

# **Guidelines for Psychological Practice with Girls and Women**

A Joint Task Force of APA Divisions 17 and 35

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During recent decades, women and girls of diverse ethnicities, social classes, sexual orientations, and life experiences have encountered dramatic and complex changes in education, health, work, reproductive and caregiving roles, and personal relationships. Although many of these changes have resulted in increased equality, opportunity, and quality of life, girls and women are also at risk for a variety of health concerns and life stresses (National Healthcare Disparities Report, 2005). Stressors in the lives of women and girls include interpersonal victimization and violence, unrealistic media images of girls and women, discrimination and oppression, devaluation, limited economic resources, role overload, relationship disruptions, and work inequities. Violence against girls and women is often predicated in sexism, racism, classism, and homophobia (Glick & Fiske, 1997; Koss, Heise & Russo, 1994; West, 2002). Salient mental health statistics reveal that women are two times more likely than men to be depressed, and girls are seven times more likely than boys to be depressed (Lewinsohn, Rhode, Seeley, & Baldwin, 2001). Women who are subject to group and individual discrimination are even more likely to experience depression (Klonis, Endo, Crosby, & Worell, 1997). Girls and women are also roughly nine times more likely to have eating disorders than boys and men (Stice & Bearman, 2001; Stice, Burton, & Shaw, 2004). Compared to men, women are two to three times more likely to experience many types of anxiety disorders (U.S. Department of Health and Human Services, Office on Women's Health, 2001). The abuse and violence in our society (e.g., abuse, battering, rape) may contribute to the development of dysfunctional behavior such as eating disorders, depression, anxiety, and suicidal behavior, while discrimination against women and girls of color can result in lowered self-expectations, anxiety, depression, and negative attitudes toward self (Keith, Jackson, & Gary, 2003). In general, the

physical and mental health concerns of women and girls are related to complex and diverse economic, biological, developmental, psychological, and sociocultural environments. The concerns, behaviors, values, attitudes, and feelings of women and girls also arise from myriad interactions among their multiple identities related to age, race, ethnicity, class, sexual orientation, marital, partnership and parental status, gender identity, ability, culture, immigration, geography, and other life experiences (Sparks & Park, 2000; Stewart & McDermott, 2004).

Although many psychologists and members of the general public may believe that women's issues in psychology were dealt with and resolved in the 1970s and 1980s, the changing and increasingly complex life experiences of girls and women and the intersection of their gender roles with ethnicity, sexual orientation, ability, SES, etc. demonstrate compelling evidence and need for professional guidance for helping psychologists (a) avoid harm in psychological practice with girls and women; (b) improve research, teaching, consultation, and psychotherapeutic and counseling training and practice; and (c) develop and enhance treatment efforts, research, prevention, teaching, and other areas of practice that will benefit women and girls. In addition, although blatant forms of sexism and racism have decreased over time (Campbell, Schellenberg, & Senn, 1997), researchers have noted the continuing presence of more subtle forms of sexist and racist bias (e.g., ambivalent, symbolic, or unintentional racism/sexism) (Glick & Fiske, 1997; Swim & Cohen, 1997). Given that the majority of those seeking mental health services continue to be females (e.g., Rhodes, Goering, To, & Williams, 2002), special attention to the unique treatment needs of girls and women of diverse backgrounds is warranted (Trimble, Stevenson, Worell, & CEMRRAT2 TF, 2003). The majority of those seeking treatment remains women and girls, and the demographics of the United States population are rapidly changing to increase more diversity in women and girls needing

psychological services. Not only is potential harm reduced, but improved treatment will also likely benefit women and girls, particularly through greater awareness, education and prevention fostered by guidelines for psychological practice with girls and women.

### ***Purpose and Scope***

The aim of this document is to articulate guidelines that will enhance gender- and culture-sensitive psychological practice with women and girls from all social classes, ethnic and racial groups, sexual orientations, and ability/disability status in the United States. These guidelines provide general recommendations for psychologists who seek to increase their awareness, knowledge, and skills in psychological practice with women and girls. The beneficiaries include all consumers of psychological practice, including clients, students, supervisees, research participants, consultees, and other health professionals. Although the guidelines and supporting literature place substantial emphasis on psychotherapy practice, the general guidelines are applicable to psychological practice in its broadest sense. Rather than offering a comprehensive review of content relevant to all areas of practice, this document provides examples of empirical and conceptual literature that supports the need for practice guidelines.

The “Criteria for Practice Guideline Development and Evaluation” (APA, 2002a) defines the term "guidelines" as "statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by enforcement mechanism. Thus, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists" (p. 1048). Guidelines may be superseded by federal or state laws. The APA (2002a) also distinguishes between treatment and practice guidelines, noting that treatment guidelines “provide specific recommendations about clinical interventions” (p. 1048). In contrast, “practice guidelines consist

of recommendations to professions concerning their conduct and the issues to be considered in particular areas of practice” (p. 1048).

The following practice guidelines have been written to be compatible with the APA *Ethical Principles of Psychologists and Code of Conduct* (2002b); the *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (APA, 2000a); the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003); and the *Guidelines for Psychological Practice with Older Adults* (APA, 2004a). These guidelines do not refer to practice with transgender individuals. These guidelines are also consistent with the products of task forces on violence and the family (APA, 1996) and women, poverty, and public assistance (1998); and with other relevant APA documents such as the Resolution on Substance Abuse by Pregnant Women (APA, 1991), the Resolution on Cultural and Gender Awareness in International Psychology (2004b), the Resolution on Women and Poverty (2000c), the Resolution on Poverty and Socioeconomic Status (APA, 2000b), recommendations of the APA Intimate Partner Abuse and Relationship Violence Working Group (2002c), and the Resolution on Male Violence Against Women (APA, 2005). We strongly encourage institutions, agencies, departments, and/or individuals to discuss ways these guidelines may be applied to their own specific settings and relevant activities. As noted by APA (2002a) criteria, practice guidelines “may not be applicable to every professional and clinical situation” (p. 1048). Consistent with APA criteria, these guidelines are not definitive and are designed to respect the decision-making judgment of individual professional psychologists. In addition, these guidelines will need to be periodically reviewed and updated at least every ten years (eight years is recommended) beginning from the year of acceptance by the

APA Council of Representatives to take into account changes in practice, research and the effects of changing contemporary social forces and context.

It should be noted that many of the guidelines and recommended practices addressed in this document apply to both genders with diverse social memberships. For example, many of the guidelines encourage psychologists to understand the consequences of gender role socialization and its interactions with other social identities such as race, ethnicity, sexual orientation, and ability as both females and males experience constraints related to their gender and the gender role socialization process (see Pleck, 1995; Pittman, 1985), and these processes influence both males' and females' mental and physical health (Addis & Mahalik, 2003; Courtenay, 2000; Murphy, 2003). Hence, the recommendation to integrate an understanding of gender role socialization into the practice of psychology should not be limited to working with girls and women. Although many of these guidelines are potentially applicable to both genders, this document focuses on the experiences of girls and women for two reasons. First, females in the United States, on average, have less economic, political, and social power than males and therefore have experiences that are more likely to contribute to issues of powerlessness. Women of color, on average, suffer from at least two sources of discrimination—gender and race/ethnicity, and therefore may feel even more powerless (Bryant, Coker, Durodoye, McCollum, Pack-Brown, Constantine, & Bryant, 2005; Moore & Madison-Colmore, 2005; Williams, 2005). The average pay gap between men and women has been persistent and significant since statistics about gender and pay have been collected. In addition, a pay gap exists between white women and women of color, which has widened during the past twenty years (Costello & Stone, 2001). The impact of such experiences upon the mental health and well-being girls and women needs to be considered as well as the manner in which such experiences affect

psychological practice with diverse members of these populations and the obstacles and discrimination with which they may be faced. Furthermore, compared to what is currently available about boys and men, a much more extensive scientific literature examines the gender role socialization and gendered experiences of girls and women in connection to issues of practice. As research proceeds on boys and men, however, future practice guidelines should expand the scope of our practice guidelines to encompass gender-sensitive concerns over the lifespan for both females and males across all identity categories. The project focusing on males began in the spring of 2005, and that writing group has been invited to borrow freely from this document.

### *Need*

Beginning in the 1960s and 1970s, psychology as a discipline was widely criticized for its biases with regard to gender, race, ethnicity, class, and sexual orientation. A number of classic studies and publications focused on these limitations. This literature challenged the extent to which existing psychological theories were androcentric and did not adequately describe women's psychological development and behavior including women of color and lesbians (APA, 1975; Barrett, Berg, Eaton, & Pomeroy, 1974; Chesler, 1972; Gilligan, 1982; Rawlings & Carter, 1977; Rice & Rice, 1973; Weisstein, 1968). Scrutiny of a variety of theories of psychotherapy, research on psychological development, diagnostic systems, assessment procedures and measures found difficulties with noninclusive versions of mental health and problematic gender and ethnic biases (Worell & Remer, 2003).

*Bias in diagnosis and treatment.* In recent times, gender bias has been observed to be more covert but still a detectable and powerful force in psychological practice. Particular areas of concern include the presence of gender bias as well as bias in other social constructs such as ethnicity, age, race, disability, and social class, within diagnostic criteria and labeling (Caplan &

Cosgrove, 2004; De Barona & Dutton, 1997; Hartung & Widiger, 1998; Marecek, 2001; Ratey & Johnson, 1997; Ross, Frances, & Widiger, 1997). Women of color and lesbians may be especially vulnerable to misdiagnosis and other forms of bias (APA, 2000a; Hall & Greene, 2003). For example, women's and girls' gender role socialization and their economic status, ethnicity, sexual orientation, and disability status as well as biased criteria and perceptions may contribute to inappropriate use and overuse of certain diagnoses such as histrionic and borderline personality disorders, depression, dissociative disorders, somatization disorder, premenstrual dysphoric syndrome, and agoraphobia (Becker & Lamb, 1994; Bekker, 1996; Campbell, Byrne, & Baron, 1992; Chrisler & Johnston-Robledo, 2002; Cosgrove, 2004; Garb, 1997; Hartung & Widiger; Klonoff, Landrine, & Campbell, 2000; Landrine & Klonoff, 1997; Lerman, 1996; Sperberg & Stabb, 1998). Many symptoms associated with the aforementioned disorders have been conceptualized as exaggerations or stereotyping of traditional female gender roles and behaviors (as defined by mainstream culture) (e.g., overreacting emotionally, attempting to sexually attract men and to preserve romantic relationships at all costs, and placating others by internalizing, denying or inefficiently expressing anger). Misdiagnosis can also occur when a client's problem behaviors are inconsistent with societal expectations such as when an Asian woman, assumed by stereotype to be meek, reacts to discrimination with anger. In another example, Crosby and Sprock (2004) found that when clinicians rated a case of a woman with antisocial symptoms, they were more likely to exhibit biases that were consistent with relying on prototypes (i.e., stereotypes regarding diagnostic categories) rather than actual diagnostic criteria. There is ample evidence that poverty and economic inequality are strong predictors of depression in women (APA, 2004b; Belle & Doucet, 2003; Brown, Abe-Kim, & Barrio, 2003). African-American women are more likely to be diagnosed with schizophrenia than White women

(Marecek, 2001). Issues of gender identity have been viewed as pathology rather than an alternate form of gender and sexual expression (American Psychiatric Association, 2000).

In addition, the specific needs and problems of girls may be overlooked and underdiagnosed because girls are more likely than boys to internalize problems or to express problems with less overt symptoms (Angold, Erkanli, Silberg, Eaves, & Costello, 2002; Fergusson, Swain-Campbell, & Horwood, 2002; Gershon, 2002; Hayward & Sanborn, 2002; Jenkins, Goodness, & Buhrmester, 2002; Quinn, 2005; Seiffge-Krenke & Stemmler, 2002), a problem that may be even more serious if the girl is also from a marginalized group. For example, girls with attention deficit disorders exhibit fewer disruptive behavior problems than boys but have been found to suffer more severe cognitive disabilities (Biederman et al., 1999). Problems that coexist with ADHD may also differ for girls and boys and across SES and ethnic groups, further complicating the diagnostic process. Underidentification of attention problems in girls appears related to fewer teacher referrals, yet attention problems are associated with lower self-esteem and more frequent peer rejection for girls than for boys (Biederman et al., 1999; Gaub & Carlson, 1997; Gershon, 2002; Quinn, 2005).

Inaccurate conceptualization of diagnoses can also be influenced by sampling biases. These biases can occur when diagnostic criteria or prevalence rates are based primarily on symptoms studied only in clinical contexts or are based on empirical studies of a disorder that include the biased representation of males or females, single sex participants, or one ethnic group. Such practices may lead to inaccurate prevalence rates, biased assessment instruments, biased thresholds for diagnosis, and diagnostic criteria that do not reflect the diversity of symptoms that may be associated with a disorder (Skodol & Bender, 2003). Hartung and Widiger (1998) identified potential gender sampling biases associated with diagnostic categories

such as histrionic personality disorder, conduct disorder, somatization disorder, gender identity disorder, and dependent personality disorder.

Problems in diagnosis and treatment may occur when the literature on a particular problem is based primarily on a sample of only men and boys, women and girls, or predominantly one ethnic group, and then generalized to all clients. Other data suggest that women and men of color are more likely to receive psychopharmacological treatment only rather than psychotherapy (Homma-True, Greene, Lopez, & Trimble, 1993). Addiction and alcohol dependence research has often been based on male samples and generalized to all clients (Greenfield, 2002). However, women and girls metabolize alcohol differently, experience impairment or intoxication after fewer drinks, are at greater risk of dying from alcohol-related incidents, experience more rapid negative consequences of alcohol abuse, and are less likely than men to seek assistance from addiction-specific treatment settings. Empirical findings have shown gender differences in rates of diagnosis, differential responses to treatment, and differing barriers to treatment for women versus men. There are also gender differences in treatment outcomes and predictors for methamphetamine, cocaine, opiates, and tobacco dependence. Research on criminal behavior has overly focused on African American men as subjects. Many assessment instruments have been critiqued for bias that pathologizes people of color, female trauma survivors, individuals with disabilities, persons with strong religious convictions, sexual minorities, older adults, and those from lower socioeconomic classes and other countries (Brown, 1994). The unique biological, social, and psychological realities of persons with diverse social identities point to the value of considering how gender and other social identities may affect the expression of a disorder.

*Trauma and other stressors.* One important diagnostic issue is found in Posttraumatic Stress Disorder (PTSD; American Psychiatric Association, 2000). Despite the greater prevalence and chronicity of PTSD among females (Tjaden & Thoennes, 2000a), the construct is based on data from male combat veteran experiences, resulting in measurement problems that can affect both research and practice (Cloitre, Koenen, Gratz, & Jakupcak, 2002; Wolfe & Kimerling, 1997). For example, girls and women may be diagnosed with other Axis I and Axis II disorders when they experience trauma symptoms that do not fit the traditional PTSD profile (Cloitre et al., 2002). Further, women and girls may be misdiagnosed with more stigmatizing and chronic disorders (e.g., borderline personality disorder or schizophrenia) than are men with posttraumatic conditions (Fish, 2004). Women of color may experience additional trauma from multiple experiences with discrimination and oppression that lead to further misdiagnosis that does not take into account context. The experience of African American women with intergenerational trauma and the ongoing effects of a history of slavery have generally not been considered in the diagnosis of trauma (Vasquez & Magraw, 2005). In addition, men and women may experience trauma differently and may respond more effectively to different treatment approaches due to the type of traumas they are likely to encounter; potential differences in neurobiological stress pathways; and cultural and gender socialization experiences that influence self-concept, expectations, and meaning systems and whether the stressor is chronic or a single event stressor (APA, 2005; Cloitre et al., 2002; Kimerling, Ouimette, & Wolfe, 2002; Krause, DeRosa, & Roth, 2002; Root, 1992, 2001). The *Resolution on Male Violence against Women* (APA, 2005) notes that more than 20% of women are physically assaulted by a partner and approximately 12% experience sexual assault at sometime in their lives. The effects of these traumatizing events are compounded by ethnicity/race, social class, physical ability, and sexual orientation as the

likelihood of assault increases for marginalized groups (Bryant-Davis, 2005; Harway & O'Neil, 1999; Neville & Heppner, 1999).

Trauma is an important area to consider in more detail because a high proportion of girls and women of all ethnic, SES, sexual orientation, and ability status are exposed to traumatic stressors and their mental health may be severely affected. It should also be noted that psychologists may not be trained to work specifically with trauma survivors (Harway & Hansen, 2004), which can reduce the effectiveness of the treatment survivors receive.

Not only are a high proportion of women (69%) exposed to a traumatic stressor in their lifetime (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), women are more than twice as likely than men to develop chronic PTSD symptoms following exposure to a traumatic stressor (Kimerling et al., 2002; Stein, Walker, & Forde, 2000; Sutherland, Bybee, & Sullivan, 1998). Rape and domestic violence seem to account for higher prevalence of trauma in girls and women of all ethnic groups, and survivors have high rates of PTSD (see review by Wolfe & Kimerling, 1997). In the 1998 National Violence against Women Survey (Tjaden & Thoennes, 1998), 25% of women and 8% of men reported being raped or physically assaulted by a spouse, partner, or date in their lifetime; men perpetrated approximately 90% of this violence. Girls are also raped. Child sexual abuse happens two to two-and-one-half times more often to girls than boys (Boney-McCoy & Finkelhor, 1995). Such abuse not only results in immediate psychological symptoms (e.g., Polusny & Follette, 1995), but also lifetime risk for self-destructive or suicidal behavior, anxiety and panic attacks, eating disorders, substance abuse, somatization disorder, and sexual adjustment disorders (Finkelhor, 1990). Rates of childhood sexual abuse are similar for Black, White, Hispanic, and Native American women (Arroyo, Simpson, & Aragon, 1997; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Although sexual assault traumas are

experienced by women of diverse social identities across the lifespan, the specific issues and challenges of girls and women vary. For example, the presence of stereotyped images of Black women can exacerbate the psychological aftereffects of rape, can contribute to the marginalization of their concerns, and may increase the likelihood of holding victims responsible for their own assault (Donovan & Williams, 2002; Varelas & Foley, 1998).

Partner abuse occurs in married, unmarried, lesbian and gay couples (Renzetti, 1997), but most of the abuse occurs in heterosexual couples of all ethnic groups and SES level where the woman is at the greatest risk for injury (Tjaden & Thoennes, 2000a; Torpy, 2002; Walker, 2001). Battered women have expressed dissatisfaction with mental health treatment and the sensitivity of their therapists (Harway & O'Neil, 1999) and a preference for relying on friends and family (Horton & Johnson, 1993). Psychology training programs are not required to provide training in domestic violence and partner abuse, and few do, despite evidence that gender-sensitive training improves attitudes towards and knowledge about women in therapy (Johnson, Searight, Handal, & Gibbons, 1993). The APA Intimate Partner Abuse and Relationship Violence Working Group (2002c) recently recommended the need for specific training in domestic violence. They stated:

...we suggest that those involved in partner violence have special treatment needs and that those who treat them must do so with sensitivity and from a base of knowledge that comes from specialized training. Psychologists who do not have the requisite training potentially endanger their clients, and likely commit an ethical violation. Those who are teaching psychologists-to-be but who do not teach them about partner violence are abrogating their responsibility and risk perpetuating the conditions which foster this problem (p. 5).

*Treatment and prognosis.* Recent research has demonstrated that some therapists and trainees expect a more positive prognosis with male clients, still stereotype women as expressive, and take a more instrumental behavioral approach with men (Fowers, Applegate, Tredinnick, & Slusher, 1996; Klonoff et al., 2000; Rudman & Glick, 2001; Seem & Johnson, 1998; Wade, 2001). They may have even lower expectations of outcomes for women of color, lesbians, and women with disabilities. In addition, studies have found that therapists as a whole interrupt female clients more than male clients (Werner-Wilson, Price, Zimmerman, & Murphy, 1997). They also may use interventions that do not consider the client's cultural background or ability level (APA, 2003; Brown et al., 2003; Jackson & Greene, 2000; Olkin, 1999; Sparks, 2002).

Practitioners also may not perceive the specific external stresses and context of the lives of women and girl and instead emphasize endogenous and/or intrapsychic factors inappropriately and/or detrimentally including not taking into account issues of discrimination and oppression based upon social groupings (Boston Women's Health Book Collective, 2005; Bullock, 2004; Davis, Matthews, & Twamley, 1999; Marecek & Hare-Mustin, 1998; Porter, 2002). Furthermore, some members of the medical and psychological communities have noted that women's physical illnesses contain psychological components that are not expected in men (Laurence & Weinhouse, 2001; Webster, 2002) and that gender bias is manifested in advertisements for psychotropic medications and the high use of psychotropic medication prescribed for women (Hansen & Osborne, 1995; Nikelly, 1995). Inattention to contextual factors may contribute to the lack of recognition of problems of women and girls such as battering and other forms of victimization (Harway & Hansen, 2004; Porter, 2002). Inattention to contextual factors also contribute to lack of recognition of the physical and mental health consequences of battering and other forms of violence. An example is the lack of recognition of

traumatic brain injury despite knowledge of the high proportion of injuries to the face, head, and neck during battering. It may also contribute to the underdiagnosis of or double standards about problems such as alcohol abuse (Collins, 2002; Greenfield, 2002), and the effects of discrimination on stress and performance. For instance, research has found that high school girls expect more educational and career barriers than high school boys, and perceived barriers (e.g., discrimination) are especially likely if girls are also members of an ethnic minority group (McWhirter, 1997). Psychologists may also lack awareness regarding the particular strengths and resources of women and girls that help them deal with stressful issues. For example, many women and girls of color in the United States live in extended families that create larger communities that provide additional support for their growth and development (Reid, 2002).

*Culture, ethnicity, and other diversities.* Another area of gender bias in psychological practice concerns inattention to the ways in which culture and ethnicity influence problems such as depression and schizophrenia in women and girls (Brown et al., 2003; Sparks, 2002). Research has demonstrated that therapist insensitivity to racial stereotypes, the interaction of race and gender, cultural values and mores, and social and economic conditions have an impact on women and girls who live in poverty and women and girls of color (Adams, 1995; APA, 2004b; Brown et al., 2003; Gil, 1996; Greene, 1996; Klonoff, Landrine, & Scott, 1995; LaFromboise, Berman, & Sohi, 1994; Ridley, Li, & Hill, 1998; Shum, 1996; Sparks, 2002). Lesbian relationships and partnerships may also be pathologized through the description of lesbian relationships by terms such as "merged," "fused," or "enmeshed" (Morton, 1998; Pardie & Herb, 1997). Social stressors and discrimination from membership in marginalized groups can lead to a variety of internal and external problems.

*Sexual misconduct/abuse by psychologists.* Perhaps the most blatant example of gender bias and abuse in psychological practice occurs when a clinician violates ethical standards in sexual relationships with clients. Despite the APA's *Ethical Principles and Code of Conduct* (APA, 2002), other ethical codes (Pipes, Holstein, & Aguirre, 2005), and increasing awareness through education and training, power abuses, including sexual relationships, still occur in therapy and training (Gilbert, 1999; Koocher & Keith-Spiegel, 1998; Lamb & Catanzaro, 1998; Pope & Vasquez, 1998). Research indicates that the overwhelming majority of psychologists who have violated professional sexual ethical standards were middle-aged men who had sex with younger female clients (Kirkland, Kirkland, & Reaves, 2004; Pope, 2001; Pope, Sonne, & Holroyd, 1993). This problem has not only the potential to interfere with treatment efficacy, it also renders women and girls more vulnerable to stress and traumatization..

*Women with disabilities.* Women with disabilities span across every ethnicity, gender, sexual orientation, SES, and age ever known. One of every five Americans has a disability (U. S. Census Bureau, 2000). Thus, it can be estimated that women with disabilities comprise approximately 10% of our nation's population. It is evident by this statistic that persons with disabilities, particularly women of color with disabilities, have less access to and availability of mental health services (Surgeon General, 1999). Moreover, children with disabilities are a distinct high risk group for abuse and neglect and are, on average, two to three times more likely to be maltreated in their homes and in institutions than are children without disabilities (Sullivan & Knutson, 2000).

Beyond increase risk for abuse and neglect, persons with disabilities traditionally have experienced systematic institutional victimization from all aspects of society including, but not limited to, the medical profession, the educational system, and the workforce. This victimization

of women with disabilities, particularly women of color with disabilities, is especially prevalent. However, disability, gender, and/or culture do not reside solely in a vacuum, and individuals from each social group face struggles within society. Women of color with disabilities experience simultaneous oppression within society by belonging to three or more marginalized groups (e.g., gender, race/ethnicity, disability, sexual orientation, SES). Persons of color with disabilities are more likely to have lower educational levels, higher unemployment, and lower incomes (Block, Balcazar, & Keys, 2002). Moreover, these individuals are faced with having to choose which marginalized identity is most salient in what time frame, which can, in itself, lead to internal conflicts.

In addition, an individual can be an oppressor, a member of an oppressed group, or simultaneously an oppressor and oppressed, adding to their psychological stress. As the layers begin to mount (e.g., societal attitudes, lower income, physical access, physical pain, accommodating others with being accommodated) the importance of practitioners knowing how to deliver disability and culturally competent treatment becomes evident. The need is overwhelming and only likely to grow. Section 2.01(b) of the APA Ethics Code (APA, 2002b) supports an affirmative need for the profession to develop disability-related competence to deliver optimal care.

### *Contemporary Social Forces*

Gender related and multicultural issues relevant to practice will change as the broader sociocultural context changes. Good practice requires that psychologists remain abreast of new developments in contemporary social forces and their interaction with gender and other social identities. There are many contemporary issues that could be cited here, however, four particularly salient and recent examples include the increasing prevalence of global terrorism,

violence, and war in which women are particularly victimized by vulnerability to rape, assault and poverty; the effects of the media in popular culture that portrays an image of woman as thin, white, sexualized, and victimized; biopsychosocial realities and changes relevant to women's reproductive experiences; and the phenomenon of increasing lifespan with an aging population that consists mostly of women.

*Terrorism and war.* A contemporary issue that directly affects the welfare and physical and mental health of girls and women of all ethnic/racial groups is terrorism and war. Violence against women and girls is recognized as a global problem (APA, 2004b; World Health Organization, 2000). Women and girls suffer the consequences of violence in war through rape, abuse, torture, and the loss of economic security. Violence against women continues as the threat of terrorism and war across the world does not abate. Literature that addresses psychological responses to the effects of terrorism and other traumatic incidents suggests that individuals, both adults and children, who directly experience traumatic incidents that involve perceived threat or actual experience of harm to physical integrity often report symptoms of either acute stress disorder or post-traumatic stress disorder (PTSD) which may be exacerbated if they have suffered earlier trauma in the form of ongoing oppression or discrimination based upon their ethnicity, SES, sexual orientation, ability, etc. (Brady, Guy, Poelstra, & Brokaw, 1999; Pine & Cohen, 2002). Mood disorders, adjustment disorders, phobias and other conditions may also be psychological sequelae for parents and children (Koplewicz et al., 2002; Schuster et al., 2001).

*Media.* In discussing the influence of contemporary forces, mention must be made of the increasingly powerful presence of the media in modern life. For example, although the terrorist attacks on the United States of 9/11 were confined to the Northeast, many Americans vicariously experienced and observed the horrific events through continuous media exposure. Media

coverage of the 2001 terrorist attacks generally emphasized men as victims and experts, rendering women and girls nearly invisible and relegating them to stereotypical support and victim roles. There was brief mention made of the sense of some African Americans that the 2001 terrorist attacks were isolated incidents, differing significantly from ongoing community violence and localized terrorism experienced by African Americans in many urban settings (Jenkins, 2002). Media coverage of school shootings has often neglected to emphasize or mention that the perpetrators of the broadcast violence are usually men and boys, with some evidence that misogyny may be one causative factor. The websites of the APA and the National Association of School Psychologists (NASP), among others, provided abundant materials for psychologists and the public to deal with the traumatization of children that might result from watching the repeated news broadcasts related to the planes hitting the World Trade Center buildings.

In general, the media has become an enormously powerful influence regarding access to information; exposure to violence; and conveyor of cultural stereotypes regarding gender, race, ethnicity, and sexual orientation. The media plays a major role in shaping contemporary values and attitudes. As an increasingly important social influence in our society, television often presents idealized images of women that are stereotyped and distorted by emphasizing youth, extreme thinness, and sexuality (Fouts & Burggraf, 2000; Irving, 2001) as well as negative racial, ethnic, and economic stereotypes (Greene, 1994). There is a large incidence of eating disorders among girls and young women in Western society (Miller & Mizes, 2000; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). Research on the effects of media images and body image disturbance finds that in some young girls and women, increased media attention to the appearance of females on television and in advertising leads to an increased preoccupation with

weight, shape, and appearance (Blaine & McElroy, 2002; Botta, 2003; Geier, Schwartz, & Brownell, 2003; Lauzen & Dozier, 2005; Monro & Huon, 2005; Posavac, Posavac, & Posavac, 1998; Posavac, Posavac, & Weigel, 2001; Simonton, 1995; Thornton & Maurice, 1997) which varies widely by ethnic groups with the most impact on White and Asian women and less on African American women. Media images of poor women represent another area of research of importance for practitioners. Women and their children are the largest group of poor individuals in this country, and gender and ethnic stereotypes about poor women can influence both the clinician and the client. Bullock, Wyche, and Williams (2001) found that while print media is sympathetic to poor women, the structural causes of poverty are not discussed. Hence, women, and particularly women of color, may be blamed for their poverty status. The limitations of the media coverage of poor women as well as a wide variety of constantly changing sociocultural context factors and their interaction with gender have the potential to affect practice.

*Biopsychosocial aspects of reproduction.* Although reproduction has always been relevant to the lives of girls and women, recent social developments have contributed to significant changes in the complexity and biopsychosocial meanings of reproduction. As the social roles and pressures experienced by girls and women have expanded, the timing of events related to menarche and childbearing have changed. Reproductive technologies and reproductive medical interventions have become more available and sophisticated, and attitudes toward reproductive choice have also changed. From the onset of menstruation, young girls and women are faced with the biological realities of reproduction (Chrisler & Johnston-Robledo, 2000). Menarche is associated with a variety of physiological, psychological, and social meanings and changes including changes in appearance beliefs, body image, self-esteem, and peer relationships as well as gains and losses in social power, as for instance in ethnic groups in which menarche is

seen as a marker of adulthood (Crawford & Unger, 2004). The diverse social identities of girls are also related to perceptions of menarche. Although White girls have shown higher depression scores after menarche, no menarche-associated differences have been found in African-American and Hispanic girls (Hayward, Hotlib, Schraedley, & Litt, 1999). Although a relationship between the timing of menarche and psychological distress is not consistently found (Stice & Whitenton, 2002), early menarche has been associated with elevated depressive symptoms, eating problems, and substance use and abuse (Stice, Presnell, & Bearman, 2001). As girls mature and gain more body fat at puberty, girls' bodies are less likely to conform to an increasingly thin cultural body ideal. Perceived pressure to be thin and the internalization of a "thin ideal" have been associated with body dissatisfaction or negative body image (Durkin & Paxton, 2002) and depressive and eating disordered symptoms, particularly for White and Asian girls (Stice & Bearman, 2001), hence, the biological event of menarche may influence attitudes toward the body. However, those girls who were socialized to think of menarche as a natural event and/or a positive affirmation of womanhood, which is more likely in African American culture, have reported positive experiences (Bishop, 1999). There is also evidence that college women perceive menstruating women as being stronger, more maternal, and more trustworthy (Forbes, Adams-Curtis, White, & Holmgren, 2003).

Similarly, issues associated with reproduction and childbirth can evoke a range of feelings from joy to fear in women and girls. Today, women have a greater freedom of choice regarding whether to become a parent and how they want to manage pregnancy and childbirth (Martin & Colbert, 1997) than they did decades ago. Most women consider pregnancy to be a very positive and joyful experience despite physical and hormonal changes and describe feeling more fulfilled when pregnant as they think about another life growing inside them, however

these feelings are not universal (Rice & Else-Quest, 2006). Some feelings of joy that emerge during pregnancy are associated with fantasizing about the future child, experiencing an altered state of being, and imagining a happy and unified family (Bondas & Eriksson, 2001). Childbirth can also be a biological and psychosocial stressor (Beck, 2002; Martin & Colbert, 1997). An important aspect of pregnancy and childbirth is the evidence of increased violence toward women during pregnancy, particularly Black women (Leigh & Huff, 2006). There is also increasing societal concern for the effects of postpartum depression after several high profile cases of women suffering from postpartum depression killing their children. Postpartum depression is characterized by extreme sadness, fatigue, loss of interest in the baby and other aspects of life, and feelings of despair (O'Hara & Stuart, 1999; Robinson & Stewart, 2001), and women who lack social and/or financial support are particularly at risk for its effects (Robinson & Stewart, 2001; Seguin, Potvin, St.-Denis, & Loiselle, 1999; Wile & Arechigo, 1999). It affects about 10-15% of women, usually developing six months after the birth, and may last for several months (O'Hara & Stuart, 1999; Robinson & Stewart, 2001). Feminists have strongly critiqued a medical care system that does not provide appropriate care and protection for such mothers. While some women experience symptoms of stress and depression in childbirth (Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993), other women recognize their personal power, and positively integrate new aspects of identity as a mother (Beck, 2002). Parenthood can be considered as a developmental stage of both women and men who wish to be parents.

Sexually transmitted diseases are a growing societal concern, particularly among girls and adolescents (Gutierrez, Oh, & Gillmore, 2000). Women are more vulnerable to STDs than men (Gutierrez, Oh, & Gillmore, 2000; Ickovics, Thayaparan, & Ethier, 2001), and women are more likely to be infected from a single sexual encounter with STDs producing few detectable

symptoms (Jadack, 2001). Women and girls suffer the most severe consequences of STDs, including infertility (Alexander, La Rosa, & Bader, 2001; Jadack, 2001).

Menopause is a biological phenomenon that had been largely ignored until the 1990s (Gannon, 1999; Greer, 1992; Sheehy, 1992). Societal assumptions that menopause is commonly associated with depression, irritability, and mood swings have been refuted (Avis, 2003; Etaugh, 1993; Robinson, 2002) as have medical accounts that treated menopause as a deficiency disease (Shore, 1999). Overemphasis on a biomedical model of menopause has led to a picture of decline and degeneration rather than the more accurate findings of generally increased and broadened interests in life and greater self-confidence (Apter, 1996; Hvas, 2001; Marcus-Newhall, Thompson, & Thomas, 2001; Rostosky & Travis, 2000; Sherwin, 2001).

Voluntary childlessness and desire for an abortion may also be choices for some women (Russo, 2000). In the case of abortion, pre-abortion levels of optimism, personal control perceptions, and high self-esteem are related to better post-abortion adjustment (Cozzarelli, 1993; Major, Richards, Cooper, Cozzarelli & Zubek, 1998). Although motherhood is often viewed as desirable, joyful, and fulfilling, a view which varies by ethnic group and SES, satisfying female gender roles are not necessarily linked with motherhood (Gillespie, 2003). Individuals who choose not to be parents may cope with social pressures and negative stereotypes (e.g., selfish or desperate) in various ways, including the use of a new more positive term to reflect their status: "childfree" (Letherby, 2002; Morell, 2000; Park, 2002).

Many women and couples who wish to conceive children are unable to do so (Brown & Davey, 2002; Henning & Strauss, 2002). Such women and couples must confront fertility issues and experience loss, grief, and mourning due to reproductive challenges (Anderson, Sharpe, Rattray, & Irvine, 2003; Georgiades & Grieger, 2003; Gerrity, 2001a,b; Kirkman, 2003).

Changes in attitudes and practices toward adoption are also relevant. Also, although early literature on adoption focused on negative experiences in adoptive children (Wegar, 2000) and ignored the common practice in some ethnic groups (e.g., African American) of extended family adoption, more recent research is focusing on the full adoption “triad” (i.e., adoptees, birthparents, and adoptive parents) and on both positive and negative aspects of the experience (Lee, 2003; Zamostny, O’Brien, Baden, & Wiley, 2003).

Recent research on maturation and change regarding reproductive capacities reveals that these aspects of women’s and girls’ identities, bodies, and lives are associated with both strengths and potential problems. The research cited in this section suggests that an integrated biopsychosocial approach to understanding both the resources and difficulties that all girls and women experience in many aspects of their lives is likely to contribute to positive psychological practice.

*Elderly women.* Our society has an increasing proportion of older individuals, and since significantly fewer men than women survive into very old age (80s, 90s and beyond), the elderly in our society are primarily women. Women are more subject to problems with financial resources, racial and ethnic bias, and bias against individuals with any specific disability associated with aging (APA, 2004a; Federal Interagency Forum on Aging-Related Statistics, 2000; Sinnott & Shifren, 2001). The typical victim of elder abuse is a woman over 75 (Collins, Bennett, & Hanzlick, 2000). Few psychologists have taken courses in aging as part of their professional training (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). By the year 2030 older adults are expected to account for nearly one fourth of the population (APA, 2004a; United States Bureau of the Census, 1996). Since women tend to marry older men and live longer than men, and men are more likely to remarry, many older women are widows and

single. Single rates are even higher for African American women who may depend more upon extended family for support than a spouse (Bedford & Blieszner, 2000; Trotman, 2002). Hence, more older women are single than older men (Spraggins, 2003). Older women are affected by poverty or low financial security, special health issues, and belonging to a disenfranchised or marginalized group (Canetto, 2001; Kinsella & Velkoff, 2001; United States Census Bureau, 2001). In addition, more negative stereotypes of aging have been directed toward women than men (e.g., witch, hag, crone) (APA, 2004a; Nelson, 2002; Markson, 2001). In fact, psychologists are more likely to rate older women as less competitive, less competent, less assertive, and less willing to take risks than young women (Danzinger & Welfel, 2000; Matlin, 2001). Culture also affects the view of the aging process. For example, in cultures or subcultures in which older women are valued as mature and wise (e.g., some Native American tribes), older women may experience positive effects including new freedoms and renewed sexuality (Lamb, 2000; Robinson, 2002; Sommer et al., 1999; Trotman & Brody, 2002). Elderly African American women have been found to be active in community organizations such as a church (Armstrong, 2001) and closely involved in the lives of their grandchildren (Barer, 2001; McWright, 2002). Many members of both the profession and the public are not aware of the benefits of aging for women in the United States including feeling freer of gender role stereotypes and gendered roles (Calasanti & Slevin, 2001; Friedan, 1993; Jackson, Chatters, & Taylor, 1993; Mitchell & Helson, 1990).

On average, women experience more years of good health than men (Altman, 1997); however, they are also more likely to live with chronic illnesses such as chronic fatigue syndrome, fibromyalgia, arthritis, thyroid conditions, migraine headaches, anemia and urinary incontinence (Misra, 2001; Schmalting, 2000). These factors have an impact on the psychological

identity and lifestyle of women (Altmaier et al., 2003; Stark-Wroblewski & Chwalisz, 2003). Older women can be especially at risk for depression and alcohol problems because they are more likely than men to outlive their spouses and to face other losses that can lead to loneliness and depression (APA, 2004a; Bedford & Blieszner, 2000; Canetto, 2001; Gatz & Fiske, 2003). This effect is less likely for women, such as African American women or others from communal cultures, who have depended upon extended family systems for their life-span (Armstrong, 2001; Bedford & Blieszner, 2000; Trotman, 2002; Reid, 2002). Women are also at greater risk for alcohol-related health problems as they age such as harmful medication interactions, injury, liver and cardiovascular disease, cognitive changes and sleep and memory problems (Gambert & Katsoyannis, 1995). As women age, outlive their spouses, and experience increasing dependency and mental and physical health issues, their primary caregivers also tend to be women, many of whom try to balance caring for both their children and elderly parents or parents-in-law while in full-time employment (Davenport, 1999; Etaugh & Bridges, 2001; Gatz & Fiske, 2003). Numerous studies have indicated that caregivers experience significant emotional, physical and financial stresses (Canetto, 2001; Etaugh & Bridges, 2001; Huyck, 1999; King, 1993). These issues have caused such concern among psychologists that APA has endorsed and published a separate set of guidelines for older adults (APA, 2004a).

These introductory pages have provided a foundation for both establishing a public need for these *Guidelines for Psychological Practice with Girls and Women* for girls and women of all social groups and the evidence of their variable, and too often, inappropriate treatment. Issues that need to be addressed include bias in diagnosis and treatment, differences in environmental stressors and trauma, and the multiple diversity intersections of ethnicity, age, sexual orientation, SES, and disability.

### *History and Development of the Guidelines*

In response to early concern about women's issues, rights, and discrimination, an APA Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice was charged with studying sexism in psychotherapy and with recommending corrective actions (APA, 1975). The 1975 Task Force was directed to "be concerned with psychotherapeutic practices as they affect women." In response, the task force developed "Guidelines for Therapy with Women" (APA, 1978) for use in training and in continuing professional practice, and this document was published in the December, 1978, issue of the *American Psychologist*. These guidelines considered issues of gender bias and sex role stereotypes, sex-discriminatory practices in society, and therapist awareness of these forces and encouraged the elimination of bias in psychological theory and practice. Building on this initial work, various divisions of APA continued to develop and refine recommendations for psychological practice with women.

In 1976 the Division 17 (Counseling Psychology) Ad Hoc Committee on Women initiated plans for developing principles for counseling women and held planning and working conferences in 1977 and 1978. These efforts culminated in a document entitled "Principles Concerning the Counseling and Psychotherapy of Women" (APA, 1979) that articulated 13 principles for counseling women. The principles were approved as an official policy statement for Division 17 (counseling psychology) and also endorsed by Divisions 12 (clinical psychology), 16 (school psychology), 29 (psychotherapy), 35 (psychology of women), and the APA Board of Educational Affairs. The principles were expanded eight years later to include literature support, rationale, and implementation recommendations entitled "The Division 17 Principles concerning the Counseling/Psychotherapy of Women: Rationale and Implementation"

(Fitzgerald & Nutt, 1986). These principles have been used in many doctoral training programs and served as a general resource document for APA (Farmer, 2002).

Almost from the inception of the Principles, the task forces and divisions recognized and anticipated the need for continuing revision of the document and greater exposition of each principle to guide psychologists in implementing their spirit and content in practice. In the early 1990s the now Division 17 Section for the Advancement of Women drafted an update of the literature section of the 1986 document, but it was not published because the principles themselves were identified as outdated and in need of major revision. It was deemed that future guidelines needed to: (a) focus on a wider range of psychological practice, (b) be relevant to both girls and women, (c) include themes and issues that have received substantial attention during recent decades (e.g., eating disorders, violence against women), (d) focus more extensively on diversity among women and girls, and (e) attend to the sociocultural context in which women's and girls' issues and problems occur.

In 1993 Division 35 organized a conference entitled "The First National Conference on Education and Training in Feminist Practice" convened to explore, integrate, and create a cohesive agenda for training and education in feminist practice for the next decade. The work of feminist psychologists at that conference resulted in the publication of the APA book, *Shaping the Future of Feminist Psychology: Education, Research, and Practice*, edited by Judith Worell and Norine Johnson (1997). One outcome of the conference was a broader definition of psychological practice to include theory, assessment, research, teaching, supervision, therapy, and advocacy. There was also an emphasis on addressing diversity and multicultural concerns. This expanded definition of psychological practice has been adopted for the current guidelines as it relates to all aspects of our concern for women and girls and all our clientele and consumers.

The Division 17 Section for the Advancement of Women held a 1998 conference in Michigan on the integration of feminism and multiculturalism. The work groups in the conference focused on similar topics as the prior Division 35 conference (therapy, assessment, research, ethics, teaching, and supervision) and similarly reinforced the momentum to develop a new set of more timely and relevant guidelines for psychological practice with diverse groups of women, including girls. This conference resulted in a series of twelve articles published in the *Journal of Multicultural Counseling & Development* from 2004 to 2006. Volume 32 published in 2004 contained a special section with a lead article on centralizing feminism and multiculturalism in counseling (Fassinger, 2004) followed by integrative articles on theory (Reynolds & Constantine, 2004), supervision (Steward & Phelps, 2004), consultation (Horne & Mathews, 2004), practice (Nutt Williams & Barber, 2004; Whalen, Fowler-Lese, Barber, Nutt Williams, Judge, Nilsson, & Shibazaki, 2004), teaching and pedagogy (Enns, Sinacore, Ancis, & Phillips, 2004; Smith-Adcock, Ropers-Huilman, & Choate, 2004), and mentoring (Benishek, Bieschke, Park, & Slattery, 2004). Later articles addressed career development (Cook, Heppner, & O'Brien, 2005), consultation and advocacy (Hoffman, Phillips, & Noumair, 2006), and further issues in supervision (Nelson, Gizara, Cromback, Weitzman, Phelps, Steward, et al., 2006).

During this period, APA's Committee on Women in Psychology (CWP) (established by the Council of Representatives in 1973) has been actively working on its mission to collect information and documentation concerning the status of women, recommend and implement guidelines, and facilitate ongoing communications with other agencies and institutions regarding the status of women. The current three priority issues for CWP relate to translating women's health research into practice and policy, women and work, and women as participants in psychological research. Some specific goals include (a) promoting the health and well-being of

women, (b) identifying and eliminating discriminatory practices against women, (c) collaborating with others as needed to achieve the empowerment of underrepresented groups, and (d) promoting the generation and communication of knowledge about women's lives. The promulgation of guidelines for psychological practice with girls and women is consistent with the mission, projects and activities of CWP.

In the 1990s, parallel efforts were initiated to develop guidelines for psychotherapy with lesbian, gay and bisexual (LGB) clients, for multicultural practice, and for psychological practice with older adults. These efforts have successfully culminated in "Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients" (APA, 2000a), "Guidelines on Multicultural Education and Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2003), and "APA Guidelines for Psychological Practice with Older Adults" (APA, 2004). In the "Criteria for Practice Guideline Development and Evaluation" (APA, 2002a) APA provided guideline developers guidance for the development and review of practice guidelines.

### ***Process***

The three co-chairs, Roberta L. Nutt, Joy K. Rice, and Carol Zerbe Enns, were appointed by Divisions 17 and 35 in April, 2000 to assemble a task force that would be responsible for drafting a new set of guidelines for counseling and therapy with women and girls. Implicit in this charge was the mandate to disseminate the document for extensive review and submit it to APA for adoption.

Members of Divisions 17, 35, and other divisions met at the APA convention in San Francisco (2001), the Mid Winter meeting and Multicultural Summit (Santa Barbara, 2001), the Houston Counseling Psychology National Conference (2001), a weekend conference retreat in Dallas (2002), the APA convention in Chicago (2002), and two chair meetings in Madison, Wisconsin (2002 and 2004). Most of the original brainstorming and promulgation of language

for guideline statements and rationale occurred at the 2002 weekend retreat for approximately 30 participants. Participants began the first session by sharing their dreams for this project and its outcomes. The dominant dream reported was a determination by participants to avoid prior clashes they had witnessed between gender and multicultural perspectives and produce a truly integrated document that honored both gender and culture. This project was funded by Divisions 17 and 35, the APA Board of Directors, Division 43, the Association for Women in Psychology, and a CODAPAR grant.

The members of the task force at various stages of writing and consultation included: Julie Ancis, Martha Bergen, Kathleen Bieschke, Michele Boyer, Laura Boykin, Mary Brabeck, Sara Bridges, Redonna Chandler, Madonna Constantine, Carmen Cruz, Donna Davenport, Amanda Dickson, Ruth Fassinger, Laura Forrest, Linda Forrest, Lisa Frey, Deborah Gerrity, Glenn Good, Barbara Gormley, Michael Gottlieb, Kris Hancock, Nancy Downing Hansen, Michele Harway, Danica Hays, Misty Hook, Kathy Hotelling, Rachel Latta, Karen Lese, Don-David Lusterman, Jim Mahalik, Connie Matthews, Dinah Meyer, Debra Mollen, Cassie Nichols, Laura Palmer, Adrienne Paulson, Randy Pipes, Beverly Pringle, Jill Rader, Faye Reimers, Pam Remer, Rory Remer, Christina Rodriguez, Holly Savoy, Anne Scott, Susan Seem, Elizabeth Skowron, Stacey Smoot, Dawn Szymanski, Virginia Theo-Steelman, Ellen Tunnell, Melba Vasquez, Heather Weiner, Ashley Williams, Libby Nutt Williams, Kacey Wilson, Judy Worell, and Karen Wyche. Twenty doctoral students from eight programs were included in this process.

### *Definitions*

*Sex and gender.* The term “sex” refers to biological aspects of being male or female, and “gender” refers to psychological, social, and cultural experiences and characteristics associated with the biological aspects of being female or male. Gender includes assumptions, social beliefs,

expectations, and stereotypes about women, girls, men, and boys (Gilbert, 1999; Gilbert & Scher, 1999) and is an active process that can be understood as “doing gender” (West & Zimmerman, 1987). Gender-related attitudes are often embedded in complex and nonconscious cognitive beliefs that are shaped and reinforced by social interactions, institutional practices, and power structures in society (Bem, 1993). Beliefs about and expectations regarding gender and gender identity also vary within and between groups associated with social categories such as ethnicity, sexual orientation, disability, class, and race (Olkin, 1999; Worell & Remer, 2003). For example, several studies of African American women revealed that whereas race was identified as the most significant aspect of identity in the realm of political orientation (Gay & Tate, 1998), gender was found to be most significant with regard to domestic violence issues (Fine & Weis, 1998). Although gender and sex can be seen as overlapping and fluid categories with multiple meanings (e.g., Golden, 2000; Lips, 2001; Marecek, 2002), this document uses the term gender to refer primarily to the social experiences and expectations associated with being a girl or woman.

*Gender bias.* Gender bias is a construct that frequently occurs in this literature. Bias is defined as a partiality or prejudice. The term gender bias is applied to beliefs, attitudes and/or views that involve stereotypes or preconceived ideas about the roles, abilities and characteristics of women and men. Gender bias is often modified by and intersects with biases related to race, class, culture, age, ability, and sexual orientation.

*Social identities.* “Social identities” encompass personal and group definitions that are embedded in a variety of social groups and statuses. These identities are associated with, but not limited to, gender, race, ability level, culture, ethnicity, geographic location, intellectual ability, sexual orientation, gender identity, class, age, body size, religious affiliation, acculturation status,

socio-economic status and other sociodemographic variables. The complex interaction of these group identities and statuses are reflected in multidimensional concepts of identity and gender that are influenced by visibility or the degree to which they are easily discernable to others, situational salience or relevance, and experiences of oppression or privilege (Deaux & Stewart, 2001; Stewart & McDermott, 2004; Worell & Remer, 2003).

*Oppression and privilege.* “Oppression” includes discrimination against and/or the systematic denial of resources to members of groups who are identified as different, inferior, or less deserving than others. Oppression is most frequently experienced by individuals with marginalized social identities. Oppression is manifested in blatant and subtle discrimination such as racism, ageism, sexism, and heterosexism; and results in powerlessness or limited access to social power (Robinson & Howard-Hamilton, 2000; Worell & Remer, 2003). In contrast, “privilege” refers to sources of social status, power, and institutionalized advantage experienced by individuals by virtue of their culturally valued social identities (McIntosh, 1998). Privilege is most frequently experienced by those persons whose life experiences and identities are associated with dominant social identities, cultural traditions, and sources of power (e.g., being white, Christian, male, and middle/upper class). It should be noted that an individual can operate from points of privilege and oppression simultaneously.

*Diversity.* This document uses the definition of diversity developed by participants in the 1993 National Conference on Education and Training in Feminist Practice (Greene & Sanchez-Hucles, 1997). These conference participants noted that a diverse psychology of women reflects all women’s and girls’ experiences, is based on data from a wide range of sources, reflects openness to and a valuing of difference, and cultivates many perspectives and experiences. This approach to diversity also recognizes the ineffectiveness of conceptualizing aspects of gendered

experiences in isolation (e.g., culture, race, gender, sexual orientation, ability) and emphasizes the complex interaction of social identities, oppressions, and privileges. Although diversity is often reflected in experiences associated with class, race, gender, ability level, ethnicity, sexual orientation, our conceptualization of diversity also allows for “other dimensions of persons or groups that are salient to their understanding of the world and of themselves” (Greene & Sanchez-Hucles, 1997, p. 185).

*Psychological practice.* For the purposes of this document, psychological practice is defined broadly to include activities related to all applied areas of psychology. Psychological practice may include clinical practice and supervision, pedagogy, research, scholarly writing, administration, leadership, social policy, and any of the other activities in which psychologists may engage (Worell & Johnson, 1997).

### **Guidelines for Psychological Practice with Girls and Women**

The eleven “Guidelines for Psychological Practice with Girls and Women” are organized into three sections: (a) Diversity, Social Context, and Power; (b) Professional Responsibility; and (c) Practice Applications. The first section presents a framework concerning social identity and gender role socialization issues that explicate the foundation for the following more applied sections on professional responsibility and actual practice applications. The supporting references in the literature review emphasize studies from approximately the past 15 years plus classic studies that provide empirical and clinical support and examples for the guidelines. The literature review, however, is not intended to be exhaustive. Recommendations in this section are consistent with broad ethical principles (endorsed by APA, 2002b) of beneficence and nonmaleficence, fidelity and responsibility, integrity, and respect for the rights and dignity of others.

### **Diversity, Social Context, and Power**

**Guideline 1: Psychologists strive to be aware of the effects of socialization, stereotyping, and unique life events on the development of girls and women across diverse cultural groups.**

#### **Rationale**

One of the most consistent patterns documented in research on gender socialization is that traditional roles related to gender and sexuality may be reinforced through the differential treatment of boys and girls and may also be enacted without self-awareness or conscious intention (APA, 2004b; Bem, 1993; Crawford & Unger, 2004). Females may be devalued relative to their male counterparts and socialized into patterns of nurturance, passivity, helplessness, and preoccupation with appearance. The presentation of women and girls as sexual objects, which begins in childhood and extends through adulthood, is promulgated by the media, and emphasizes the role of appearance and beauty (Brown, Steele, & Walsh-Childers, 2002; Calvert, 1999). The internalization of stereotypes about their abilities and social roles (e.g., less competent, dependent) has been shown to produce decrements in the performance and aspirations of women and girls (Davies, Spencer, & Steele, 2005; Lesko & Corpus, 2006).

Each girl and woman is also socialized within a unique cultural milieu and set of visible and invisible social group memberships (Ballou, Matsumoto, & Wagner, 2002; Sparks & Park, 2000; Stewart & McDermott, 2004; Suyemoto & Kim, 2005) that may include, but are not limited to, gender, race/ethnicity, class, age, sexual orientation, socioeconomic status, spiritual orientation, nationality, physical or cognitive ability, and body size. The multiple group memberships of girls and women intersect and influence each other and are enacted within the

family and cultural institutions (schools, religion), through peer influences, and within media (Deaux & Stewart, 2001; Erkut, Fields, Sing, & Marx, 1996; Greene & Boyd-Franklin, 1996). For example, most women of color in the United States live within an ethnic minority family, which is typically located in the context of an ethnic minority community, which is embedded within the dominant White society (Reid, 2002). The unique developmental and life experiences of girls and women related to their reproductive capacities contribute to the complexities of multiple group memberships for girls and women. Events such as menarche, pregnancy and childbirth, voluntary childlessness and abortion, fertility issues, postpartum responses, and menopause are associated with a variety of cultural, psychological, physiological, and social meanings and changes.

### **Application**

Psychologists strive to be aware of socialization processes, to recognize stereotyping, and to communicate the subtle ways in which beliefs and behaviors related to gender may affect the life experiences and well-being of girls and women at various points of the lifespan. Research reveals, for example, that when women are aware of the potential impact of stereotypes, affirm valued attributes in themselves, or perform roles in identity-safe environments, they are less vulnerable to the negative effects of stereotypes (Davies, Spencer, & Steele, 2005; Martens, Johns, Greenberg, & Schimel, 2006).

Psychologists also strive to recognize that all girls and women are socialized into multiple social group memberships and that within their group memberships, girls and women have both shared and unique identities and developmental pathways. Psychologists endeavor to understand the life issues and special challenges related to the development of girls and women, the diverse beliefs and values of girls and women with whom they work, and how these factors

may have an impact on each girl's and woman's experience. Psychologists also strive to recognize the biopsychosocial effects of unique developmental experiences such as reproduction on women's lives and work to support healthy transitions, prevent problems, and remediate difficulties.

**Guideline 2: Psychologists are encouraged to recognize and utilize information about oppression, privilege, and identity development as they may affect girls and women.**

**Rationale**

Because girls and women have multiple personal and social group memberships, they may simultaneously belong to both socially privileged and disempowered groups (e.g., White, heterosexual, lower socioeconomic status, and female) or to multiple socially oppressed groups (e.g., African American, female, lesbian, disabled) (Ancis & Ladany, 2001; Greene & Sanchez-Hucles, 1997; Suyemoto & Kim, 2005). Numerous authors have documented the stress of managing multiple identities associated with oppression, sometimes labeled double or triple jeopardy (Banks & Marshall, 2004; Espín, 1993; Greene, 1997; Robinson & Howard-Hamilton, 2000). Saliency of a particular identity is determined by several factors including socialization experiences (Cross & Vandiver, 2001) and the amount of social support received in a particular situation (Wyche & Rice, 1997). For example, coming out as a lesbian, gay, or bisexual (LGB) person may be more complicated or less acceptable within some racial/ethnic groups because of the complexity of balancing issues of racism, ethnic discrimination, and homophobia (APA, 2000a; Greene, 1997; McCarn & Fassinger, 1996).

Identity development may include an individual's movement from internalized prejudice and privilege toward increased awareness of societal prejudices and privilege, cognitive

flexibility, and internal standards of self-definition (Cross & Vandiver, 2001; Downing & Roush, 1985; Moradi, Subich, & Phillips, 2002). For a young woman, developing a healthy sense of self and gender identity is a complex process and is shaped by her awareness of the power of male identity and other dominant identities within the culture (Abrams, 2003). Consequently, compared to boys, young adolescent girls have been found to report less favorable gender identity beliefs and lower self-esteem (Brown, 2003; Spence, Sheffield, & Donovan, 2002; Tolman & Brown, 2001). In addition, both gender and race-related stress have been linked to higher levels of emotional and behavioral problems (DuBois, Burk-Braxton, Swenson, Tevendale, & Hardesty, 2002). Young women may resist cultural norms in a variety of ways (Abrams, 2003) (e.g., by refusing to engage in high risk behaviors such as sexual intercourse or assuming stereotypically “masculine” behaviors such as aggression, truancy, and substance abuse). Studies also reveal that girls of color may often show greater ability to resist cultural messages, which may provide a protective effect against some of the vulnerabilities associated with adolescence (Basow & Rubin, 1999; Tolman & Brown, 2001) and provide strengths upon which they may build.

### **Application**

To understand more fully girls and women, psychologists are encouraged to identify the social group memberships of girls and women, the extent to which they accept or deny these memberships, their experience of oppression and/or privilege within the context of these memberships, and their abilities to resist confining or oppressive messages. In addition, psychologists strive to understand and appreciate differences in various aspects of identity formation (e.g., sexual and social identity development) in the complexities of the stages through

which these various identities may emerge (Cross & Vandiver, 2001; Helms, 1993, 1995; Helms & Cook, 1999; McIntyre, 2000).

Psychologists are encouraged to develop awareness about how their own self-perceptions and levels of identity awareness influence their psychological assessments and perceptions of girls' and women's salient identities. The practitioner may, for example, be cognizant of the importance of avoiding gender and racial stereotyping in practice decisions, but not aware of the subtle interactions between gender and race for girls and women who may experience unique child raising, socialization, and gender role development experiences related to biracial identity (Root, 1992; 2001). Psychologists are also encouraged to use psychological methods that help recognize the multiple identities of a girls and women and conceptualize their experiences within a contextual framework. This framework includes the culture's traditional gender, racial, ethnic, and sexual stereotypes; discrimination within the larger culture; family and community strengths and problems; and the girl's or woman's coping resources and identity development (Worell & Remer, 2003; Wyche & Rice, 1997).

**Guideline 3: Psychologists strive to understand the impact of bias and discrimination upon the physical and mental health of those with whom they work.**

#### **Rationale**

Bias and discrimination are imbedded in and driven by organizational, institutional and social structures. These dynamics legitimize and foster inequities, influence personal relationships, and affect the perception and treatment of a person's mental and behavioral problems. Discrimination has been shown to contribute more to women's perceptions of their psychiatric and physical symptoms than any other environmental stressor (Klonoff et al., 2000;

Moradi & Subich, 2002). Women who perceive that they are subject to group and individual discrimination are more likely to experience depression (Klonis, Endo, Crosby, & Worell, 1997). Violence against women is often predicated in sexism, racism, classism, and homophobia (Glick & Fiske, 1997; Koss, Heise, & Russo, 1994). The extent to which bias and discrimination can impact the physical and mental health of women and girls is illustrated by the fact that these dynamics have been documented in diverse contexts.

*Health systems.* Because of the structure of the health care system, women and girls often receive unequal treatment in health insurance, in health research, and in health care and specific interventions (Landrine & Klonoff, 2001). Women are often neglected in healthcare research (Rothbart, 1999), stereotyped regarding their ability to handle healthcare information (Chrisler, 2001), and given too much care in some areas (e.g., cesarean section surgeries) (Livingston, 1999) and too little care in others (e.g., coronary heart disease) (Gan et al., 2000). Women of color are especially likely to receive inadequate healthcare (Landrine & Klonoff, 2001). Women tend to live longer than men, and are more subject to problems in financial resources, racial or ethnic bias, and bias against individuals with specific disability status associated with aging (APA, 2004a; Federal Interagency Forum on Aging-Related Statistics, 2000). In mental health systems, ignorance about the specific therapeutic needs of women and girls may lead to inadequate care. Gender bias in the diagnosis of mental disorders may result in pathologizing the normal development of women (e.g., menstruation, child birth, menopause, aging) (Caplan, 1995; Landrine & Klonoff, 2001) and overlooking depression in some girls who tend to internalize personal problems consistent with gender stereotypes (Ferguson, Swain-Campbell & Horwood, 2002; Hayward & Sanborn, 2002). Other conditions (e.g., conduct disorders) may be underdiagnosed because of gender differences in the manifestation of

aggressive behavior (Delligatti, Akin-Little, & Little, 2003). Gender differences regarding responses to psychopharmacological treatments have received insufficient attention (Ackerman, 1999). Feminist psychologists have offered alternative approaches for working with girls and women in psychotherapy, have attempted to address bias in mental health treatment (e.g., Ballou & Brown, 2002; Brown, 1994; Worell & Remer, 2003), and have begun to demonstrate empirically the successful use of feminist therapeutic strategies (Worell, 1996, 2001; Worell & Johnson, 2001).

*Education.* Although girls and women have benefited by many positive developments in educational systems (e.g., access to educational opportunities), documented differences in the treatment of male and female children in educational settings suggest that problems persist. These problems include exclusion, marginalization, and the devaluation of girls and women in the classroom, curriculum, leadership opportunities, and extra curricular activities. The shortage of women in positions of power and influence at all levels in the educational system and educational information about successful women have been cited as barriers to the success of females in academic pursuits, particularly females who also are members of ethnic minority groups (Fassinger, 2002; Trimble, Stevenson, Worell, & CEMRRAT2 TF, 2003). The encouragement and mentoring of boys over girls, discriminatory testing and counseling practices, and the harassment and bullying of girls and women have also been reported (AAUW, 2001; Brown, 2003). Since educational disadvantages provide a foundation for a lifetime of underachievement, these educational issues are particularly important.

*Workplace.* Women face particular stressors associated with workplace discrimination (Fassinger, 2002; Yoder, 2007). Women as a group continue: (a) to earn less than men; (b) to be disproportionately represented in jobs that underutilize their capabilities and talents and offer

neither status nor opportunity for advancement; (c) to face discriminatory practices in hiring, evaluation, resource allocation, promotion; (d) to confront the lack of supportive infrastructures with regard to child care facilities, availability of part-time status and adequate remuneration, and sufficient paid maternity and paternity leave; (e) to experience devaluation, exclusion, and harassment; and (f) to shoulder most of the burden of managing the home and family (Dempsey, 2000; Fassinger, 2002). Work-related problems may be exacerbated by other diversity factors such as class, sexual orientation, and disability and discrimination based upon expectations of male defined behavior and attitudes in the workplace (Costello & Stone, 2001; Croteau, Anderson, DiStefano, & Kampa-Kokesch, 2000; Yoder, 2002). For example, women with disabilities make half the income of men with disabilities (Holcomb & Giesen, 1995). These problems result in less job satisfaction and have a negative impact on mental health.

*Religious institutions.* It is relatively rare for women to hold decision-making positions in religious institutions. In some religions, women are denied access to roles considered important within the hierarchy of churches, temples and mosques (Gilkes, 2001). Women are often allowed, however, to teach children, prepare fundraisers, and cook and clean. These roles and role restrictions may impact the self-perception of women and girls. Patriarchy within religions may perpetuate discrimination against women and impact their self-perception (Jones & Shorter-Gooden, 2003; Starr Sered, 1999).

*Legal system.* In the legal system, discriminatory experiences for women are two-pronged: (a) barriers to career advancement in the system and (b) limitations on access to legal rights (Guinier, Fine, & Balin, 1997). The shortage of women in the justice system and government decreases their opportunities to design and influence legislation that may protect them and children from violence and ensure their basic human rights (Fassinger, 2002). Women

make up only 13% of the Senate and 14% of the House. Women often receive less than their equal financial share in divorces (Gorlick, 1995), and lesbian mothers are often in danger of losing their children in legal challenges (Falk, 1993). In the justice system, girls are more likely to experience severe sanctions for lesser offenses or status offenses than boys (Harway & Liss, 1999), and girls from marginalized ethnic groups are more likely to be identified as delinquent than boys or white girls (MacDonald & Chesney-Lind, 2001).

*Families and couples.* In family and couple relationships, women continue to assume disproportionate responsibility for child care, elder care, household management, and partner/spouse relationships (Kulik, 2002; Sanderson & Sanders-Thompson, 2002; Steil, 2001). Although it has been well documented that multiple roles and relationships may lead to increased overall mental health for women (Perrone & Worthington, 2001), stress and overload may occur (Barnett & Hyde, 2001). Power inequities within couple and family relationships as well as the larger social context may create conditions under which sexual abuse, rape, sexual harassment, bullying, and other forms of relationship violence (APA, 2005; Koss et. al., 1994; Leigh & Huff, 2006) become acceptable and may contribute to self-blame and personal dysfunction or decreased mental health (Harway & O'Neil, 1999; Nutt, 1999). Cultural differences exert considerable variation on duties and acceptable styles of relating and dividing household labor (John & Shelton, 1997). Physical abuse in older couples has also become a growing concern (APA, 2004a; Wilber & McNeilly, 2001).

*Research methods and language.* The use of biased research methods and non-inclusive language (e.g., using “mankind” to represent all people) can negatively affect girls and women (APA, 2001; Gilbert & Scher, 1999). Sexist, racist, classist, homophobic or heterosexist, ageist, ableist, and ethnocentric language conveys disregard and disrespect and can have a negative

impact on the identity and self worth of girls and women. An example of bias in research questions are the multitude of studies that have searched for negative effects on children from working mothers (Rice, 1994). Over-reliance on what are considered objective and value free empirical methods may result in the removal of persons from situations and power structures such that results may be unrepresentative or unrealistic (Kimmel & Crawford, 2001; Morrow, 2000).

### **Application**

Psychologists strive to educate themselves to recognize and understand the pervasive impact that structural and power inequities in a wide variety of societal arenas may have on the lives of diverse girls and women. Psychologists endeavor to use gender-fair research results to inform their practice and make use of language that is inclusive and reflects respect for all their clients and students. Further, psychologists also strive to understand the interplay of women's roles, religion, and the cultural values of relevant ethnic groups in order to develop a careful and sensitive approach to helping girls and women deal with bias and power inequities. Psychologists are urged to keep in mind that gender discrimination may exact a high negative toll on the physical and mental health of girls and women. Psychologists strive to recognize the stressful demands of working and having a family and the pervasiveness of negative perceptions of changing gender roles, particularly for women (e.g., Etaugh & Folger, 1998). They try to educate themselves about how gender socialization may influence their own perceptions and experiences of working, having multiple roles, and the pressures of dual-earner relationships (Stevens, Riger, & Riley, 2001).

Psychologists are also encouraged to help females understand the impact of bias and discrimination so they can better overcome the impact of obstacles that are external in origin as

well as internal. To move toward healthy functioning, girls and women need to understand what external forces are creating problems for them, which aids in developing the means to dispute and overcome them. For example, in working with a young girl who reports bullying in her school setting, the psychologist's awareness of the history and pervasiveness of bullying and discrimination in school systems aids in conceptualizing the issue and developing effective intervention strategies that might involve the girl and her family as well as school personnel and policy makers. For a woman reporting harassment in the workplace, the psychologist's awareness of the prevalence of workplace harassment aids in understanding the woman's story, placing it in workplace context, and working toward developing effective coping strategies. Assistance from a psychologist may help women to develop awareness of discriminatory experiences within the legal or educational system and strategies to overcome their effects (e.g., in obtaining equitable divorce settlements and adequate child support or equal opportunities for educational advancement and leadership). Within the family, understanding of the wide spread disagreements among couples about the distribution and sharing of household responsibilities can aid a psychologist in helping couples develop reasonable and equitable solutions. Appreciation of power inequities also helps psychologists deal with violence and abuse issues that may emerge in couples and families. Knowledge about bias and discrimination in a wide variety of societal arenas can deepen the psychologist's understanding of feelings of depression, discouragement, and powerlessness presented by women and girls and provide ideas for successful interventions and greater self-efficacy.

### **Professional Responsibility**

#### **Guideline 4: Psychologists strive to use gender and culturally sensitive, affirming practices in providing services to girls and women.**

##### **Rationale**

As discussed in the introductory section of these guidelines, assessment, diagnostic, and psychotherapy practices can represent important sources of bias against girls and women. In addition, models and practices implying that the typical experiences of middle class White women are normative for all girls and women have the potential to marginalize or exclude the experiences and concerns of other girls and women (Reid, 1993; Reid & Kelly, 1994; Saris & Johnston-Robledo, 2000). Women of color, lesbian women, and women with disabilities may be especially vulnerable to misdiagnosis and other forms of bias (APA, 2000a; Banks & Kaschak, 2003; Leigh & Huff, 2006; National Healthcare Disparities Report, 2005).

Psychological measures designed to assess intellectual ability, scholastic achievement, and personality functioning may underestimate the full capabilities of girls and women, particularly women and girls of color and women with disabilities (Olkin, 1999; Sadker & Sadker, 1994; Smedley, Stith, & Nelson, 2003). Authors and researchers (some identified below) have also identified subtle, but problematic gender biases in theories of psychotherapy. These include (a) overvaluing individualism and autonomy and undervaluing relational qualities; (b) overvaluing rationality instead of viewing mental health from a holistic perspective; (c) paying inadequate attention to context and external influences on girls' and women's lives; (d) basing definitions of positive mental health on behaviors that are most consistent with masculine stereotypes or life experiences; and (e) portraying mothering in problematic ways. Approaches to

mental health that have been identified as noninclusive or as containing subtle biases include humanistic (e.g., Lerman, 1992), psychodynamic and object relations (e.g., Okun, 1992), cognitive behavioral (e.g., Kantrowitz & Ballou, 1992), and couples and family therapies (e.g., Philpot, Brooks, Lusterman, & Nutt, 1997; Rice, 2003). Practitioners may, of course, still use these theoretical frameworks after careful examination and removal of any parts that contain bias (Greene, 1997; Worell & Remer, 2003).

Issues related to access to treatment and practice services may also disproportionately affect women. These issues include: (a) lack of consumer or provider knowledge about psychological services, (b) stigma, (c) high insurance copayments and deductibles, (d) inadequate insurance limits, (e) inability to obtain time off from work, (f) primary family responsibilities, and (g) the unavailability of child and elder care for which women are disproportionately responsible (National Institute of Mental Health, 2000). Major barriers related to the utilization of mental health and substance abuse services for women include the financial burden of seeking help (Collins, Rowland, Salganicoff & Chiat, 1994); the reality that women are more likely than men to receive mental health care from a general practitioner (Alvidrez & Azocar, 1999); and lack of health insurance coverage, which may not be available to low income women, older women, and single parent mothers working part-time or in entry level jobs (Greenley & Mullen, 1990). Other research demonstrates a direct correlation between the structure of an insurance plan and the type of care received. Women with HMO coverage are much more likely to receive medications and less likely to receive psychotherapy than are women covered under fee-for-service insurance plans (Glieb, 1998). Studies also show that women receive more prescriptions than men for all types of medications and particularly for anxiolytics and antidepressants (Hohmann, 1989; Marsh, 1995). This statistic is of particular

concern since most drug treatment regimens have been developed on male participants. These circumstances lead APA Division 35 (psychology of women) to approve a series of position statements that begins: "Training in prescription privileges needs to include both mainstream and specialized focus on treatment of Women and Girls of all ethnic groups, and Men of Color....U.S. research needs to be expanded to include women in areas other than reproductive health.....Research funds should be especially targeted toward the effects of medication on women" (Division 35, 1996). Women also may respond to and metabolize medication differently than men (Ackerman, 1999). Additionally, some women of color have different needs and may metabolize medication differently from their European American counterparts (Comas-Diaz & Jacobsen, 1995; Jacobsen & Comas-Diaz, 1999; Ruiz, 2000). Other data suggest that women and men of color with mental health problems are more likely to receive psychopharmacological treatment than psychotherapy (Homma-True, Greene, Lopez, & Trimble, 1993). In addition, because of significant reductions in spending for outpatient psychotherapy, total spending on mental health care for women with depression has fallen to half its prior amount (APA Summit, 2002d).

### **Application**

Psychologists strive to be knowledgeable about the theoretical and empirical support for the assessment, treatment, research, consultation, teaching, and supervision practices they use with girls and women. Psychologists are encouraged to be aware of assumptions in theory, research, and practice that are noninclusive and to use theories and practices that pay equal attention to relational and autonomous qualities. Psychologists endeavor to understand the biopsychological factors that influence the response of women and girls to psychological treatment and medication. They are urged to show caution when using methods that have not

been developed with the specific needs of diverse groups of girls and women in mind. In considering and deciding which treatments and practices to employ, psychologists are also urged to consider the many biopsychosocial factors that contribute to substantial within gender differences (Gilbert & Scher, 1999; Hyde & Kling, 2001). In the area of testing and diagnosis, psychologists are encouraged to be knowledgeable about validity, reliability, standardization processes, and norming information, and to use multiple methods of assessment, especially when research support is limited (Pope & Vasquez, 2005).

Being attentive to the strengths and personal resources of girls and women may also help decrease the likelihood of committing inadvertent biases, overemphasizing problematic aspects of behavior, or pathologizing adaptive behaviors. Psychologists are encouraged to challenge information and hypotheses that may be inconsistent with common assumptions about gender and other diverse identities. For example, instead of identifying some lesbian intimate relationships as “enmeshed” or “fused,” which may inappropriately pathologize the relationship, the psychologist is encouraged to consider the relationship as one between two persons who highly value connection (Morton, 1998).

Psychologists are also urged to be knowledgeable about and work to help eliminate barriers to psychological treatment for girls and women and to insure full access to psychological services. Psychologists are encouraged to help their female clients gain access to quality mental health services and equitable insurance coverage that will enable them to have continuing, appropriate treatment. They strive to promote access to recovery-focused, evidence-based treatment for both their female and male clients that is gender and culturally sensitive, and tailored to the needs and circumstances of the individual. Such tailoring may include the recognition that for some women and girls, recovery-focused may not be entirely appropriate

(e.g., in cases of chronic disability within which the client may be powerless to change the circumstances, although work on coping skills may still be helpful). In another example, in working with women with post-partum depression, a psychologist can promote the benefits of early screening and intervention and the use of a biopsychosocial model of treatment that addresses the physical and mental health needs of the woman client, her child, and her family. In treating women who present with physical problems (e.g., adjustment to breast cancer), a psychologist can affirm a woman's personal strength and resiliency in coping with pain, anxiety and change in body image and also refer her to appropriate survivor groups for additional help and support. It must be noted that while evidence-based encompasses a broad definition of evidence, for some groups of women and girls, little research has been conducted or published.

**Guideline 5: Psychologists are encouraged to recognize how their socialization, attitudes, and knowledge about gender may affect their practice with girls and women.**

#### **Rationale**

The practice of psychologists is likely to be influenced by their culture, values, biases, socialization, and experiences of privilege and oppression or disempowerment. Limited self-knowledge may contribute to subtle belief systems that can be potentially harmful to girls and women with diverse social identities. For example, studies have revealed that psychotherapists may engage in subtle forms of differential treatment of male and female clients (e.g., Friedlander, Wildman, Heatherington, & Skowron, 1994; Werner-Wilson et al., 1997), and thereby be at risk for reinforcing views about gender, sexual orientation, culture, and family life that may be detrimental to girls and women. Similar results have been reported for evidence of

personal bias related to culture and/or sexual orientation in other APA practice guidelines (APA, 2000a, 2003).

Although blatant and deliberate forms of sexism and racism have decreased over time (Campbell, Schellenberg, & Senn, 1997), researchers have also noted the presence of more subtle forms of bias (e.g., ambivalent, symbolic, or unintentional racism/sexism) associated with nonconscious or subtle biases within society (e.g., Dovidio, Gaertner, Kawakami, & Hodson, 2002; Glick & Fiske, 1997; Swim & Cohen, 1997). Self-awareness allows psychologists to use their values consciously and helps psychologists avoid imposing their values and biases on clients. However, achieving self-awareness by self-examination alone may not be sufficient to ensure optimal practice. Research shows that education about gender leads to attitude change (Worell, Stilwell, Oakley, & Robinson, 1999). Further, trainees of multiculturally-focused supervisors are more likely to develop conceptualizations of client treatment that included attention to issues of client culture and race (Ladany, Inman, Constantine, & Hofheinz, 1997). Studies have also shown that gender sensitivity and diversity training enhances therapists' skills for working with girls, women, and families (Dankoski, Penn, Carlson, & Hecker, 1998; Woolley, 2000). Activities such as education and supervision also strengthen psychologists' ethical competence and contribute to life-long professional growth and development (Pope et al., 1993).

### **Application**

Psychologists are encouraged to gain specialized education, training and experience with issues particularly relevant to the experiences and problems of women and girls including, but not limited to, treatment of trauma and its sequelae. This training may occur in graduate school or be part of life-long learning, professional growth, and development.

Psychologists, who are products of their socialization and culture, are encouraged to be aware of their attitudes toward and expectations for women and girls from a variety of backgrounds and to be mindful of the ways in which their values and attitudes about salient social issues may influence their practice with girls and women (APA, 2000b; 2004b; Robinson & Howard-Hamilton, 2000). Psychologists are urged to engage in ongoing examination of values, attitudes, and stereotypes toward girls and women to ensure that their attitudes support optimal practice (APA, 2000a; 2003). The benefits of such awareness and self-exploration include a greater sensitivity to the world views of others, attentiveness to possible power differentials, and an enhanced level of professional responsiveness and responsibility which will positively affect the psychologist's work with clients, supervisees, and other consumers of their services.

### **Practice Applications**

**Guideline 6: Psychologists are encouraged to employ interventions and approaches that have been found to be effective in the treatment of issues of concern to girls and women.**

#### **Rationale**

The practice of psychologists is enhanced by knowledge about the challenges, strengths, social contexts, and identities of girls and women as well as interventions that are associated with positive outcomes. In the case of psychotherapy, positive outcomes are consistently associated with the therapeutic alliance and common curative psychotherapy factors (e.g., Lambert & Bergin, 1994; Wampold, 2001) such as client expectations and openness, therapist sensitivity and expertise in implementing interventions, length of treatment, and the similarity of the client's

and psychologist's worldviews (e.g., Fischer, Jome, & Atkinson, 1998; Kopta, Lueger, Saunders, & Howard, 1999). If evidence-based interventions are not used, there is the danger of not being helpful or even causing harm (Werner-Wilson et al., 1997; Woolley, 2000).

Specific interventions have been found to be associated with positive outcomes for specific types of concerns relevant to women and girls. The following examples are illustrative and not all inclusive. Therapies that teach female clients to modify negative internalized self attitudes and expectations about body size have been found to be effective in the treatment of eating disorders such as bulimia (Thompson-Brenner, Glass, & Westen, 2003; Williamson & Netemeyer, 2000). Psychotherapy approaches that focus on interpersonal issues and challenge ruminative and distorted thinking are related to positive outcomes in the treatment of depression (Mazure, Keita, & Blehar, 2002) as well as eating disorders (e.g., Wilfley, Dounchis, & Welch, 2000; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). For survivors of domestic abuse and sexual abuse/assault, positive outcomes are associated with therapies that help women cope with trauma-related memories, reduce negative self-talk, and change their distorted sense of responsibility for trauma (Foa & Street, 2001; Kubany, Hill, & Owens, 2003; Resick, 2001). With women diagnosed with PTSD, approaches that help restore women's sense of control and efficacy are related to positive outcomes (Blake & Sonnenberg, 1998; Foa & Meadows, 1997) and may include specific training for developing assertive communication and self-advocacy skills (Kubany et al., 2003). For women facing major health challenges, interventions such as stress management techniques, relaxation training, psychoeducation, guided imagery, meditation, contemplative techniques and cognitive-behavioral methods have been identified as helping to increase women's knowledge and control of symptoms, helping women adjust to life changes,

and facilitating coping with physical and psychological pain (Altmaier et al, 2003; Salmon, Sephton, Weissbecker, Hoover, Ulmer, & Studts, 2004).

Knowledge about strengths and resilience in girls and women is also relevant to a wide range of educational, therapeutic, and prevention interventions (Johnson, 2003; Quermit & Conner, 2003). For example, factors associated with health and well-being in adolescent girls include healthy relationships with parents and important adults (Resnick et al., 1997), positive attitudes toward the sciences (Denmark, 1999), assertiveness (Way, 1995), participation in athletic activities (Pyle, McQuivey, Brassington, & Steiner, 2001), problem-solving skills and self-efficacy (Spence, Sheffield, & Donovan, 2002), and the ability to resist messages that support negative or ambivalent attitudes toward femininity, the body, and sexuality (Tolman & Brown, 2001). Studies have also demonstrated the success of programs that focus on developing problem-solving and independence skills in adolescents (Spence et al., 2002; Strader, Collins, & Roe, 2000).

### **Application**

Psychologists are therefore encouraged to (a) implement interventions that encourage the development of protective factors such as healthy relationships and body image, (b) reframe girls' and women's concerns from a coping and ecological perspective, and (c) emphasize a strength and empowerment perspective in psychotherapy treatment, research, advocacy, teaching, consultation, and supervision. Psychologists are further encouraged to participate in ongoing educational activities and incorporate into their practice information about (a) psychotherapy climate and process issues (e.g., Jordan, 1997); (b) interventions that are demonstrated to be effective for high prevalence issues of girls and women (e.g., anxiety and depression); and (c) strategies that empower girls and women (e.g., Worell, 2001; Worell &

Remer, 2003). In addition, further training regarding abuse and trauma-related theory and treatment (e.g., APA, 2005; Courtois, 1999; Foa & Rothbaum, 1998) and interventions and models that are helpful for countering the negative impacts of culture and media on girls and women that manifest themselves as body objectification, body image, and eating problems (e.g., Stein et al., 2001; Worell & Johnson, 2001) may be warranted. Especially important is education regarding the cultural appropriateness of various models and interventions as they interact with a client's multiple identities (e.g., APA, 2003, 2004b; Greene & Croom, 2000; Sparks, 2002). These issues are also important within individual, family, and group modalities (Chin, 2001; Philpot et al., 1997).

**Guideline 7: Psychologists strive to foster therapeutic relationships and practices that promote initiative, empowerment, and expanded alternatives and choices for girls and women.**

**Rationale**

Symptoms of depression, disturbed body image and eating disorders, and dependency in girls and women can emerge in a context of powerlessness (Enns, 2004; Mazure et al., 2002). Fear of rape and other forms of violence and coercion may limit girls' and women's full participation in society and can contribute to passivity and learned helplessness (APA, 2005; Gutek & Done, 2001; Koss, 1993). These issues may be compounded by the impact of their intersection with social class, race/ethnicity, sexual orientation, physical illness, and physical ability (Harway & O'Neil, 1999; Koss et al., 1994; Neville & Heppner, 1999). Gender roles related to the giving and receiving of caregiving and social support are relevant to empowerment (Harway & Nutt, 2006). The experience of giving and receiving social support is often a major

emotional resource for women and is strongly related to women's life satisfaction (Diener & Fujita, 1995). Under some conditions, however, gender roles of girls and women (e.g., caregiving) can also contribute to the depletion of emotional resources and to a lack of self-development, independence, and personal choice (Farran, Miller, Kaufman, Donner, & Fogg, 1999).

Within psychotherapy, research has indicated that the active participation of clients in therapy is associated with improved outcomes regarding empowerment (Moradi, Fischer, Hill, Jome, & Blum, 2000; Rader, 2003). Cooperative mutuality and connection facilitate psychotherapy, supervision, teaching, and consultation (Miller & Stiver, 1997; Porter & Vasquez, 1997). In addition, studies have suggested that counselors and therapists who prioritize issues of power with their clients are more likely to engage in behaviors that promote empowerment of clients (Worell, 2001). Empowerment goals are also associated with client self-ratings of improvement over time (Chandler, Worell, Johnson, Blount, & Lusk, 1999). Empowerment flourishes in an environment of safety, and this condition is protected by appropriate boundaries.

Therapeutic and other professional relationships should never be sexualized (APA, 2002b; Pope, 1994, 2001). Problems of sexualization range from viewing attractive clients, students, or supervisees as seductive, to actually engaging in sexual relationships with them. Sexual misconduct with clients has been and remains a primary reason for psychological harm to clients, and the overwhelming majority of such cases involve male clinicians with female clients (Pope, 1994; Pope & Vetter, 1991).

## **Application**

In therapy, teaching, research, and supervision, psychologists are encouraged to become aware not only of the challenges that women and girls have faced, but of the resiliency and strength that women and girls have shown in response to these challenges (Brown, 1994; Morrow & Smith, 1995). Psychologists are encouraged to make efforts to help women and girls develop an improved sense of initiative and resilience, personal power, and expand non-stereotyped alternatives and choices. One example might be to encourage a girl who loves math and science to consider engineering or other nontraditional career choices. Psychologists maintain appropriate boundaries with their female clients and students. They strive to foster relationships that are characterized by careful attention to gender roles and other dynamics related to power differences, especially as the position of privilege or oppression widens between themselves and their clients, students, and supervisees. Psychologists are encouraged to implement culturally sensitive and collaborative goal-setting and decision-making in their work with girls and women.

The APA (2002b) *Ethical Principles of Psychologists and Code of Conduct* also requires that psychologists practice informed consent, which includes open discussions of a number of important issues (e.g., the psychologist's approach to treatment and supervision, understanding of the problem, course of treatment, alternative options, fees and payment, accessibility, and after hours availability) (see also Feminist Therapy Institute [FTI], 2000). Such open discussion conveys respect for the decision-making capacity and personal agency of girls and women. It also empowers girls and women by providing the information needed to make educated decisions regarding therapy, education, and personal and career choices.

**Guideline 8: Psychologists strive to provide appropriate, unbiased assessments and diagnoses in their work with women and girls.**

**Rationale**

Psychologists have identified gender bias in the following areas of assessment and diagnosis: clinical judgment, theoretical foundations of assessment, diagnostic processes, psychological assessment measures, and the conceptualization of developmental experiences (e.g., APA, 2000b, 2003, 2004b; Marecek, 2001). As one example, an element of women's normal development often viewed as problematic, rather than normative, is menopause. Some cultural stereotypes of menopause associate this period with loss and depression, but many women feel happier and more energized during menopause (Apter, 1996; Rostosky & Travis, 2000; Sherwin, 2001). Some societies view menopause as a time of freedom from menstruation, pregnancy, and social limitations on appropriate female behavior with postmenopausal women viewed as wise and valuable (Beyene, 1992; Lamb, 2002; Robinson, 2002).

Subtle bias in the form of omissions may also be present in assessment. For example, usual history-taking practices have often failed to include assessments of past and present trauma in spite of the fact that more than half of all women in the United States report having been physically assaulted at some point in their lives (Farley, 2004; Tjaden & Thoennes, 2000a, b). Moreover, 40% to 60% of all patients seeking psychiatric care have experienced physical or sexual abuse of some type (Koss, 1993; Rozee & Koss, 2001). Girls are often especially vulnerable to abuse, especially sexual abuse by adults as well as more powerful peers and siblings (McCloskey, 1997). In addition, it is important to note that the most typical victim of elder abuse is a woman over 75 (Collins, Bennett, & Hanzlick, 2000).

Although attention to developmental issues, interactions among problems, and the context in which they occur is important to any comprehensive assessment, it may be viewed as particularly important in the assessment of girls and women. For example, girls are more likely to experience depression and attempt suicide than boys (Lewinsohn, Rhode, Seeley, & Baldwin, 2001). Depression in girls has been found to co-occur with substance abuse and use (Kubik, Lytle, Birnbaum, Murray, & Perry, 2003; Stice et al., 2001), body image disturbances and eating disorders (Stice, Burton, & Shaw, 2004), delinquent behaviors (Wiesner, 2003), high risk sexual behavior (Bachanas et al, 2002), and deficits in parental social support (Stice, Ragan, & Randall, 2004). In women, the causes of depression are similar to many of those experienced by men, but women appear to experience more of these external stressors than men (Nolen-Hoeksema, 2002). Poverty and economic inequality are predictors of depression in women (APA, 2002d; Belle & Doucet, 2003; Brown et al., 2003) as is violence against women (Koss, Bailey, Yuan, Herrera, & Lichter, 2003). Older women who are depressed may be less likely to show classic symptoms of depression such as active dysphoria, but are more likely to show symptoms of anxiety, malaise, confusion, fatigue, and physical complaints (APA, 2004a; Gatz & Fiske, 2003). In both girls and women, problems such as depression are likely to have multiple facets or dimensions that can only be understood through complex models that consider biological, psychological, multicultural, and social factors and contexts (Mazure et al., 2002).

### **Application**

Psychologists therefore strive to make unbiased, appropriate assessments and diagnoses by considering multiple relevant aspects of the experiences of girls and women. These may include, but are not limited to: developmental experiences, physical and psychological health, violence and other traumatic events, life history (including experiences of privilege and

discrimination), social and kinship support systems, educational and work experiences, geographical and national affiliation influences, various multiple group memberships, and other relevant aspects related to the cultural context as it uniquely interacts with gender (APA, 2004b; De Barona & Dutton, 1997; Worell & Remer, 2003).

Psychologists are also encouraged to work toward developing mutual, collaborative assessments of problems, goals, and plans with their female clients by integrating the psychologist's expertise with a client's knowledge of her own experience (Ballou & West, 2000; Brown, 1994) as is consistent with other APA guidelines (APA, 2000a; APA, 2003).

Psychologists are encouraged to explore information about the strengths of girls and women, their coping capacities, and their past accomplishments in the assessment process and to help their female clients reframe perceived personal deficits as experiences that occur in a complex social context (Enns, 2000; Wyche & Rice, 1997). Assessment tools such as social, cultural, and gender role identity analyses may be especially useful for facilitating assessment of the experiences of girls and women (e.g., Brown, 1994; Worell & Remer, 2003). Psychologists are also urged to show caution when using assessment procedures and tests developed in the United States in countries in which cultural differences and norms have not been considered (APA, 2004b).

**Guideline 9: Psychologists strive to consider the problems of girls and women in their sociopolitical context.**

**Rationale**

As discussed in Guideline 3, sociocultural variables, oppressive environments, and power differentials may precipitate and maintain problematic issues for women and girls, limit their

access to resources, or contribute to blaming girls and women for their problems (Martinez, Davis, & Dahl, 1999). Social statuses of women and girls, such as gender, ethnicity, disability, age, sexual orientation, and culture, may influence their development, behavior, and symptom presentation. As an example, it is normative in some cultural contexts for women to be physically coerced within marriage. Psychologists' perceptions of the social roles and identities of women and girls, as well as psychologists' personal biases, values, and social identities, may also have an impact on their understanding and ratings of the adjustment, traits, symptoms, and assumptions about future behavior of girls and women (Becker & Lamb, 1994; Porter, 1995). A psychologist with a traditional gender role orientation, for example, might perceive exaggerations of the traditional female gender role as markers of a personality disorder rather than considering the full range of sociopolitical factors that may contribute to her problems.

Considering factors related to the life satisfaction of girls and women is also relevant to placing their concerns in sociopolitical and geopolitical context. Such a consideration carries special meaning for immigrant women and girls and other groups of women and girls of color. Life satisfaction is highest among nations typified by gender equality (Cowan & Cowan, 1998), care for human rights, political freedom, acceptance of diversity, and access to knowledge. In addition, personality factors that are related to life satisfaction for both females and males include: psychological resilience, assertiveness, empathy, internal locus of control (Haworth, Jarman, & Lee, 1997), extraversion, and openness to experience (Magnus, Diener, Fujita, & Pavot, 1993). Developmental life stages may also be associated with life satisfaction. For example, older women report many advantages to growing older including freedom from earlier restricted roles and expectations, time to develop new interests, and the ability to integrate independence and confidence with compassion and helpfulness (Friedan, 1993; Matlin, 2001).

## **Application**

To support the personal growth, independence, and empowerment of girls and women, psychologists strive to integrate cultural and contextual information into their conceptualizations and interventions. Such contextual factors include immigration, race, ethnicity, geography (e.g., rural or urban residence), sexual orientation, disability, socioeconomic status, age, and other sociocultural influences (APA, 2000c, 2000e, 2003, 2004a, 2004b; Comas-Díaz & Jansen, 1995; Espín, 1999; Kenkel, 2003; Sanchez-Hucles & Hudgins, 2001). In their practice with girls and women, psychologists are encouraged to facilitate explorations by girls and women of how they may have internalized negative or positive societal messages about their minority group statuses and how these messages may influence their problems and coping resources (Moradi & Subich, 2002; Szymanski, Chung, & Balsam, 2001). For example, to decrease guilt reactions and increase feelings of empowerment, a female client who has been raped and believes she is to blame might be educated about the power and control issues involved in rape and abuse. Likewise, a psychologist working with a female client with an eating disorder might help her examine the ways in which she has internalized unreasonable and unhealthy expectations about body size from the media and other sources. Psychologists are encouraged to identify ways to suggest alternative interpretations that encourage and empower girls and women while also maintaining awareness of and respect for the complexities of their social identities and cultural realities (Lopez & Guarnaccia, 2000).

**Guideline 10: Psychologists strive to acquaint themselves with and utilize relevant mental health, education, and community resources for girls and women.**

## **Rationale**

The APA Code of Ethics (2002b) principle of fidelity and responsibility states that "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" (p. 3). Gaining information about the availability of community resources has also been identified as a culturally and sociopolitically relevant factor in a client's history (see for example, Guideline 16: *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients*, APA, 2000a; *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, APA, 2003; Guideline 18: *Guidelines for Psychological Practice with Older Adults*, APA, 2004a). Complex psychological problems with multiple causes are likely to be best addressed by collaborative approaches that draw upon personal, interpersonal, educational, and community resources. Community based, culturally competent, collaborative systems of care can complement or enhance therapeutic, educational, and research efforts. These resources include women's self-help groups; women's centers, shelters, and safe houses; psychoeducational experiences for girls and women; work/training experiences; and public assistance resources.

### **Application**

Psychologists strive to become knowledgeable about community resources and to consult others with expertise about community resources that can help girls and women. Psychologists are encouraged to help meet consumers' needs by creating and maintaining current resource lists of local financial, legal, parenting, aging, reproductive health, religious and/or spiritual, professional, and social service providers or organizations that are sensitive to the needs and experiences of girls and women, as well as boys and men, in all of their intersecting identities. Many community colleges have on-site resources to help women (e.g., re-entry centers to provide educational and employment resources for women). Psychologists may also assist in

identifying and evaluating self-help books and electronic information and support structures (e.g., discussion boards and Web pages) as potential self-help resources for girls and women. In addition, psychologists are encouraged to be aware of their own limits and the expertise of other psychologists in their community and to refer their female clients, students, or supervisees to other professionals and other community resources when appropriate.

**Guideline 11: Psychologists are encouraged to understand and work to change institutional and systemic bias that may impact girls and women.**

**Rationale**

As directed by the APA Ethical Principles (APA, 2002b), psychologists "recognize that fairness and justice entitle all persons to have access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists" (p. 1062). In addition, "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" (p. 1063) and "seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons" (p. 1062).

Other codes of ethics in the psychological arena include a commitment to social change and justice within health and mental health, political, religious, economic, legal, and educational institutions (Brabeck & Brown, 1997; Brabeck & Ting, 2000; Feminist Therapy Institute [FTI] 2000). Similarly, multicultural guidelines (APA, 2003) encourage psychologists "to use organizational change process to support culturally informed organizational (policy)

development and practices" (p. 392). The multicultural guidelines also identify the value of "psychologists acting as change agents and policy planners" (p. 394) who strive to promote organizational and societal change. Improving the status and welfare of girls and women and promoting an egalitarian society can be facilitated through a multitude of prevention, education, and social policy activities (Chin & Russo, 1997). Examples of organized efforts to influence public policy have included APA task forces on male violence against women (Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Koss, 1993), violence within the family (APA, 1996), and women and poverty (APA, 1998; Rice, 2001; Rice, Wyche, & Lott, 1997).

### **Application**

Psychologists are encouraged to participate in prevention, education, and social policy as forms of psychological practice that improve the mental health and lives of women and girls. Such activities may occur at many levels including local, county, state, national, and international levels. The nature and extent of psychologists' participation is likely to be influenced by their expertise, interests, spheres of influence, and the focus of their psychological practice (e.g., teaching, psychotherapy, research, consultation). For example, when working with girls and adolescents in school systems, psychologists may contribute their expertise to promote leadership opportunities, help develop nonsexist reading materials, or monitor how testing meets the needs of girls and adolescents. Psychologists' activities may also address the consequences of unequal power dynamics, for example, by questioning practices that are potentially harmful to girls and women or by assisting clients who are intervening on their own behalf (FTI, 2000). When facing discriminatory world-views or abusive practices, psychologists may, for example, provide interventions or collaborate with court systems to establish standards of practice and

public education for cases involving abuse of children, intimate partner violence, hate crimes or other victimizations of girls, women and others.

In the area of public policy, psychologists are encouraged to apply psychological research findings to major social issues such as family leave, work-family interface, poverty, discrimination, homelessness, intimate violence, affirmative action policies, the effects of trauma, services for the elderly, and media depictions of girls and women (Ballou & West, 2000; Rice, 2001; Vasquez, 2001). The range of potential involvement in education, prevention, and public policy issues is extensive and may include incorporating diversity issues into lectures and presentations, conducting action research that places individual problems in social context, providing pro-bono services and consultation to community organizations, questioning possible discriminatory and noninclusive theories and practices within psychology and other professions, and diagnosing and working within organizational contexts and with other constituent groups to ensure effective service provision and increase access to psychological practice in its many forms (Roze & Koss, 2001; Worell & Remer, 2003).

Finally, psychologists are also encouraged to support their clients' contributions to positive microlevel and/or macrolevel actions that increase a sense of empowerment and influence. For example, microlevel behaviors may involve confronting a supervisor or acquaintance about sexist, racist, or heterosexist practices within one's workplace or relationships; whereas macrolevel activities may involve helping to change policy relating to rape, sexual harassment, child or elder abuse at a state or national level.

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