2015. Adapted from the American Psychological Association Education Directorate sample policy statements developed in January 2014 by the BEA Working Group on Trainee Conflicts Serving a Diverse Clientele.

AMERICAN PSYCHOLOGICAL ASSOCIATION

Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations

Introduction

There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs, and cultural expectations have been introduced into educational, political, business, and healthcare systems by the physical presence of these groups. The issues of language and culture do impact on the provision of appropriate psychological services.

Psychological service providers need a sociocultural framework to consider diversity of values, interactional styles, and cultural expectations in a systematic fashion. They need knowledge and skills for multicultural assessment and intervention, including abilities to:

1. recognize cultural diversity;
2. understand the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations;
3. understand that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups;
4. help clients to understand/maintain/resolve their own sociocultural identification; and understand the interaction of culture, gender, and sexual orientation on behavior and needs.

Likewise, there is a need to develop a conceptual framework that would enable psychologists to organize, access, and accurately assess the value and utility of existing and future research involving ethnic and culturally diverse populations.

Research has addressed issues regarding responsiveness of psychological services to the needs of ethnic minority populations. The focus of mental health research issues has included:

1. The impact of ethnic/racial similarity in the counseling process (Acosta & Sheenan, 1976; Atkinson, 1983; Parham & Helms, 1981);
2. Minority utilization of mental health services (Cheung & Snowden, 1990; Everett, Proctor, & Cartmell, 1983; Rosado, 1986; Snowden & Cheung, 1990);
3. Relative effectiveness of directed versus nondirected styles of therapy (Acosta, Yamamomoto, & Evans, 1982: Dauphinais, Dauphinais, & Rowe, 1981; Lorion, 1974);
4. The role of cultural values in treatment (Juarez, 1985; Padilla & Ruiz, 1973; Padilla, Ruiz, & Alvarez, 1975; Sue & Sue, 1987);
5. Appropriate counseling and therapy models (Comas-Diaz & Griffith, 1988; McGoldrick, Pearce, & Giordino, 1982; Nishio & Blimes, 1987);
6. Competency in skills for working with specific ethnic populations (Malgady, Rogler, & Constantino, 1987; Root, 1985; Zuniga, 1988).

The APA's Board of Ethnic Minority Affairs (BEMA) established a Task Force on the Delivery of Services to Ethnic Minority Populations in 1988 in response to the increased awareness about psychological service needs associated with ethnic and cultural diversity. The populations of concern include, but are not limited to the following groups: American Indians/Alaska Natives, Asian Americans, and Hispanics/Latinos. For example, the

populations also include recently arrived refugee and immigrant groups and established U.S. subcultures such as Amish, Hasidic Jewish, and rural Appalachian people.

The Task Force established as its first priority development of the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. The guidelines that follow are intended to enlighten all areas of service delivery, not simply clinical or counseling endeavors. The clients referred to may be clients, organizations, government and/or community agencies.

Guidelines

Preamble: The Guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations.

1. Psychologists educate their clients to the processes of psychological intervention, such as goals and expectations; the scope and, where appropriate, legal limits of confidentiality; and the psychologists' orientations.

   a. Whenever possible, psychologists provide information in writing along with oral explanations.
   b. Whenever possible, the written information is provided in the language understandable to the client.

2. Psychologists are cognizant of relevant research and practice issues as related to the population being served.

   a. Psychologists acknowledge that ethnicity and culture impacts on behavior and take those factors into account when working with various ethnic/racial groups.

   b. Psychologists seek out educational and training experiences to enhance their understanding to address the needs of these populations more appropriately and effectively. These experiences include cultural, social, psychological, political, economic, and historical material specific to the particular ethnic group being served.

   c. Psychologists recognize the limits of their competencies and expertise. Psychologists who do not possess knowledge and training about an ethnic group seek consultation with, and/or make referrals to, appropriate experts as necessary.

   d. Psychologists consider the validity of a given instrument or procedure and interpret resulting data, keeping in mind the cultural and linguistic characteristics of the person being assessed. Psychologists are aware of the test's reference population and possible limitations of such instruments with other populations.

3. Psychologists recognize ethnicity and culture as significant parameters in understanding psychological processes.

   a. Psychologists, regardless of ethnic/racial background, are aware of how their own cultural background/experiences, attitudes, values, and biases influence psychological processes. They make efforts to correct any prejudices and biases.
   Illustrative Statement: Psychologists might routinely ask themselves, 'Is it appropriate for me to view this client or organization any differently than I would if they were from my own ethnic or cultural group?'

   b. Psychologists' practice incorporates an understanding of the client's ethnic and cultural background. This includes the client's familiarity and comfort with the majority culture as well as ways in which the client's culture may add to or improve various aspects of the majority culture and/or of society at large.
   Illustrative Statement: The kinds of mainstream social activities in which families participate may offer information about the level and quality of acculturation to American society. It is important to distinguish acculturation from length of stay in the United States, and not to assume that these issues are relevant only for new immigrants and refugees.

   c. Psychologists help clients increase their awareness of their own cultural values and norms, and they facilitate discovery of ways clients can apply this awareness to their own lives and to society at large.

Illustrative Statement: Psychologists may be able to help parents distinguish between generational conflict and culture gaps when problems arise between them and their children. In the process, psychologists could help both parents and children to appreciate their own distinguishing cultural values.

d. Psychologists seek to help a client determine whether a 'problem' stems from racism or bias in others so that the client does not inappropriately personalize problems.
Illustrative Statement: The concept of 'healthy paranoia,' whereby ethnic minorities may develop defensive behaviors in response to discrimination, illustrates this principle.

e. Psychologists consider not only differential diagnostic issues but also cultural beliefs and values of the clients and his/her community in providing intervention.
Illustrative Statement: There is a disorder among the traditional Navajo called 'Moth Madness.' Symptoms include seizure-like behaviors. The disorder is believed by the Navajo to be the supernatural result of incestuous thoughts or behaviors. Both differential diagnosis and intervention should take into consideration the traditional values of Moth Madness.

4. Psychologists respect the roles of family members and community structures, hierarchies, values, and beliefs within the client's culture.

a. Psychologists identify resources in the family and the largercommunity.

b. Clarification of the role of the psychologist and the expectations of the client precede intervention. Psychologists seek to ensure that both the psychologist and client have a clear understanding of what services and roles are reasonable.
Illustrative Statement: It is not uncommon for an entire American Indian family to come into the clinic to provide support to the person in distress. Many of the healing practices found in American Indian communities are centered in the family and the whole community.

5. Psychologists respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychosocial functioning, and expressions ofdistress.

a. Part of working in minority communities is to become familiar with indigenous beliefs and practices and to respect them.
Illustrative Statement: Traditional healers (e.g., shamans, curanderos, espiritistas) have an important place in minority communities.

b. Effective psychological intervention may be aided by consultation with and/or inclusion of religious/spiritual leaders/practitioners relevant to the client's cultural and beliefsystems.

6. Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral.

a. Problems may arise when the linguistic skills of the psychologist do not match the language of the client. In such a case, psychologists refer the client to a mental health professional who is competent to interact in the language of the client. If this is not possible, psychologists offer the client a translator with cultural knowledge and an appropriate professional background. When no translator is available, then a trained paraprofessional from the client's culture is used as a translator/culturebroker.

b. If translation is necessary, psychologists do not retain the services of translators/paraprofessionals that may have a dual role with the client to avoid jeopardizing the validity of evaluation or the effectiveness of intervention.

c. Psychologists interpret and relate test data in terms understandable and relevant to the needs of those assessed.

7. Psychologists consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions.

a. Types of intervention strategies to be used match to the client's level of need (e.g., Maslow's hierarchy of needs).
Illustrative Statement: Low income may be associated with such stressors as malnutrition, substandard housing, and poor medical care; and rural residency may mean inaccessibility of services. Clients may resist treatment at government agencies because of previous experience (e.g., refugees' status may be associated with violent treatments by government officials and agencies).

b. Psychologists work within the cultural setting to improve the welfare of all persons concerned, if there is a conflict between cultural values and human rights.

8. Psychologists attend to as well as work to eliminate biases, prejudices, and discriminatory practices.

a. Psychologists acknowledge relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population beingserved.
Illustrated Statement: Depression may be associated with frustrated attempts to climb the corporate ladder in an organization that is dominated by a top echelon of White males.

b. Psychologists are cognizant of sociopolitical contexts in conducting evaluations and providing interventions; they develop sensitivity to issues of oppression, sexism, elitism, and racism.
Illustrative Statement: An upsurge in the public expression of rancor or even violence between two ethnic or cultural groups may increase anxiety baselines in any member of these groups. This baseline of anxiety would interact with prevailing symptomatology. At the organizational level, the community conflict may interfere with open communication among staff.

9. Psychologists working with culturally diverse populations should document culturally and sociopolitically relevant factors in the records.

a. number of generations in the country
b. number of years in the country
c. fluency in English
d. extent of family support (or disintegration of family)
e. community resources
f. level of education
g. change in social status as a result of coming to this country (for immigrant or refugee)
h. intimate relationship with people of differentbackgrounds
i. level of stress related to acculturation

References

Acosta, F. X., & Sheehan, J. G. (1976). Preference towards Mexican American and Anglo American psychotherapists. *Journal of Consulting and Clinical Psychology*, 44(2), 272-279.

Acosta, F., Yamamoto, J., & Evans, L (1982). *Effective psychotherapy for low income and minority patients*. New York: Plenum Press.

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologists*, 11, 79-92.

Cheung, F. K., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal*, 26, 277-291.

Comas-Diaz, L., & Griffith, E. H. (1988). *Clinical guidelines in cross-cultural mental health*. John Wiley.

Dauphinais, P., Dauphinais, L., & Rowe, W. (1981). Effects of race and communication style on Indian perceptions of counselor effectiveness. *Counselor Education and Supervision*, 20, 37-46.

Everett, F., Proctor, N., & Cartmell, B. (1983). Providing psychological services to American Indian children and families. *Professional Psychology: Research and Practice*, 14(5), 588-603.

Juarez, R. (1985). Core issues in psychotherapy with the Hispanic child. *Psychotherapy*, 22(25), 441-448.

Lorion, R. P. (1974). Patient and therapist variables in the treatment of low income patients. *Psychological Bulletin*, 81, 344-354.

Malgady, R. G., Rogler, L. H., & Constantino, G. (1987). Ethnocultural and linguistic bias in mental health evaluation of Hispanics. *American Psychologist*, 42(3), 228-234.

McGoldrick, M., Pearce, J. K., & Giordano, J. (1982). *Ethnicity and family therapy*. New York: Guilford Press.

Nishio, K., & Bilmes, M. (1987). Psychotherapy with Southeast Asian American clients. *Professional Psychology: Research and Practice*, 18(4), 342-346.

Padilla, A. M., & Ruiz, R. A. (1973). *Latino mental health: A review of literature* (DHEW publication No. HSM 73-9143). Washington, DC: U.S. Government Printing Office.

Padilla, A. M., Ruiz., R. A., & Alvarez, R. (1975). Community mental health for the Spanish-speaking/surnamed population. *American Psychologist*, 30, 892-905.

Parham, T. A., & Helms, J. E. (1981). The influence of Black students racial identity attitudes on preferences for counselor's race. *Journal of Counseling Psychology*, 28, 250-257.

Root, Maria P. P. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy*, 22(2s), 349-356.

Rosado, J. W. (1986). Toward an interfacing of Hispanic cultural variables with school psychology service delivery systems. *Professional Psychology: Research and Practice*, 17(3), 191-199.

Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, 45, 347-355.

Sue, D., & Sue, S. (1987). Cultural factors in the clinical assessment of Asian American. *Journal of Consulting and Clinical Psychology*, 55(4), 479-487.

Zuniga, M. E. (1988). Assessment issues with Chicanas: practical implications. *Psychotherapy*, 25(2), 288-293.

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Find this article at:
http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx

For an updated version (2017), please refer to http://www.apa.org/about/policy/multicultural-guidelines.pdf for the 212-page guidelines.

Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists

American Psychological Association

Approved as APA policy by the APA Council of Representatives, August 2002

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Author Note: This document was approved as policy of the American Psychological Association (APA) by the APA Council of Representatives in August, 2002. This document was drafted by a joint Task Force of APA Divisions 17 (Counseling Psychology) and 45 (The Society for the Psychological Study of Ethnic Minority Issues). These guidelines have been in the process of development for 22 years, so many individuals and groups require acknowledgement. The Divisions 17/45 writing team for the present document included Nadya Fouad, PhD, Co- Chair, Patricia Arredondo, EdD, Co-Chair, Michael D'Andrea, EdD and Allen Ivey, EdD. These guidelines build on work related to multicultural counseling competencies by Division 17 (Sue et al., 1982) and the Association of Multicultural Counseling and Development (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992). The Task Force acknowledges Allen Ivey, EdD, Thomas Parham, PhD, and Derald Wing Sue, PhD for their leadership related to the work on competencies. The Divisions 17/45 writing team for these guidelines was assisted in reviewing the relevant literature by Rod Goodyear, PhD, Jeffrey S. Mio, PhD, Ruperto (Toti) Perez, PhD, William Parham, PhD, and Derald Wing Sue, PhD. Additional writing contributions came from Gail Hackett, PhD, Jeanne Manese, PhD, Louise Douce, PhD, James Croteau, PhD, Janet Helms, PhD, Sally Horwatt, PhD, Kathleen Boggs, PhD, Gerald Stone, PhD, and Kathleen Bieschke, PhD. Editorial contributions were provided by Nancy Downing Hansen, PhD, Patricia Perez, Tiffany Rice, and Dan Rosen. The Task Force is grateful for the active support and contributions of a series of presidents of APA Divisions 17, 35, and 45, including Rosie Bingham, PhD, Jean Carter, PhD, Lisa Porche Burke, PhD, Gerald Stone, PhD, Joseph Trimble, PhD, Melba Vasquez, PhD, and Jan Yoder, PhD. Other individuals who contributed through their advocacy include Guillermo Bernal, PhD, Robert Carter, PhD, J. Manuel Casas, PhD, Don Pope-Davis, PhD, Linda Forrest, PhD, Margaret Jensen, PhD, Teresa LaFromboise, PhD, Joseph G. Ponterotto, PhD, and Ena Vazquez Nuttall, EdD.

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Preface

All individuals exist in social, political, historical, and economic contexts, and psychologists are increasingly called upon to understand the influence of these contexts on individuals' behavior. The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists reflect the continuing evolution of the study of psychology, changes in society-at-large, and emerging data about the different needs for particular individuals and groups historically marginalized or disenfranchised within and by psychology based on their ethnic/racial heritage and social group identity or membership. These Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change reflect knowledge and skills needed for the profession in the midst of dramatic historic sociopolitical changes in U.S. society, as well as needs from new constituencies, markets, and clients.

The specific goals of these Guidelines are to provide psychologists with: (a) the rationale and needs for addressing multiculturalism and diversity in education, training, research, practice, and organizational change; (b) basic information, relevant terminology, current empirical research from psychology and related disciplines, and other data that support the proposed guidelines and underscore their importance; (c) references to enhance on-going education, training, research, practice, and organizational change methodologies; and (d) paradigms that broaden the purview of psychology as a profession.

In these Guidelines, education refers to the psychological education of students in all areas of psychology, while training refers more specifically to the application of that education to the development of applied and research skills. We refer to research that involves human participants, rather than research using animals or mathematical simulations. Practice refers to interventions with children, adolescents, adults, families, and organizations, typically conducted by clinical, consulting, counseling, organizational, and school psychologists. Finally, we focus on the work of psychologists as administrators, consultants, and in other organizational management roles positioned to promote organizational change and policy development.[1]

These Guidelines address U.S. ethnic and racial minority groups as well as individuals, children, and families from biracial, multiethnic, and multiracial backgrounds. Thus, we are defining "multicultural" in these Guidelines narrowly, to refer to interactions between individuals from minority ethnic and racial groups in the United States and the dominant European-American culture. Ethnic and racial minority group membership includes individuals of Asian and Pacific Islander, Sub-Saharan Black African, Latino/Hispanic, and Native American/American Indian descent, although there is great heterogeneity within each of these groups. The Guidelines also address psychologists' work and interactions with individuals from other nations, including international students and immigrants and temporary workers in this country.

The term "guidelines" refers to pronouncements, statements or declarations that suggest or recommend specific professional behavior, endeavors or conduct for psychologists (APA, 1992). Guidelines differ from standards in that standards are mandatory and may be

accompanied by an enforcement mechanism (APA, 2001). They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists. In addition, federal or state laws may supersede these Guidelines.

Scope of Guidelines

This document is comprehensive but not exhaustive. We intend to reflect the context and rationale for these Guidelines in multiple settings and situations, but also acknowledge that we expect the document to evolve over time with more illustrative examples and references. In the current document we will initially provide evidence for the need for multicultural guidelines with an overview of the most recent demographic data on racial/ethnic diversity in the United States, and the representation of racial/ethnic minorities in education and psychology. We then discuss the social and political developments in the United States and the profession of psychology that provide a context for the development of the Guidelines, and the fundamental principles on which we base the Guidelines. Each Guideline is then presented, with the first two Guidelines designed to apply to all psychologists from two primary perspectives: (a) knowledge of self with a cultural heritage and varying social identities; and (b) knowledge of other cultures. Guidelines # 3-6 address the application of multiculturalism in education, training, research, practice, and organizational change.

While these Guidelines have attempted to incorporate empirical studies of intergroup relations and ethnic identity, professional consensus, and other perceptions and experiences of ethnic and racial minority groups, it is beyond the scope of this document to provide a thorough and comprehensive review of all literature related to race, ethnicity, intergroup processes, and organizational development strategies to address multiculturalism in employment and professional education contexts. Rather, we have attempted to provide examples of empirical and conceptual literature relevant to the Guidelines where possible.

Racial/Ethnic Diversity in the United States and Psychology

Individuals of ethnic and racial minority and/or with a biracial/multiethnic/multiracial heritage represent an increasingly large percentage of the population in the United States (Judy & D'Amico, 1997; United States Census Bureau, 2001; Wehrly, Kenney, & Kenney, 1999). While these demographic trends have been discussed since the previous census of 1990, educational institutions, employers, government agencies, and professional and accrediting bodies are now beginning to engage in systematic efforts to become more knowledgeable, proficient, and multiculturally responsive. Census 2000 data clarify the changes in U.S. diversity (U.S. Census Bureau, 2001). Overall, about 67% of the population identify as White. Of the remaining 33%, approximately 13% indicated they were African American, 1.5% American Indian or Alaskan Native, 4.5% Asian/Pacific Islander, 13% Hispanic, and about 7% indicated some other race. These categories overlap, since individuals were able to choose more than one racial affiliation. Racial/ethnic diversity varies greatly by state. Summarized in a series of maps by Brewer and

Suchan from the Census 2000 data (2001), high diversity states (those with 60-77% racial/ethnic minority groups) tend to be on the coast, or Mexican border and include California, Texas, Arizona, New Mexico, and Virginia. In addition to these, however, medium-high diversity (49%- 59% racial/ethnic minority groups) states are found across the country, and include Maryland, New York, Illinois, Washington State, Nevada, Colorado, Montana, Alaska, North Dakota, South Dakota, Minnesota, Wisconsin, Michigan, Arkansas, Louisiana, Alabama, and North and South Carolina.

In the past 10 years, percentage-wise, the greatest increases are reported for Asian American/Pacific Islanders and Latinos/Hispanics, and in some parts of the country, White European Americans are no longer a clear majority of the population. Brewer and Suchan (2001) found that diversity increased in all states in the country, and in parts of some states increased as much as 34%. States that had the most growth in diversity varied geographically, including the Midwest (Nebraska, Iowa, Kansas, Eastern Colorado), South (Georgia, Florida, Texas, and Oklahoma), and Northwest (Idaho, Oregon). In addition, for the first time, Census 2000 allowed individuals to check more than one racial/ethnic affiliation (U.S. Census Bureau, 2001). While only 2.4% of the U.S. populations checked more than one racial affiliation, 42% of those who checked two or more races were under 18, indicating an increase in the birthrate of biracial individuals. Certainly, the United States is becoming more racially and ethnically diverse, increasing the urgency for culturally responsive practices and services.

Ethnic, racial, and multiracial diversity in the population is reflected in higher education. This is important to psychologists because it reflects changes in the ethnic composition of students we teach and train. College enrollment increased 62% for students of color between 1988 and 1998 (the latest data available), although college completion rates differed among Whites and racial/ethnic minority students. College completion rates in 2000 (U.S. Census Bureau, 2001) for White individuals between 25–29 years was 29.6%, compared to 17.8% for African Americans, 53.9% for Asian/Pacific Islander Americans, and 9.7% for Hispanics. Corresponding statistics in 1991 vs. 1974, were 24.6% vs. 22% for Whites, 11% vs. 7.9% for African Americans/Blacks, and 9.2% vs. 5.7% for Hispanics. Data for Hispanics were first collected in 1974; data for Asian/Pacific Islanders were not collected until the mid-90's. Clearly these data indicate that racial/ethnic minority students are graduating at a lower rate than White students, but the data also show that they are making educational gains.

Completion of a psychology degree is particularly germane to these Guidelines, since obtaining a college degree is the first step in the pipeline to becoming a psychologist. The National Center on Educational Statistics collects information on degrees conferred by area, reported by race/ethnicity. Their latest report (NCES, 2001) indicates that 74,060 bachelor's degrees were awarded in psychology last year, 14,465 master's degrees were awarded in psychology, and 4310 doctoral degrees were awarded in psychology. Of those degrees, the majority was awarded to Whites (72% of Bachelor's and master's degrees and 77% of doctoral degrees). African Americans received 10% of both bachelor's and master's degrees and 5% of doctoral degrees, Hispanics received 10% of bachelor's degrees and 5% of both master's and doctoral degrees, Asian/Pacific Islanders received 6% of bachelor's degrees, 3% of master's, and 4% of doctoral degrees in psychology. American Indians received less than 1% of all the degrees in psychology. Compared to the percent of the population for each of these minority groups,

noted above, racial/ethnic minority students are underrepresented at all levels of psychology, but most particularly at the doctoral level, the primary entry point to be a psychologist.

Thus, racial/ethnic minority students, either because of personal or because of environmental reasons (e.g., discrimination and barriers due to external constraints), progressively drop out of the pipeline to become psychologists. The racial representation within the profession of psychology is similarly small. Kite et al., (2001) reported that the numbers of ethnic minority psychologists were too small to break down by ethnicity. Indeed, in 2002, APA membership data indicated that 0.3% of the membership is American Indian, 1.7% is Asian, 2.1% is Hispanic, and 1.7% African American (APA Research Office, 2002a), clearly delineating the serious under representation of Psychologists of Color within the organization. Representation is slightly better within APA governance in 2002–1.7% of those in APA governance are American Indian, 3.6% are Asian, 5.1% are Black, and 4.8% are Hispanic (APA Research Office 2002b).

These Guidelines are based on the central premise that the population of the United States is racially/ethnically diverse, and that students, research participants, clients and the workforce will be increasingly likely to come from racially/ethnically diverse cultures. Moreover, educators, trainers of psychologists, psychological researchers, providers of service, and those psychologists implementing organizational change are encouraged to gain skills to work effectively with individuals and groups of varying cultural backgrounds. We base our premise on psychologists' ethical principles to be competent to work with a variety of populations (Principle A), to respect others' rights (Principle D), to be concerned to not harm others (Principle E), and to contribute to social justice (Principle F; APA, 1992). We believe these Guidelines will assist psychologists in seeking and using appropriate culturally centered education, training, research, practice and organizational change.

Also informing these Guidelines is research, professional consensus, and literature addressing perceptions of ethnic minority groups and intergroup relationships (Dovidio & Gaertner, 1998; Dovidio, Gaertner, & Validzic, 1998; Gaertner & Dovodio, 2000), experiences of ethnic and racial minority groups (Sue, 1999; Swim & Stagnor, 1998; USHHS, 2000, 2001), multidisciplinary theoretical models about worldviews and identity (Arredondo & Glauner, 1992; Helms, 1990; Hofstede, 1980; Kluckhohn & Strodbeck, 1961; Markus & Kitayama, 2001; Sue & Sue, 1977); and the work on cross cultural and multicultural guidelines and competencies developed over the past 20 years (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). Although the authors acknowledge that the issues addressed in these Guidelines are increasingly important to consider in a global context, the Guidelines focus on the context within the United States and its commonwealths or territories such as Puerto Rico and Guam.

Definitions

There is considerable controversy and overlap in terms used to connote race, culture, and ethnicity (Helms & Talleyrand, 1997; Phinney, 1996). In this section we define the following terms that will be used throughout these Guidelines.

Culture. "Culture" is defined as the 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; Fiske, Kitayama, Markus, & Nisbett, 1998). Inherent in this definition is the acknowledgement that all individuals are cultural beings and have a cultural, ethnic, and racial heritage. 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. These definitions suggest that culture is fluid and dynamic, and that there are both cultural universal phenomena as well as culturally specific or relative constructs.

Race. The biological basis of race has, at times, been the source of fairly heated debates in psychology (Fish, 1995; Helms & Talleyrand, 1997; Jensen, 1995; Levin, 1995; Phinney, 1996; Rushton, 1995; Sun, 1995; Yee, Fairchild, Weizmann, & Wyatt, 1993). Helms and Cook (1999) note that "race" has no consensual definition, and that, in fact, biological racial categories and phenotypic characteristics have more within group variation than between group variation. In these Guidelines, the definition of race is considered to be socially constructed, rather than biologically determined. Race, then, is the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result. Thus, "people are treated or studied as though they belong to biologically defined racial groups on the basis of such characteristics" (Helms & Talleyrand, 1997).

Ethnicity. Similar to the concepts of race and culture, the term "ethnicity" does not have a commonly agreed upon definition; in these Guidelines we will refer to ethnicity as the acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging. We also note that, consistent with Brewer (1999), Sedikides and Brewer (2001), and Hornsey and Hogg (2000), individuals may have multiple ethnic identities that operate with different salience at different times.

Multiculturalism and Diversity. The terms "multiculturalism" and "diversity" have been used interchangeably to include aspects of identity stemming from gender, sexual orientation, disability, socioeconomic status, or age. Multiculturalism, in an absolute sense, recognizes the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions. All of these are critical aspects of an individual's ethnic/racial and personal identity, and psychologists are encouraged to be cognizant of issues related to all of these dimensions of culture. In addition, each cultural dimension has unique issues and concerns. As noted by the Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000), each individual belongs to/identifies with a number of identities and some of those identities interact with each other. To effectively help clients, to effectively train students, to be most effective as agents of change and as scientists, psychologists are encouraged to be familiar with issues of these multiple identities within and between individuals. However, as we noted earlier, 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.

The concept of diversity has been widely used in employment settings, with the term given greater visibility through research by the Hudson Institute reported in *Workforce 2000* (Johnson & Packer, 1987) and *Workforce 2020* (Judy & D'Amico, 1997). The application of the term began with reference to women and Persons of Color, underrepresented in the workplace,

particularly in decision-making roles. It has since evolved to be more encompassing in its intent and application by referring to individuals' social identities including age, sexual orientation, physical disability, socioeconomic status, race/ethnicity, workplace role/position, religious and spiritual orientation, and work/family concerns (Loden, 1996).

Culture-centered. We use the term "culture-centered" throughout the Guidelines to encourage psychologists to use a "cultural lens" as a central focus of professional behavior. In culture-centered practices, psychologists recognize that all individuals including themselves are influenced by different contexts, including the historical, ecological, sociopolitical, and disciplinary. "If culture is part of the environment, and all behavior is shaped by culture, then culture-centered counseling is responsive to all culturally learned patterns" (Pedersen, 1997, p. 256). For example, a culture-centered focus suggests to the psychologist the consideration that behavior may be shaped by culture, the groups to which one belongs, and cultural stereotypes including those about stigmatized group members (Gaertner & Dovidio, 2000; Major, Quinton, & McCoy, in press; Markus & Kitayama, 1991; Steele, 1997).

Historical and Sociopolitical Developments for Guidelines

There are a number of national events, APA-specific developments, and initiatives of other related professional associations that provide an historical context for the development of multicultural and culture-specific guidelines, with a focus on racial/ethnic minority groups. Nationally, in 1954, the Supreme Court struck down the "separate but equal" doctrine of segregated education. Benjamin and Crouse (2002) note that in addition to setting the stage for greater social equity in education, *Brown vs Board of Education* was an important turning point for psychology, because it was the "first time that psychological research was cited in a Supreme Court decision" (p. 38). A decade later, the 1964 passage of the Civil Rights Act set the stage for sociopolitical movements and the development of additional legislation to protect individual and group rights at national, state, and local levels. These movements and resulting legislation have specifically addressed the rights of equity and access based on gender, age, disability, national origin, religion, sexual orientation, and of course, ethnicity and race. However, it is also important to note that movements to dismantle Affirmative Action in California, Michigan, and Texas, are sociopolitical efforts that threaten the advancement of the rights of individuals and groups historically marginalized.

National issues regarding healthcare and mental health disparities for ethnic/racial minority groups culminated in psychologists playing a role in President Clinton's dialogue in the mid 1990's about race and racism, and in the U.S. Surgeon General's Reports in 2000 and 2001. The national debates also led to noteworthy organizational structural changes. For example the National Institute of Mental Health established an office in Minority Research in 1971, and reorganized to incorporate ethnic minority focused research in all areas in 1985, including justifications for diversity of research populations. Findings from this funded research have been instrumental in setting policies specific to racial/ethnic minority groups.

Psychologists' perspective of the role of race in education has been addressed for nearly a century (a historical perspective is provided by Suzuki & Valencia, 1997). Indeed the construct of race, culture, and intergroup relationships have been areas of research for psychologists since

nearly the beginning of psychology, including Clark & Clark (1940), Allport (1954), and Lewin (1945) (see Duckitt, 1992, for a historical review).

Within the profession of psychology, attention to culture as a variable in clinical practice was first mentioned at the Vail Conference of 1973 (Korman, 1974). One of the recommendations from this conference was to include training in cultural diversity in all doctoral programs and through continuing education workshops. Attention to appropriate training based on multicultural and culture-specific constructs and contexts continued through the next two decades. The APA Committee on Accreditation's "Accreditation Domains and Standards" included cultural diversity as a component of effective training in 1986 and continuing to the 2002 guidelines (APA, 2002). These efforts recognize the importance of cultural and individual differences and diversity in the training of clinical, counseling, and school psychologists. Subsequently, the training councils of these disciplines began to incorporate cultural diversity into their model programs, including the Council of Counseling Psychology's model training program in counseling psychology (Murdock, Alcorn, Heesacker, & Stoltenberg, 1998), and Standards of the National Council of Schools and Programs of Professional Psychology (Peng & Nisbett, 1999). Concomitantly, changes to reflect greater attention to cultural diversity were occurring through structural and functional changes within the APA organization. The Office of Ethnic Minority Affairs (OEMA) was established in 1979. A year later the Board of Ethnic Minority Affairs (BEMA) was established. BEMA was charged with promoting the scientific underpinning of the influence and impact of culture, race, and ethnicity on individuals' behavior, as well as advancing the participation of ethnic minority psychologists within the organization. BEMA established a Task Force on Minority Education and Training in 1981, and a second Task Force on Communication with Minority Constituents was formed in 1984. In 1990, the Board for the Advancement of Psychology in the Public Interest (BAPPI) was formed, as was the Committee on Ethnic Minority Affairs (CEMA). These entities replaced BEMA within APA's governance structure. The Commission on Ethnic Minority Recruitment, Retention, and Training was formed in 1994, and published a report and 5-year plan to increase the number of students in psychology. These multiple efforts of APA and the Divisions began to culminate in the production of policy. The *General Guidelines for Providers of Psychological Services* were "developed with the understanding that psychological services must be planned and implemented so that they are sensitive to factors related to life in a pluralistic society such as age, gender, affectional orientation, culture and ethnicity" (APA, 1987).

In 1990, APA published the *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990). Following this, the 1992 revision of the Ethics code included Principle D: Respect of People's Rights and Dignity, which states in part, "Psychologists are aware of cultural, individual, and role differences, including those related to age, gender, race, ethnicity, national origin, …" (p. 1598). The Ethics code also contains ethical standards related to cultural diversity related to competence (1.08), assessment (2.04), and research (6.07 and 6.11).

The current Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change have developed as a result of the sociopolitical environment within the United States and the resulting work of psychologists within the professional organization. While there have been a variety of organizational initiatives that have focused on race and ethnicity, these Guidelines are the first to address the implications of race and ethnicity in psychological

education, training, research, practice and organizational change. These Guidelines are the latest step in an on-going effort to provide psychologists in the United States with a framework for services to an increasingly diverse population and to assist psychologists in the provision of those services. In effect, there is a societal and guild/organizational history steadily indicating a rationale for attending to a multicultural and culture-specific agenda more formally.

Introduction to the Guidelines: Assumptions and Principles

These Guidelines, as noted earlier, pertain to the role of psychologists of both racial/ethnic minority and non-minority status in education, training, research, practice, and organizations, as well as to students, research participants, and clients of racial/ethnic heritage minority heritage. In psychological education, training, research, and practice, all transactions occur between members of two or more cultures. As identity constructs and dynamic forces, race and ethnicity can impact psychological practice and interventions at all levels. These tenets articulate respect and inclusiveness for the national heritage of all cultural groups, recognition of cultural contexts as defining forces for individuals' and groups' lived experiences, and the role of external forces such as historical, economic, and socio-political events.

This philosophical grounding serves to influence the planning and implementation of culturally and scientifically sound education, research, practice, and organizational change and policy development in the larger society. To have a profession of psychology that is culturally informed in theory and practice calls for psychologists, as primary transmitters of the culture of the profession, to assume the responsibility for contributing to the advancement of cultural knowledge, sensitivity, and understanding. In other words, psychologists are in a position to provide leadership as agents of prosocial change, advocacy, and social justice, thereby promoting societal understanding, affirmation, and appreciation of multiculturalism against the damaging effects of individual, institutional, and societal racism, prejudice, and all forms of oppression based on stereotyping and discrimination.

The Guidelines for Multicultural Education and Training, Research, and Practice in Psychology are founded upon the following principles:

1. Ethical conduct of psychologists is enhanced by knowledge of differences in beliefs and practices that emerge from socialization through racial and ethnic group affiliation and membership and how those beliefs and practices will necessarily affect the education, training, research and practice of psychology (Principles D and F, APA Code of Ethics, 1992; Council of National Associations for the Advancement of Ethnic Minority Issues, 2000).
2. Understanding and recognizing the interface between individuals' socialization experiences based on ethnic and racial heritage can enhance the quality of education, training, practice, and research in the field of psychology (American Council on Education, 2000; American Council on Education and American Association of University Professors, 2000; Biddle, Bank, & Slavings, 1990).
3. Recognition of the ways in which the intersection of racial and ethnic group membership with other dimensions of identity (e.g., gender, age, sexual orientation, disability,

religion/spiritual orientation, educational attainment/experiences, and socioeconomic status) enhances the understanding and treatment of all people (Berberich, 1998; Greene, 2000; Jackson-Triche, Sullivan, Wells, Rogers, Camp, & Mazel, 2000; Wu, 2000).

4. Knowledge of historically derived approaches that have viewed cultural differences as deficits and have not valued certain social identities helps psychologists to understand the under representation of ethnic minorities in the profession, and affirms and values the role of ethnicity and race in developing personal identity (Coll, Akerman, & Cicchetti, 2000; Medved, Morrison, Dearing, Larson, Cline, & Brummans, 2001; Mosely-Howard & Burgan Evans, 2000; Sue, 1999; Witte & Morrison, 1995).
5. Psychologists are uniquely able to promote racial equity and social justice. This is aided by their awareness of their impact on others and the influence of their personal and professional roles in society (Comas-Díaz, 2000).
6. Psychologists' knowledge about the roles of organizations, including employers and professional psychological associations are potential sources of behavioral practices that encourage discourse, education and training, institutional change, and research and policy development, that reflect rather than neglect, cultural differences. Psychologists recognize that organizations can be gatekeepers or agents of the status quo rather than leaders in a changing society with respect to multiculturalism.

Commitment to Cultural Awareness and Knowledge of Self and Others

Guideline #1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Psychologists, like all people, are shaped and influenced by many factors. These include, but are not limited to, their cultural heritage(s), various dimensions of identity including ethnic and racial identity development, gender socialization, and socioeconomic experiences, and other dimensions of identity that predispose individual psychologists to certain biases and assumptions about themselves and others. Psychologists approach interpersonal interactions with a set of attitudes, or worldview, that helps shape their perceptions of others. This worldview is shaped in part by their cultural experiences. Indeed, cross-cultural and multicultural literature consistently indicates that all people are "multicultural beings," that all interactions are cross-cultural, and that all of our life experiences are perceived and shaped from within our own cultural perspectives (Arredondo et al., 1996; Brewer & Brown, 1998; Fiske et al., 1998; Fouad & Brown, 2000; Markus & Kitayama, 1991; Pedersen, 2000; Sue et al., 1992; Sue et al., 1982; Sue, Ivey, & Pedersen, 1996).

Psychologists are encouraged to learn how cultures differ in basic premises that shape worldview. For example, it may be important to understand that a cultural facet of mainstream culture in the United States is a preference for individuals who are independent, focused on achieving and success, who have determined (and are in control of) their own personal goals, and who value rational decision-making (Fiske et al., 1998; Markus & Kitayama, 1991; Oyserman, Coon, & Kemmelmeir, 2002). By contrast, individuals with origins in cultures of East Asia may prefer interdependence with others, orientation towards harmony with others, conforming to

social norms, and subordination of personal goals and objectives to the will of the group (Fiske et al., 1998). A preference for an independent orientation may shape attitudes towards those with preferences for same, or other orientations. This preference is a concern when a different orientation is unconsciously and automatically judged negatively (Greenwald & Banaji, 1995). The perceiver in an interaction integrates not only the content of the interaction, but also information about the target person, including personality traits, physical appearance, age, sex, ascribed race, ability/disability, among other characteristics (Kunda & Thagard, 1996). All of these perceptions are shaped by the perceiver's worldview, and organized in some coherent whole to make sense of the other person's behavior. The psychological process that helps to organize the often-overwhelming amount of information in perceiving others is to place people in categories, thereby reducing the information into manageable chunks of information that go together (Fiske, 1998). This normal process leads to associating various traits and behaviors with particular groups (e.g., all athletes are more brawn than brain, all women like to shop) even if they are inaccurate for particular, many, or even most individuals.

The most often used theoretical framework for understanding approaches that emphasize attention to categories has been social categorization theory, originally conceptualized by Allport (1954). In this framework, people make sense of their social world by creating categories of the individuals around them, which includes separating the categories into in-groups and out-groups (Brewer & Brown, 1998; Fiske, 1998; Hornsey & Hogg, 2000; Tajfel & Turner, 1986; Turner, Brown & Tajfel, 1979). Categorization has a number of uses, including speed of processing and efficiency in use of cognitive resources, in part because it appears to happen fairly automatically (Fiske, 1998).

Relevant to these Guidelines are factors that influence categorization and its effect on attitudes towards individuals who are racially or ethnically different from self. These include a tendency to exaggerate differences between groups and similarities within one group and a tendency to favor one's in-group over the out-group; this, too, is done outside conscious processing (Fiske, 1998). In-groups are more highly valued, more trusted, and engender greater cooperation as opposed to competition (Brewer & Brown, 1998; Hewstone, Rubin, & Willis, 2002), and those with strongest in-group affiliation also show the most prejudice (Swim & Mallett, 2002). This becomes problematic when one group holds much more power than the other group or when resources among in-groups are not distributed equitably, as is currently the case in the United States.

Thus, it is quite common to have automatic biases and stereotypic attitudes about people in the out-group, and for most psychologists, individuals in racial/ethnic minority groups are in an out-group. The stereotype, or the traits associated with the category become the predominant aspect of the category, even when disconfirming information is provided (Kunda & Thagard, 1996) and particularly when there is some motivation to confirm the stereotype (Kunda & Sinclair, 1999). These can influence interpretations of behavior and influence people's judgments about that behavior (Fiske, 1998; Kunda & Thagard, 1996). Automatic biases and attitudes may also lead to miscommunication, since normative behavior in one context may not necessarily be understood or valued in another. For example, addressing peers, clients, students, or research participants by their first name may be acceptable for some individuals, but may be considered a sign of disrespect for many racial/ethnic minority individuals who are accustomed to more formal interpersonal relations with individuals in an authority role.

Although the associations between particular stereotypic attitudes and resulting behaviors have not been consistently found, group categorization has been illustrated to influence intergroup behavior including behavioral confirmation (Stukas & Snyder, 2002), in-group favoritism (Hewstone et al., 2002), and subtle forms of behaviors (Crosby, Bromely, & Saxe, 1980). Psychologists are urged to become more aware and sensitive to their own attitudes towards others as these attitudes may be more biased and culturally limiting then they think. It is sobering to note that, even those who consciously hold egalitarian beliefs, have shown unconscious endorsement of negative attitudes toward and stereotypes about groups (Greenwald & Banaji, 1995). Thus, psychologists who describe themselves as holding egalitarian values and/or as professionals who promote social justice may also unconsciously hold negative attitudes or stereotypes.

Given these findings, many have advocated that improvements in intergroup relationships would occur if there was a de-emphasis on group membership. One way that this has been done is that those who have desired to improve intergroup relationships have taken a "color-blind" approach to interactions with individuals who are racially or ethnically different from them. In this approach, racial or ethnic differences are minimized, and emphasis is on the universal or "human" aspects of behavior. This has been the traditional focus in the United States on assimilation, with its melting pot metaphor, that this is a nation of immigrants that together make one whole, without a focus on any one individual cultural group. Proponents of this approach suggest that alternative approaches that attend to differences can result in inequity by promoting, for instance, categorical thinking including preferences for in-groups and use of stereotypes when perceiving out groups. In contrast, opponents to the color-blind approach have noted the differential power among racial/ethnic groups in the United States, and have noted that ignoring group differences can lead to the maintenance of the status quo and assumptions that racial/ethnic minority groups share the same perspective as dominant group members (Schofield, 1986; Sidanius & Pratto, 1999; Wolsko, Park, Judd, & Wittenbrink, 2000).

While the color-blind approach is based in an attempt to reduce inequities, social psychologists have provided evidence that a color-blind approach does not, in fact, lead to equitable treatment across groups. Brewer and Brown (1998), in their review of the literature, note "…ignoring group differences often means that, by default, existing intergroup inequalities are perpetuated" (p. 583). For example, Schofield (1986) found that disregarding cultural differences in a school led to reestablishing segregation by ethnicity. Color-blind policies have also been documented as playing a role in differential employment practices (Brewer & Brown). In these cases, the color-blind approach may have the effect of maintaining a status quo in which Whites have more power than do People of Color. There is also some evidence that a colorblind approach is less accurate than a multicultural approach. Wolsko et al., (2000) for example, found that when White students were instructed to adopt a color-blind or multicultural approach, those with a multicultural approach had stronger stereotypes of other ethnic groups as well as more positive regard for other groups. White students in a multicultural approach also had more accurate perceptions of differences due to race/ethnicity and used category information about both ethnicity and individual characteristics more than those in the color-blind condition. Wolsko et al. concluded, "When operating under a colorblind set of assumptions, social categories are viewed as negative information to be avoided, or suppressed. … In contrast, when operating under a multicultural set of assumptions, social categories are viewed as simply a consequence of

cultural diversity. Failing to recognize and appreciate group similarities and differences is considered to inhibit more harmonious interactions between people from different backgrounds." (p. 649)

Consistent with the multicultural approach used by Wolsko et al. (2000), culture-centered training and interventions acknowledge cultural differences and that worldviews differ among cultures, as do experiences of being stigmatized (Crocker, Major, & Steele, 1998). This perspective is discussed more fully in Guideline #2. However, knowing all there is to know about a person's ethnic and racial background is not sufficient to be effective unless psychologists are cognizant of their positions as individuals with a worldview and that this worldview is brought to bear on interactions they have with others. As noted earlier, the worldview of the client, student, or research participant, and psychologist maybe quite different, leading to communication problems or premature relationship termination. This does not argue that psychologists should shape their world view to be consistent with clients and students, but rather that they are able to be aware of their own worldview to be able to understand others' frame of cultural reference (Ibrahim, 1999; Sodowsky & Kuo, 2001; Triandis & Singelis, 1998).

The literature on social categorization places all human interaction within a cultural context, and encourages an understanding of the various factors that influence our perceptions of others. These premises suggest that the psychologist is a part of the multicultural equation; therefore, on-going development of one's personal and cross-cultural awareness, knowledge, and skills is recommended. Fiske (1998) notes that automatic biases can be controlled with motivation, information, and appropriate mood. Given the above research, psychologists are encouraged to explore their worldview – beliefs, values, and attitudes – from a personal and professional perspective. They are encouraged to examine their potential preferences for within group similarity, and realize that, once impressions are formed, these impressions are often resistant to disconfirmation (Gilbert, 1998). Moreover, psychologists are encouraged to understand their own assumptions about ways to improve multicultural interactions and the potential issues associated with different approaches. Psychologists' self-awareness and appreciation of cultural, ethnic, and racial heritage may serve as a bridge in cross-cultural interactions, not necessarily highlighting but certainly not minimizing these factors as they attempt to build understanding (Arredondo et al., 1996; Hofstede, 1980; Ibrahim, 1985; Jones, Lynch, Tenglund, & Gaertner, 2000; Locke, 1992; Sue, 1978**;** Sue & Sue, D., 1999; Triandis & Singelis, 1998).

The research on reducing stereotypic attitudes and biases suggest a number of strategies (Hewstone et al., 2002) that psychologists may use. The first and most critical is awareness of those attitudes and values (Devine, Plant, & Buswell, 2000; Gaertner & Dovidio, 2000). The second and third strategies are effort and practice in changing the automatically favorable perceptions of in-group and negative perceptions of out-group. How this change occurs has been the subject of many years of empirical effort, with varying degrees of support (Hewstone et al., 2002). It appears, though, that increased contact with other groups (Pettigrew, 1998) is helpful, particularly if in this contact, the individuals are of equal status and the psychologist is able to take the other's perspective (Galinsky & Moskowitz, 2000) and has empathy for him/her (Finlay & Stephan, 2000). Some strategies to do this have included actively seeing individuals as individuals, rather than as members of a group, in effect decategorizing (Brewer & Miller, 1988). Another strategy is to change the perception of "us vs. them" to "we," or recategorizing the out-

group as members of the in-group (Gaertner & Dovidio, 2000). Both of these models have been shown to be effective, particularly under low-prejudice conditions and when the focus is on interpersonal communication (Brewer & Brown, 1998; Hewstone et al., 2002). In addition, psychologists may want to actively increase their tolerance (Greenberg, Solomon, Pyszczynski, Rosenblatt, & et al. 1992) and trust of racial/ethnic groups (Kramer, 1999).

Thus, psychologists are encouraged to be aware of their attitudes and work to increase their contact with members of other racial/ethnic groups, building trust in others and increasing their tolerance for others. Since covert attempts to suppress automatic associations can backfire, with attempts at suppression resulting in increased use of stereotypes (Macrae & Bodenhausen, 2000), psychologists are urged to become overtly aware of their attitudes towards others. It has been shown, though, that repeated attempts at suppression have been found to lead to improvements in automatic biases (Plant & Devine, 1998). Such findings suggest that psychologists' efforts to change their attitudes and biases help to prevent those attitudes from detrimentally affecting their relationships with students, research subjects and clients who are racially/ethnically different from them.

Guideline #2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.

As noted in Guideline #1, membership in one group helps to shape perceptions of not only one's own group, but also other groups. The link between those perceptions and attitudes are loyalty to and valuing of one's own group, and devaluing the other group. The Minority Identity Development model (Atkinson, Morten, & Sue, 1998) is one such example applying to ethnic/racial minority individuals but also to others who have experienced historical oppression and marginalization. The devaluing of the other group occurs in a variety of ways, including the "ultimate attributional error" (Pettigrew, 1979), the tendency to attribute positive behaviors to internal traits within one's own group, but negative behaviors to the internal traits of the out group (although Gilbert, 1998, suggests that the ultimate attribute error may be culturally specific to individually oriented cultures, such as the United States). In the United States, then, the result may be positive, such as ensuring greater cooperation within one's group, or negative, such development of prejudice and stereotyping of other groups. Decades of research and multiple theories have been developed to reduce prejudice of other groups, most developing around the central premise that greater knowledge of, and contact with, the other groups will result in greater intercultural communication and less prejudice and stereotyping (Brewer & Miller, 1998; Gaertner & Dovidio, 2000). Brewer and Miller delineate the factors that have been found to be successful in facilitating prejudice reduction through contact among groups: social and institutional support, sufficient frequency and duration for relationships to occur, equal status among participants, and cooperation. It appears, as discussed in Guideline #1, that attention to out-group stereotyping reduces prejudice (Reynolds & Oakes, 2000), as does overt training to reduce stereotyping (Kawakami, Dovidio, Moll, Hermsen, & Russin, 2000).

It is within this framework that psychologists are urged to gain a better understanding and appreciation of the worldview and perspectives of those racially and ethnically different from themselves. Psychologists are also encouraged to understand the stigmatizing aspects of being a

member of a culturally devalued "other group." (Crocker et al., 1998; Major et al., in press). This includes experience, sometimes daily, with overt experiences of prejudice and discrimination, awareness of the negative value of one's own group in the cultural hierarchy, the threat of one's behavior being found consistent with a racial/ethnic stereotype (stereotype threat), and the uncertainty (e.g., due to prejudice or individual behavior) of the attribution of the stigmatizing comments and outcomes.

Understanding a client's or student's or research participant's worldview, including the effect of being in a stigmatized group, helps to understand his/her perspectives and behaviors. Racial and ethnic heritage, worldview, and life experiences as a result of this identity may affect such factors as the ways students present themselves in class, their learning style, their willingness to seek, and trust the advice and consultation from faculty, their ability and interest in working with others on class projects (Neville & Mobley, 2001). In the clinical realm, worldview and life experiences may affect how clients present symptoms to therapists, the meaning that illness has in their lives, motivation and willingness to seek treatment, social support networks, and perseverance in treatment (Anderson, 1995; USDHSS, 2000, 2001). People of Color are underrepresented in mental health services, in large part, because they are less likely to seek services (Kessler et al., 1996; Zhang, Snowden, & Sue, 1998). The Surgeon General's report on culture and mental health (2001) strongly suggests, "cultural misunderstanding or communication problems between clients and therapists may prevent minority group members from using services and receiving appropriate care" (p. 42). One way to address this problem is for psychologists to gain greater knowledge and understanding of the cultural practices of clients.

Psychologists are encouraged to increase their knowledge of the multicultural bases of general psychological theories and information from a variety of cultures and cultural/racial perspectives and theories, such as Mestizo psychology (Ramirez, 1998), psychology of Nigrescence (Cross, 1978; Helms, 1990; Parham, 1989, 2001; Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001; Worrell, Cross, & Vandiver, 2001), Latino/Hispanic frameworks (Padilla, 1995; Ruiz, 1990; Santiago-Rivera et al., 2002) Native American models (Cameron, in press; LaFromboise & Jackson, 1996), biracial/multiracial models (Wehrly et al., 1999; Root, 1992) specific to racial/ethnic minority groups in the United States. In addition, psychologists are encouraged to become knowledgeable about how history has been different for the major U.S. cultural groups. Past experiences in relation to the dominant culture including slavery, Asian concentration camps, the American Indian holocaust, and the colonization of the major Latino groups on their previous Southwest homelands contribute to some of the sociopolitical dynamics, influencing worldview. Psychologists may also become knowledgeable about the psychological issues and gender related concerns related to immigration and refugee status (Cienfuegos & Moneli, 1983; Comas-Díaz & Jansen, 1995; Espin, 1997, 1999; Fullilove, 1996).

As noted in Guideline #1, one of the premises underlying these Guidelines is that all interpersonal interactions occur within a multicultural context. To enhance sensitivity and understanding further, psychologists are encouraged to become knowledgeable about federal legislation including the Civil Rights Act, Affirmative Action, and Equal Employment Opportunity (EEO) that were enacted to protect groups marginalized due to ethnicity, race, national origin, religion, age, and gender (Crosby & Cordova, 1996). Concomitantly, psychologists are encouraged to understand the impact of the dismantling of Affirmative Action

and anti-bilingual education legislation on the lives of ethnic and racial minority groups (Fine, Weis, Powell, & Wong, 1997; Glasser, 1988).

Built on variations of the social categorization models described in Guideline #1 ethnic and racial identity models such as the Minority Identity Model (Atkinson et al., 1998) noted earlier have also been developed for specific racial/ethnic minority groups (Cross, 1978; Helms, 1990; Parham, 1989, 2001; Ruiz, 1990; Vandiver et al., 2001; Worrell et al., 2001). These models propose that members of racial/ethnic minority groups initially value the other group (dominant culture) and devalue their own culture, move to valuing their own group and devalue the dominant culture, and integrate a value for both groups in a final stage. These models are key constructs in the cross cultural domain, and psychologists are encouraged to understand how the individual's ethnic and racial identity status and development affects beliefs, emotions, behavior and interaction styles (Brewer & Brown, 1998; Fiske et al., 1998; Hays, 1995; Helms & Cook, 1999). This information will help psychologists to communicate more effectively with clients, peers, students, research participants, and organizations and to understand their coping responses (Crocker et al., 1998; Major et al., in press; Swim & Mallet, 2002). Psychologists are encouraged to become knowledgeable about ethnic and racial identity research including research on Asian, Black, White, Mexican, Mestizo, minority, Native American, and biracial identity models (Atkinson et al., 1998; Cross, 1991; Fouad & Brown, 2000; Helms, 1990; Hong & Ham, 2001;
Phinney, 1991; Ramirez, 1998; Root, 1992; Ruiz, 1990; Sodowsky, Kuo-Jackson, & Loya, 1997; & Wehrly et al., 1999). Additionally, psychologists may also learn about other theories of identity development that are not stage models, as well as other models that demonstrate the multidimensionality of individual identity across different historical contexts (Santiago-Rivera et al., 2000; Oetting & Beauvais, 1990-1991; Oyserman, Gant, & Ager, 1995; Robinson & Howard-Hamilton, 2000; Root, 1999; Sellers, Smith, Shelton, Rowley, & Chavous, 1998; Thompson & Carter, 1997).

Education

Guideline #3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Psychology has historically focused on biological determinants of behavior versus historical and sociopolitical forces (Bronstein & Quiana, 1988). Some have expressed fear of creating stereotypes by addressing cultural differences, discussed earlier as the color-blind approach (Ridley, 1995), fear of categorization processes such as cognitive and behavioral confirmation biases (Wolsko et al., 2000) and a discomfort with discussing difficult and uncomfortable subjects (Abreu, 2001). Sue and Sue (1999) describe another historical concern – ethnocentric monoculturalism – which is characterized, in part, by a belief in the superiority of one's own group and inferiority of another's group and the use of power to impose one's values on the less-powerful group. Finally, in part, the omission of culture in psychology has stemmed from a belief that culture and multiculturalism are not legitimate areas of study (Bronstein & Quiana, 1988; Betancourt & Lopez, 1993; Fowers & Richardson, 1996; Hall, 2001). This has been manifested in preventing graduate students from conducting cross-cultural and multicultural research; non-acceptance of manuscripts in this area due to studies with small samples; lack of

available measures to assess the effects of multicultural training; and the emphasis on quantitative versus qualitative research (CNPAAEMI, 2000; Sue et al., 1998). These concerns have extended to incorporating a culture-centered approach to education as well. However, scholars and cross-cultural researchers began calling for a revision of psychology education and training to incorporate a more culture-centered perspective in the mid 1980's. In this document, the context of education refers to teaching of psychology at the undergraduate and graduate levels as well as in clinical and research supervision, advisement and mentoring, and continuing post-graduate education.

In the past two decades, studies have documented an increase in programs that have incorporated an emphasis on cultural diversity into the curriculum in graduate programs as well as in internship settings (Constantine, Ladany, Inman, & Ponterotto, 1996; Lee et al., 1999; Ponterotto, 1997; Quintana & Bernal, 1995; Rogers, Hoffman, & Wade, 1998). This infusion is based both on the premise that multicultural and culture-specific knowledge in education is effective in producing more competent researchers, educators, therapists, and other applied practitioners, as well as adhering to accreditation guidelines to incorporate diversity into the curriculum.

As discussed in Guideline #1, all interactions are cross-cultural and, by extension, all classroom interactions are multicultural. Thus, these Guidelines apply to teaching about multiculturalism as well as to the practice of teaching in general. Multicultural education has been found to promote student self-awareness and to increase their therapeutic competence (Brown, Parham, & Yonker, 1996; D'Andrea, Daniels, & Heck, 1991; Pope-Davis & Ottavi, 1994). Multicultural and culture-specific education may also help to counteract stereotyping and automatic social processes leading to prejudice against ethnic minority individuals (Abreu, 2001; Steele, 1997).

The benefits of diversity as well as the teaching from culture-centered perspectives have been reported by a variety of researchers and organizations (American Council on Education & American Association of University Professors, 2000; Chang, Witt, Jones, & Hakuta, 2000). It has been found that individual, institutional, and societal benefits result from a culture-centered perspective. At the individual level, benefits include an enhanced commitment to work toward racial understanding. Institutional advantages may be found for employers, who have a workforce with greater preparation in cross-cultural understanding. Societal benefits may be located, for example, in institutions of higher education, where scholars conduct research addressing issues of gender, race, and ethnicity as well as research on affirmative action in the workplace (American Council on Education & American Association of University Professors, 2000).

Other forces of change influencing attention to culture in education come from accrediting bodies. For example, the California Postsecondary Education Commission (1992, cited in Grieger & Toliver, 2001) mandated that all postsecondary institutions in California bear responsibility for creating an equitable environment for all students, and prepare them to function in a multicultural setting. As previously noted, the APA Committee on Accreditation (COA), which accredits training programs in counseling, clinical, and school psychology, now requires programs to document the ways that they have both included education about diversity for students, and have attended to creating an ethnically/racially diverse faculty and student body (APA, 2002).

During the past 10-15 years, more reports and perspectives about best practices and guidelines for cross culture–centered education and training have emerged. Psychologists in the role of educators in multicultural training have reported on the excitement of teaching, conducting research, and providing supervision (Arredondo, 1985; Constantine, 1997; Grieger & Toliver, 2001; Kiselica, 1998; Rooney, Flores, & Mercier, 1998; Stone, 1997). At the same time, they acknowledge that, by focusing on ethnic/racial issues, approaches, literature, projects, and so forth, they often encounter resistance from students and professional colleagues (Ponterotto, 1998; Sue et al., 1998). Unlike other psychology coursework, multicultural coursework moves into what is viewed as more personal domains beyond listening skills and personality theories. Culture-centered faculty introduce material many students have never thought about, may not care about, and may have reluctance to engage in, even if the course work is required (Jackson, 1999). Thus the challenges for faculty, advisors, and supervisors require multiple skills to ensure a safe learning environment, an ability to know the course content, and to manage emotions that emerge (Abreu, 2001; American Council on Education & American Association of University Professors, 2000; Chang et al., 2000; Lenington-Lara, 1999).

Psychologists as educators strive to become knowledgeable about different learning models and approaches to teaching from multiple cultural perspectives. In order to go beyond a single multicultural counseling course or to mention in passing that the racial/ethnic diversity is increasing in the United States, it is suggested that educators include statements of philosophy and principles in course syllabi that guide the multicultural educational focus (Leach & Carlton, 1997). Psychologists are encouraged to review philosophical models that influence multicultural training. These include race-based models (Carter, 1995; Helms, 1990); theories regarding oppression (Atkinson, Morten, & Sue, 1998; Freire, 1970; Katz, 1985); Multicultural Counseling and Therapy (MCT) (Sue et al., 1996); Multicultural Facets of Cultural Competence (Sue, 2001); common factors within psychotherapy and healing (Fischer, Jome, & Atkinson, 1998; Frank & Frank, 1998) and multicultural competency–based models (Arredondo & Arciniega, 2001; Arredondo et al., 1996; Middleton, Rollins, & Harley, 1999). In addition, the research on intergroup biases and categorization theories described in Guidelines #1 and #2 suggest that optimal intergroup contact is predicted by equal status among those interacting (e.g., teacher and students), cooperation as opposed to competition, perspective taking, and empathy (Finlay & Stephan, 2000; Gaertner & Dovidio, 2000; Galinsky & Moskowitz, 2000; Hewstone et al., 2002; Pettigrew, 1998). These models and approaches, then, may be used to encompass didactic courses across the curriculum (e.g., learning about career theories and practices related to various cultural groups) as well as assessment, organizational behavior, clinical practice and supervision, and research approaches.

Literature based on tried and effective approaches is available to assist psychologists in adapting and creating new curricula, infusing multicultural and culture-specific concepts into research, assessment and clinical course work, and in developing more culturally sensitive and inclusive learning environments for faculty, staff, and students alike (Arredondo, 1999; Arredondo & Arciniega, 2001; Lee, 1999; Evans & Larabee, 2002; Manese, Wu, & Nepomuceno, 2001; Pope-Davis & Coleman, 1997; Ridley et al., 1997; Sue, 1997). Psychologists as educators are encouraged to consider these approaches when designing culture- centered curriculum. Rather than attempt to cover culture-specific and multicultural material in

one course, psychologists are encouraged to consider ways to make the multicultural focus thematic to the educational program.

It was previously noted that resistance to multicultural coursework and to the assigned Faculty of Color, who are often charged with teaching a single course on multicultural issues or practices, is not uncommon (Abreu, 2001; Jackson, 1999; Mio & Awakuni, 2000). Several studies report on issues of emotions, including resistance, that may be stirred up when a multicultural course is taught or when course content addresses multicultural perspectives. These studies investigated variables such as racial prejudice, individual and collective guilt, and other forms of emotional reactions (Jackson, 1999; Reynolds, 1995; Shanbhag, 1999; Steward et al., 1998). Psychologists as educators may need to anticipate a range of emotional reactions and be prepared to understand and facilitate respectful discussion and disagreement. Accordingly, psychologists may also want to examine a study in which students indicated that the professors' amiability, non-judgmental demeanor, enthusiasm, self-disclosure, and overall leadership in the class were sources of encouragement and positive modeling (Lenington-Lara, 1999). Findings support the importance of this posture by faculty when teaching about multicultural issues. While this is challenging to maintain, psychologists are encouraged to consider the implications of this study.

Psychologists as educators are encouraged to continue to be knowledgeable about research findings about the effects of multicultural counseling and psychology coursework (Constantine & Yeh, 2001; Holcomb-McCoy & Myers, 1999; Kiselica, 1998; Klausner, 1998; Koeltzow, 2000; Manese et al., 2001; Parker et al, 1998; Ponterotto, 1998; Pope-Davis, Breaux, & Lui, 1997; Salvador, 1998; Sevig & Etzkorn, 2001; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998) and general undergraduate education (American Council on Education & American Association of University Professors, 2000; Chang et al., 2000).

Research

Guideline # 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Major demographic shifts in the United States (noted earlier) are underway. These population shifts have resulted in different constituencies for which new and expanded psychological research will be necessary. The aging baby boomers, new immigrants particularly from China, India, Mexico, and the Philippines, younger individuals of Latino heritage (Judy & D'Amico, 1997), and the growing biracial populations will likely require new research agendas (Ory, Lipman, Barr, Harden, & Stahl, 2000). Additionally, according to the U.S. Census Bureau (2001), a greater share of Americans speak a language other than English at home (27 million speak Spanish, 1 million or more speak Chinese, French, German, Tagalog, Vienamese, Korean, and Italian). Expanding age, cultural and linguistic diversity, just as three examples, have implications for research in a wide variety of psychological specialty areas, including, but not limited to, developmental, gender, health, school, clinical, counseling, and organizational aspects of psychology.

The treatment of culture in psychological research has shifted in the past century from ignoring cultural variables to treating culture as a nuisance variable. Thus, for example, early research participants were White males, yet the results were assumed to generalize to the entire population. Feminists began to call attention to this, and to decry the bias inherent in this practice (Grady, 1981; Keller, 1982; Sherif, 1979) as did early multicultural researchers (Katz, 1985; Korchin, 1980; Sue & Sue, 1977; Triandis & Brislin, 1984). Both groups questioned the practice of using White middle class males to define normal behavior, and that all behavior that differed from White norms was either described as deviant or less desirable. The result was a movement to incorporate gender and ethnicity/race in research studies as a nuisance variable, rather than as a central contextual variable that helps to explain human behavior. Compounding this practice was failure to consider within-group differences of an ethnic minority group, such as regional differences, socioeconomic status, education, and national origin, e.g., Blacks who may have come from Africa, Haiti, or the United States, voluntary or involuntary. The fundamental problem remained that when research does not adequately incorporate culture as a central and specific contextual variable, behavior is misidentified, pathologized, and, in some cases, psychologists are at risk of perpetuating harm (Hall, 2001; Rogler, 1999; Sue et al., 1998; Sue & Sue, 1999). As an example, Kwan (1999) found in a study of the comparison of the MMPI in China and the United States, that on some MMPI scales, Chinese subjects' scores were elevated relative to the norms in the United States. Not incorporating a culture-centered perspective might lead a researcher to conclude a high level of psychopathology in the Chinese sample. Kwan questioned, however, whether the elevated scales may have been the result of cultural influences, which would lead to a different conclusion for this study, and one presumes, in treatment based on the test scores. As another example, Reid (2002) noted the decades of conclusions about women's and racial/ethnic minority students' lack of educational attainment from research studies that focused on the students' lack of individual achievement rather than in social disadvantage. Again, using a culture-centered perspective would lead to different conclusions in these studies, as well as in the application of this research in school systems and college admissions.

A number of scholars have voiced concerns about the cultural limitations of psychological research in the United States. First, as noted above, when human behavior is viewed as individualistically determined, culture is viewed as a nuisance variable – something to be controlled and statistically manipulated rather than a central explanatory variable (Perez, 1999; Quintana et al., 2001). Second, although scholars began to heed the call for culturally diverse samples in research, many research samples continue to be predominantly White and middle class with People of Color underrepresented in these samples. When the samples are racially diverse, they are much more likely to be samples of convenience, which may not be representative of the target group, such as samples of college students representing all Asian Americans. This affects the external validity of a study, or to whom the findings may be generalized (Fuertes, Bartolomeo, & Nichols, 2001; Sue, 1999). Sue (1999) suggests that psychological science has ignored external validity problems, and that we have erred in the direction of inaccurately generalizing from findings based on small subsets of people to the population at large.

A third concern is that all People of Color are presumed to be similar, and, as discussed in Guideline #1, large within-group differences are ignored (Fouad & Brown, 2000; Quintana et

al., 2001). In fact, the CNPAAEMI (2001) Guidelines for Research in Ethnic Minority Communities (2000) describes the great within-group heterogeneity of all the major racial/ethnic groups in the United States, as does the Surgeon General's Report on race, culture and mental health (USDHHS, 2000; 2001). Indeed using only African Americans from the southern United States and generalizing from this sample to all African Americans would raise questions about the appropriateness of doing so. Similarly, there are studies that make reference to Native Americans, overlooking the fact that there are more than 550 tribes in the United States. Psychologists are encouraged to consider the multidimensionality of ethnic, linguistic, and racial minority individuals and groups when planning research studies.

Finally, some scholars have voiced concerns that racial/ethnic communities do not directly benefit from studies in which their members participate. These concerns have led to calls for research to be designed explicitly to be of benefit to the participants' communities (CNPAAEMI, 2000; LaFromboise & Jackson, 1996; Marin & Marin, 1991; Parham, 1993). To insure fidelity to the community that will be involved in the study, psychologists are encouraged to develop relationships with leaders and/or cultural brokers who may be essential brokers in the community. Even though researchers may have a particular design and implementation plan in mind, through collaborations with members of the community and potential participants, they are likely to develop credibility and trust. They also are likely to develop a more beneficial study to the community.

Thus, psychological researchers are encouraged to be grounded in the empirical and conceptual literature on the ways that culture influences the variables under investigation, as well as psychological and social science research traditions and skills. This may be divided into three areas, research design, assessment, and analysis.

Research generation and design. This first area begins with the research question that is asked. Goodwin (1996) delineates this as three steps: generation of the research question, suitability of the research question, and then piloting the research question. All three steps are influenced by the researcher's cultural milieu. For example, Fiske (1998) notes that the perceptions of Whites by racial/ethnic minority individuals are rarely studied, because most researchers are White, and they are more interested in the perceptions of their own group towards others. This is consistent, as we noted in Guidelines #1 and #2, with preferences for in-group vs. out-group in social categorization. Clearly, one's cultural worldview helps to shape the questions one has about behavioral phenomena. This is not necessarily a problem unless the researcher believes that his or her worldview is universal and objective. Davis, Nakayama, and Martin (2000) suggest that this is the fallacy of objectivity, followed by the fallacy of homogeneity, the latter defined as the assumption that all members of a group are similar. Psychological researchers are encouraged to be aware of the cultural assumptions on which their research questions are based (Egharevba, 2001).

Related to the research question is choosing culturally appropriate theories and models on which to inform theory-driven inquiry (Quintana et al., 2001). Psychological researchers are encouraged to be aware of, and if appropriate, to apply indigenous theories when conceptualizing research studies. They are encouraged to include members of cultural communities when conceptualizing research, with particular concern for the benefits of the research to the community (Fontes, 1998; LaFromboise, 1988). This may include involving representatives from the population and the host communities in research design, sampling, and inviting feedback

from the community in the final written versions of the report (Gil & Bob, 1999; Rogler, 1999). Culturally centered psychological researchers are encouraged to consider the psychological (rather than demographic) contextual factors of race, ethnicity, language, gender, sexual orientation, socio-economic status, and other social dimensions of personal experience in conceptualizing their research design (Fouad & Brown, 2000; Quintana et al., 2001).

Culturally centered psychological researchers are encouraged to seek appropriate grounding in various modes of inquiry and to understand both the strengths and limitations of the research paradigms applied to culturally diverse populations (Atkinson, 1985; Costantino, Malgady, & Rogler, 1986, 1994; Highlen, 1994; LaFromboise & Foster, 1992; Marin & Marin, 1991; Sue, S., 1999; Sue & Sue, 1999; Suzuki, Prendes-Lintel, Wertlieb, & Stallings, 1999). They strive to recognize and incorporate research methods that most effectively complement the worldview and lifestyles of persons who come from a specific cultural and linguistic population; e.g., quantitative and qualitative research strategies (Hoshmand, 1989; Marin & Marin, 1991; Ponterotto & Casas, 1991). This may include being knowledgeable about the ways in which ethnic and racial life experiences influence and shape participants' responses to research questions (Clarke, 2000; Kim, Atkinson, Umemoto, 2001; Westermeyer & Janca, 1997).

Assessment. The second area of research is assessment. Culturally sensitive psychological researchers strive to be knowledgeable about a broad range of assessment techniques, data generating procedures, and standardized instruments whose validity, reliability, and measurement equivalence have been investigated across culturally diverse sample groups (CNPAAEMI, 2000; Helms, 1992; Marin & Marin, 1991; Padilla, 1995; Spengler, 1998). They are encouraged not to use instruments that have not been adapted for the target population, and they are also encouraged to use both pilot tests and interviews to determine the cultural validity of their instruments (Samuda, 1998; Sue, 1999). They are encouraged to be knowledgeable not only about the linguistic equivalence of the instrument (e.g., that it is appropriately translated into the target language), but also the conceptual and functional equivalence of the constructs tested. In other words, they are encouraged to ascertain whether the constructs assessed by their instruments have the same meaning across cultures, as well as the same function across cultures (Rogler, 1999). In this, psychological researchers are urged to consider culturally sensitive assessment techniques, data-generating procedures, and standardized instruments whose validity, reliability, and measurement equivalence have been tested across culturally diverse sample groups, particularly the target research group(s). They are encouraged to present reliability, validity, and cultural equivalence data for use of instruments across diverse populations.

Analysis and Interpretation. The final area of consideration in culturally sensitive research is analysis and interpretation. In analyzing and interpreting their data, culturally sensitive psychological researchers are encouraged to consider cultural hypotheses as possible explanations for their findings, to examine moderator effects, and to use statistical procedures to examine cultural variables (Quintana et al., 2001).

Finally, culture-centered psychological researchers are encouraged to report on the sample group's cultural, ethnic, and racial characteristics and to report on the cultural limitations and generalizability of the research results as well. It is also recommended that researchers design the study to be of benefit to participants, and to include participants in the interpretation of results. They are encouraged to find ways for the results to be of benefit to the community, and to represent the participants' perspectives accurately and authentically (CNPAAEMI, 2000).

Practice

Guideline #5: Psychologists strive to apply culturally-appropriate skills in clinical and other applied psychological practices.

Consistent with previous discussions in Guidelines # 1 and # 2, culturally-appropriate psychological applications assume awareness and knowledge about one's worldview as a cultural being and as a professional psychologist, and the worldview of others particularly as influenced by ethnic/racial heritage. This Guideline refers to applying that awareness and knowledge in psychological practice. It is not necessary to develop an entirely new repertoire of psychological skills to practice in a culture-centered manner. Rather, it is helpful for psychologists to realize that there will likely be situations where culture-centered adaptations in interventions and practices will be more effective. Psychological practice is defined here as the use of psychological skills in a variety of settings and for a variety of purposes, encompassing counseling, clinical, school, consulting, and organizational psychology. This Guideline further suggests that regardless of our practice site and purview of practice, psychologists are responsive to the Ethics Code (APA, 1992). In the Preamble to the Ethics Code is language that advocates behavior that values human welfare and basic human rights.

Psychologists are likely to find themselves increasingly engaged with others ethnically, linguistically, and racially different from and similar to themselves as human resource specialists, school psychologists, consultants, agency administrators, and clinicians. Moreover, visible group membership differences (Atkinson & Hackett, 1995; Carter, 1995; Cross, 1991; Helms, 1990; Herring, 1999; Hong & Ham, 2001; Niemann, 2001; Padilla, 1995; Santiago- Rivera et al., 2002; Sue & Sue, 1999) may belie other identity factors also at work and strong forces in individuals' socialization process and life experiences. These include language, gender, biracial/multiracial heritage, spiritual/religious orientations, sexual orientation, age, disability, socioeconomic situation, and historical life experience; e.g., immigration and refugee status (Arredondo & Glauner, 1992; Davenport & Yurich, 1991; Espin, 1997; Hong & Ham, 2001; Lowe & Mascher, 2001; Prendes-Lintel, 2001). Projections regarding the increasing numbers of individuals categorized as ethnic and racial minorities have been discussed earlier in these Guidelines. The result of these changes is that in urban, rural, and other contexts, psychologists will interface regularly with culturally pluralistic populations (D'Andrea & Daniels, 2001; Ellis, Arredondo, & D'Andrea, 2000; Lewis, Lewis, Daniels, & D'Andrea, 1998; Middleton, Arredondo, & D'Andrea, 2000).

However, while Census 2000 shows that the population of the United States is more culturally and linguistically diverse than it has ever been (U.S. Census Bureau, 2001), individuals seeking and utilizing psychological services continue to under represent those populations. With respect to clinical/counseling services, Sue and Sue (1999) highlighted some of the reasons for the underutilization of services, including lack of cultural sensitivity of therapists, distrust of services by racial/ethnic clients, and the perspective that therapy "can be used as an oppressive instrument by those in power to…mistreat large groups of people" (p. 7). A number of authors (Arroyo, Westerberg, & Tonigan, 1998; Dana, 1998; Flaskreud & Liu 1991; McGoldrick, Giordano, & Pearce, 1996; Ridley, 1995; Santiago-Rivera et al., 2002; Sue,

et al., 1998; Sue, Bingham, Porche-Burke, & Vasquez, 1999; Sue & Sue, 1999) have outlined the urgent need for clinicians to develop multicultural sensitivity and understanding.

Essentially, the concern of the authors noted above is that the traditional, Eurocentric therapeutic and interventions models in which most therapists have been trained are based on and designed to meet the needs of a small proportion of the population (White, male, and middle- class persons). Ironically, the typical dyad in psychotherapy historically was a White middle- class woman treated by a White middle-class therapist. These authors note that Eurocentric models may not be effective in working with other populations as well, and indeed, may do harm by mislabeling or misdiagnosing problems and treatments.

Psychologists are encouraged to develop cultural sensitivity and understanding to be the most effective practitioners (therapists) for all clients. The discussion that follows, however, will primarily relate to therapeutic settings where individual, family, and group psychotherapy interventions are likely to take place. The discussion addresses three areas: focusing on the client within his or her cultural context, using culturally appropriate assessment tools, and having a broad repertoire of interventions (Arredondo, 1999, 1998; Arredondo et al., 1996; Arredondo & Glauner, 1992; Costantino et al., 1994; Dana, 1998; Duclos, Beals, Novins, Martin, Jewett, & Manson, 1998; Flores & Carey, 2000; Fouad & Brown, 2000; Hays, 1995; Ivey & Ivey, 1999; Kopelowicz, 1997; Lopez, 1989; Lukasiewicz & Harvey, 1991; Parham, White, & Ajamu, 1999; Pedersen, 1999; Ponterotto & Pedersen, 1993; Prieto, McNeill, Walls, & Gomez, 2001; Rodriguez & Walls, 2000; Root, 1992; Santiago-Rivera et al., 2002; Seeley, 2000; Sue, 1998; Sue, Ivey, & Pedersen, 1996).

Client-in-context. Clients might have socialization experiences, health and mental health issues, and workplace concerns associated with discrimination and oppression (e.g., ethnocentrism, racism, sexism, ableism, and homophobia). Thus, psychologists are encouraged to acquire an understanding of the ways in which these experiences relate to presenting psychological concerns (Byars & McCubbin, 2001; Fischer et al., 1998; Flores & Carey, 2000; Fuertes & Gretchen, 2001; Helms & Cook, 1999; Herring, 1999; Hong & Ham, 2001; Lowe & Mascher, 2001; Middleton, Rollins, & Harley, 1999; Sanchez, 2001; Sue & Sue, 1999). This may include how the client's worldview and cultural background(s) interact with individual, family, or group concerns.

Thus, in client treatment situations, culturally and socio-politically relevant factors in a client's history may include: relevant generational history (e.g., number of generations in the country, manner of coming to the country); citizenship or residency status (e.g., number of years in the country, parental history of migration, refugee flight, or immigration); fluency in "standard" English (and other languages or dialects); extent of family support or disintegration of family; availability of community resources; level of education, change in social status as a result of coming to this country (for immigrant or refugee); work history, and level of stress related to acculturation (Arredondo, 2002; Ruiz, 1990; Saldana, 1995; Smart & Smart, 1995). When the client is a group or organization in an employment context, another set of factors may apply. Recognizing these factors, culturally centered practitioners are encouraged to take into account how contextual factors may affect the client worldview (behavior, thoughts, or feelings).

Historical experiences for various populations differ. This may be manifested in the expression of different belief systems and value sets among clients and across age cohorts. For example, therapists are strongly encouraged to be aware of the ways that enslavement has shaped

the worldviews of African Americans (Cross, 1991; Parham et al., 1999). At the same time, the within-group differences among African Americans and others of African descent also suggest the importance of not assuming that all persons of African descent will share this perspective. Thus, knowledge about sociopolitical viewpoints and ethnic/racial identity literature would be important and extremely helpful when working with individuals of ethnic minority descent. Culturally centered practitioners assist clients in determining whether a "problem" stems from institutional or societal racism (or other prejudice) or individual bias in others so that the client does not inappropriately personalize problems (Helms & Cook, 1999; Ridley, 1995; Sue et al., 1992). Consistent with the discussion in Guideline #2 about the effects of stigmatizing, psychologists are urged to help clients recognize the cognitive and affective motivational processes involved in determining whether they are targets of prejudice (Crocker et al., 1998). Psychologists are also encouraged to be aware of the environment (neighborhood, building, and specific office) and how this may appear to clients or employees. For example, bilingual phone service, receptionists, magazines in the waiting room, and other signage can demonstrate cultural and linguistic sensitivity (Arredondo, 1996; Arredondo et al., 1996; Grieger & Ponterotto, 1998). Psychologists are also encouraged to be aware of the role that culture may play in the establishment and maintenance of a relationship between the client and therapist. Culture, ethnicity, race, and gender are among the factors that may play a role in the perception of, and expectations of therapy and the role the therapist plays (American Psychiatric Association, 1994; Carter, 1995; Comas-Díaz & Jacobsen, 1991; Cooper-Patrick et al., 1999; Seely, 2001).

Assessment. Consistent with Standard 2.04 of the APA Ethics Code (American Psychological Association, 1992), multiculturally sensitive practitioners are encouraged to be aware of the limitations of assessment practices, from intakes to the use of standardized assessment instruments (Constantine, 1998; Helms, 2002; Ridley, Hill, & Li, 1998), diagnostic methods (Ivey & Ivey, 1998; Sue, 1998), and instruments used for employment screening and personality assessments in work settings. Clients unfamiliar with mental health services and who hold worldviews that value relationship over task may experience disrespect if procedures are not fully explained. Thus, if such clients do not feel that the therapist is valuing the relationship between the therapist and client enough, the client may not adhere to the suggestions of the therapist. Psychologists are encouraged to know and consider the validity of a given instrument or procedure. This includes interpreting resulting data appropriately and keeping in mind the cultural and linguistic characteristics of the person being assessed. Culture-centered psychologists are also encouraged to have knowledge of a test's reference population and possible limitations of the instrument with other populations. When using standardized assessment tools and methods, multicultural practitioners exercise critical judgment (Sandoval, Frisby, Geisinger, Scheuneman, & Ramos-Grenier, 1998). Multiculturally sensitive practitioners are encouraged to attend to the effects on the validity of measures of issues related to test bias, test fairness, and cultural equivalence (APA, 1990, 1992; Arredondo, 1999; Arredondo et al., 1996; Dana, 1998; Grieger & Ponterotto, 1995; Lopez, 1989; Paniagua, 1994, 1998; Ponterotto, Casas, Suzuki, & Alexander, 1995; Samuda, 1998).

Interventions. Cross-culturally sensitive practitioners are encouraged to develop skills and practices that are attuned to the unique worldview and cultural backgrounds of clients by striving to incorporate understanding of client's ethnic, linguistic, racial, and cultural background into therapy (American Psychiatric Association, 1994; Falicov, 1999; Flores & Carey, 2000;

Fukuyama & Ferguson, 2000; Helms & Cook, 1999; Hong & Ham, 2001; Langman, 1998; Middleton, Rollins, & Harley, 1999; Santiago-Rivera et al., 2002). They are encouraged to become knowledgeable about the *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990) and *Guidelines for Research in Ethnic Minority Communities* (CNPAAEMI, 2000). They are encouraged to learn about helping practices used in non-Western cultures within as well as outside the North American and Northern European context that may be appropriately included as part of psychological practice. Multiculturally sensitive psychologists recognize that culture-specific therapy (individual, family, and group) may require non-traditional interventions and strive to apply this knowledge in practice (Alexander & Sussman, 1995; Fukuyama & Sevig, 1999; Ridley, 1995; Santiago- Rivera et al., 2002; Sciarra, 1999; Society for the Psychological Study of Ethnic Minority Issues, Division 45 of the American Psychological Association & Microtraining Associates, Inc., 2000; Sue et al., 1998; Sue & Sue, 1999). This may include inviting recognized helpers to assist with assessment and intervention plans. Psychologists are encouraged to participate in culturally diverse and culture-specific activities. They are also encouraged to seek out community leaders, change agents, and influential individuals (ministers, storeowners, non-traditional healers, natural helpers), when appropriate, enlisting their assistance with clients as part of a total family or community-centered (healing) approach (Arredondo et al. 1996; Grieger & Ponterotto, 1998; Lewis et al., 1998).

Multiculturally sensitive and effective therapists are encouraged to examine traditional psychotherapy practice interventions for their cultural appropriateness, e.g., person-centered, cognitive-behavioral, psychodynamic forms of therapy (Bernal & Scharoon-del-Rio, 2001). They are urged to expand these interventions to include multicultural awareness and culture-specific strategies. This may include respecting the language preference of the client and ensures that the accurate translations of documents occur by providing informed consent about the language in which therapy, assessments, or other procedures will be conducted. Psychologists are also encouraged to respect the client's boundaries by not using interpreters who are family members, authorities in the community, or unskilled in the area of mental health practice.

Organizational Change and Policy Development

Guideline #6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

Psychology exists in relationship to other disciplines, organizations, and facets of society. As a dynamic profession, our education prepares us to be change agents, promulgators of new knowledge through research that informs policies in different sectors of society, and as organizational leaders in the profession, the private sector, government agencies, and other work environments. In the application of our skills in a wide range of organizations and contexts, psychologists are encouraged to become knowledgeable about the possible ways to facilitate culturally informed organizational development of policies and practices.

This Guideline is designed to inform psychologists about the following: (1) the contemporary and future contexts that provide motivators for psychologists' proactive behavior with organizational change processes; (2) perspectives about psychologists in transition; (3)

frameworks and models to facilitate multicultural organizational development; and (4) examples of processes and practices reflective of psychologists' leadership in the development of culture-centered organizations. Supporting this Guideline are contextual data that provide a rationale for positioning multiculturalism as thematic to structures, functions, and strategic planning within an organization as well as example of changes in psychology policies and practices.

Changing Context for Psychologists

While the debate about multiculturalism continues within psychology with varying and mutually exclusive perspectives (Betancourt & Lopez, 1993; Fowers & Richardson, 1996; Gergen, 2001; Sue, 2001) looking externally not just internally becomes increasingly necessary. Psychology education, research, and practice today is driven by multiple societal forces introduced by other disciplines and the consequences of world-wide events. Cloning, global terrorism, genetic research breakthroughs, the efficacy of different medications for both health and mental healthcare, world-wide migration, and environmental climate change are but a few of the external forces influencing our work and training. In addition, as noted earlier, continuing increases of ethnic minority and non-English speaking populations in the U.S., the gap between the richest and the poorest in the United States continues to accelerate; top 10 states for this gap have been identified (U.S. Census Bureau, 2001), the aging and longer living baby boomers, and changing family patterns have implications for psychology-at-large.

The demographic shifts and implications for education discussed earlier in the introduction also have implications for employment projections, such as who works, where they will work, and how their work may change. For example, the demographic changes noted earlier include a growth in the population between 50-65, the so-called "aging baby boomer." Ethnic/racial minority elderly account for a significant proportion of the overall increase in longevity in the United States and their rates of growth are expected to exceed those of Whites over the next 50 years (Ory et al., 2000). There is a greater need for psychologists working with the elderly overall, and a need for them to be able to work with a racially/ethnically diverse population, as well as working with employers and organizations as they cope with an aging work force.

In another demographic shift, it is projected that 50% of new entrants to the workforce between 1994 and 2005 will be women of all ethnic groups (Judy & D'Amico, 1997); psychologists will be called upon to help women make work and family choices, help employers cope with the transitions to the work force, and ideally, help communities understand and develop resources as more families have both parents working (Haas, Hwang, & Russell, 2000). As another example, Latinos are the youngest ethnic/racial group and the fastest growing one as well (U.S. Census Bureau, 2001); they will be entering schools in greater numbers, as well as representing a greater proportion of the workforce. Psychologists will likely be called upon to help school systems, organizations, and communities cope successfully with these transitions. In addition, U.S. organizations are dealing with global and rapid technology evolution, more global integration in to the U.S. economy, national and global deregulation, and quick economic growth in heretofore-underdeveloped nations (Judy & D'Amico, 1997). All of these examples have implications for psychology, as psychologists will be called upon to engage with other disciplines and sectors of society, including government agencies, in attempting to forge new

policies and guidelines that promote human development, knowledge-building, and societal improvement. While these forces will, of necessity, influence our own work, we are also uniquely trained to help others cope with these changes. All of these data and forces highlight the necessity of institutional change particularly for the delivery of health and mental health services (Schlesinger & Gray, 1999) psychology education, and employment practices.

Psychologists in Transition

The changing landscape of psychology is also apparent as we consider psychologists who have entered political life, psychologists as administrators in healthcare institutions and employee assistance programs (EAP), as deans and provosts in higher education, in the CIA (Psychologists in the CIA, 2002), and as consultants to corporate entities. All of these roles involve psychologists in different types of functions and systems driven by forces cited in *Workforce 2020* and of course involved with people of different social identities and professions (Judy & D'Amico, 1997).

Examples of changes in policy and practices have also come from within the profession. In 1993, the Massachusetts state licensing board approved a regulation change, requiring doctoral coursework and internship experiences with multicultural and cross-cultural foci (Daniel, 1994). Georgia passed a similar change in 2000. More recently, the state of New Mexico passed legislation that now allows psychologists to prescribe medication, recognition of our scientific roots. Part of the rationale for change in prescription privileges was to provide greater access for rural patients and clients with mental health concerns, which includes a large number of People of Color. When such policies go into effect, there are challenges and opportunities that ensue for training programs, internship sites, and institutions that hire psychologists.

Examples of change within APA were cited in the introductory section. In addition, the organization has sponsored initiatives such as the development of guidelines to address concerns of women (Fitzgerald & Nutt, 1986) and gay, lesbian, and transgendered individuals (APA, 2001), creation of guidelines for conducting research with linguistic minority populations (CPNAAEMI, 2000) and for providing health care and culture-specific mental health services (APA, 1990; CPNAAEMI, 2002); and through interdivisional efforts promoted by the Committee on Division/APA Relations (Arredondo, 2000). The establishment of a number of Divisions with a special interest focus in the last 15-20 years is also noteworthy. Divisions that have developed to address health psychology, the study of peace, conflict, and violence, addictions, interests of men, international psychology, and pediatric psychology are a few examples of psychologists' organizational change behavior. These organizational outcomes are indicative of psychologists' responsiveness to societal changes. It is unlikely that new Divisions will be established for all current and emerging issues. Psychologists are encouraged to continue to apply learning organization principles. One of the primary principles is to scan the environment and anticipate trends and changes allowing for a systemic proactive rather than reactive response.

Frameworks and Models for Multicultural Organizational Development

Psychologists play a variety of roles in a society that is undergoing rapid change, and are therefore encouraged to familiarize themselves with methods, frameworks and models for

multicultural organizational development (Adler, 1986; Arredondo, 1996; Cox, 1993; Cox & Finley, 1995; Garcia-Caban, 2001; Sue, 2001). These models, among others, provide blueprints for planning for organizational change that may lead to cultural awareness and knowledge and result in a "best practices" approach for culture-centered organizations. In addition, a culture-centered focus provides processes for weaving together contextual forces, the mission of the organization, and development of people that may lead to enhanced and culturally proficient and inclusive systems and practices. Most of these models or frameworks describe attributes at particular phases or statuses, and cognitive, affective, and behavioral processes that will promote multicultural organizational change and growth. For example, Cross, Bazron, Dennis, and Issacs (1989) have outlined a cultural competence continuum with stages and indicators from "cultural destructiveness" to "cultural proficiency." Underscoring work in global businesses, Adler (1986) offers three models: parochial, ethnocentric, and synergistic. The latter is described as a response to organizational cultural diversity, "In synergistic organizations members believe that...the combination of our ways and their ways produces the best ways to organize and work" (p. 87).

To assist organizations in clarifying their approach to multiculturalism and diversity, Thomas and Ely (1996) conceptualize a continuum of philosophical positions that range from fairness and equity to valuing diversity. Sue (2001) offers another conceptualization through his multidimensional facets of cultural competence model. He posits cultural competence at individual, professional, organizational, and societal levels. By bringing in the societal foci, Sue is also addressing issues of social justice and responsibility, and opportunities for psychologists' change agency.

Based on empirical research, Cox (1993) proposes organizational transformation based on the interplay of the climate for diversity, individual outcomes, and organizational effectiveness. His model has three states: monolithic, pluralistic, and multicultural. Each state is influenced by the interplay between the climate for diversity, individual (employee) outcomes, and organizational effectiveness on a number of criteria. Another scientifically informed model outlines a development process with various stages and tasks that lead to a multicultural and diversity-centered organization (Arredondo, 1996). Unlike other models, this is not a typology but rather a data-driven approach to promote organizational change and development through a focus on multiculturalism and diversity. Among the stages are planning for a diversity initiative, a self-study, and an evaluation of measurable objectives. This developmental approach has served as the basis for conducting applied research in more than 50 organizations such as social and mental health agencies, colleges and universities, and the private sector.

One of the most comprehensive reviews of organizational cultural competence models, instrumentation, research and focus was prepared by Garcia-Caban (2001). She identified 19 instruments used to conduct organizational research in a variety of domains including relational behavioral styles, cultural competence in service delivery, and psychologists' knowledge, attitude and behavior skills.

Borrowing from the work of organizational change consultants, psychologists can become knowledgeable about recommendations from learning organization models (Morgan, 1997; Senge, 1990). These advocate for organizations to anticipate environmental change, "developing an ability to question, challenge and change operating norms and assumptions" (Morgan, 1997, p. 90), and engage in new planning. By so doing, psychologists, prepared as change agents, have the opportunity to apply clinical and research methodology to promote goal- oriented systems change with measurable outcomes.

Examples of Multicultural Practices within Organizations

Psychologists are encouraged to review examples of multicultural organizational change that are reported in publications from a variety of sources within APA, as well as from the American Counseling Association and management journals. These evolutionary processes of change are both deliberate and systemic (e.g., Arredondo & D'Andrea, 2000; D'Andrea, Daniels, & Arredondo, 1999; D'Andrea et al., 2001). Examples from both APA and the American Counseling Association point to behaviors at the professional organization level with implications for the practice of psychology. Thematic to these examples is the role of leadership, sustained attention to diversity-related objectives, and changes in policy and practices that make the organization operationalize its mission of inclusiveness and pluralism. Division 17, Counseling Psychology; Division 35, Society for the Psychology of Women; Division 44, Society for the Psychological Study for Lesbian, Gay, and Bisexual Issues; Division 51, Society for the Psychological Study of Men and Masculinity; and Division 42, Psychologists in Independent Practice all have dedicated slates or positions for an ethnic/racial minority psychologist on their executive councils or as representatives to the Council of Representatives. Division 12, Society of Clinical Psychology, has recently voted to have an ethnic minority slate for Council of Representatives when two positions are vacant at the same time. Additional examples come from Divisions 12, 17, and 35 that have subcommittees or sections to address ethnic/racial minority objectives. Finally, Division 45, Society for the Psychological Study of Ethnic Minority Issues has added a "diversity" Member-at-Large position, inviting representation from a member who is not a person of color (all other positions have traditionally been Persons of Color). These are practices that operationalize a given Division's mission and objectives to promote multiculturalism and diversity, and organizational change. By the same token, APA's immediate response to the terrorist attacks of September 11, 2001, and the work of individual psychologists within their communities are ways that psychologists have responded quickly to a changing world.

The strategies applied by these Divisions and the organization parallel ones that have taken place in the employment sector for more than 15 years, and that undoubtedly will continue. Moreover, psychologists are well suited to be central to these structural changes as well as likely candidates to implement these new developments. For example, universities have begun to create positions for campus diversity directors and ombudspersons. Both roles often require knowledge and skills that are psychological and well-grounded in the understanding of diversity and multicultural issues. Accrediting bodies, including the Joint Commission for Accreditation of Hospital Organizations (JCAHO) and the National Council on Accreditation of Teacher Education (NCATE) require that institutions demonstrate how they address diversity. Industries of all types, from the government, media, sports, recreation, hospitality, hi-tech, and manufacturing (e.g., aviation, consumer products) have diversity and multiculturalism in their business plans. With the presence of psychologists from different specializations in non- traditional and other disciplinary contexts (e.g., CIA) as noted previously, knowledge and understanding of these Guidelines seems very timely.

Psychologists as Change Agents and Policy Planners

The focus on organizational change and policy development in these Guidelines highlights the multiple opportunities for psychologists, regardless of our specialty domains, to lead change and influence policy. The Surgeon General's report on gaps in mental health care for ethnic minorities in the United States is one example (USDHSS, 2000, 2001). Psychologists representing different specializations were involved in the development of this report, sharing their research and other data that have contributed to a compelling document. Psychologists are often called upon to provide expert testimony to legislative bodies, boards of directors, and the courts on issues that involve ethnic/racial minority individuals and groups. Though it may appear that we are speaking from our informed voices as psychologists, psychologists' participation in these venues reflects the potential for policy development and structural organizational change.

Psychologists are encouraged to become familiar with findings from specific psychology training program self-studies and empirical studies (e.g., Rogers, Hoffman, & Wade, 1998), that can provide information about how different constituencies (faculty, students, staff, and community partners) experience psychology training programs. These experiences may be evaluated on organizational climate criteria: interpersonal respect and valuing, curriculum, policies and practices, advisement and mentoring, research methodology flexibility, resource availability and support, rewards and recognition, community relations, and professional development for faculty and staff.

Practices such as mentoring, promoting cross-racial dialogues, reducing in-group and out-group behavior, recruitment and selection processes, and the infusion of multicultural and diversity concepts in traditional psychology education (undergraduate through continuing education) have been demonstrated to be effective mechanisms for systems change (Fiske, 1993; Major et al., 1993; Schmader et al., 2001; Thomas & Gabarro, 1999). The expanding literature from social psychology on stereotype threat (Steele, 1997), tokenism (Wright & Taylor, 1998), social stigma (Crocker et al., 1998), the social identity approach (Haslam, 2001), and social cognition (Eccles & Wigfield, 2002) as these relate to organizational diversity can inform objectives and processes of change. Psychologists are encouraged to become familiar with practices that can be replicated to different organizational settings thereby leading to multicultural organizational enhancement and policy development.

Promoting organizational change through multiculturalism and diversity offers psychologists opportunities to learn about best practices and also view the domain of multicultural development as an opportunity for personal and professional growth. Psychological interventions in organizations are not new, but there are various approaches that can be examined and integrated in to one's leadership within an educational department, agency, or business.

Traditional and evolutionary perspectives in applied psychology (Colarelli, 1998), and models of organizational change (Hofstede, 1986; Lewin, 1951; Morgan, 1997) can guide behavior that allows psychology to bridge with the multiple communities with which it interacts. Psychologists are encouraged to become familiar with leadership literature (Greenleaf, 1998; Nanus, 1992) as this offers constructs and descriptions of roles relevant to psychologists in policy planning. In effect, policy development is a change management process, one that can be informed by the vision, research, and experiences of psychologists.

Conclusion

Psychology has been traditionally defined by and based upon Western, Eurocentric, and biological perspectives and assumptions. These traditional premises in psychological education, research, practice, and organizational change, and have not always considered the influence and impact of racial and cultural socialization. They also have not considered that the effects of related biases have, at times, been detrimental to the increasingly complex needs of clients and the public interest. These Guidelines were designed to aid psychologists as they increase their knowledge and skills in multicultural education, training, research, practice and organizational change.

Readers will note that these Guidelines are scheduled to expire in 2009. This document was intended as a living document. The empirical research on which the rationale for the various guidelines are based will continue to expand, as will legislation and practices related to an increasingly diverse population. The integration of the psychological constructs of racial and ethnic identity into psychological theory, research, and therapy has only just begun. Psychologists are starting to investigate the differential impact of historical, economic, and sociopolitical forces on individuals' behavior and perceptions. Psychology will continue to develop a deeper knowledge and awareness of race and ethnicity in psychological constructs, and to actively respond by integrating the psychological aspects of race and ethnicity into the various areas of application in psychology. It is anticipated that, with this increased knowledge base and effectiveness of applications, the Guidelines will continue to evolve over the next seven years.

References

Abreu, J. M. (2001). Theory and research on stereotypes and perceptual bias: A resource guide for multicultural counseling trainers. *The Counseling Psychologist, 29,* 487–512.

Adler, N. J. (1986). *International dimensions of organizational behavior*. Belmont, CA: Wadsworth.

Alexander, C. M., & Sussman, L. (1995). Creative approaches to multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 375–384). Thousand Oaks, CA: Sage.

Allport, G. W. (1954). *The nature of prejudice.* Cambridge, MA: Addison-Wesley. American Council on Education. (2001). *18th Annual Status Report on Minorities in Higher Education*. Washington, DC: Author.

American Council on Education and American Association of University Professionals. (2000). *Does diversity make a difference? Three research studies on diversity in college classrooms.* Washington, DC: Authors.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4^{th} ed.). Washington, DC: Author. American Psychological Association. (1987). General guidelines for providers of psychological services. *American Psychologist, 42*(7), 1–12.

American Psychological Association. (1990). *Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations.* Washington, DC: Author.

American Psychological Association. (1992). Ethical principles and code of conduct. *American Psychologist, 48,* 1597–1611.

American Psychological Association. (2000). Professional practice guidelines for psychotherapy with lesbian, gay and bisexual clients. *American Psychologist, 55,* 1440–1451.

American Psychological Association. (2001). *Criteria for practice guideline development and evaluation.* Washington, DC: Author.

American Psychological Association. (2002). *Guidelines and principles for accreditation.* Washington, DC: Author.

Anderson, N. B. (1995). Behavioral and sociological perspectives on ethnicity and health: Introduction to the special issue. *Health Psychology, 14,* 589–591.

Arredondo, P. (1985). Cross cultural counselor education and training. In P. Pedersen (Ed.). *Handbook of Cross Cultural Counseling and Therapy* (pp. 281–289). Westport, CT: Greenwood.

Arredondo, P. (1996). *Successful diversity management initiatives: A blueprint for planning and implementation*. Thousand Oaks, CA: Sage.

Arredondo, P. (1998). Integrating multicultural counseling competencies and universal helping conditions in culture-specific contexts. *The Counseling Psychologist, 26,* 592–601.

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling and Development, 77,* 102–108.

Arredondo, P. (2000, November/December). Suggested "best practices" for increasing diversity in APA divisions. *The APA/Division Dialogue*, pp. 1–3.

Arredondo, P. (2002). Counseling individuals from specialized, marginalized and underserved groups. In P. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (5th ed., pp. 241–250). Thousand Oaks, CA: Sage.

Arredondo, P., & Arciniega, G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 29,* 263–273.

Arredondo, P., & Glauner, T. (1992). *Personal dimensions of identity model.* Boston: Empowerment Workshops, Inc.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24,* 42–78.

Arroyo, J. A., Westerberg, V. S., & Tonigan, J. S. (1998). Comparison of treatment utilization and outcome for Hispanics and non-Hispanic Whites. *Journal of Studies on Alcohol, 59,* 286–291.

Atkinson, D. R. (1985). A meta-review of research on multicultural counseling and psychotherapy. *Journal of Multicultural Counseling and Development, 13,* 138– 153.

Atkinson, D. R., & Hackett, G. (1995).*Counseling diverse populations* (2nd ed.). Boston: McGraw Hill.

Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities*. (5^{th} ed.). New York: McGraw-Hill.

Benjamin, L. T., Jr., & Crouse, E. M. (2002). The American Psychological Association's response to Brown v. Board of Education: The case of Kenneth B. Clark. *American Psychologist, 57,* 38–50.

Berberich, D. A. (1998). Posttraumatic stress disorder: Gender and cross-cultural clinical issues. *Psychotherapy in Private Practice, 17,* 29–41.

Bernal, G., & Scharro-del-Rio, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity & Ethnic Minority Psychology, 7,* 328–342.

Betancourt, H., & Lopez, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist, 48*, 629–637.

Biddle, B. J., Bank, B. J., & Slavings, R. L. (1990). Modality of thought, campus experiences, and the development of values. *Journal of Educational Psychology, 82,* 671-682.

Brewer, C. A., & Suchan, T. A. (2001). *Mapping Census 2000: The geography of U.S. diversity.* Washington, DC: U.S. Government Printing Office.

Brewer, M. B. (1999). The psychology of prejudice: Ingroup love or outgroup hate? *Journal of Social Issues, 55,* 429–444.

Brewer, M. B., & Brown, R. J. (1998). Intergroup relations. In D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology, Vol. 2* (4th ed., pp. 554–594). New York: McGraw-Hill.

Brewer, M. B., & Miller, N. (1988). Contact and cooperation: When do they work? In P. A. Katz & D. A. Taylor (Eds.), *Eliminating racism: Profiles in controversy.* (pp. 315–326). New York: Plenum.

Bronstein, P. A., & Quina, K. (1988). *Teaching a psychology of people.* Washington, DC: American Psychological Association.

Brown, S. P., Parham, T. A., & Yonker, R. (1996). Influence of a cross-cultural training on racial identity attitudes of White women and men. *Journal of Counseling and Development, 74,* 510–516.

Byars, A. M., & McCubbin, L. D. (2001). Trends in career development research with racial/ethnic minorities: Prospects and challenges. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (2nd ed., pp.633–654). Thousand Oaks, CA: Sage.

Cameron, S. (in press). American Indian Mental Health: An examination of resiliency in the face of overwhelming odds. In F. D. Harper & J. McFadden (Eds.), *Culture and counseling: New approaches* (in press). Boston: Allyn/Bacon.

Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy*. New York: John Wiley.

Carter, R. T. (Ed.). (2000). *Addressing cultural issues in organizations: Beyond the corporate context.* Thousand Oaks, CA: Sage.

Chang, M., Witt, D., Jones, J., & Hakuta, K. (Eds.). (2000). *Compelling interest: Examining the evidence on racial dynamics in higher education.* Palo Alto, CA: Stanford University Press.

Cinfuegos, A. J., & Monelli, C. (1983). The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry, 53,* 43–51.

Clark, K. B., & Clark, M. K. (1940). Skin color as a factor in racial identification of Negro preschool children. *Journal of Social Psychology, 11,* 159–169.

Clarke, I, III. (2000). Extreme response style in multicultural research: An empirical investigation. *Journal of Social Behavior & Personality, 15,* 137–152.

Colarelli, S. M. (1998). Psychological interventions in organizations: An evolutionary perspective. *American Psychologist, 53,* 1044–1056.

Coll, C. G., Akerman, A., & Cicchetti, D. (2000). Cultural influences on developmental processes and outcomes: Implications for the study of development and psychopathology. *Development & Psychopathology, 12,* 333–356.

Comas-Diaz, L. (2000). An ethnopolitical approach to working with People of Color. *American Psychologist, 55,* 1319–1325.

Comas-Diaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61,* 392–402.

Comas-Daiz, L., & Jansen, M. A. (1995). Global conflict and violence against women. *Peace and conflict: Journal of Peace Psychology, 1,* 315–331.

Constantine, M. G. (1997). Facilitating multicultural competency in counseling supervision: Operationalizing a practical framework. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, Education and training, and supervision*. Thousand Oaks, CA: Sage.

Constantine, M. (1998). Developing competence in multicultural assessment: Implications for counseling psychology training and practice. *The Counseling Psychologist, 6,* 922–929.

Constantine, M. G., Ladany, N., Inman, A. G., & Ponterotto, J.G. (1996). Students' perceptions of multicultural training in counseling psychology programs. *Journal of Multicultural Counseling and Development, 24,* 155–164.

Constantine, M. G., & Yeh, C. (2001). Multicultural training, self-construals, and multicultural competence of school counselors. *Professional School Counseling, 4,* 202–207.

Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association, 282,* 583–589.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting & Clinical Psychology, 54,* 639–645.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1994). Storytelling through pictures: Culturally sensitive psychotherapy for Hispanic children and adolescents. *Journal of Clinical Child Psychology, 23,* 13–20.

Council of National Associations for the Advancement of Ethnic Minority Issues. (2000). *Guidelines for research in ethnic minority communities.* Washington, DC: American Psychological Association.

Cox, T. H., Jr. (1993). *Cultural diversity in organizations*. San Francisco: Berrett-Koehler.

Cox, T. H., Jr., & Finley, J. A. (1995). An analysis of work specialization and organizational level as a dimension of workforce diversity. In M. M. Chemers and S. Oskamp (Eds.), *Diversity in organizations: New perspectives for a changing workplace* (pp. 62–88). Thousand Oaks, CA: Sage.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert & S. T. Fiske, (Eds.), *The handbook of social psychology, Vol. 2* (4th ed., pp. 504–553). New York: McGraw-Hill.

Crosby, F., Bromley, S., & Saxe, L. (1980). Recent unobtrusive studies of Black and White discrimination and prejudice: A literature review. *Psychological Bulletin, 87,* 546–563.

Crosby, F. J., & Cordova, D. I. (1996). Words worth of wisdom: Toward an understanding of affirmative action. *Journal of Social Issues, 52,* 33–49.

Cross, W. E., Jr. (1978). The Thomas and Cross models of psychological nigrescence: A review. *Journal of Black Psychologist, 5,* 15–31.

Cross, W. E., Jr. (1991). *Shades of Black: Diversity in African American identity.* Philadelphia: Temple University Press.

Cross, T., Bazron, B., Dennis, K., & Issacs, M. (1989). Toward a culturally competent system of care. Vol. 1: *Monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: CASSP Technical Assistance Center. Georgetown University Child Development Center.

D'Andrea, M., & Daniels, J. (1997). Multicultural counseling supervision: Central issues, theoretical considerations, and practical strategies. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment education and training, and supervision*. Thousand Oaks, CA: Sage.

D'Andrea, M., & Daniels, J. (2001, in press). *Respectful counseling.* Pacific Grove, CA: Brooks/Cole. D'Andrea, M., & Daniels, J., & Arredondo, P. (1999, August). Using cultural audits as tools for change. *Counseling Today*, p. 14.

D'Andrea, M., Daniels, J., & Heck, R. (1992). Evaluating the impact of multicultural counseling training. *Journal of Counseling and Development, 70,* 143–150.

D'Andrea, M., Daniels, J., Arredondo, P., Ivey, A. E., Ivey, M. B., Locke, D. C., O'Bryant, B., Parham, T. A., & Sue. D. W. (2001). Fostering organizational changes to realize the revolutionary potential of the multicultural movement: An updated case study. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 222–254). Thousand Oaks, CA: Sage.

Dana, R. H. (1998). *Understanding cultural identity in intervention and assessment.* Thousand Oaks, CA: Sage.

Daniel, J. H. (1994). Leadership and legacy in Psychology. *FOCUS: Notes from the Society for the Psychological Study of Ethnic Minority Issues, 8,* 2.

Davenport, D. S., & Yurich, J. M. (1991). Multicultural gender issues. *Journal of Counseling and Development, 70,* 64–71.

Davis, O. I., Nakayama, T. K., & Martin, J. N. (2000). Current and future directions in ethnicity and methodology. *International Journal of Intercultural Relations, 24,* 525–539.

Devine, P. G., Plant, E. A., & Buswell, B. N. (2000). Breaking the prejudice habit: Progress and obstacles. In S. Oskamp (Ed), *Reducing prejudice and discrimination* (pp. 185–208). Mahwah, NJ: Erlbaum.

Dovidio, J. F., & Gaertner, S. L. (1998). On the nature of contemporary prejudice: The causes, consequences, and challenges of aversive racism. In J. L. Eberhardt, & S. T. Fiske (Eds), *Confronting racism: The problem and the response* (pp. 3–32). Thousand Oaks, CA: Sage.

Dovidio, J. F., Gaertner, S. L., & Validzic, A. (1998). Intergroup bias: Status, differentiation, and a common in-group identity. *Journal of Personality & Social Psychology, 75,* 109–120.

Duckitt, J. H. (1992). Psychology and prejudice: A historical analysis and integrative framework. *American Psychologist, 47,* 1182–1193.

Duclos, C. W., Beals, J., Novins, D. K., Martin, C., Jewett, C. S., & Manson, S. M. (1998). Prevalence of common psychiatric disorders among American Indian adolescent detainees. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 866–873.

Eccles, J. S., & Wigfield, A. (2002). Motivational beliefs, values, and goals. *Annual Review of Psychology, 53,* 109–132.

Egharevba, I. (2001). Researching an-'other' minority ethnic community: Reflections of a Black female researcher on the intersections of race, gender and other power positions in the research process. *International Journal of Social Research Methodology: Theory & Practice, 4,* 225–241.

Ellis, C., Arredondo, P., & D'Andrea, M. (2000, November). How cultural diversity affects predominantly white towns. *Counseling Today,* p. 25.

Espin, O. M. (1997). *Latina realities. Essays on healing, migration, and sexuality.* Boulder, CO: Westview.

Espin, O. M. (1999). *Women crossing boundaries: A psychology of immigration and transformation of sexuality.* New York: Routledge.

Evans, K. M., & Larabee, M. J. (2002). Teaching the multicultural counseling competencies and revised career counseling competencies simultaneously. *Journal of Multicultural Counseling and Development, 30,* 21–39.

Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice.* New York: Guilford Press.

Fine, M., Weis, L. Powell, L. C., & Wong, L. M. (Eds.). (1997). *Off white: Readings on race, power, and society.* Florence, KY: Taylor & Francis/Routledge.

Finlay, K. A., & Stephan, W. G. (2000). Improving intergroup relations: The effects of empathy on racial attitudes. *Journal of Applied Social Psychology, 30,* 1720–1737.

Fish, J. M. (1995). Why psychologists should learn some anthropoloy. *American Psychologist, 50,* 44–45.

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist, 26,* 525–588.

Fiske, A. P., Kitayama, S., Markus, H. R., & Nisbett, R. E. (1998). The cultural matrix of social psychology. In D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology, Vol. 2* (4th ed., pp. 915–981). New York: McGraw-Hill.

Fiske, S. T. (1993). Controlling other people: The impact of power on stereotyping. *American Psychologist, 48,* 621–628.

Fiske, S. T. (1998). Stereotyping, prejudice, and discrimination. In D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology, Vol. 2* (4th ed., pp. 357–411). New York: McGraw-Hill.

Fitzgerald, L. F., & Nutt, R. (1986). The Division 17 principles concerning the counseling/psychotherapy of women: Rationale and implementation. *Counseling Psychologist, 14,* 180–216.

Flaskerud, J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity, and gender match on utilization and outcome of therapy. *Community Mental Health Journal, 27,* 31–41.

Flores, M. T., & Carey, G. (Eds.). (2000). *Family therapy with Hispanics*. Needham Heights, MA: Allyn & Bacon.

Fontes, L. A. (1998). Ethics in family violence research: Multicultural issues. Family Relations. *Interdisciplinary Journal of Applied Family Studies, 47,* 53–61.

Fouad, N. A., & Brown, M. (2000). Race, ethnicity, culture, class and human development. In S. D. Brown & R. W. Lent (Eds.), *Handbook of Counseling Psychology,* (3rd. ed., pp. 379–410). New York: Wiley.

Fowers, B. J., & Richardson, F. C. (1996). Why is multiculturalism good? *American Psychologist, 51*, 609–621.

Frank, J. D., & Frank, J. B. (1998). Comments on "Reconceptualizing multicultural counseling: Universal healing conditions." *The Counseling Psychologist, 26*, 589–591.

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Continuum.

Fuertes, J. N., Bartolomeo, M., & Nichols, C. M. (2001). Future research directions in the study of counselor multicultural competency. *Journal of Multicultural Counseling and Development, 29*, 3–12.

Fuertes, J. N., & Gretchen, D. (2001). Emerging theories of multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed, pp. 509–541). Thousand Oaks, CA: Sage.

Fukuyama, M. A., & Ferguson, A. D. (2000). Lesbian, gay, and bisexual People of Color: Understanding cultural complexity and managing multiple oppressions. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 81–106). Washington, DC: American Psychological Association.

Fukuyama, M. A., & Sevig, T. D. (1999). *Integrating spirituality into multicultural counseling*. Thousand Oaks, CA: Sage.

Fullilove, M. T. (1996). Psychiatric implications of displacement: Contributions from the psychology of place. *American Journal of Psychiatry, 153*, 1516–1523.

Gaertner, S. L., & Dovidio, J. F. (2000). *Reducing intergroup bias: The common ingroup identity model.* Philadelphia: Brunner/Mazel.

Galinsky, A. D., & Moskowitz, G. B. (2000). Perspective-taking: Decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *Journal of Personality & Social Psychology, 78*, 708–724.

Garcia-Caban, I. (2001). *Improving systems of care for racial and ethnic minority consumers: Measuring cultural competence in Massachusetts acute care hospital settings.* Unpublished doctoral dissertation, Brandeis University, Waltham, MA.

Gergen, K. (2001). Psychological science in a post-modern context. *American Psychologist, 56*, 203–213.

Gil, E. F., & Bob, S. (1999). Culturally competent research: An ethical perspective. *Clinical Psychology Review*, *19*, 45–55.

Gilbert, D. T. (1998). Ordinary personalogy. In. D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology, Vol.* 2 (4th ed., pp. 89–150). New York: McGraw-Hill.

Glaser, I. (1988). Affirmative action and the legacy of racial injustice. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating racism: Profiles in controversy* (pp. 341–357). New York: Plenum.

Goodwin, R. (1996). A brief guide to cross-cultural psychological research. In J. Haworth (Ed.), *Psychological research: Innovative methods and strategies* (pp. 78–91). Florence, KY: Taylor & Francis/Routledge.

Grady, K. E. (1981). Sex bias in research design. *Psychology of Women Quarterly, 5*, 628–636.

Greenberg, J., Solomon, S., Pyszczynski, T., Rosenblatt, A., & et al. (1992). Why do people need self-esteem? Converging evidence that self-esteem serves an anxiety-buffering function. *Journal of Personality & Social Psychology, 63*, 913–922.

Greene, B. (2000). African American lesbian and bisexual women. *Journal of Social Issues, 56*, 239–249.

Greenleaf, R. K. (1998). *The power of servant-leadership: Essays.* San Francisco: Berrett-Koehler.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102,* 4–27.

Grieger, I., & Ponterotto, J. G. (1995). A framework for assessment in multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 357–374). Thousand Oaks, CA: Sage.

Grieger, I., & Ponterotto, J. G. (1998). Challenging intolerance. In C. L. Lee & G.R. Walz (Eds.), *Social Action A Mandate for Counselors* (pp. 17–50). Alexandria, VA: American Counseling Association and Greensboro, NC: ERIC Counseling & Student Services Clearinghouse.

Grieger, I., & Tolliver, S. (2001). Multiculturalism on predominantly White campuses: Multiple roles and functions for the counselor. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 825–848). Thousand Oaks, CA: Sage.

Haas, L. L., Hwang, P., & Russell, G. (2000). *Organizational change and gender equity: International perspectives on fathers and mothers in the workplace.* Thousand Oaks, CA: Sage.

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting & Clinical Psychology, 69,* 502–510.

Haslam, S. A. (2001). *Psychology in organizations.* Thousand Oaks, CA: Sage. Hays, P. A. (1995). Multicultural applications of cognitive-behavior therapy. *Professional Psychology: Research and Practice, 26,* 309–315.

Helms, J. (1990). *Black and White racial identity: Theory, research, and practice.* Westport, CT: Greenwood.

Helms, J. E. (1992). Why is there no study of cultural equivalence in standardized cognitive ability testing? *American Psychologist, 47,* 1083–1101.

Helms, J. E. (2002). A remedy for the Black-White test-score disparity. *American Psychologist, 57,* 303–304.

Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process.* Boston: Allyn & Bacon.

Helms, J. E., & Talleyrand, R. M. (1997). Race is not ethnicity. *American Psychologist, 52,* 1246–1247.

Herring, R. D. (1999). *Counseling with Native American Indians and Alaska Natives: Strategies for helping professionals.* Thousand Oaks, CA: Sage.

Hewstone, M., Rubin, M., & Willis, H. (2002). Intergroup bias. *Annual Review of Psychology, 53,* 575–604.

Highlen, P. S. (1994). Racial/ethnic diversity in doctoral programs of psychology: Challenges for the twenty-first century. *Applied and Preventive Psychology, 3,* 91–108.

Hofstede, G. (1980). *Culture's consequences*. London: Sage.

Holcomb-McCoy, C., & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development, 77,* 294–302.

Hong, G. K., & Ham, M. D. C. (2001). *Psychotherapy and counseling with Asian American clients.* Thousand Oaks, CA: Sage.

Hornsey, M. J., & Hogg, M. A. (2000). Assimilation and diversity: An integrative model of subgroup relations. *Personality & Social Psychology Review, 4,* 143–156.

Hoshmand, L. S. T. (1989). Alternate research paradigms: A review and teaching proposal. *The Counseling Psychologist, 17,* 3–79.

Ibrahim, F. A. (1985). Effective cross cultural counseling and psychotherapy: A framework. *The Counseling Psychologist, 13,* 625–638.

Ibrahim, F. A. (1999). Transcultural counseling: Existential worldview theory and cultural identity. In J. McFadden (Ed.), *Transcultural counseling* (2nd ed., pp. 23– 58). Alexandria, VA: American Counseling Association.

Ivey, A., & Ivey, M. (1998). Reframing DSM-IV: Positive strategies from developmental counseling and therapy. *Journal of Counseling and Development, 76,* 334–350.

Ivey, A., & Ivey, M. (1999). *Intentional interviewing and counseling: Facilitating multicultural development*. Pacific Grove, CA: Brooks/Cole.

Jackson, L. C. (1999). Ethnocultural resistance to multicultural training: Students and faculty. *Cultural Diversity & Ethnic Minority Psychology, 5,* 27–36.

Jackson-Triche, M. E., Sullivan, J. G., Wells, K. B., Rogers, W., Camp, P., & Mazel, R. (2000). Depression and health-related quality of life in ethnic minorities seeking care in general medical settings. *Journal of Affective Disorders, 58,* 89–97.

Jensen, A. R. (1995). Psychological research on race differences. *American Psychologist, 50,* 41–42.

Johnson, W. B., & Packer, A. H. (1987). *Workforce 2000.* Indianapolis, IN: Hudson Institute.

Jones, J. M., Lynch, P. D., Tenglund, A. A. & Gaertner, S. L. (2000). Toward a diversity hypothesis multidimensional effects of intergroup contact. *Applied & Preventive Psychology, 9,* 53–62.

Judy, R. W., & D'Amico, C. (1997). *Workforce 2020.* Indianapolis, IN: Hudson Institute.

Katz, J. H. (1985). The sociopolitical nature of counseling. *Counseling Psychologist, 13,* 615– 624.

Kawakami, K., Dovidio, J. F., Moll, J., Hermsen, S., & Russin, A. (2000). Just say no (to stereotyping): Effects of training in the negation of stereotypic associations on stereotype activation. *Journal of Personality & Social Psychology, 78,* 871–888.

Keller, E. F. (1982). Feminism and science. *Signs, 7,* 589–602.

Kessler, R. C., Berglund, P. A., Zhao, S., Leaf, P. I., Kouzis, A. C., Bruce, M. L. et al. (1996). The 12-month prevalence and correlates of serious mental illness. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States* (Pub. No. [SMA] 96-3098). Rockville, MD: Center for Mental Health Services.

Kim, B. S. K., Atkinson, D. R., Umemoto, D. (2001). Asian cultural values and the counseling process: Current knowledge and directions for future research**.** *The Counseling Psychologist, 29,* 570–603.

Kiselica, M. S. (1998). Preparing Anglos for the challenges and joys of multiculturalism. *The Counseling Psychologist, 26,* 5–21.

Kite, M. E., Russo, N. F., Brehm, S. S., Fouad, N. A., Hall, C. C., Hyde, J. S., & Keita, G. P. (2001). Women psychologists in academe: Mixed progress, unwarranted complacency. *American Psychologist, 56,* 1080–1098.

Klausner, M. B. (1998). Multicultural training in graduate psychology programs: Impacts and implications. *Dissertation Abstracts International, 58 (9-B),* 5124.

Kluckhohn, F. R., & Strodbeck, F. L. (1961). *Variations in value orientations.* Evanston, IL: Row, Patterson & Co.

Koeltzow, D. A. (2000). Research into the relationships among multicultural training, racial and gender identity attitudes and multicultural competencies for counselors. *Dissertation Abstracts International: The Sciences and Engineering, 61,* 1672.

Kopelowicz, A. (1997). Social skills training: The moderating influence of culture in the treatment of Latinos with schizophrenia. *Journal of Psychopathology and Behavioral Assessment, 19*, 101–108.

Korchin, S. J. (1980). Clinical psychology and minority problems. *American Psychologist, 35,* 262–269.

Korman, M. (1974). National conference on levels and patterns of professional training in psychology. *American Psychologist, 29*, 441–449.

Kramer, R. M. (1999). Trust and distrust in organizations: Emerging perspectives, enduring questions. *Annual Review of Psychology, 50,* 569–598.

Kunda, Z., & Sinclair, L. (1999). Motivated reasoning with stereotypes: Activation, application, and inhibition. *Psychological Inquiry, 10,* 12–22.

Kunda, Z., & Thagard, P. (1996). Forming impressions from stereotypes, traits, and behaviors: A parallel-constraint-satisfaction theory. *Psychological Review, 103,* 284–308.

Kwan, K.-L. K. (1999). MMPI and MMPI-2 performance of the Chinese cross-cultural applicability. *Professional Psychology: Research and Practice, 30*, 260–268.

LaFramboise, T. (1988). American Indian mental health policy. *American Psychologist, 43*, 388–397.

LaFromboise, T. D., & Foster, S. L. (1992). Multicultural training: Scientist-practitioner model and methods. *Counseling Psychologist, 20,* 472–489.

LaFromboise, T. D., & Jackson, M. (1996). MCT theory and Native-American populations. In D. W. Sue, A. E. Ivey & P. B. Pedersen (Eds.), *A theory of multicultural counseling & therapy* (pp. 192–203). Pacific Grove, CA: Brooks/Cole.

Langman, P. F. (1998). *Jewish issues in multiculturalism: A handbook for educators and clinicians*. Northvale, NJ: Jason Aronson, Inc.

Leach, M. M., & Carlton, M. A. (1997). *Toward defining a multicultural training philosophy*. Thousand Oaks, CA: Sage.

Lee, W. M. L. (1999). *An introduction to multicultural counseling*. Philadelphia: Accelerated Development.

Lee, R. M., Chalk, L. Conner, S. E., Kawasaki, N., Janetti, A, LaRue, T., & Rodolfa, E. (1999). The status of multicultural training at counseling center internship sites. *Journal of Multicultural Counseling and Development, 27*, 58–74.

Lenington-Lara, M. (1999). Exploring the subjective experience of participants in multicultural awareness training course. *Dissertation Abstracts Internation, 60*, (2-B): 085.

Levin, M. (1995). Does race matter? *American Psychologist*, *50,* 45–46.

Lewin, K. (1945). The Research Center for Group Dynamics at Massachusetts Institute of Technology. *Sociometry, 8,* 126–136.

Lewin, K. (1951). *Field theory in social science: Selected theoretical papers*. New York: Harpers.

Lewis, J. A., Lewis, M. D., Daniels, J. A., & D'Andrea, M. J. (1998). *Community counseling: Empowerment strategies for a diverse society.* San Francisco: Brooks/Cole.

Locke, D. C. (1992). *Increasing multicultural understanding*. Newbury Park, CA: Sage.

Loden, M. (1996). *Implementing Diversity.* Chicago: Irwin.

López, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological consideration. *Psychological Bulletin, 106,* 184–203.

Lowe, S. M., & Mascher, J. (2001). The role of sexual orientation in multicultural counseling: Integrating bodies of knowledge. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 755–778). Thousand Oaks, CA: Sage.

Lukasiewicz, M., & Harvey, E. (Producers). (1991, September 26). *True Colors on 20/20: Primetime Live*. New York: ABC.

Macrae, C. N., & Bodenhausen, G. V. (2000). Social cognition: Thinking categorically about others. *Annual Review of Psychology, 51,* 93–120.

Major, B., Quinton, W. J., & McCoy, S. K. (in press). Antecedents and Consequences of Attributions to Discrimination: Theoretical and Empirical Advances. In M. P. Zanna (Ed.), *Advances in experimental social psychology, Vol. 34*. New York: Academic Press.

Major, B., Sciaccitano, A. M., & Crocker, J. (1993). In-group versus out-group comparisons and self-esteem. *Personality and Social Psychology Bulletin, 19,* 711–721.

Manese, J. E., Wu, J. T., & Nepomuceno, C. A. (2001). The effect of training on multicultural competencies: An exploratory study over a ten-year period. *Journal of Multicultural Counseling and Development, 29,* 31–40.

Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations*. Thousand Oaks, CA: Sage.

Markus, H. R., & Kitayama, S. (2001). The cultural construction of self and emotion: Implications for social behavior. In W. G. Perrod (Ed.), *Emotions in social psychology: Essential reading* (pp 119–137). Philadelphia: Brunner-Routledge.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98,* 224–253.

McGoldrick, M., Giordano, J., & Pearce, J. K. (Eds.). (1996). *Ethnicity & family therapy* (2nd ed.). New York: Guilford.

Medved, C. E., Morrison, K., Dearing, J. E., Larson, R. S., Cline, G., & Brummans, B. H. (2001). Tensions in community health improvement initiatives: Communication and collaboration in a managed care environment. *Journal of Applied Communication Research, 29,* 137–151.

Middleton, R. A., Rollins, C. W., & Harley, D. A. (1999). The historical and political context of the civil rights of persons with disabilities: A multicultural perspective for counselors. *Journal of Multicultural Counseling & Development, 27,* 105–120.

Middleton, R., Arredondo, P., & D'Andrea, M. (2000). The impact of Spanish-speaking newcomers in Alabama towns. *Counseling Today,* p. 24.

Mio, J. S., & Awakuni, G. I. (2000). *Resistance to multiculturalism: Issues and interventions.* Philadelphia: Brunner/Mazel.

Mio, J. S., & Morris, D. R. (1990). Cross-cultural issues in psychology training programs: An invitation for discussion. *Professional Psychology: Research and Practice, 21,* 434–441.

Morgan, G. (1997). *Images in organizations*. Thousand Oaks, CA: Sage.

Mosley-Howard, G. S., & Burgan Evans, C. (2000). Relationships and contemporary experiences of the African American family: An ethnographic case study. *Journal of Black Studies, 30,* 428–452.

Murdock, N. L., Alcorn, J., Heesacker, M., & Stoltenberg, C. (1998). Model training program in counseling psychology. *Counseling Psychologist, 26,* 658–672.

Nanus, B. (1992). *Visionary Leadership. Creating a compelling sense of direction for your organization.* San Francisco: Jossey-Bass.

National Center for Education Statistics. (2001). *The condition of education.* Washington, DC: US Department of Education.

Neville, H. A., & Mobley, M. (2001). Social identities in contexts: An ecological model of multicultural counseling psychology processes. *Counseling Psychologist, 29,* 471–486.

Niemann, Y. F. (2001). Stereotypes about Chicanas and Chicanos: Implications for counseling. *The Counseling Psychologist, 29,* 55–90.

Oetting, G. R., & Beauvais, F. (1990–1991). Orthogonal cultural identification theory: The cultural identification of minority adolescents. *International Journal of the Addictions, 25,* 655–685.

Ory, M. G., Lipman, P. D., Barr, R., Harden, J. T., & Stahl, S. M. (2000). A national program to enhance research on minority aging and health promotion. *Journal of Mental Health & Aging, 6,* 9–18.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128,* 3–72.

Oyserman, D., Gant, L., & Ager, J. (1995). A socially contextualized model of African American identity: Possible selves and school persistence. *Journal of Personality & Social Psychology, 69,* 1216–1232.

Padilla, A. M. (1995). (Ed.). *Hispanic psychology: Critical issues in theory and research.* Thousand Oaks, CA: Sage.

Paniagua, F. (1994). *Assessing and treating culturally different clients*. Newbury Park, CA: Sage.

Paniagua, F. (1998). *Assessing and treating culturally diverse clients* (2nd ed.). Thousand Oaks, CA: Sage.

Parham, T. A. (1989). Cycles of psychological nigrescence. *Counseling Psychologist, 17,* 187–226.

Parham, T. A. (1993). White researchers conducting multicultural counseling research: Can their efforts be "mo betta"? *The Counseling Psychologist, 21,* 250–256.

Parham, T. A. (2001). Psychological nigrescence revisited: A foreword. *Journal of Multicultural Counseling and Development, 29,* 162–164.

Parham, T. A., White, J. L., & Ajamu, A. (1999). *The psychology of Blacks: An African centered perspective* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Parker, W. A., Moore, M. A., & Neimeyer, G. J. (1998). Altering White racial identity and interracial comfort through multicultural training. *Journal of Counseling and Development, 76,* 302–310.

Pedersen, P. (1997). *Culture-centered counseling interventions: Striving for accuracy.* Thousand Oaks, CA: Sage.

Pedersen, P. (1999). *Multiculturalism as a fourth force.* Philadelphia: Brunner/Mazel.

Pedersen, P. (2000). *Hidden messages in culture-centered counseling: A triad training model*. Thousand Oaks, CA: Sage.

Peng, K., & Nisbett, R. E. (1999). Culture, dialectics, and reasoning about contradiction: National Council of Schools and Programs of Professional Psychology. In R. L. Peterson, D. R. Peterson, & J. C. Abrams (Eds.), *Standards for education in professional psychology*. Washington, DC: American Psychological Association and National Council of Schools of Professional Psychology.

Perez, J. E. (1999). Clients deserve empirically supported treatments, not romanticism. *American Psychologist, 54*, 205–206.

Pettigrew, T. F. (1979). The ultimate attribution error: Extending Allport's cognitive analysis of prejudice. *Personality & Social Psychology Bulletin, 5*, 461–476.

Pettigrew, T. F. (1998). Applying social psychology to international social issues. *Journal of Social Issues, 54*, 663–675.

Phinney, J. S. (1991). Ethnic identity and self-esteem: A review and integration. *Hispanic Journal of Behavioral Sciences, 13*, 193–208.

Phinney, J. S. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist, 51*, 918–927.

Plant, E. A., & Devine, P. G. (1998). Internal and external motivation to respond without prejudice. *Journal of Personality & Social Psychology, 75*, 811–832.

Ponterotto, J. G. (1997). Multicultural counseling training: A competency model and national survey. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 111–130). Thousand Oaks, CA: Sage.

Ponterotto, J. G. (1998). Charting a course for research in multicultural counseling training. *Counseling Psychologist, 26*, 43–68.

Ponterotto, J. G., & Casas, J. M. (1991). *Handbook of racial/ethnic minority counseling research.* Springfield, IL: Charles C. Thomas.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (1995). *Handbook of multicultural counseling.* Thousand Oaks, CA: Sage.

Ponterotto, J. G., & Pedersen, P. B. (1993). *Preventing prejudice: A guide for counselors and educators.* Newbury Park, CA: Sage.

Pope-Davis, D. B., Breaux, C., & Lui, W. M. (1997). *A multicultural immersion experience: Filling a void in multicultural training*. Thousand Oaks, CA: Sage.

Pope-Davis, D. B., & Coleman, H. L. K. (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision*. Thousand Oaks, CA: Sage.

Pope-Davis, D. B., & Ottavi, T. M. (1994). Examining the association between self-expressed multicultural counseling competencies and demographic variables among counselors. *Journal of Counseling and Development, 72*, 651–660.

Prendes-Lintel, M. (2001). A working model in counseling recent refugees. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 729–752). Thousand Oaks, CA: Sage.

Prieto, L. R., McNeill, B. W., Walls, R. G., & Gomez, S. P. (2001). Chicanas/os and mental health services: An overview of utilization, counselor preference and assessment issues. *The Counseling Psychologist, 29*, 18–54.

Psychologists in the CIA. (2002, April). *Monitor on Psychology, 33*.

Quintana, S. M., & Bernal, M. E. (1995). Ethnic minority training in counseling psychology: Comparisons with clinical psychology and proposed standards. *The Counseling Psychologist, 23*, 102–121.

Quintana, S. M., Troyano, N., & Taylor, G. (2001). Cultural validity and inherent challenges in quantitative methods for multicultural research. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling*, (2nd ed., pp. 604–630). Thousand Oaks, CA: Sage.

Ramirez, M. (1998). *Multicultural/multiracial psychology: Mestizo perspectives in personality and mental health.* Northvale, NJ: Jason Aronson.

Reid, P. T. (2002). Multicultural psychology: Bringing together gender and ethnicity. *Cultural Diversity & Ethnic Minority Psychology, 8*, 103–114.

Research Office. (2002a). *Demographic characteristics of APA members by race/ethnicity, analyses of APA directory survey: 2000.* Washington DC: American Psychological Association.

Research Office. (2002b). *Race/ethnicity of APA members and APA governance members: Analyses of APA governance survey.* Washington DC: American Psychological Association.

Reynolds, A. L. (1995). Challenges and strategies for teaching multicultural counseling courses. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 312–330). Thousand Oaks, CA: Sage.

Reynolds, K. J., & Oakes, P. J. (2000). Variability in impression formation: Investigating the role of motivation, capacity, and the categorization process. *Personality & Social Psychology Bulletin, 26,* 355–373.

Ridley, C. (1995). Overcoming unintentional racism in counseling and therapy: A Practitioner's guide to intentional intervention. Thousand Oaks, CA: Sage.

Ridley, C. R., Espelage, D. L., & Rubinstein, K. J. (1997). Course development in multicultural counseling. In D. B. Pope-Davis & H. L. K. Coleman (Eds.). *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 131–158). Thousand Oaks, CA: Sage.

Ridley, C., Hill, C., & Li, L. (1998). Revisiting and refining the multicultural assessment procedure. *Counseling Psychologist, 6*, 939–947.

Robinson, T. L., & Howard-Hamilton, M. (2000). *The convergence of race, ethnicity, and gender.* Upper Saddle River, N.J.: Prentice-Hall.

Rodriquez, R., & Walls, N. (2000). Culturally educated questioning: Toward a skillbased approach in multicultural counselor training. *Applied & Preventive Psychology, 2,* 89–99.

Rogers, M. R., Hoffman, M. A., & Wade, J. (1998). Notable multicultural training in APA-approved counseling psychology and school psychology programs. *Cultural Diversity & Ethnic Minority Psychology, 4,* 212–226.

Rogler, L. H. (1999). Methodological sources of cultural insensitivity in mental health research. *American Psychologist, 54*, 424–433.

Rooney, S. C., Flores, L. Y., & Mercier, C. A. (1998). Making multicultural education effective for everyone. *The Counseling Psychologist, 26*, 22–32.

Root, M. P. P. (Ed). (1992). *Racially mixed people in America.* Newbury Park, CA Sage.

Root, M. P. P. (1999). The biracial baby boom: Understanding ecological constructions of racial identity in the 21st century. In R. H. Sheets & E. R. Hollins (Eds.), *Racial and ethnic identity in school practices: Aspects of human development* (pp. 67–89). Mahwah, NJ: Erlbaum.

Ruiz, A. S. (1990). Ethnic identity: Crisis and resolution. *Journal of Multicultural Counseling and Development, 18*, 29–40.

Rushton, J. P. (1995). Construct validity, censorship, and the genetics of race. *American Psychologist, 50,* 40–41.

Saldana, D. (1995). Acculturative stress: Minority status and distress. In A. M. Padilla (Ed.), *Hispanic psychology* (pp. 43–56). Thousand Oaks, CA: Sage.

Salvador, C. M. (1998). Effects of the intercultural awareness development courses on first year students' multicultural competency. *Dissertation Abstracts International, 58 (11-B)*, 5874.

Samuda, R. J. (1998). *Psychological testing of American minorities*. Thousand Oaks, CA: Sage.

Sanchez, A. R. (2001). Multicultural family counseling: Toward cultural sensibility. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 672–700). Thousand Oaks, CA: Sage.

Sandoval, J., Frisby, C. L., Geisinger, K. F., Scheuneman, J. D., & Grenier, J. R. (Eds.). (1998). *Test interpretation and diversity: Achieving equity in assessment.* Washington, DC: American Psychological Association.

Santiago-Rivera, A., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia: A practitioner's guide.* Thousand Oaks, CA: Sage.

Schlesinger, M., & Gray, B. (1999). Institutional change and its consequences for the delivery of mental health services. In A. Horwitz & T. Scheid (Eds.), *A Handbook for the study of mental health: Social contexts, theories, and systems* (pp. 427–448). New York: Cambridge University Press.

Schmader, T., Major, B., & Gramzow, R. H. (2001). Coping with ethnic stereotypes in the academic domain: Perceived injustice and psychological disengagement. *Journal of Social Issues, 57*, 93–111.

Schofield, J. W. (1986). Causes and consequences of the colorblind perspective. J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 231– 253). San Diego, CA: Academic Press.

Sciarra, D. T. (1999). *Multiculturalism in counseling*. Itasca, IL: Peacock.

Sedikides, C., & Brewer, M. B. (2001). *Individual self, relational self, collective self.* Philadelphia: Brunner-Routledge.

Seeley, K. M. (2000). *Cultural psychotherapy.* Northvale, NJ: Jason Aronson.

Sellers, R. M., Smith, M. A., Shelton, J. N., Rowley, S. A., & Chavous, T. M. (1998). Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality & Social Psychology Review, 2*, 18–39.

Senge, P. (1990). *The fifth discipline*. New York: Doubleday.

Sevig, T., & Etzkorn, J. (2001). Transformative training: A year-long multicultural counseling seminar for graduate students. *Journal of Multicultural Counseling and Development, 29*, 57–72.

Shanbhag, M. G. (1999). The role of covert racial prejudice, attitudinal ambivalence, and guilt in receptivity to multicultural training. *Dissertation Abstracts International, 59(9-B)*: 5111.

Sherif, C. W. (1979). Social values, attitudes, and involvement of the self. *Nebraska Symposium on Motivation, 27*, 1–64.

Sidanius, J., & Pratto, F. (1999). *Social dominance: An intergroup theory of social hierarchy and oppression.* New York: Cambridge University Press.

Smart, J., & Smart, D. W. (1995). Acculturative stress of Hispanics: Loss and challenge. *Journal of Counseling & Development, 73*, 390–396.

Society for the Psychological Study of Ethnic Minority Issues, Division 45 of the American Psychological Association & Microtraining Associates, Inc. (Sponsors and producers). (2000). *Culturally-competent counseling and therapy: Live demonstrations of innovative approaches.* [Films]. (Available from Microtraining Associates, Inc., P.O. Box 9641, North Amherst, MA 01059-9641).

Sodowsky, G. R., & Kuo, P. Y. (2001). Determining cultural validity of personality assessment: Some guidelines. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *The intersection of race, class, and gender: Implications for multicultural counseling* (pp. 213–240). Thousand Oaks, CA: Sage.

Sodowsky, G. R., Kuo-Jackson, P., & Loya, G. (1997). Outcome of training in the philosophy of assessment: Multicultural counseling competencies. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment education and training, and supervision*. Thousand Oaks, CA: Sage.

Sodowsky, G. R., Kuo-Jackson, P.Y., Richardson, M. F., & Corey, A.T. (1998). Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control racial ideology, and multicultural training. *Journal of Counseling Psychology, 45,* 256–264.

Spengler, P. M. (1998). Multicultural assessment and a scientist-practitioner model of psychological assessment. *Counseling Psychologist, 6,* 930–938.

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist, 52,* 613–629.

Steward, R. J., Wright, D. J., Jackson, J. D., & Jo, H. (1998). The relationship between multicultural counseling training and the evaluation of culturally sensitive and culturally insensitive counselors. *Journal of Multicultural Counseling & Development, 3*, 205–217.

Stone, G. L. (1997). Multiculturalism as a context for supervision: Perspectives, limitations, and implications. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and anecdotal training* (pp. 263–289). Thousand Oaks, CA: Sage.

Stukas, A. A., Jr., & Snyder, M. (2002). Targets' awareness of expectations and behavioral confirmation in ongoing interactions. *Journal of Experimental Social Psychology, 38,* 31–40.

Sue, D. (1978). Eliminating cultural oppression in counseling: Toward a general theory. *Journal of Counseling Psychology, 25*, 419–428.

Sue, D. (1997). Multicultural training. *International Journal of Intercultural Relations, 21,* 175–193.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*, 790–821.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70,* 477– 483.

Sue, D. W., Bernier, J., Durran, M., Feinberg, L., Pedersen, P., Smith, E., & Vasquez-Nuttall, E. (1982). Position paper: Multicultural counseling competencies. *The Counseling Psychologist, 10*, 45–52.

Sue, D. W., Bingham, R. P., Porche-Burke, L., & Vasquez, M. (1999). The diversification of psychology: A multicultural revolution. *American Psychologist, 54,* 1061–1069.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., LaFromboise, T., Manese, J. E., Ponterotto, J. G., & Vazquez-Nutall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.

Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.

Sue, D.W., & Sue, D. (1977). Ethnic minorities: Failures and responsibilities of the social sciences. *Journal of Non-White Concerns in Personnel and Guidance, 5,* 99–106.

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: Wiley.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53,* 440–448.

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist, 54,* 1070–1077.

Sun, K. (1995). The definition of race. *American Psychologist, 50,* 43–44.

Suzuki, L. A., Prendes-Lintel, M., Wertlieb, L., & Stallings, A. (1999). Exploring multicultural issues using qualitative methods. In M. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 123–133). Thousand Oaks, CA: Sage.

Suzuki, L. A., & Valencia, R. R. (1997). Race-ethnicity and measured intelligence: Educational implications. *American Psychologist, 52,* 1103–1114.

Swim, J., & Mallett, R. (2002). *Pride and prejudice: A multi-group model of identity and its association with intergroup and intragroup attitudes.* Manuscript submitted for publication.

Swim, J., & Stangor, C. (1998). *Prejudice: The target's perspective.* San Diego, CA: Academic Press.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 7–24). Chicago: Nelson-Hall.

Thomas, D. A., & Ely, R. J. (1996). Making differences matter: A new paradigm for managing diversity. *Harvard Business Review, 74,* 79–90.

Thomas, D. A., & Gabarro, J. (1999). *Breaking through: The making of minority executives in corporate America*. Boston: Harvard Business School Press.

Thompson, C. E., & Carter, R. T. (1997). *Racial identity theory: Applications to individual, group, and organizational interventions.* Mahwah, NJ: Erlbaum.

Triandis, H. C., & Brislin, R. W. (1984). Multicultural psychology. *American Psychologist, 39,* 1006–1016.

Triandis, H. C., & Singelis, T. M. (1998). Training to recognize individual differences in collectivism and individualism within culture. *International Journal of Intercultural Relations, 22,* 35–47.

Turner, J. C., Brown, R. J., & Tajfel, H. (1979). Social comparison and group interest in ingroup favouritism. *European Journal of Social Psychology, 9,* 187–204.

U.S. Census Bureau. (2001). U.S. Census 2000, Summary Files 1 and 2. Available from U.S. Census Bureau web site, http://www.census.gov.

U.S. Department of Health and Human Services. (2000; 2001). *Mental health: Culture, race and ethnicity—A supplement to Mental Health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Office, Office of the Surgeon General.

Vandiver, B. J., Fhagen-Smith, P. E., Cokley, K. O., Cross, W. E., Jr., & Worrell, F. C. (2001). Cross' nigrescence model: From theory to scale to theory. *Journal of Multicultural Counseling and Development, 29,* 174–200.

Wehrly, B., Kenney, K. R., & Kenney, M. E. (1999). *Counseling multiracial families.* Thousand Oaks, CA: Sage.

Westermeyer, J., & Janca, A. (1997). Language, culture and psychopathology: Conceptual and methodological issues. *Transcultural Psychiatry, 34*, 291–311.

Witte, K., & Morrison, K. (1995). Intercultural and cross-cultural health communication: Understanding people and motivating healthy behaviors. In R. L. Wiseman (Ed.), *Intercultural communication theory* (pp. 216–246). Thousand Oaks, CA: Sage.

Wolsko, C., Park, B., Judd, C. M., & Wittenbrink, B. (2000). Framing interethnic ideology: Effects of multicultural and color-blind perspectives on judgments of groups and individuals. *Journal of Personality & Social Psychology, 78*, 635– 654.

Worrell, F. C., Cross, W. E., Jr., Vandiver, B. J. (2001). Nigrescence theory: Current status and challenges for the future. *Journal of Counseling and Development, 29*, 201–213.

Wright, S. C., & Taylor, D. M. (1998). Responding to tokenism: Individual action in the face of collective justice. *European Journal of Social Psychology, 28*, 647–667.

Wu, A. W. (2000). Quality-of-life assessment in clinical research: Application in diverse populations. *Medical Care, 38*, II130–II135.

Yee, A. H., Fairchild, H. H., Weizmann, F., & Wyatt, G. E. (1993). Addressing psychology's problem with race. *American Psychologist, 48*, 1132–1140.

Zhang, A. Y., Snowden, L. R., & Sue, S. (1998). Differences between Asian and White-Americans' help-seeking and utilization patterns for the Los Angeles area. *Journal of Community Psychology, 26*, 317–326.

Theory and Research on Stereotypes and Perceptual Bias:
A Didactic Resource for Multicultural Counseling Trainers

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This article presents theory and selected research on stereotyping and cognitive automaticity as a didactic resource base for multicultural counselor educators. Multicultural trainers can use this information in the classroom to establish the existing scientific evidence indicating that perceptual processes taking place outside of conscious awareness give rise to biased perceptions involving racial or ethnic categories. The objective of this didactic resource is to impress upon counseling trainees the importance of coming to terms with racial prejudice and biases often hidden from conscious scrutiny. In addition to the didactic material, several experiential exercises designed to elicit awareness of biases in personal attitudes and beliefs toward culturally diverse groups are presented. Suggestions for future research are also included.

It has been more than 15 years since the American Psychological Association (APA) Division 17 position paper (Sue et al., 1982) that defined specific cross-cultural counseling competencies appeared in this journal. This turned out to be a very influential paper, as its guidelines were incorporated into the APA Accreditation Handbook (APA, 1986); into the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (Task Force, 1993); and in Principles A and D of APA's ethics code (APA, 1992). In addition, numerous models of training that promote cultural sensitivity in counseling practices have been proposed (Arredondo et al., 1996; Brown, Parham, & Yonker, 1996; Corvin & Wiggins, 1989; Das, 1995; LaFromboise & Foster, 1992; Lopez et al., 1989; Parker, 1998; Ponterotto, 1988; Ridley, Mendoza, & Kanitz, 1994) and continue to permeate the counseling literature (Bieschke, Eberz, Bard, & Croteau, 1998; Fischer, Jome, & Atkinson, 1998; Kiselica, 1998).

Sue et al. (1982) identified three general competencies that characterize a culturally skilled counseling psychologist: (a) awareness of personal beliefs/attitudes toward culturally diverse clients, (b) knowledge about diverse cultures, and (c) ability to use intervention skills or techniques that are culturally responsive (see also Sue, Arredondo, & McDavis, 1992). Among the counselor training approaches cited above, Arredondo et al.'s (1996) contribution is perhaps the one most closely associated with Sue et al. (1982), representing an operationalization of the three multicultural competencies with suggested training strategies to achieve them.

Arredondo et al. (1996) lay out quite clearly the training implications for the knowledge and skills competencies. The operationalizations of a competent counselor in the cultural knowledge area, for example, include "can discuss recent research addressing issues of racism, White identity development, antiracism, and so forth"(p. 60) and "can describe at least two different models of minority identity development and their implications for counseling" (p. 64). Competent counselors in the area of technical skills "can give examples of how they may modify a technique or intervention or what alternative intervention they may use to more effectively meet the needs of a client" (p. 71) and "can describe concrete examples of situations in which it is appropriate and possibly necessary for a counselor to exercise institutional intervention skills on behalf of a client" (p. 71). Importantly, by way of defining the competencies of knowledge and skills, Arredondo et al.'s operationalizations suggest the training needed to attain them. For example, coursework readings or presentations on racial/gender/sexual-identity development, acculturation theory, and sociopolitical histories of minority groups that emphasize the impact of oppression on self-concept are all likely catalysts to the attainment of the knowledge competency. Likewise, the teaching of counseling techniques particularly well suited for work with specific cultural groups can be expected to help counseling students improve their multicultural skills.

The process that leads to competency in beliefs/attitudes, however, is not well developed and, consequently, it is more problematic from a training perspective. Consider Arredondo et al.'s (1996) operationalizations: "[culturally competent counselors in beliefs/attitudes] can identify social and cultural influences on their cognitive development and current information processing style" (p. 60) and "can recognize their stereotyped reactions to people different from themselves...consciously attend to examples that contradict stereotypes...[and] give specific examples of how their stereotypes...can affect the counselor-client relationship" (p. 63). Notice that these operationalizations do not clearly suggest the content of training needed to help counseling

students achieve this competency. Indeed, what educational experiences could be developed to promote the type of counselor self-awareness that precede changes in personal attitudes and beliefs toward clients who differ from the counselor ethnically and/or culturally?

Perhaps due to a lack of didactic materials, educational approaches designed to promote awareness of racism and other biases in counseling trainees typically rely on experiential exercises and activities. Corvin and Wiggins's (1989) antiracism training model for White professionals, for example, is composed of a sequence of experiential activities designed for each one of four White racial identity stages of development. Activities are structured around group discussions to prompt participants to start thinking of themselves as racial beings. Suggested questions for discussion include "What ideas were you encouraged to believe about people of your own racial group?" and "How were you taught to interact with people of other racial groups?" Other activities involve brainstorm sessions to generate and discuss racial stereotypes ascribed to minority groups as well as identification of action strategies to confront racism on a personal, institutional, and cultural level.

Another example of a multicultural educational approach is described by Brown et al. (1996), who divided their training course into three phases: (1) personal beliefs/self-awareness, (2) knowledge of five ethnocultural populations, and (3) development of preliminary skills to counsel diverse clients. Phase 1, which bears the most import to the present article, was entirely composed of experiential activities, including participation in a mock version of Jane Elliott's blue-eyed brown-eyed experience,[1] actual interviews with individuals racially or ethnically different from the interviewer (e.g., a White student interviewing a Latino classmate), and other such experiences to promote group bonding and raise consciousness of personal biases. Phase 2 calls for guest speakers representing each of five ethnocultural groups to present material on the issues, history, and dynamics of the guests' racial/ethnic heritage. Phase 3 involves skills training, such as identification and interpretation of verbal and nonverbal communication. Though Brown et al. acknowledge the importance of "emphasizing self awareness [Phase 1] as a preliminary step to knowledge acquisition and skill development" (p. 515), no provisions were made to address any resistance from trainees to participate in a personally meaningful fashion, a situation very likely to occur during this phase of multicultural training.

Resistance to multicultural training is not uncommon. In describing personal experiences teaching a cross-cultural counseling course, Ponterotto (1988) classified trainee reactions to his course along a "zealot-defensive" continuum, wherein some become very zealous and involved in fostering a pro-minority perspective, whereas at the other end of the spectrum, some become withdrawn and passive recipients of class activities. Ten years later, trainees enrolled in an APA-approved program of counseling psychology (Steward, Morales, Bartell, Miller, &Weeks, 1998) were asked to indicate if their overall reaction to diversity-related content addressed in departmental courses was either positive or negative; one third (33.3%) indicated having a negative experience and that their exposure to multicultural literature was meaningless and unnecessary. One likely source of apathy among some multicultural counseling trainees is that meaningful personal changes in attitudes and beliefs toward culturally or ethnically different people require self-discovery and acknowledgment of socially undesirable characteristics—such as bias or prejudice—that are in turn likely to inhibit self-learning. Because of the inherent difficulties in acknowledging biases and prejudice at a personal level, an experiential educational approach capitalizing on affect may activate a defensive rather than an open frame of mind, inhibiting rather than promoting personal learning.

Tomlinson-Clarke (1999) and Ota Wang and Briggs (1997) have suggested that multicultural training may be more effective when experiential/affective training is preceded by didactic/cognitive instruction. In their discussion of racial/cultural training for the development of counselor multicultural competencies, Tomlinson-Clarke and Ota Wang (1999) assert that

> discussions of race and racism often result in the "conspiracy of silence about racism." …Emotionally powerful feelings, potentially explosive situations, and feelings of guilt from members of racial groups who have intentionally or unintentionally benefited from who they are (e.g., White privilege) have often fueled this conspiracy of silence. (p. 160)

Their premise of a didactic component preceding experiential activities is intuitively appealing, as beginning multicultural training with didactic instruction would be expected to reduce preliminary nervousness and defensiveness among counseling trainees, facilitating emotional readiness for affective exercises as well as other multicultural teaching.

A recent qualitative study that examined the outcomes of a multicultural training course provides preliminary empirical support to this premise. Tomlinson-Clarke (1999) directed counseling psychology students to complete written evaluations immediately upon completing a multicultural training course and then again at a 4- month follow-up. Among her many findings, Tomlinson-Clarke reported that didactic, cognitively based aspects of training apparently helped students feel more comfortable with, and eager to learn, other training components. She concluded that

> the recognition of the need for further cultural self-awareness and self-knowledge is critical in viewing multicultural competence as a process in which professionals and trainees continue to challenge deeply embedded cultural assumptions and increase understanding of oneself as a racial-cultural being. (p. 16)

Counseling students may resist multicultural training for a variety of reasons. For example, from a White racial identity development (WRID) perspective (Sabani, Ponterotto, & Borodovski, 1991), inhibited multicultural learning may be especially relevant to trainees in the preexposure/precontact and conflict stages of development who may be opposed to, or experience distress from, self-discovery of racism and prejudice. Briefly, the WRID's stages and related themes are as follows:

> *Preexposure/precontact*. There is a lack of contact with racial diversity and a lack of awareness of self as a racial being and the presence of racism in society.
> *Conflict*. Interaction with members of minority groups leads to awareness of prejudicial attitudes toward racial minorities. An awareness of conflict develops between wanting to conform to White norms while upholding humanitarian values.
> *Prominority/antiracism*. There is identification with minority concerns coupled with anger toward White *status* quo.
> *Retreat into White culture*. This is a retreat into the familiarity of White culture as a way to deal with perceived rejection from minority community.
> *Redefinition and integration*. There is development of a racial identity that includes a sense of Whiteness as well as personal commitment to a culturally transcendent worldview.

PURPOSE AND OVERVIEW

The primary purpose of this article is to introduce theory and selected research on stereotyping and cognitive automaticity as a didactic resource base for multicultural trainers. The objective of this approach is to make self-awareness of covert prejudicial attitudes and beliefs easier to acknowledge by establishing, scientifically, that perceptual biases that involve racial categories are normative and apply to most everyone (Devine, 1989; Fiske, 1998). Intended specifically to facilitate the beliefs/attitudes multicultural counseling competency, this article is by no means a comprehensive multicultural training package, although it can nicely supplement the existing curricula of trainers who teach multicultural counseling courses or of instructors who otherwise infuse their courses with a multicultural component. In addition to a didactic resource component—which immediately follows and is the mainstay of this article—a brief experiential component is also presented that specifies a series of exercises designed to elicit awareness of biases in personal attitudes and beliefs toward culturally diverse groups. Sections articulating implications for practice and research are also included.

DIDACTIC COMPONENT

The goal of this component is to establish the scientific evidence indicating the unconscious nature of perceptual biases involving racial or ethnic categories. Trainers can use this information to enhance their existing training curricula covering the area of counselor attitudes and beliefs toward minority clients. This didactic resource is organized under six sections. In the first section, labels such as *biased*, *prejudiced*, and *racist* are briefly introduced as concepts that are more accurately conceptualized as continua rather than dichotomies. The second section defines the nature of stereotypes and how they function to produce biased perceptions. The third section reviews a series of studies that examine the role of automatic processes in perception. The fourth section presents

research evidence clearly showing how stereotypes work outside of conscious awareness to promote racial bias. The fifth section reviews the clinical and analogue literature on differential treatment of ethnic minority clients and the influence of stereotypes on counselor perceptual processes. The sixth and final section introduces a line of research that has begun to examine more closely the dynamics of how stereotypes change as well as the conditions under which automatic processes operate.

Bias, Prejudice, and Racism as Continua

Webster's Dictionary (1990) defines *bias* as "a temperamental or emotional leaning to one side"; *prejudice* as "a preconceived opinion, usually unfavorable"; and *racism* as "the assumption that characteristics of an individual are determined by race." As labels, these words are often used as dichotomous constructs rather than continua; that is, a person is perceived as being either biased, prejudiced, racist or not. A person is often categorized as racially biased or prejudiced, for example, if he or she displays racially prejudicial sentiments in public, conjuring up images of individuals like the once-popular television character Archie Bunker or of organized groups such as the Ku Klux Klan. One problem with this type of dichotomous thinking is the implied assumption that anyone not engaged in extreme forms of prejudicial behavior is not prejudiced (or racist or biased).

Yet, far from suggesting clear-cut dichotomies, theories of racial prejudice suggest that in reality prejudice, bias, and racism are more like continua, affecting—in varying degrees—most everyone (Devine, 1989; Fiske, 1998; Gaertner & Dovidio, 1986; McConahay, 1986). For example, aversive racism theory (Gaertner & Dovidio, 1986) holds that most people embrace egalitarian values toward racial diversity while still harboring negative feelings about minority groups. As a coping mechanism for this ambivalence, negative feelings are repressed, surfacing only in subtle or covert ways. Likewise, McConahay's (1986) theory of modern racism posits that people are generally unaware of their prejudices, but rather than repressing their negative affect toward minority groups, they rationalize it: "Minorities get more breaks than they deserve," or "Minorities are getting too demanding in their push for civil rights." Katz's (1981) racial prejudice model, on the other hand, stipulates that people are generally cognizant of their prejudicial attitudes or beliefs. Commitment to values of equality, however, leads to internal ambivalence characterized by the presence of both positive (sympathy) and negative (contempt) feelings. The result is behavioral instability, with positive and negative responses toward minority individuals, depending on the situation.

Research evidence indicating an unconscious component to racial bias and prejudice (e.g., Devine, 1989; Greenwald, Banaji, Nosek, & Bhaskar, 1998; Greenwald, McGhee, & Schwartz, 1998) is generally consistent with theoretical models of prejudice. Devine (1989), for example, found that participants who identified themselves as being high-prejudice or low-prejudice were equally prone to perceptual biases mediated by racial stereotypes. According to Devine, the reason for this is that personal attitudes and beliefs toward racial and ethnic diversity involve cognitive structures (schemas and stereotypes) and processes (automaticity) that pervasively and effectively filter and shape human social reality, including those realities connected to racial or ethnic group categories.

Instructor/trainee resources. The purpose of this brief introduction is to highlight the importance and relevance of the material that follows, especially for students that feel reasonably prejudice free. Instructors may find it helpful to assign the McConahay (1986) chapter as a required or suggested reading.

The Functions of Cognitive Schemas and Stereotypes

Stereotypes are special types of cognitive structures involved in categorizing individuals or social targets. Lippman (1921) defined stereotypes as oversimplified generalizations about groups or categories of people. These generalizations have also been identified as schemas (Taylor & Crocker, 1981), prototypes (Brewer, Dull, & Liu, 1981), and expectancies (Hamilton, Sherman, & Ruvolo, 1990). Though differences exist among these constructs, they all define stereotypes as organized cognitive abstractions within which incoming information can be stored and represented in memory. These structures develop via firsthand experience with members of the group that is stereotyped or from information made available through family, friends, and the media. When an individual is categorized as a member of a particular social group, the group-relevant cognitive structure or stereotype is activated, and subsequent information relative to this person is processed within the framework of that particular stereotype. Activation of a stereotype can influence what aspects of the available information are attended to

(information that fits stereotypical expectations is more likely to enter into the information processing system), how that information is interpreted and encoded, and what information will be available for later retrieval.

Another defining feature of stereotypes is that they lack flexibility. One would think that information contradicting a stereotypical belief or expectancy might lead the perceiver to question the validity of that belief. Although this is theoretically feasible (Rothbart, 1981), some researchers feel that instead of a drastic change in beliefs, the perceiver's conception of the stereotyped group becomes subtyped, with one subtype maintaining the existing stereotype and another subtype representing the disconfirming instances (Crocker, Fiske, & Taylor, 1984; Hamilton, 1981). Preservation of stereotypes is also inherent to the way people in general go about testing their social reality. Confirmation of an initial (stereotypical) assessment of any one individual is often accomplished by asking questions where the overall likelihood of a yes, confirming the initial hypothesis, is high. This propensity for hypothesis-confirmatory strategies serves as a basis for the maintenance of stereotypical beliefs (Klayman & Ha, 1987; Skov & Sherman, 1986).

A more recent model of stereotyping is based on retrieval mechanisms sensitive to social cues (Smith & Zarate, 1990, 1992; Zarate & Smith, 1990) rather than to cognitive, category-based abstractions. According to this model, a social target activates a large variety of exemplars stored in memory that do not necessarily belong to the same category. The attributes of these exemplars are then summarized to form inferences or judgments about the target. For example, undergraduates attending a class lecture for the first time may form their impressions of a bearded, Black, male history professor by activating in memory relevant exemplars, including Black males, male professors, history professors, bearded men, and so on. When this occurs, no racial stereotyping is said to take place, as perceptions are likely to be multidimensional. Stereotyping occurs, however, when the exemplars activated are members of the same social category, such as race. Staying with the example, when inferences about a Black male professor are based on activated exemplars of Black males but exclude other nonracial dimensions (such as age, profession, the presence of facial hair, etc.), then the professor is likely to be perceived as stereotypically Black.

Zarate and Smith (1990) acknowledge that although there are many ways to categorize an individual, all equally correct, the determinants of which classifications (i.e., skin color, sex, age, etc.) are used and when they are used are largely unknown. Smith and Zarate (1992) go on to speculate that stimulus characteristics and cultural default values are likely to modulate a perceiver's allocation of attention to specific stimulus attributes. For example, in Western culture, male sex, White race, nondisabled physical status, heterosexual orientation, and young age are treated as cultural expectations, assumed to characterize a person if no dimension-relevant information is explicitly provided (Eagly & Kite, 1987). A departure from the expected attribute value will be likely to attract attention and be the basis for categorizing the target.

Kunda and Thagard's (1996) parallel-constraint-satisfaction theory is yet another approach explicating the effects of stereotyping on impression formation. This theory assumes that stereotypes, traits, and observed behaviors are interconnected nodes in a spreading cognitive activation network. The spread of activation between nodes is constrained by positive and negative associations. Figure 1 portrays a schematic illustration of the activation network that explains why the behavior of a person observed elbowing another may be interpreted as a jovial shove when performed by a White person but a violent push when performed by a Black person (see Duncan, 1976; Sagar& Schofield, 1980). In this illustration, the trait (node) *aggressive* has a positive excitatory connection with *violent push* and a negative inhibitory connection with *jovial push*. When the observed target is White, aggressive is activated only once. When the target is Black, the aggressive node is activated twice, due to the stereotypical view of Blacks as being aggressive. Thus, the violent push ends up with more activation when the stimulus target is Black rather than White, indicating how stereotypes can constrain the meaning of observed behavior.

Instructor/trainee resources. The information covered in this section is intended to help counseling trainees understand the nature of stereotypes, that is, what they are and how they filter social reality. In describing the various formulations of stereotypes since Lippman (1921) first coined the term, students are expected to gain an appreciation for the longstanding and continued scientific interest on this topic as well as for the vast amount of information substantiating this body of knowledge. The following recommendations are made as helpful instructor resources for lecture or possible reading assignments for trainees. Haslam, Turner, Oakes, McGarty, and Reynolds (1998) review the relevant research on processes that contribute to consensual stereotypes of both outgroups and ingroups. Hamilton and Sherman (1994) and Hamilton and Trolier (1986) provide reviews of research on the mental representations of stereotypes.

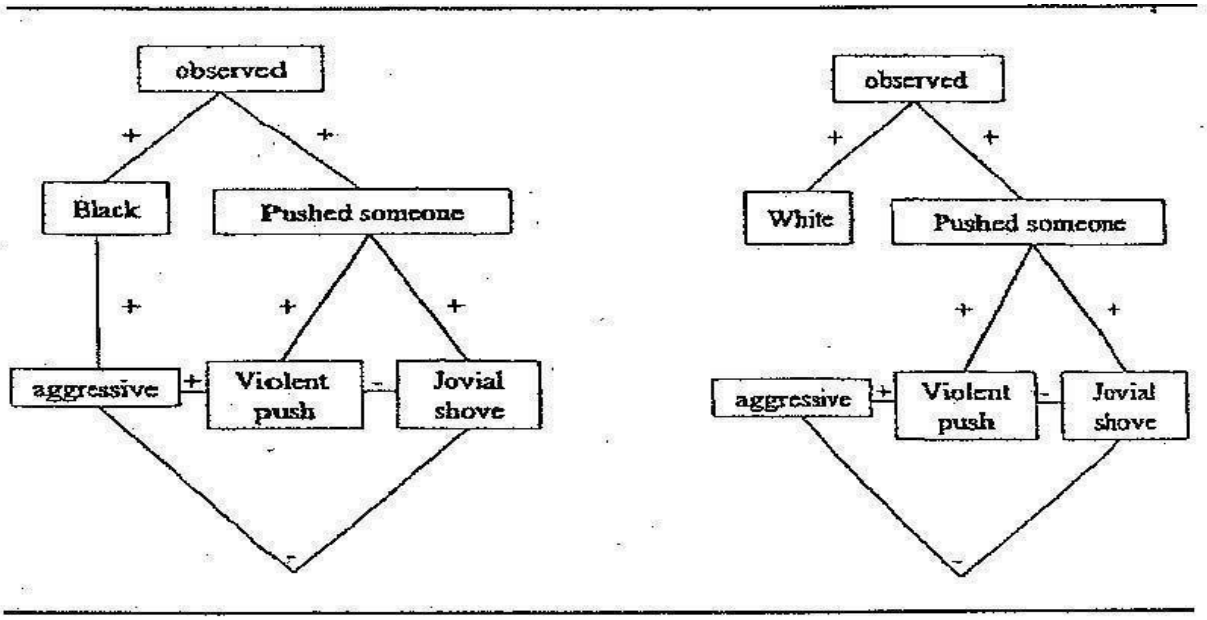

Figure 1. Stereotypes affect meaning of behavior.
SOURCE: Kunda and Thagard (1996). Copyright 1996 by the American Psychological Association (APA). Reprinted by permission of APA.
NOTE: Violent push is activated more strongly in the network on the left than in the network on the right.

Automaticity in Perceptual Bias

The processes involved in social perceptions are often automatic, occurring outside of conscious awareness. More specifically, automatic processes involve the unintentional and spontaneous activation of some well-learned category of associations, such as schemas or stereotypes that have been developed through repeated activation in memory. These processes do not require conscious effort and appear to be initiated or primed by the presence of category-related stimulus cues in the environment (Higgins & King, 1981; Higgins, Rholes, & Jones, 1977; Shiffrin & Dumais, 1981; Srull & Wyer,1980).

Automaticity in perceptual bias is clearly demonstrated in the (now classic) priming study reported by Bargh and Pietromonaco (1982). These researchers developed a strategy to activate information processing along a categorical dimension using passive priming, that is, activation of a cognitive category that takes place outside of conscious awareness. In a task described to participants as a "perceptual vigilance task," the authors presented their study participants with very brief word flashes (100 milliseconds each) via a computer screen. This procedure precluded conscious processing of the words presented. Either 0%, 20%, or 80% of these words were semantically related to hostility. In an ostensibly unrelated second task, participants read a description of a stimulus person involved in ambiguously hostile behavior and were then asked to rate this person (or target) on several hostility- related dimensions. Their hostility ratings were reliably and positively related to the proportion of hostility words to which they were exposed, indicating that the priming, though passive or unconscious, effectively biased participant perceptions of the stimulus target.

A more recent line of priming research indicates that automatically activated stereotypes, aside from promoting biases in perceptions, also appear to have an effect on behavior (Bargh, Chen, & Burrows, 1996). Bargh et al. (1996) used words associated with the construct of rude or polite to prime, respectively, two groups ofresearch

participants. Results indicated that participants in the rude priming condition interrupted the experimenter more quickly and frequently than did participants in the polite priming condition. In a second experiment, participants for whom an elderly stereotype was primed walked more slowly down the hallway when leaving the experiment than did control participants. These findings point to the possibility that people may (unintentionally) elicit the very type of behavior expected of stereotyped social targets, but being unaware of these contingencies, the target's behavior may be interpreted as a confirmation of the stereotype—a self-fulfilling prophesy.

Instructor/trainee resources. The information in this, as well as the next, section bears the most relevance to one of the most important objectives of this entire didactic component, that is, recognition of the insidious nature of stereotyping and the personal relevance of a process that often operates outside of conscious awareness. To promote personal integration of the material, instructors may want to probe students with questions such as, How does it feel to think that your perceptions can be influenced passively or unconsciously by environmental stimuli? What about the notion that your own behavior may elicit the confirmation of stereotypes, a dynamic operating outside of your awareness? For suggested readings, consider Bargh (1994) and Wegner and Bargh (1996); both provide excellent reviews on the role of automaticity in attitudes and socialcognition.

Automaticity in Racial Bias

Automatic processes leading to perceptual biases are not only evident with attribute-level cognitive schemas (i.e., "rude," "polite"). Automaticity has also been shown to operate with group-level information. For example, instead of using hostility-related prime words—as did Bargh and Pietromonaco (1982)—Devine (1989) used stereotypical descriptors ascribed to African Americans (e.g., *Harlem, basketball, rhythm*) as the primes. Either 20% or 80% of words flashed tachistoscopically were primes (nonprimewords used were *water, tree*, etc.), representing the two independent conditions of a design otherwise identical to Bargh and Pietromonaco's (described previously). Following the priming procedure, participants read a description of a target person of undisclosed ethnicity engaged in hostile behavior; they then rated this individual on several dimensions. Results indicated that participants made stereotype-congruent (negative) evaluations of the stimulus target, with ratings of hostility more extreme in the 80% condition than in the 20% condition. Devine concluded that hostility must be linked categorically to Blacks because the priming included no words semantically related to hostility. She reasoned that the obtained effect was mediated by the stereotyped or biased perception that African Americans are hostile (Dovidio, Evans, & Tyler, 1986). Results reported in studies similar to Devine's have been consistent in indicating that automaticity is a well-established phenomenon in social perceptions that involve racial categories (Greenwald, McGhee,&Schwartz, 1998; Kawakami, Dion, & Dovidio, 1998; Lepore & Brown, 1997; Wittenbrink, Judd, & Park, 1997). The last in a series of experiments reported in Bargh et al. (1996)—which essentially replicated and extended Devine's (1989) findings—documented evidence indicating that racial stereotypes may affect behavior as well as perceptions. Rather than using prime words associated with Black stereotypes, as did Devine, Bargh et al. used black-and-white photographs of African American or Caucasian faces as the two priming conditions, with the pictures flashed subliminally on a computer screen. While the pictures were being flashed, participants were involved in a lengthy and tedious bogus task. At the end of the task, the experimenter then came back into the room and announced, "I'm sorry, the computer failed to save your data; you'll have to do the experiment over again." The critical dependent measures were the participants' videotaped reactions to this information. Two coders who were blind to the experimental conditions and hypotheses rated all the videotaped facial expressions on a 5-point scale of hostility (ranging from *not at all hostile* to *extremely hostile*). Results indicated that participants primed subliminally with the African American faces reacted with more hostility to the vexation manipulation than did their counterparts primed with Caucasian faces. Thus automatic activation of stereotypes is not only likely to promote biased perceptions, as shown by Devine (1989), but may also affect perceiver behaviors in ways that elicit the expected responses from targets or members of stereotyped groups, an insidious behavioral contingency likely to perpetuate stereotypes by way of self-fulfillingprophesy.

Instructor/trainee resources. This is an extremely important section to help students realize how they may be racially biased or prejudiced in covert ways, without really being aware of it. It may be useful to integrate this information to the "bias as a continuum" concept presented in the introductory section. This may be done by asking probing questions such as, What does it mean for you to be biased by racial stereotypes? If this bias takes place

outside of your awareness, could you argue that you are not really being racially biased? Prejudiced? Racist? Devine (1989) and Bargh et al. (1996) are essential readings for this section, as they provide very convincing empirical evidence of the unconscious nature of racial biases in social perceptions. Greenwald, McGhee, and Schwartz (1998) also present, very convincingly, the prevalence of covert biases involving social categories.

Stereotypes and Counselor Bias

Automatic, unconscious processes in social perceptions may explain the psychotherapist bias in the diagnosis and treatment of racial minorities documented in the clinical literature (e.g., Balch & Balch, 1975; Baskin, Bluestone, & Nelson, 1981a, 1981b; Cole & Pilisuk, 1976; Jones, 1982; Lloyd & Moodley, 1992; Paradis, Hatch, & Friedman, 1994; Snowden & Cheung, 1990). Baskin et al. (1981a), for example, found that White and Asian clinicians diagnosed higher levels of pathologies in Black clients than did Black or Hispanic clinicians, and in their second study (Baskin et al., 1981b), the authors reported that Black women were diagnosed more often as psychotic and less often as depressed than women of other races. Jones (1982) reported that White therapists gave more severe diagnoses to Black clients than to White clients. Snowden and Cheung (1990), and later Paradis et al. (1994), reported that African Americans were more likely than Whites to be diagnosed with a psychotic disorder than an affective disorder. In reference to this literature, Adebimpe (1994) wrote, "The evidence of different treatment experiences can no longer be regarded as 'scanty, piecemeal, and inconclusive' or as an artifact of a transient period of heightened research interest in blacks" (p. 30).

It is worth noting that clinical studies do not always show evidence of racial bias in diagnostic practices. For example, Bishop and Richards (1987), and later Tomlinson-Clark and Camilli (1995), used counseling center data (instead of hospital records) to look for racial bias, but they found no evidence indicating overpathologizing of Black clients by participating counselors. Also, in his insightful analysis of clinical diagnosis, Lopez (1989) argues that racial bias in diagnosis can occur in opposite directions. For example, overpathologizing a Black client may occur when symptoms of persecution are automatically interpreted as a sign of paranoid delusions rather than as an appropriate response to a hostile, racist environment. On the flip side, when these same symptoms are automatically assumed to be the result of a racist environment, underpatholgizing may occur.

Although clinical studies have consistently reported negative biases toward minority (particularly Black) clients in terms of diagnosis and treatment assignment, analogue studies generally find no bias among participating counselors (e.g., Abramowitz & Murray, 1983; Littlewood, 1992) or even a "pro-Black" bias (e.g., Merluzzi & Merluzzi, 1978; Strickland, Jenkings, Myers, & Adams, 1988). For these studies, clinical materials such as audiotaped interviews or case summaries are presented to clinicians who are then asked to provide clinical ratings on clients identified as either Black or White. For example, Strickland et al. (1988) presented clinical psychology trainees bogus clinical profiles, with patient race (manipulated) as the independent variable of interest; they were then asked to rate patient level of psychopathology. Strickland et al. reported that patients portrayed as White neurotics and psychotics were given higher ratings of severity than were Black neurotics and psychotics, whereas Black normals were rated more "normal" than White clients. Some writers attribute this type of pro-Black bias in analogue research to social desirability response sets occurring when client race is a transparent variable of interest, and research participants likely "discern the true objectives of the study and adjust their responses so as to put themselves and their profession in a favorable light" (Abramowitz & Murray, 1983, p. 218). In contrast, participants in studies based on actual clinical data (e.g., Adebimpe, 1994) are generally not aware that their clinical judgments are part of an investigation.

When analogue studies involving client race are designed to circumvent or minimize social desirability responses, counselor responses generally manifest biased perceptions. For example, in a study by Casas, Wampold, and Atkinson (1981), Anglo and ethnic minority counselor trainees were asked to make judgments of hypothetical student targets based on the recall of information previously presented to them relating to ethnicity, blood type, and stereotypical characteristics (an illusory correlation design). Casas et al. found that, when recalling information about minority targets, Anglo-American trainees made fewer errors on those items for which a stereotypical response was correct than on those items for which the stereotypical response was incorrect, indicating they were more prone to be influenced by ethnic stereotypes, when compared to other trainees (see also Wampold, Casas, & Atkinson, 1982).

A recent study (Abreu, 1999) that used priming procedures modeled after the Bargh and Pietromonaco (1982) and Devine (1989) investigations described earlier has added further strength to the hypothesis that counselor

racial bias is associated with cognitive processes involving stereotypes. In this study, counselors randomly assigned to one of two priming conditions were primed with African American stereotypes and category labels (e.g., *ghetto, basketball, Black* in the experimental condition) or neutral words (e.g., *water, television, things* in the control condition) using 80-millisecond flash-words via a computer screen. This procedure activates information processing outside of conscious awareness. After this task, participants were exposed to a brief vignette introducing "Mr. X," a client referred for treatment, and were then asked to rate Mr. X on various dimensions. Participants primed with stereotype words rated Mr. X more negatively (e.g., hostile, unfriendly, dislikable) than did participants in the neutral priming condition when items rated were related to hostility. The pattern of ratings on hostility unrelated attributes (e.g., boring, conceited, narrow-minded), however, was reversed: More favorable ratings obtained among participants in the experimental group compared to the control group. Abreu (1999) concluded that hostility must be related to African Americans via a broad category such as "emotional expressiveness" and that stereotype biases do not necessarily lead to perceptions that have a negative valence.

Instructor/trainee resources. The purpose of this section is to highlight the relevance of the previous sections to counseling process. It is important for counseling students to recognize the need to be open to multicultural training, especially in the area of self-awareness of covert racial attitudes and beliefs. Instructors may want to emphasize the notion that unconscious racial biases undermine a counselor's effectiveness with his or her minority clients and that acknowledging the presence of these biases is a crucial first step to becoming a more culturally sensitive counselor. Possible reading assignments for this section include analogue research reports indicating ethnic or racial biases among counselors (Abreu, 1999; Casas et al., 1981; Wampold et al., 1982) and clinical evidence of diagnostic biases involving client race (Paradis et al., 1994; Snowden & Cheung, 1990).

Research on Stereotype Change

The research reviewed up to this point supports the idea that stereotypes and automatic processes give rise to biases in social perceptions, a rather disturbing set of findings. Yet, there is reason to be optimistic. A recent line of research has begun to examine more closely the dynamics of how stereotypes change (Dunton & Fazio, 1997; Plant & Devine, 1998; Rothbart, 1996; Stewart, Doan, Gingrich, & Smith, 1998) as well as the conditions under which automatic processes operate (Blair & Banaji, 1996; Macrae, Bodenhausen, Milne, Thorn, & Castelli, 1997; Wittenbrink et al., 1997). For example, in testing the hypothesis that favorable experiences with individual members of a disliked group can generalize to the group as a whole, Rothbart (1996) found that the ability of a group stereotype to remain uninfluenced by experiences with individual members depends on the magnitude of discrepancy between category and social target. More specifically, when the discrepancy between a racial stereotype and social experiences with an individual member of a stereotyped group was large, the general stereotype was likely to remain insulated from the experience. This may be so because the target may be subtyped as not being a typical representative of his or her group. However, when the discrepancy between stereotype and individual was modest in size, Rothbart concluded, "there is reason to be optimistic that the stereotype will move slowly, but inexorably, in the direction of reality" (p. 320). Social psychologists are also beginning to develop research instruments and strategies to study how level of racial prejudice interfaces with social impression formation, egalitarian motivation, and behaviors (Dunton & Fazio, 1997; Plant & Devine, 1998; Stewart et al., 1998). Stewart et al. (1998), for example, found that low-prejudice Whites formed individuated representations when judging African American actors on stereotypical behavior, whereas high-prejudice Whites formed representations consisting primarily of aspects of the actors' identity indicative of their ethnic category. The authors concluded that their findings support the notion that resistance to stereotype changes is associated with level of prejudice.

Another line of research findings and theoretical speculation has focused on the possibility that stereotype activation is conditionally rather than unconditionally automatic (Blair & Banaji, 1996; Macrae et al., 1997; Wittenbrink et al., 1997). Blair and Banaji (1996), for example, demonstrated that automatic activation of gender stereotypes was conditional on participant (manipulated) expectations about the experimental task. Facilitative priming effects (shorter reaction times) were obtained when participants expected stereotype-congruent stimuli; however, participants led to expect stereotype- incongruent stimuli showed no evidence of priming facilitation, even though they were exposed to the same stimuli as the previous group. These results led Blair and Banaji to speculate that stereotypical cues need not always result in a stereotypical response, implying that the automatic impact of

stereotypes on perceptions may be brought under conscious control by perceivers willing to develop self-awareness of their own expectations.

Although more research is needed to shed light on specific strategies to combat the unwanted influence of stereotypes, what we do know up to this point highlights the need to repeatedly scrutinize how our perceptual system may function to bias perceptions and attitudes toward others. Devine (1989) argues that "inhibiting stereotype-congruent or prejudice-like responses and intentionally replacing them with nonprejudiced responses can be likened to the breaking of a bad habit" (p. 15), which requires (a) personal commitment to stop old behavior and (b) active endorsement of this resolution, leading ultimately to (c) perseverance in efforts to eradicate the habit.

Instructor/trainee resources. Instructors can use this section for at least two purposes: (a) to show that, although stereotypes tend to resist change, research does suggest that change is possible and, relatedly, (b) to help trainee transition into the experiential component, which follows.

EXPERIENTIAL COMPONENT

The objective of the previous sections was to provide multicultural trainers with a succinct and scientifically sound didactic resource base to impress upon counseling trainees the role of stereotypes in promoting perceptual biases and covert beliefs that involve racial categories. The experiential component now presented is intended to supplement didactic instruction by way of exercises designed to promote self-awareness of prejudicial biases and stereotypes.

The labeling exercise. This training exercise, which takes approximately 1 hour, was recently developed and tested by Goldstein (1997). Its purpose is to convey to participants the multidimensional impact of stereotypes on perceivers as well as on targets. Briefly, adhesive labels with different stereotypical trait descriptors, such as *uneducated*, *lazy*, *good at math*, *violent*, and so on, are randomly assigned and attached to participants' heads or backs. Participants are then asked to mingle with each other as if they were at a cocktail party and to discuss a specific topic, such as future goals, with the added instruction to treat each other according to the trait depicted on the label. After about 15 to 20 minutes of mingling, a debriefing and discussion session can begin. This is an opportunity for participants to discuss their own behavior and how others treated them. Participants may then view their labels. Goldstein identifies several issues or themes that instructors can process with participants. For example, participants usually notice the ease with which one can find stereotype-confirming information, highlighting the role stereotypes play in selective attention and attribution. Participants may expend a great deal of time trying to disprove or prove a label, or they may otherwise acknowledge the difficulty of ignoring stereotypical treatment. Another theme involves the significance of the exercise for prejudice reduction, including the need to attend to stereotype- disconfirming information.

The implicit association test. Greenwald, McGhee, and Schwartz (1998) developed the Implicit Association Test (IAT) designed to measure differential associations of two target concepts with an attribute. For example, when the attribute *pleasant* is presented, participants respond faster by pressing a key that corresponds to the word *flower* than to *insect*, a response contingency that is reversed for the attribute *unpleasant*. In similar fashion, positive attributes such as *joy* and *peace* are more quickly associated with names considered White (e.g., Chip, Peggy) than with names considered Black (e.g., Jamal, Lashonda); when negative attributes such as *evil* and *hate* are used, participants respond more quickly to Black names than to White names. The IAT, now available via the Internet (Greenwald, Banaji, et al., 1998), has consistently found unconscious prejudice in 90% to 95% of people who take it. The authors caution that results from the IAT could be disturbing, especially to individuals who consider themselves prejudice-free. Instructors teaching in classrooms with multimedia capability can demonstrate the use of the IAT during class, or the test can be assigned for students to take at their convenience and then discuss the results during the next class session.

Other experiential exercises. Various training exercises have been proposed to correct beliefs and attitudes toward racial and ethnic minorities and to counter the negative influences of race-based bias and prejudice in the counseling process. Hulnick (1977), for example, recommended that counselors analyze the factors that make them feel uncomfortable or inhibited in any given cross-cultural counseling situation; effective interaction with clients

depends on the extent to which these difficulties are identified and worked through. An awareness group experience proposed by Parker, Bingham, and Fukuyama (1985) was designed to promote group exploration of attitudes, feelings, beliefs, and behaviors toward ethnic minority persons, as well as a group plan to increase each member's contact with ethnically dissimilar people. Beale's (1986) cross-cultural dyadic encounter is a training exercise designed to facilitate open-ended questions between members of different cultures to stimulate dialogue about culturally relevant information. The cultural attitudes repertory technique (Fukuyama & Neimeyer, 1985) is yet another approach to elicit personally held attitudes and beliefs about cross-cultural interaction. Finally, Mio (1989) recommends pairing up with a culturally different partner to become acquainted with and to share culturally relevant experiences.

IMPLICATIONS FOR PRACTICE

Like perhaps many other instructors of multicultural counseling courses, I organize my multicultural counseling course as did Brown et al. (1996), that is, one unit or phase for each of the three multicultural competencies (i.e., personal beliefs/attitudes, cultural knowledge, multicultural skills). Thus, about one third of the semester-long course I teach deals with beliefs/attitudes issues, which I further divide into didactic and experiential components, much as this article was organized. The course I teach is required of master's and doctoral counseling trainees, with a class size of about 15 students. As noted previously, this article does not represent a comprehensive training program, and it was not intended to replace existing curricula. Rather, it was intended as a resource for trainers to facilitate the development of the awareness/ beliefs aspect of multicultural competency in their counseling trainees. Consequently, I envision much flexibility in how trainers may choose to adapt the material in this article to fit their course format and needs.

The training approach described in this article may be of special interest to multicultural counseling instructors looking for away to address the needs of students who become defensive or resistant to course material (Ponterotto, 1988; Steward et al., 1998;Tomlinson-Clarke & Ota Wang, 1999).Tomlinson-Clark and Ota Wang (1999), for example, believe that a didactic approach during the early stages of a course is a good way to prepare students for experiential learning or for class discussion in this topical area. This line of reasoning suggests that the present didactic component may yield the best results when presented early in a multicultural course or teaching unit. However, it is also quite possible that presentation of the didactic material late in the course (or unit) may lead trainees to consider the meaningfulness of previous course material—including experiential activities—from a new perspective, leading to a salient or otherwise more lasting impression of the importance diversity issues play in the counseling process.

There are some cautions pertaining to the teaching components described in this article that need to be raised. The didactic component in this article can take considerable time to implement; it takes me at least two (3- hour) class sessions to cover this material in lecture. Because some of the experiments covered in the didactic component utilize complex methods (e.g., priming procedures), I use overheads and the chalkboard to illustrate them as I entertain questions from students, which they often raise. The point is that instructors interested in implementing the present didactic component need to consider their time constraints carefully, and some may choose to truncate it or otherwise revise it in order to better fit their needs. Trainers should also prepare for possible counterproductive reactions from their students. Normalization of prejudice and bias, for example, may provide comfort to some students, which could then lead to reinforcement of cultural encapsulation rather than commitment to become less prejudiced or biased. For this reason, I am always careful to clarify that although stereotyping occurring outside of conscious awareness may explain the prevalence of covert prejudicial behaviors in our society, this is no ground for justification. Finally, untoward reactions to one or more of the activities outlined in the experiential component are possible and may require an extended debriefing session or discussion in order to process the experience.

Evidence at my disposal of the effectiveness in approaching counselor bias and prejudice from a didactic perspective is at this point anecdotal. For example, I have noted that, in general, students taking my course have been much more willing to participate freely and openly in class discussions and activities since I started infusing my curriculum with the didactic component documented in this article. Also, my teaching evaluations now contain many positive comments about the helpfulness of the "early lectures on social psychology." Objective methods for evaluating the teaching components articulated in this article are presented in the followingsection.

IMPLICATIONS FOR RESEARCH

Pretest-posttest designs can be developed to determine the effectiveness of the teaching approach articulated in this article, with the didactic component specified as the experimental manipulation. For example, trainee multicultural competence can be measured before and after completion of a multicultural counseling course or teaching unit, with only half of the participants (experimental group) exposed to the didactic component offered in this article. Assuming intervention effectiveness, control group trainees can receive the didactic component after the second measurement of cultural competence, which can then be measured a third time (i.e., pre-post-post). Several instruments are available (or can be adapted) for trainees to self-assess multicultural competence: the Cross- Cultural Counseling Inventory–Revised (LaFromboise, Coleman, & Hernandez, 1991), the Multicultural Awareness Scale– Form B (Ponterotto, Sanchez, & Magids, 1991), the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), and the Multicultural Awareness–Knowledge–Skills Survey (D'Andrea, Daniels, & Heck, 1991). Ponterotto, Rieger, Barrett, and Sparks (1994) provide a critical review of these instruments.

Another possibility for testing the effectiveness of the didactic component among White students is to utilize a White racial identity (WRI) scale as a dependent measure rather than (or in addition to) a multicultural competence instrument. Brown et al. (1996), for example, concluded that racial identity attitudes among their counseling trainees, as measured by the White Racial Identity Attitudes Survey (Helms & Carter, 1990), were significantly influenced by cross-cultural training. Other available WRI instruments include the White Racial Consciousness Development Scale (Claney & Parker, 1988; Choney & Rowe, 1994) and the Oklahoma Racial Identity Attitudes Scale–Preliminary Form (Choney & Behrens, 1996).

At an intuitive level, Blair and Banaji's (1996) findings suggest that the didactic component proposed in this article would be expected to reduce stereotype priming if it effectively modified or changed perceiver expectations about stereotyped social targets. As noted earlier, Blair and Banaji found that manipulation of perceiver expectations as to whether target attributes were consistent or inconsistent with a stereotype led to a significant reduction of stereotype priming. Specifically, participants led to expect stereotype-congruent stimuli had shorter reaction times to the stimuli (priming effect facilitation) compared to participants led to expect stereotype- incongruent stimuli. This outcome led Blair and Banaji to conclude that stereotype activation may be conditional and that social category cues are not always associated with priming effects. In their concluding comments, these authors encouraged more research to shed light on specific conditions or strategies that offset the influence of stereotypes on perceptions and behaviors.

Would didactic information about stereotypes and perceptual biases delivered in a convincing manner effectively eliminate or at least lessen the automatic effects of stereotypes? If it does, is this effect always mediated by changes in perceiver expectations, or does it represent a transformation in how stereotypes are represented mentally?

The point is that future research seeking answers to these questions can go beyond multicultural training program evaluation, as these answers may further contribute to our general understanding of how stereotyping effects can be actively decreased or neutralized.

NOTE

1. Elementary schoolteacher Jane Elliot developed a unique classroom experience to help her students understand discrimination (Peters, 1971). On the first day of the experiment, Elliot announced that brown-eyed children were to sit in the back of the classroom and that they could not use the drinking fountain. Blue-eyed children were given extra recess time and got to leave for lunch first. Mixing of brown-eyed and blue-eyed children was prevented, and the latter were told they were cleaner and smarter. Elliot also made an effort to constantly criticize and belittle the brown-eyed children. To her surprise, the blue-eyed children joined in and soon were outdoing her in the viciousness of their attacks. Test scores for brown-eyed children fell. These effects, however, were short lived. Two days later, the roles of the children were reversed, and the same destructive effects occurred again, but this time in reverse.

REFERENCES

Abramowitz, S. I., & Murray, J. (1983). Race effects in psychotherapy. In J. Murray & P. R. Abramson (Eds.), *Bias in psychotherapy* (pp. 215-255). New York: Praeger.

Abreu, J. M. (1999). Conscious and nonconscious African American stereotypes: Impact on first impression and diagnostic ratings by therapists. *Journal of Consulting and Clinical Psychology*, *67*, 387-393.

Adebimpe, V. R. (1994). Race, racism, and epidemiological surveys. *Hospital and Community Psychiatry*, *45*, 27- 31.

American Psychological Association. (1986). *Accreditation handbook*. Washington, DC: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, *47*, 1597-1611.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, *24*, 42-78.

Balch, P., & Balch, K. (1975). A racial comparison of admissions, diagnosis, and releases in a state mental hospital system: A five-year review. *Catalog of Selected Documents in Psychology*, *5*, 197. (Manuscript No. 868)

Bargh, J. A. (1994). The four horsemen of automaticity: Awareness, intention, efficiency, and control in social cognition. In R. S. Wyer, Jr., & T. K. Srull (Eds.), *Handbook of social cognition: Vol. 1. Basic processes* (2nd ed., pp. 1-40). Hillsdale, NJ: Lawrence Erlbaum.

Bargh, J. A., Chen, M., & Burrows, L. (1996). Automaticity of social behavior: Direct effects of trait construct and stereotype activation on action. *Journal of Personality and Social Psychology*, *71*, 230-244.

Bargh, J. A., & Pietromonaco, P. (1982). Automatic information processing and social perception: The influence of trait information presented outside of conscious awareness on impression formation. *Journal of Personality and Social Psychology*, *43*, 437-449.

Baskin, D., Bluestone, H., & Nelson, M. (1981a). Ethnicity and psychiatric diagnosis. *Journal of Clinical Psychology*, *37*, 529-537.

Baskin, D., Bluestone, H., & Nelson, M. (1981b). Mental illness in minority women. *Journal of Clinical Psychology*, 37, 491-498.

Beale, A. V. (1986). A cross-cultural dyadic encounter. *Journal of Multicultural Counseling and Development*, *14*, 73-76.

Bieschke, K. J., Eberz, A. B., Bard, C. C., & Croteau, J. M. (1998). Using social cognitive career theory to create affirmative lesbian, gay, and bisexual research training environments. *The Counseling Psychologist*, *26*, 735-753.

Bishop, J. B, & Richards, T. F. (1987). Counselor intake judgments about White and Black clients in a university counseling center. *Journal of Counseling Psychology*, *34*, 96-98.

Blair, I., & Banaji, M. (1996). Automatic and controlled processes in stereotype priming. *Journal of Personality and Social Psychology*, *70*, 1142-1163.

Brewer, M. B, Dull, V., & Liu, L. (1981). Perceptions of the elderly: Stereotypes and prototypes. *Journal of Personality and Social Psychology*, *41*, 656-670.

Brown, P. B., Parham, T. A., Yonker, R. (1996). Influence of a cross-cultural training course on racial identity attitudes of White women and men. *Journal of Counseling & Development*, *74*, 510-516.

Casas, J. M., Wampold, B. E., & Atkinson, D. R. (1981). The categorization of ethnic stereotypes by university counselors. *Hispanic Journal of Behavioral Sciences*, *3*, 75-82.

Choney, S. K., & Behrens, J. T. (1996). Developing the Oklahoma Racial Attitudes Scale—Preliminary Form (ORAS-P). In G. R. Sodowsky & J. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 225-240). Lincoln, NE: Buros Institute of Mental Measurements.

Choney, S. K., & Rowe, W. (1994). Assessing White racial identity: The White Racial Consciousness Development Scale (WRCDS). *Journal of Counseling & Development*, *73*, 102-104.

Claney, D., & Parker, W. M. (1988). Assessing White racial consciousness and perceived comfort with Black individuals: A preliminary study. *Journal of Counseling and Development*, *67*, 449-451.

Cole, J., & Pilisuk, M. (1976). Differences in the provision of mental health services by race. *American Journal of Orthopsychiatry*, *46*, 510-525.

Corvin, S. A., & Wiggins, F. (1989). An antiracism model for White professionals. *Journal of Multicultural Counseling and Development*, *17*, 105-114.

Crocker, J., Fiske, S. T., & Taylor, S. E. (1984). Schematic bases of belief change. In J. R. Eiser (Ed.), *Attitudinal judgment* (pp. 197-226). New York: Springer-Verlag.

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training in counselor education. *Journal of Counseling & Development*, *70*, 143-150.

Das, A. K. (1995). Rethinking multicultural counseling: Implications for counselor education. *Journal of Counseling and Development*, *74*, 45-52.

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology*, *56*, 5-18.

Dovidio, J. F., Evans, N. E., & Tyler, R. B. (1986). Racial stereotypes: The contents of their cognitive representations. *Journal of Experimental Psychology*, *22*, 22-37.

Duncan, B. L. (1976). Differential social perception and attribution of intergroup violence: Testing the lower limits of stereotyping of Blacks. *Journal of personality and Social Psychology*, *34*, 590-598.

Dunton, B. C., & Fazio, R. H. (1997). An individual difference measure of motivation to control prejudiced reactions. *Personality and Social Psychology Bulletin*, *23*, 316-326.

Eagly, A. H., & Kite, M. E. (1987). Are stereotypes of nationalities applied to both men and women? *Journal of Personality and Social Psychology*, *53*, 451-462.

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist*, *26*, 525-588.

Fiske, S. T. (1998). Stereotyping, prejudice, and discrimination. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 357-411). Boston: McGraw-Hill.

Fukuyama, M. A., & Neimeyer, G. J. (1985). Using the cultural attitudes repertory technique (CART) in a cross-cultural counseling workshop. *Journal of Counseling and Development*, *63*, 304-305.

Gaertner, S. L., & Dovidio, J. F. (1986). The aversive form of racism. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 61-89). New York: Academic Press.

Goldstein, S. B. (1997). The power of stereotypes: A labeling exercise. *Teaching of Psychology*, *24*, 256-258.

Greenwald, A., Banaji, M., Nosek, B., & Bhaskar, R. (1998). *Implicit association test.* Available: http://depts.washington.edu/iat/

Greenwald, A. G., McGhee, D. E., & Schwartz, L. K. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology*, *74*,1464-1480.

Hamilton, D. L. (1981). *Cognitive processes in stereotyping and intergroup behavior*. Hillsdale, NJ: Lawrence Erlbaum.

Hamilton, D. L., & Sherman, S. J. (1994). Stereotypes. In R. S. Wyer, Jr., & T. K. Srull (Eds.), *Handbook of social cognition* (2nd ed., Vol. 2, pp. 1-68.). Hillsdale, NJ: Lawrence Erlbaum.

Hamilton, D. L., Sherman, S. J., & Ruvolo, C. M. (1990). Stereotype-based expectancies: Effects on information processing and social behavior. *Journal of Social Issues*, *46*, 35-60.

Hamilton, D. L., & Trolier, T. K. (1986). Stereotypes and stereotyping: An overview of the cognitive approach. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 127-163). Orlando, FL: Academic Press.

Haslam S. A., Turner, J. C., Oakes, P. J., McGarty, C., & Reynolds, K. J. (1998). The group as a basis for emergent stereotype consensus. In H. Miles & S. Wolfgang (Eds.), *European review of social psychology* (Vol. 8, pp. 203-239). Chichester, UK: Wiley.

Helms, J. E., & Carter, R. T. (1990). White Racial Identity Attitude Scale (Form WRIAS). In J. E. Helms (Ed.), *Black and White racial identity: Theory, research, and practice* (pp. 249-251). Westport, CT: Greenwood.

Higgins, E. T., & King, G. (1981). Accessibility of social constructs: Information-processing consequences of individual and contextual variability. In N. Cantor & J. F. Kihlstrom (Eds.), *Personality and social interaction* (pp. 69-121). Hillsdale, NJ: Lawrence Erlbaum.

Higgins, E. T., Rholes, W. S., & Jones, C. R. (1977). Category accessibility and impression formation. *Journal of Experimental Social Psychology*, *13*, 141-154.

Hulnick, R. H. (1977). Counselor: Know thyself. *Counselor Education & Supervision*, *17*, 69-72.

Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology*, *38*, 722-731.

Katz, I. (1981). *Stigma: A social psychological analysis*. Hillsdale, NJ: Lawrence Erlbaum.

Kawakami, K., Dion, K. L., & Dovidio, J. F. (1998). Racial prejudice and stereotype activation. *Personality and Social Psychology Bulletin*, *24*, 407-416.

Kiselica, M. S. (1998). Preparing Anglos for the challenges and joys of multiculturalism. *The Counseling Psychologist*, *26*, 5-21.

Klayman, J., & Ha, Y. W. (1987). Confirmation, disconfirmation, and information in hypothesis testing. *Psychological Review*, *94*, 211-228.

Kunda, Z., & Thagard, P. (1996). Forming impressions from stereotypes, traits, and behaviors: A parallel-constraint-satisfaction theory. *Psychological Review*, *103*, 284-308.

LaFromboise, T. D., Coleman, H.L.K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory–Revised. *Professional Psychology: Research and Practice*, *22*, 380-388.

LaFromboise, T. D., & Foster, S. L. (1992). Cross-cultural training: Scientist-practitioner model and methods. *The Counseling Psychologist*, *20*, 472-489.

Lepore, L., & Brown, R. (1997). Category and stereotype activation: Is prejudice inevitable? *Journal of Personality* and Social Psychology, 72, 275-287.

Lippman, W. (1921). *Public opinion*. New York: Harcourt Brace Jovanovich.

Littlewood, R. (1992). Psychiatric diagnosis and racial bias: Empirical and interpretative approaches. *Social Science and Medicine*, *34*, 141-149.

Lloyd, K., & Moodley, P. (1992). Psychotropic medication and ethnicity: An inpatient survey. *Social Psychiatry and Psychiatric Epidemiology*, *27*, 95-101.

Lopez, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychological Bulletin*, *106*, 184-203.

Lopez, S. R., Grover, K. P., Holland, D., Johnson, M. J., Kain, C. D., Kanel, K., Mellins, C. A.,& Rhyne, M. C. (1989). Development of culturally sensitive psychotherapists. *Professional Psychology: Research and Practice*, *20*, 389-376.

Macrae, C. N., Bodenhausen, G. V., Milne, A. B., Thorn, T.M.J., & Castelli, L. (1997). On the activation of social stereotypes: The moderating role of processing objectives. *Journal of Experimental Social Psychology*, *33*, 471-489.

McConahay, J. B. (1986). Modern racism, ambivalence, and the modern racism scale. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 91-125). Orlando, FL: Academic Press.

Merluzzi, B. H., & Merluzzi, T. V. (1978). Influence of client race on counselors' assessment of case materials. *Journal of Counseling Psychology*, *25*, 399-404.

Mio, J. S. (1989). Experiential involvement as an adjunct to teaching cultural sensitivity. *Journal of Multicultural Counseling and Development*, *17*, 38-46.

Ota Wang, V., & Briggs, K. (1997). *The role of cognitive information processing and racial identity attitudes on causal attributions*. Paper presented at the 14th Annual Winter Roundtable on Cross-Cultural Psychology and Education, Teachers College, Columbia University, New York.

Paradis, C. M., Hatch, M., & Friedman, S. (1994). Anxiety disorders in African Americans: An update. *Journal of the National Medical Association*, *86*, 609-612.

Parker, W. M. (1998). *Consciousness-raising: A primer for multicultural counseling* (2nd ed.). Springfield, IL: Charles C Thomas.

Parker, W. M., Bingham, R. P., & Fukuyama, M. (1985). Improving cross-cultural effectiveness of counselor trainees. *Counselor Education and Supervision*, *24*, 349-352.

Peters, W. A. (1971). *A class divided*. Garden City, NY: Doubleday.

Plant, A. E., & Devine, P. G. (1998). Internal and external motivation to respond without prejudice. *Journal of Personality and Social Psychology*, *75*, 811-832.

Ponterotto, J. G. (1988). Racial consciousness development among White counselor trainees. *Journal of Multicultural Counseling and Development*, *16*, 146-157.

Ponterotto, J. G., Rieger, B. P., Barrett, A., & Sparks, R. (1994). Assessing multicultural competence: A review of instrumentation. *Journal of Counseling and Development*, *72*, 316-322.

Ponterotto, J. G., Sanchez, C. M., & Magids, D. M. (1991, August). *Initial development and validation of the Multicultural Counseling Awareness Scale (MCAS)*. Paper presented at the annual meeting of the American Psychological Association, San Francisco, CA.

Ridley, R. R., Mendoza, D.W., & Kanitz, B. E. (1994). Multicultural training: Reexamination, operationalization, and integration. *The Counseling Psychologist*, *22*, 227-289.

Rothbart, M. (1981). Memory processes and social beliefs. In D. L. Hamilton (Ed.), *Cognitive processes in stereotyping and intergroup behavior* (pp. 145-181). Hillsdale, NJ: Lawrence Erlbaum.

Rothbart, M. (1996). Category-exemplar dynamics and stereotype change. *International Journal of Intercultural Relations, 20*, 305-321.

Sabani, H. B., Ponterotto, J. G., & Borodovski, L. G. (1991). White racial identity development and cross-cultural training. *The Counseling Psychologist*, *19*, 76-102.

Sagar, H. A., & Schofield, J. W. (1980). Racial and behavioral cues in Black and White children's perceptions of ambiguously aggressive acts. *Journal of Personality and Social Psychology*, *39*, 590-598.

Shiffrin, R. M., & Dumais, S. T. (1981). The development of automatism. In J. R. Anderson (Ed.), *Cognitive skills and their acquisition* (pp. 111-140). Hillsdale, NJ: Lawrence Erlbaum.

Skov, R. B., & Sherman, S. J. (1986). Information-gathering processes: Diagnosticity, hypotheses is confirmatory strategies, and perceived hypothesis confirmation. *Journal of Experimental Social Psychology*, *22*, 93-121.

Smith, E. R., & Zarate, M. A. (1990). Exemplar and prototype use in social categorization. *Social Cognition*, *8*, 243-262.

Smith, E. R.,& Zarate, M. A. (1992). Exemplar-based model of social judgment. *Psychological Review, 99*, 3-21.

Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, *45*, 347-355.

Sodowsky, G. R., Taffe, R. C., Gutkin, T., & Wise, S. L. (1994). Development and applications of the Multicultural Counseling Inventory. *Journal of Counseling & Development*, *72*, 316-322.

Srull, T. K., & Wyer, R. S. (1980). Category accessibility and social perception: Some implications for the study of person memory and interpersonal judgments. *Journal of Personality and Social Psychology*, *38*, 841-856.

Steward, J. R., Morales, C. P., Bartell, A. P., Miller, M., & Weeks, D. (1998). The multiculturally responsive versus the multiculturally reactive. *Journal of Multicultural Counseling and Development*, *26*, 13-27.

Stewart, T. L., Doan, K. A., Gingrich, B. E., & Smith, E. R. (1998). The actor as context for social judgments: Effects of prior impressions and stereotypes. *Journal of Personality and Social Psychology*, *75*, 1132-1154.

Strickland, T. L., Jenkings, J. O., Myers, H. F., & Adams, H. E. (1988). Diagnostic judgments as a function of client and therapist race. *Journal of Psychopathology and Behavioral Assessment*, *10*, 141-151.

Sue, D. W, Arredondo, P., & McDavis, J. (1992). Multicultural competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477-486.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttal, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, *10*, 45-52.

Task Force on the Delivery of Services to Ethnic Minority Populations. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48*, 45-48.

Taylor, S. E., & Crocker, J. (1981). Schematic bases of social information processing. In E. T. Higgins, C. P. Herman, & M. P. Zanna (Eds.), *Social cognition: The Ontario symposium* (Vol. 1, pp. 89-134). Hillsdale, NJ: Lawrence Erlbaum.

Tomlinson-Clarke, S. (1999). *A qualitative study assessing outcomes in a multicultural training course*. Manuscript submitted for publication.

Tomlinson-Clarke, S., & Camilli, G. (1995). An exploratory investigation of counselor judgments in multicultural research. *Journal of Multicultural Counseling and Development*, *23*, 237-245.

Tomlinson-Clarke, S., & Ota Wang, V. (1999). A paradigm for racial-cultural training in the development of counselor cultural competencies. In M. S. Kiselica (Ed.), *Confronting prejudice and racism during multicultural training*. Alexandria, VA: ACA.

Wampold, B. E., Casas, J. M., & Atkinson, D. R. (1982). Ethnic bias in counseling: An information processing approach. *Journal of Counseling Psychology*, *28*, 498-503.

Webster's *Dictionary of the English Language*. (1990). New York: Lexicon.

Wegner, D. M., & Bargh, J. A. (1996). Control and automaticity in social life. In D. T. Gulbert, S. T. Fiske, & G. Linsey (Eds.), *Handbook of social cognition* (4th ed.). New York: McGraw-Hill.

Wittenbrink, B., Judd, C. M., & Park, B. (1997). Evidence for racial prejudice at the implicit level and its relationship with questionnaire measures. *Journal of Personality and Social Psychology, 72,*262-274.

Zarate, M. A., & Smith, E. R. (1990). Person categorization and stereotyping. *Social Cognition*, *8*, 161-185.

Ethical Principles of Psychologists and Code Of Conduct

2010 Amendments

CONTENTS

INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles, and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., reasonably, appropriate, potentially) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People’s Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

Standard 1: Resolving Ethical Issues

1.1 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.2 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.3 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.4 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.5 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.6 Cooperating with Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.7 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.8 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

Standard 2: Competence

2.1 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.2 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services areavailable.

2.3 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.4 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.5 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.6 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work- related duties. (See also Standard 10.10, Terminating Therapy.)

Standard 3: Human Relations

3.1 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.2 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.3 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.4 Avoiding Harm

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.5 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.6 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.7 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to

confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.8 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter with Clients/Patients; 7.07, Sexual Relationships with Students and Supervisees; 10.05, Sexual Intimacies with Current Therapy Clients/Patients; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients.)

3.9 Cooperation with Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual’s rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of theservice.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

Standard 4: Privacy and Confidentiality

4.1 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.2 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances maywarrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.3 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.4 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.5 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.6 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.7 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

Standard 5: Advertising and Other Public Statements

5.1 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or researchfindings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which theypractice.

5.2 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.3 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.4 Media Presentations

When psychologists provide public advice or comment via print, internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.5 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.6 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

Standard 6: Record Keeping and Fees

6.1 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.2 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.3 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.4 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.5 Barter with Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.6 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis.

(See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.7 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals.)

Standard 7: Education and Training

7.1 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.2 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.3 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.4 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.5 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, MultipleRelationships.)

7.6 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.7 Sexual Relationships with Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

Standard 8: Research and Publication

8.1 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.2 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent toResearch.)

8.3 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.4 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.5 Dispensing with Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.6 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter with Clients/Patients.)

8.7 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.8 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.9 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

Standard 9: Assessment

9.1 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.2 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessmentissues.

9.3 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to

Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.4 Release of Test Data

(a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.5 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.6 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.7 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.8 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.9 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11. Maintaining Test Security

The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

Standard 10: Therapy

10.1 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of thesupervisor.

10.2 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.3 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.4 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.5 Sexual Intimacies with Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.6 Sexual Intimacies with Relatives or Significant Others of Current TherapyClients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.7 Therapy with Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.8 Sexual Intimacies with Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.9 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

History and Effective Date

The American Psychological Association's Council of Representatives adopted this version of the APA Ethics Code during its meeting on August 21, 2002. The Code became effective on June 1, 2003. The Council of Representatives amended this version of the Ethics Code on February 20, 2010. The amendments became effective on June 1, 2010. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First St. NE, Washington, DC 20002-4242. The Ethics Code and information regarding the Code can be found on the APA web site, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:

American Psychological Association. (1953). Ethical standards of psychologists. Washington, DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. American Psychologist, 14, 279-282.

American Psychological Association. (1963). Ethical standards of psychologists. American Psychologist, 18, 56-60.

American Psychological Association. (1968). Ethical standards of psychologists. American Psychologist, 23, 357-361.

American Psychological Association. (1977, March). Ethical standards of psychologists. APA Monitor, 22-23.

American Psychological Association. (1979). Ethical standards of psychologists. Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. American Psychologist, 36, 633-638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). American Psychologist, 45, 390-395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. American Psychologist, 47, 1597-1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. American Psychologist, 57, 1060-1073.

Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242, or phone (202) 336-5510.

NICPP "Fun Stuff"

Balance in the workplace. While you are completing your doctoral internship training, there are certainly times where your life will feel "out of balance." You will have competing demands on your time and it is vital that you fulfill your duties and responsibilities as an intern and as a doctoral student in professional psychology. We also recognize that as psychologists (and humans!) it is important that we take care of ourselves. If you are not healthy physically and mentally, you will limit your abilities to be an effective psychologist. This section of the intern handbook is designed to help you think about how you achieve balance in your life.

If this is your first visit to Nebraska, we have provided you with information from the Lincoln, Omaha, and Beatrice Chambers of Commerce. There are a lot of areas to explore in this great state. Do you know where Carhenge is? Have you thought about going tanking down the Niobrara river? Do you know what "tanking" is? Did you know that there are over 90 miles of biking and running trails in Lincoln? The Lincoln half-marathon and the Lincoln marathon are held annually in May. If you're a runner, it's a great (flat!) race with great spectators. What about organizing a running club with your fellow interns? If you're not a runner, what about organizing a book club with some of your fellow interns? The arts are alive and well in Nebraska. The Lied Center in Lincoln and the Orpheum Theater in Omaha have great shows/plays/concerts. Speaking of concerts, the Quest Center in Omaha brings in top performers. Get on ticketmaster.com to check out some of these offerings. Both Lincoln and Omaha host Saturday morning farmers' markets that are a blast. They run from May to October. These are just a few ideas for some fun things to do in Nebraska.

Suggested readings:

1. Braza, J. (1997). *Moment by moment: The art and practice of mindfulness*. Boston: Charles Tuttle, Co., Inc.

2. Kabat-Zinn, J. (2005). *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*. Hyperion.

3. Kerr, D. R. (2000). *Becoming a therapist: A workbook for personal exploration*. Prospect Heights, IL: Waveland Press, Inc.

4. Norcross, J. C. & Guy, J. D. (2007). *Leaving it at the office: A guide to psychotherapist self-care*. NY The Guilford Press.

5. Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York: Harper Perennial.

Thirteen Rules of Success: A Message for Students

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Recently a student I care about flunked out of graduate school. It is a relatively rare thing, especially in our program which bends over backwards to prevent that. But it has made me think again about just what it is that distinguishes highly successful students from others. We all recognize that some students and some young professionals will make it while others, who are equally bright, will not. Why is this? What are they doing differently?

Let me admit before I start that success is a relative term, and a multidimensional one at that. Too many of us are workaholics, and tend to define success too narrowly, downplaying success as a friend, success in enjoying life, success in personal growth, and the like. I secretly hope and suspect that the student who flunked out is, in part, responding to muses that will lead to success in other areas. The purpose of this short paper, however, is limited to the work habits and general approaches to tasks that characterize successful students in scientific training.

I've tried to distill my opinions down into 13 "rules of success." None are absolute: I personally violate one or more of these rules almost every day. But I have noticed that when I keep them, things work much better than when I don't. I've also noticed that students who keep more of them tend to be much more successful.

Rule 1. Care About the Process, Not Just the Outcome

Few of us will be projected into success suddenly. More probably we will nibble away, and pieces will fall together one by one. The small things can end up being crucial, as skills and knowledge combine in unexpected ways. We simply cannot always predict which of our actions at any given moment will advance our career.

This creates a problem. If success as an outcome is too important, we are likely to cut ourselves off from the processes that might produce it. For example, suppose a professor raises an interesting issue about an "irrelevant" intellectual area. If the student is too outcome oriented, there is a temptation to close down intellectually, and the opportunity to learn something that might later be important is missed.

Successful students have a richness about them that comes from an openness to such moments, and a consistency in quality that reveals a general tendency to care. The most successful professionals care about a wide variety of things in the field and emphasize the intrinsic value of the tasks. They are working toward outcomes all the time, but they don't forget the value of the process.

I have a preferred word for this: Play. I don't use this word to trivialize the tasks involved. I use it to point to the source of the consequences that maintain behavior and keep it high quality. The best reason to go to a journal discussion group, attend a convention, or do research is to play professionally. It is the "best" reason because playful engagement in a quality process is always immediately available.

The concrete outcomes of these activities (e.g., jobs, money, reputation, praise), when and if they arrive, may be subtle and long-delayed. If you rely on such consequences to maintain the activities, they will almost surely drop away.

Stephen Jay Gould provides an example of what happens if one takes intellectual play seriously. Yes, he is a paleontologist. But he also has written beautifully about psychology, baseball, architecture, and the human meaning of the millennium. It is obvious that he is entertained by his own scholarly play. Like any playful game, he follows the rules: He knows his evidence. The best students I have ever worked with are those who do things like staying up until 3 a.m. perfecting a presentation to a local group

Hayes, S. C. (1998). *The Behavior Therapist,* 21, 47-48, 55.

just because the task itself seems important, even though in some larger view of reality it is not. Importantly, they will show the same care when they are writing a funny poem, or arguing an arcane point in philosophy of science. I suspect that Stephen Jay Gould was like that as a student.

Rule 2. Talk and Write—a Lot

Science is a largely verbal enterprise. Successful scientists must speak, write, persuade, and debate. The only way to become skilled at professional verbal behavior is to engage in it. Talk in class. Talk at conventions. Talk in the halls. Listen and respond. Propose and consider. Argue. Share thoughts. If you think you have something to say, say it. If you wonder if you have something to say, and worry that it is not worthwhile, say it anyway. Chronic fearful silence is a young scientist's worst enemy, and it is shockingly common. At least half of the wonderfully bright students we recruit into our department rarely talk in class, and in my experience, that is a terrible predictor if it continues.

Now, it is true that occasional thoughtful silence is a good thing. You have to learn to discriminate when to talk and when to listen. But, frankly, it is much easier to quiet a loud mouth than to jump-start a mute, so the discrimination is more easily learned from that end of the continuum.

The same thing applies to writing. Writing with ease comes with practice, but most students seem to think that this “practice” should consist of reading, thinking, outlining, or planning. Those are important, but to get facile with professional writing you also have to write. You must put words on paper and put them in front of an audience.

There are many opportunities to do this, even without creating them. For example, if you write a paper for a class, write it as if you would publish it. Then try to do just that.

Rule 3. Say Yes Easily, and Mean It

Early in your career you should expose yourself to different things. Broaden your repertoire. When someone talks about a good project, say "let's do it." If someone asks for help with a project, say yes. Then deliver. Do more than is expected. If your part of the project is to design a computer program, have it done tomorrow instead of next week and add some bells and whistles to it. If you have agreed to organize the lab, do it elegantly.

Rule 4. Work with Others, and Share Easily

You can learn a lot from others. They help push you and they teach you new things. So collaborate. Form teams. Network. Give more than you ask.

The thing that usually prevents collaboration is fear that you have nothing to contribute, or (worse) that someone else will get more than you. The latter is possible, but if you aim to prevent that, you kill collaboration. Worry about order of authorship when the time comes and, even then, do so with ease. In the larger scheme of things, whether you end up third author versus second doesn’t matter much.

Similarly, if someone else gets some credit for “your ideas,” well there should be plenty more where that one came from if you take advantage of all that others have to teach you.

Rule 5. Keep Your Commitments

This is the most important rule of all. This one rule separates the successful from the unsuccessful student more than any other, but its value cannot be known until you do it. So figure out a way. Set up a program, make it life or death, ransom your grandmother. Do it. Of course, no one always does it. Okay, so when you slip, go back and do it one hundred percent. I violate this one nearly every day. Yet I continue to fight to keep it.

Rule 6. Even Dogs Never Urinate in Their Own Beds

In one sense, the outcome of success is dominantly social: People think well of you and your work. But we are all afraid we will fail. Students have the extra burden of dependency combined with some degree of powerlessness. A horribly seductive way to deal with this fear and this burden is through cynicism, criticism, paranoia, gossip, and the like. For example, students can complain to one another about their program, or this or that instructor, but not openly where something might be done. You begin

to gather together a group (e.g., fellow students) who will all agree that things are terrible, no one could achieve these standards, the instructors are dolts anyway, and so on. The effect is that (a) you get a thin version of the social benefits of success (a supportive verbal community) but without achievement, (b) control of the larger scientific verbal community and that of the program you are in diminishes, and (c) you can righteously feel bad about where you are. You create a social community in which each person is supported in doing what does not work. It feels good but it goes nowhere.

I have seen this process destroy the training of many students. Sometimes they catch themselves after a year or so and pull out of it. Sometimes they leave the program. The most tragic are those who do their training in a half-hearted (but secretly righteously angry) way, and years later they realize that they wasted their opportunity. The solution is simply to refuse to do it, to walk away when others try to draw you in, and to take responsibility for your career. After all, even dogs never urinate in their ownbeds.

Rule 7. Acknowledge Your Own Power and Behave Accordingly

Let me tell you something incredible: You can make a huge difference in your discipline. We are not talking about fields that require a gazzilion dollar superconducting supercollider to do good work. We are talking about fields that are young and accessible, in which even one person can make a big difference. The unsuccessful students will withdraw in fear from that statement (see Rule 6), or will mistake dreams for action. The successful student will acknowledge his or her own power, and will push on vigorously to make it manifest.

Nelson Mandela, in his inauguration speech, made a point that I particularly like:

Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that most frightens us. We ask ourselves, "who am I to be brilliant, gorgeous, talented, fabulous?" Actually, who are you NOT to be? You are a child of God. Your playing small does not serve the world. There is nothing enlightened about shrinking so that other people won't feel insecure around you. We are born to make manifest the glory of God that is within us. It is not just in some of us, it is in every one. And as we let our light shine, we give others permission to do the same. As we are liberated from our fears our presence liberates others.

Rule 8. Acknowledge Your Own Finitude and Behave Accordingly

You do not know how long you have on this planet. Regardless of how many years, the time is certainly short. I tell my students to be mindful of this in the area of research and to try to do work that is both entertaining and important. For example, sometimes weak students come up with research ideas that are minor variations of what someone else has done in the literature. It is as if they think that is all they can aspire to (see Rule 7) or as if they think they have all the time in the world. My question to students in this circumstance is this: Suppose, unknown to you, you only have two or three research studies allotted to you before you die. Do you want to spend one on that? Successful students aspire to make a difference in the time theyhave.

Rule 9. Network With Your Betters

There is a tendency for students to think of experienced and highly successful professionals in two erroneous ways: as persons on a pedestal or as dinosaurs to be overthrown. Unsuccessful students gravitate toward the first error, somewhat more successful students toward the second. But the most useful reaction is to see them as people who have earned respect through their sweat and effort, and from whom you can learn. With a few exceptions, well-known professionals are likeable, hard-working, and smart. This is not surprising since they would not be well known if they were not. People try to make jerks fail, and dumb or lazy people rarely come up with ideas that withstand the test of time. Successful students want to know successful people; they want to talk with them, correspond with them, listen to them. They want a dialogue of ideas. Unsuccessful students are too afraid or uninterested, or they want only to showoff.

Get to know the leaders of the field. Listen to their talks. Talk to them at cocktail parties. Write to them. Send them copies of your work if it seems appropriate. Nice, bright, hardworking people are just good people to learn from.

This networking will help you create a forum for your ideas. Successful students tend to use their intellectual contacts to create opportunities to play. For example, even fairly junior students can organize a symposium and participate in it. If you can get well-known people to play on your stage it will elevate your own talk. Then all you have to do is to give a darn good one, which, in turn will allow you to network with others about your ideas.

Rule 10. Guard Your Integrity

Anonymous self-reports tell us that a larger percentage of students have at some time cheated in school. Perhaps it was to pass a test or get a better grade on a paper. Students in training know that science is supposed to be above that sort of thing, but we spend little time dealing with the human realities that lead to cheating, preferring instead to moralize. It is very rare that cheating in science is even talked about, and as a result, most students do not realize how pervasive the temptation is to cheat in research.

People who want to be successful are especially susceptible to the kind of shaping that can lead to biased data, or outright dishonesty. In order to publish that paper or get that grant, it is tempting to throw out a few outliers or change an exclusionary criterion post hoc. You can often even justify it, but shades of gray compromises can lead to black and white cheating. I've seen highly successful careers tragically destroyed by this shaping process.

Prophylactically, it helps to focus on the process, not the outcome (Rule 1). Watch out for things that might lead to internal pressure to cut corners, especially a needless outcome orientation. For example, never do a study "to show x"; and if you catch yourself using such a phrase, self-edit it immediately. Do it "to see if x is so." Wanting to be right is your enemy. Wanting a specific outcome is your enemy. Wanting to find out is your friend.

Focusing for the moment on the student scientists (and not the consumers of science, which is another important matter), the most tragic human cost of scientific cheating is not the careers that are destroyed—after all, most cheaters will “get away with it.” The cost is this: If you violate your integrity, even in little ways, to achieve a particular outcome, you will find the activity itself to be less intrinsically reinforcing. It always works that way. The playfulness disappears. It's now a means to some other end. Science is no longer fun.

Rule 11. Follow Your Bliss

Successful students are confident. I don’t mean they necessarily feel confident. I mean that they follow their bliss: They are true to themselves. This is confidence (*con: with; fidence: fidelity*). If you have an odd mixture of interests, well, maybe that mixture will lead to new and exciting things even though someone will tell you that you have to focus on something safer. Take the risk. If it worries you, build a little safety net. Do not, however, violate what seems important to you. You will pay very dearly for the violation because it will take away your compass for scientific entertainment. You can get lost without a compass.

Rule 12. Say No Easily and Mean It

As your career progresses, you will naturally focus. It is the only way to maintain your quality. As you focus, learn to say no. Set priorities. Stick to them. I’m still learning this rule (actually I do it more and more, but the distractions and requests go up too, so it seems that I never have quite enough Rule 12 for Rule 5 to be 100%).

Rule 13. Open Your Mail, Return Your Phone Calls, and Keep Your Desk Clean

Oh well. Not every rule can be followed.

Hayes, S. C. (1998). *The Behavior Therapist,* 21, 47-48, 55.

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