WILIAM & MARY

Counseling Center
Internship in Health Service
Psychology

Manual

2017-2018

COMMON SENSE GUIDELINES

The following guidelines have been established through the years given experiences we have had when they had not been made explicit from the start. As such, they are given to you as a preventive measure to clarify policies and expectations.

General Counseling Center related issues:

- **Interns are to comply with the Center's hours of operation. The Center is open from 8am-5pm and it is closed during the lunch hour.**
- **It is expected that, like the rest of the staff, interns will be flexible with their schedules to meet the needs of the community while doing outreach and when there is special need to attend to an emergency. Evening and weekend hours are often necessary for outreach purposes and/or respond to crises.**
- **To help with communication at the Center, it is expected that trainees will read email at the very least twice (morning and afternoon) during the work day. Please reply to all emails that are asking for your response or input.**
- **Professional attire is expected while at work.** Our clinical staff strives to balance appearing warm and approachable while maintaining a professional image. We all attempt to do so, respecting our individuality, taste, and cultural traditions while being mindful of the emotional vulnerability of clients, the intimacy that characterized therapeutic encounters, and the potential for sexualization of the therapy hour/therapist.
- **In order to maintain a comfortable and clean lounge area, it is encouraged that we all clean any area or appliance we use. Cleaning as soon as something spills is easier than cleaning after it has dried out.** Please inform us if there are any cleaning supplies that are needed.
- **The front office is Lynn and Bernice's only office space. Please be respectful of their privacy and personal space while in this area. Please also wait until there are no clients at the window if you need to ask them something.** They are skilled at multi-tasking but it may become confusing when their attention is called in different directions.
- **There are times when you will need to use College equipment for educational purposes (dissertation, contact with graduate program or committee members, etc.). Please take into consideration when others may need the equipment to print or fax for Counseling Center business purposes.**

Clinical Related Issues:

- **Confidential information (clients' files, case notes, reports, assessment measures, etc.) is to be kept at the Counseling Center. It is illegal to take information out of the Counseling Center.** Remember that the Ethics Code emphasizes the obligation to protect confidential information.
- **For security reasons, all documentation of clinical services is to be done using TITANIUM.** Word documents are not protected in the same way Titanium is protected.
- **At the end of the day, please make sure any clinical information is locked in your desk, and that your office door is locked and closed.** This ensures confidentiality is maintained.
- **Assessment instruments are not to leave the Counseling Center (unless they are public assessment measures such as the LVI).** Remember that the Ethics Code addresses the need to maintain the integrity and security of test materials and the confidentiality of test data.
- **All signed consent forms for supervision/digital recording as well as consent to release information are to be scanned and kept in clients' clinical files. . Hard copies should be shredded only after they are properly scanned to the right file.**
- **A new consent form for supervision is to be completed in the spring and/or summer if there is a change of supervisor for that client between semesters.** Informed consent regarding supervision requires that clients are not only informed that a trainee is under supervision but also the names of the supervisors.
- **All supervision notes with your practicum student(s) are to stay at the Counseling Center upon your departure. . Return these to your supervisor of supervision when you have completed the practicum student's final evaluation.**
- **All faxes are to be sent with a cover page that indicates that the information is coming from the Counseling Center. Information fax is to be scanned into the client's file (even if the same information is already in the file as a note) to indicate that in fact the information was faxed to the office/person intended to be faxed to. It is good practice to include the confirmation from the fax machine. Feel free to create a personal fax cover page for any personal faxes.**
- **It is possible to open two windows with Titanium. This is for instance useful when you are typing a termination report and you want to look at client's file for any given reason.**

Training:

- **Seminars have readings that will add to the time at the office. The time spent reading counts towards the required 2000 internship hours and should be recorded in the log. Also count any readings done in preparation for work with certain clients, to learn about certain clinical issues, etc.**
- **Test all equipment (e.g. digital camera) before your first initial assessment/therapy session. Let Training Director or Director know immediately if you experience any technical malfunctions.**
- **Please keep in mind that the staff at the Counseling Center is committed to training and to the professional and clinical development of interns. Feedback is provided with the intent of promoting growth.** It is the hope of the staff that interns would recognize that the aim of the corrective feedback they will offer during the year is to create possibilities and stimulate growth.
  Similarly, the staff at the Counseling Center appreciates constructive feedback from interns. We are interested in learning if there are ways in which we can better address your training needs.
- Given our **commitment to training and if believed to be helpful**, different staff members may **watch videos** of or discuss your work. This may result in additional understanding of a case or ideas on how to proceed. Similarly, it may be helpful for a multiple number of reasons, for a staff member, in addition to the supervisor of supervision, to watch tape of or discuss your supervision with the practicum student.
- Peer supervision is an important component for professional growth. As such it is **expected that you would complete evaluations of each other's presentations when those are requested and provide ongoing support for the work of other trainees.**

Building and Office Access (Key Policy)

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

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

Assigned key are to be used ONLY by Counseling Center Staff!

DO NOT allow anyone not affiliated with the Counseling Center to use your keys!

THE COLLEGE OF WILLIAM & MARY COUNSELING CENTER

Inclement Weather Policy

The policy regarding university operations in the event of seriously inclement weather conditions (usually heavy snow or ice) is as follows:

1. The university will remain open under most reasonably foreseeable weather conditions, especially during periods when classes are in session.
2. If weather conditions are such as to make it impossible to maintain a reasonable level of academic activity, the university will be closed. Such announcements will cancel all classes and work obligations for everyone except those personnel identified as essential to maintenance, security and health services.
3. The person charged by the President to make such decisions regarding weather is the Provost. For information regarding closings, call the Office of University Relations at (757) 221-1766.
4. The decision to close the university in full or in part will be given as soon as possible during the morning (if weather develops overnight) to the Campus Police.
5. Note: this policy is understood as affecting the Williamsburg campus only. The Virginia Institute of Marine Science will announce closures of the Gloucester campus.
6. Decisions to close will be given to the following radio stations:

Gloucester
WXGM-AM 1420
WXGM-FM 99.1

Norfolk/Hampton Roads
WHRO-FM 90.3
WHRV-FM 89.5
WJCD-AM 92.1
WJCD-FM 107.7
WKCK-FM 106.1
WKUS-FM 105.3
WNIS-AM 790
WOWI-FM 102.9
WPYA-FM 93.7
WROX-FM 96.1
WTAR-AM 850

Richmond
WBTJ-FM 106.5
WCVE-FM 88.9
WDYL-FM 101.1
WKHK-FM 101.5
WKLR-FM 96.5
WMXB-FM 103.7
WRNL-AM 910
WRVA-AM 1140
WRVQ-FM 94.5
WRXL-FM 102.1
WTVR-FM 98.1
WXGI-AM 950

Virginia Beach
WCMS-AM 1050
WGH-AM 1310
WGH-FM 97.3
WFOG-AM 1050
WPTE - FM 94.9
WXEZ-FM 94.1
WXMM-FM 1050
WWDE-FM 101.3

7. Among television stations reporting closings will be:
   Norfolk - WVEC Channel 13, WTKR Channel 3 Portsmouth - WAVY Channel 10
   Richmond - WWBT Channel 12; WTVR Channel 6; WRIC Channel 8

Information on closings may also be obtained by calling **221-1SNO or 221-1766**.

WILLIAM & MARY
CHARTERED 1693

Counseling Center
Blow Memorial Hall, Suite 240
Post Office Box 8795
262 Richmond Road
Williamsburg, VA 23187-8795

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

Counseling Center Front Office Information

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

Weather policy

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

Campus Emergencies

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

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

The Building Emergency Coordinator Program involves building occupants in emergency planning and response and addresses the unique needs of specific buildings. Building Emergency Coordinators are the conduit for the information flow between the Emergency Management Team and the occupants of the facility.

Members of the College community should familiarize themselves with the responsibilities of building coordinators and identify the coordinators for the buildings they use most.

Blow Hall: Shannon Turnage Shannon.Turnage@wm.edu

Fire Drills

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

IF THERE'S A FIRE

FOLLOW C.A.R.E. PROCEDURES

Close doors

Alert others

Report the fire- call 911

Evacuate the building

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

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

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

Emergency Alarms

The College has a number of ways to communicate to the campus community during an emergency situation and it's important that you take an active role in staying informed.
The College has three emergency sirens that are stationed on top of the Integrated Science Center, the School of Education building and the Law School. The sirens are 120-decibels. That's loud – about the same as a jet engine flying.

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

The William & Mary Mission Statement

The College of William & Mary, a public university in Williamsburg Virginia, is the second-oldest institution of higher learning in the United States. Established in 1693 by British royal charter, William & Mary is proud of its role as the Alma Mater of generations of American patriots, leaders and public servants. Now, in its fourth century, it continues this tradition of excellence by combining the best features of an undergraduate college with the opportunities offered by a modern research university. Its moderate size, dedicated faculty, and distinctive history give William & Mary a unique character among public institutions, and create a learning environment that fosters close interaction among students and teachers.

The university's predominantly residential undergraduate program provides a broad liberal education in a stimulating academic environment enhanced by a talented and diverse student body. This nationally acclaimed undergraduate program is integrated with selected graduate and professional programs in five faculties -- Arts and Sciences, Business, Education, Law, and Marine Science. Masters and doctoral programs in the humanities, the sciences, the social sciences, business, education, and law provide a wide variety of intellectual opportunities for students at both graduate and undergraduate levels.

At William & Mary, teaching, research, and public service are linked through programs designed to preserve, transmit, and expand knowledge. Effective teaching imparts knowledge and encourages the intellectual development of both student and teacher. Quality research supports the educational program by introducing students to the challenge and excitement of original discovery, and is a source of the knowledge and understanding needed for a better society. The university recognizes its special responsibility to the citizens of Virginia through public and community service to the Commonwealth as well as to national and international communities. Teaching, research, and public service are all integral parts of the mission of William & Mary.

Goals

In fulfilling its mission, College of William and Mary adopts the following specific goals:

- to attract outstanding students from diverse backgrounds;
- to develop a diverse faculty which is nationally and internationally recognized for excellence in both teaching and research;
- to provide a challenging undergraduate program with a liberal arts and sciences curriculum that encourages creativity, independent thought, and intellectual depth, breadth, and curiosity;
- to offer high quality graduate and professional programs that prepare students for intellectual, professional, and public leadership;
- to instill in its students an appreciation for the human condition, a concern for the public well-being, and a life-long commitment to learning; and
- to use the scholarship and skills of its faculty and students to further human knowledge and understanding, and to address specific problems confronting the Commonwealth of Virginia, the nation, and the world.

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

College of William and Mary
Division of Student Affairs Mission & Vision

Through student-centered programs, policies, and services, the Division of Student Affairs prepares students to learn, lead, and live with integrity and purpose.

Our vision is to create an engaging learning environment where community is strengthened and individuals flourish.

Student Affairs Departments

The broad range of responsibilities within the Division of Student Affairs is shared among several departments and offices, organized into five thematic areas.

Campus Living

- First Year Experience
- Residence Life

Career Development

- Career Center

Health & Wellness

- Campus Recreation
- Counseling Center
- Health Promotion
- Student Health Center

Student Engagement & Leadership

- Community Engagement
- Sadler Center and Campus Center
- Student Leadership Development, including:
    - Programming
    - Clubs & Organizations
    - Greek Life
    - Leadership

Student Success

- Center for Student Diversity
- Dean of Students Office, including:
    - Academic Enrichment
    - Disability Services
    - Parent & Family Programs
    - Student Conduct and Honor System
    - Transfer Student Services

Student Affairs Diversity Statement

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

Values

- **Celebration**
  We encourage and carry out activities that recognize achievement, support innovation, celebrate tradition, welcome humor and a sense of play, and affirm the contributions of individuals and groups in our community.

- **Collaboration**
  We work together on tasks and activities by sharing time, resources, and expertise with individuals and offices. We share responsibility and embrace the strengths and abilities of one another while working toward common goals.

- **Inclusion**
  We value the uniqueness of people and perspectives. We embrace and celebrate one another's differences, talents, and abilities.

- **Integrity**
  We maintain open and transparent decision-making in all processes through the departments and division to the greatest extent possible. We work together with fairness and cooperation, and act in ways that are consistent with our values.

- **Professional Excellence**
  We strive to be exceptional in all that we do by establishing and achieving high expectations. We distinguish ourselves through activities that invest and contribute to the future of the division, institution, and profession.

- **Respect**
  We treat each individual with high regard, appreciation, and courtesy. We honor the contributions of individuals and departments.

- **Student Centeredness**
  We remember that students are central to our mission and we encourage and promote the student voice. Our work is guided by a commitment to their holistic development and learning.

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College of William & Mary — Division of Student Affairs

Vice President for Student Affairs

- Assistant to the VP (Diversity) Center for Student Diversity
- Assistant to the Vice President Chief of Staff
- Director of Planning and Assessment

Associate Vice President for Student Affairs—Campus Living Director of Residence Life

- Director of Housing Operations
- Assistant Director Fraternity/Sorority Housing
- Associate Director for Administration and St. Andrews Liaison
- Associate Director for Community Development
- Assistant Director for Community Development
- Area Directors 7 Positions
- First Year Experience and Orientation Director
  - Assistant Director

Dean of Students

- Associate Dean Parent & Family Programs
- Director of Care Support Services
- Assistant Dean and Director of Enrollment & Transfer Student Support Services
- Associate Dean Director of Student Conduct
- Assistant Dean Director of Student Accessibility Services
- Assistant Dean Student Conduct
- Center for Student Diversity Senior Associate Dean of Students/ Director-Center for Student Diversity
  - Associate Director Center for Student Diversity
  - Assistant Director Center for Student Diversity
  - Assistant Dean Student Services
  - Coordinator—The Haven

Assistant Vice President for Student Affairs — Executive Director—Career Development

- Director Programs and Services
- Director Business Careers and Employer Development
- Assistant Director Business Careers/Marketing
- Assistant Director Business Careers Accounting & Finance
- Assistant Director Internships
- Associate Director Science Liaison
- Assistant Director Freshman/Sophomore Experience
- Assistant Director Education Liaison
- Assistant Director

Assistant Vice President for Student Affairs — Student Engagement and Leadership

- Community Engagement Director
- Sadler/Campus Centers Director
  - Associate Director Operations
    - Assistant Director Operations
  - Assistant Director Tech Services
- Student Leadership Development Director
  - Associate Director (2 positions)
    - Events
    - Fraternity/Sorority Life
  - Coordinator (2 positions)
    - Events/AMP
    - Fraternity/Sorority Life

Associate Vice President for Student Affairs—Health and Wellness Director of Health Promotion

Campus Recreation Director

- Associate Director Facilities & Aquatics
- Assistant Director Facilities & Equipment
- Assistant Director Fitness/Wellness
- Assistant Director Intramurals
- Assistant Director Outdoor Recreation
- Assistant Director Sports Clubs

Counseling Center Director

- Associate Director Director of Training
- Staff Psychiatrist
- Senior Staff Social Worker
- Staff Psychologist Coordinator of Practicum
- Staff Psychologists Sports Psychologist
- Mental Health Services Coordinator

Student Health Center Director

- Staff Physicians (3 positions)
- Nurse Practitioners (2 positions)
- Pharmacist
- Head Nurse

- Assistant Directors (2) Health Promotion
- Assistant Director Sexual Violence Prevention Specialist

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262 Richmond Road
Williamsburg, VA 23187-8795

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

COUNSELING CENTER

Building and Office Access (Key Policy)

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Assigned key are to be used ONLY by Counseling Center Staff!

DO NOT allow anyone not affiliated with the Counseling Center to use your keys!

William and Mary Counseling Center
Scope of Services

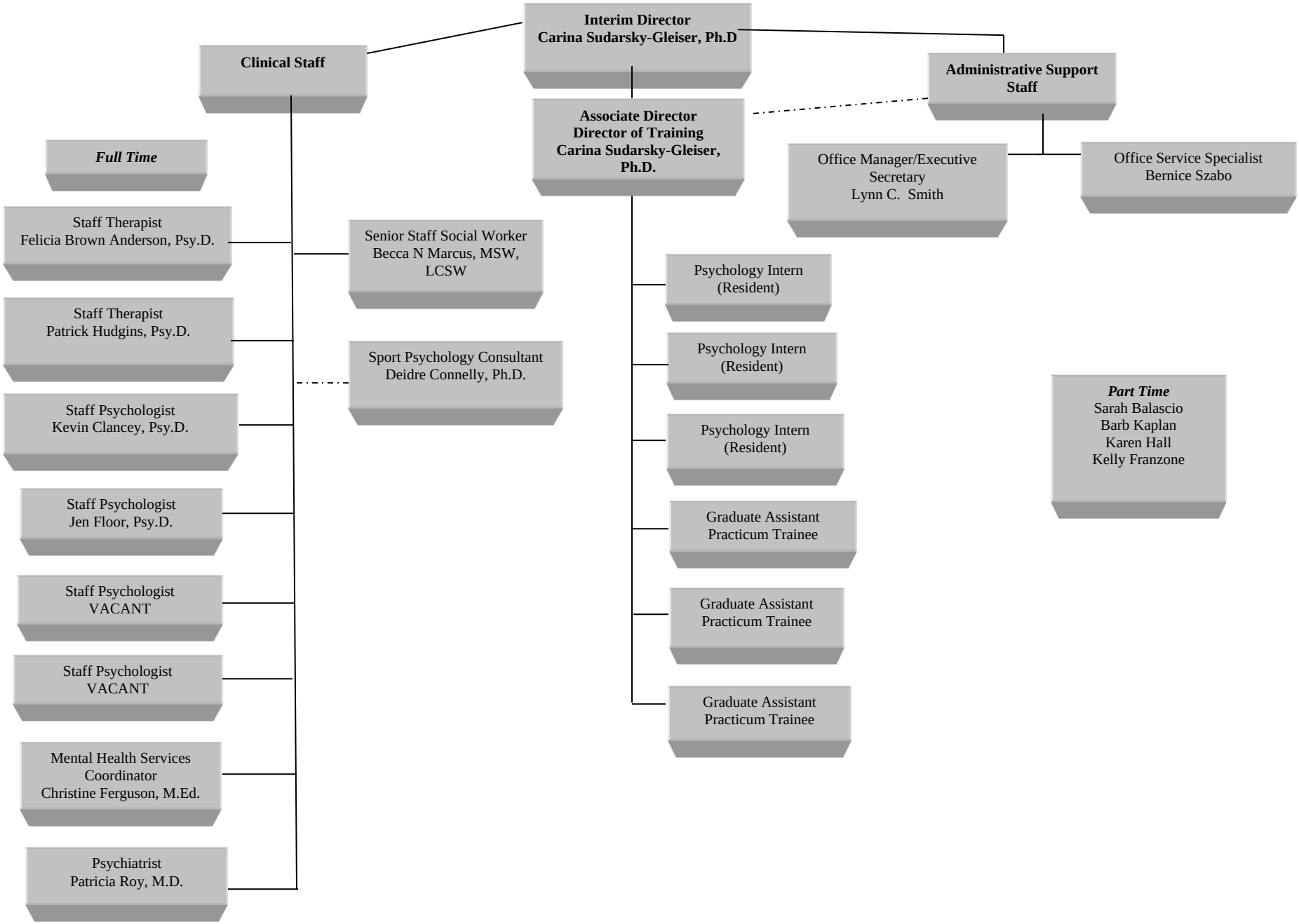
The Counseling Center is designed to provide short-term, time-limited counseling, in order to offer services to as many students as possible. In keeping with the mission of the Division of Student Affairs, the Counseling Center strives to provide brief treatment in order to facilitate adjustment, improve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

For those students whose presenting issues suggest a need for more long-term services, the staff at the Counseling Center can help facilitate a referral to private mental health care in the community. Counseling Center services will not be an appropriate substitute for long-term, intensive psychological services. Some common examples of issues that may be more suited to an outside referral include but are not limited to:

- student issues that may require more than weekly appointments
- student issues which require a specific type of therapy not practiced by staff
- student issues which required long-term, ongoing psychotherapy before coming to William and Mary
- student issues that tend to worsen in short-term counseling

If you are unsure whether or not the Counseling Center services are the best fit for your needs, our staff will be happy to meet with you to discuss your individual situation.

College of William and Mary Counseling Center
Organizational Chart



COLLEGE OF WILLIAM AND MARY
COUNSELIGN CENTER
MISSION STATEMENT

The William & Mary Counseling Center enriches the campus community by promoting the interpersonal and psychological well-being of students. The Counseling Center actively demonstrates commitment to diversity in its broadest form and serves as an advocate for social justice in the college community and beyond. Through our multi-level training program, we dedicate ourselves to instilling these practices and values in future professionals. Our role in facilitating the lifelong development of students is congruent with the mission of the College and the Division of Student Affairs.

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Intern: _____ Supervisor(s): _____ _____

Summer Overall Total: 0.00 **Clinical/Direct Hours:** 0.00 **Overall Direct Clinical Hours:** 0.00 **Intership Overall Total:** 0.00

ACTIVITY	**T**	**W44**	**W45**	**W46**	**W47**	**W48**	**W49**	**W50**	**W51**	**W52**	**W53**
Clinical Service											
Individual/Couples-10	0.00										
Immediate Crisis-V	0.00										
Initial Assessment-2	0.00										
On-Call Contact-V	0.00										
Supervision & Seminars											
Individual Supervision-2	0.00										
Case Conference-2	0.00										
Admin, Case Mgt & Prep											
Assessment Prep-V	0.00										
Outreach Prep-V	0.00										
Supervision Prep-1	0.00										
Case Prep: sup, pres, research	0.00										
Admin: e-mail, checking vm	0.00										
Case Mgt/Paperwork-V	0.00										
Meetings											
Meeting w/Training Director-V	0.00										
Prof Dev: job rel, conf-V	0.00										
Dissertation/Research-V	0.00										
Intern Support Meeting-V	0.00										
Other-V	0.00										
Leave Time	0.00										
Holiday	0.00										
Weekly Total Hours		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Overall Total Hours	0.00										

Evaluations

_____ Quarterly evaluation w/Supervisors
***July**
_____ End of Internship evaluation

Seminar Feedback

_____Assessment
_____Clinical & Professional Issues
_____ Diversity
_____Outreach
_____ Supervision/SOS

Summer Project

_____

Client Demographics	**# of clients**	**Cumulative Totals**
African-American/Black/African Origin		0
Asian-American/Asian Origin/Pacific Islander		0
Latino/a/Hispanic		0
American Indian/Alaska Native/Aboriginal Canadian		0

European Origin/White		0
Biracial/Multiracial		0
Heterosexual		0
Gay		0
Lesbian		0
Bisexual		0
Male		0
Female		0
Transgendered		0
Physical/Orthopedic Disaability		0
Blind/Visually Impaired		0
Deaf/Hard of Hearing		0
Learning/Cognitive Disability		0
Developmental Disability		0
Other		0

Intern: _____ Supervisor(s): _____

Spring Overall Total: 0.00 **Clinical/Direct Hours:** 0.00 **Overall Direct Clinical Hours:** 0.00 **Intership Overall Total:** 0.00

ACTIVITY	**T**	**W23**	**W24**	**W25**	**W26**	**W27**	**W28**	**W29**	**W30**	**W31**	**W32**	**W33**	**W34**	**W35**	**W36**	**W37**	**W38**	**W39**	**W40**	**W41**	**W42**	**W43**
Clinical/Direct Service																						
Individual/Couples-15	0.00																					
Group Therapy-1.5	0.00																					
Initial Assessment-3	0.00																					
Immediate Crisis-V	0.00																					
Assessment: face to face-V	0.00																					
Sup w/Prac Student-2	0.00																					
Outreach: face to face-V	0.00																					
On-Call Contact-V	0.00																					
Supervision & Seminars																						
Individual Supervision-2	0.00																					
Group Therapy Sup-1.5	0.00																					
Case Conference-1	0.00																					
Sup of Sup-1	0.00																					
Sup Seminar/SOS-BW1	0.00																					
Diversity Seminar: BW-1	0.00																					
Outreach & Consultation-V	0.00																					
Teaching: V	0.00																					
Admin, Case Mgt & Prep																						
Assessment Prep-V	0.00																					
Outreach Prep-V	0.00																					
Supervision Prep-1	0.00																					
Case Prep: sup, pres, research	0.00																					
Admin: e-mail, checking vm	0.00																					
Case Mgt/Paperwork-V	0.00																					
Meetings																						
Orientation-V	0.00																					
Staff Meeting-1	0.00																					
Student Affair Meetings-2/mo	0.00																					
Networking-V	0.00																					
Staff Development-V	0.00																					
Meeting w/Training Director-V	0.00																					
Prof Dev: job rel, conf-V	0.00																					
Dissertation/Research-V	0.00																					
Intern Support	0.00																					
Other-V	0.00																					
Leave Time	0.00																					
Holiday	0.00																					
Weekly Total Hours		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Overall Total Hours	0.00																					

REQUIREMENTS CHECKLIST

Assessment Requirments

_____ Assessment Case 2: _____ _____ Protocol 3: _____

_____ Protocol 4: _____

Outreach Requirements

_____ Screening Program: _____

_____ Bulletin Board: _____

_____ Didactic/Interactive Presentation 3: _____

_____ Didactic/Interactive Presentation 4: _____

_____ Program & File Development: _____
(topic/title)

FILE DUE NO LATER THAN LAST DAY OF FEBRUARY AND PRESENTATION NO LATER THAN 1ST WEEK OF APRIL

Outreach Notes:

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

Other

_____Research Presentation

Evaluations

____ Mid-semester evaluation w/Practicum student

_____ End of semester evaluation w/Practicum student

_____ Quarterly evaluation w/Supervisors

***January** ***April**

Client Demographics	**# of clients**	**Cumulative Totals**
African-American/Black/African Origin		0
Asian-American/Asian Origin/Pacific Islander		0
Latino/a/Hispanic		0
American Indian/Alaska Native/Aboriginal Canadian		0
European Origin/White		0
Biracial/Multiracial		0
Heterosexual		0
Gay		0
Lesbian		0
Bisexual		0
Male		0
Female		0
Transgendered		0
Physical/Orthopedic Disaability		0
Blind/Visually Impaired		0
Deaf/Hard of Hearing		0
Learning/Cognitive Disability		0
Developmental Disability		0
Other		0

Formal Case Presentation Requirements

_____ Case Presentation 2 *PRESENT BEFORE MARCH 30TH*

_____ Supervision Case Presentation 2

Intern: _____ Supervisor(s): _____

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

ACTIVITY	T	8/1 W1	W2	W3	W4	W5	W6	W7	W8	W9	W10	W11	W12	W13	W14	W15	W16	W17	W18	W19	W20	W21	W22
Clinical/Direct Service																							
Individual/Couples-15	0.00																						
Group Therapy-1.5	0.00																						
Initial Assessment-4	0.00																						
Immediate crisis-V	0.00																						
Assessment: face to face-V	0.00																						
Outreach: face to face-V	0.00																						
On-Call Contact-V	0.00																						
Supervision & Seminars																							
Individual Supervision-2	0.00																						
Group Therapy Sup-1.5	0.00																						
Case Conference-1	0.00																						
Integrative Seminar-2	0.00																						
Sup Seminar/SOS-1	0.00																						
Diversity Seminar: BW-1	0.00																						
Outreach & Consultation-V	0.00																						
Teaching: V	0.00																						
Admin, Case Mgt & Prep																							
Assessment Prep-V	0.00																						
Outreach Prep-V	0.00																						
Supervision Prep-1	0.00																						
Case Prep: sup, pres, etc.-V	0.00																						
Admin: e-mail, checking vm	0.00																						
Case Mgt/Paperwork-V	0.00																						
Meetings																							
Orientation-V	0.00																						
Staff Meeting-1	0.00																						
Student Affair Meetings-2/mo	0.00																						
Networking-V	0.00																						
Staff Development-V	0.00																						
Meeting w/Training Director	0.00																						
Prof Dev: job rel, conf-V	0.00																						
Dissertation/Research-V	0.00																						
Intern Support Meeting-V	0.00																						
Other-V	0.00																						
Leave Time	0.00																						
Holiday	0.00																						
Weekly Total Hours		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Overall Total Hours	0.00																						

REQUIREMENTS CHECKLIST

Assessment Requirments

_____ Assessment Case 1: _____

_____ Protocol 1: _____

_____ Protocol 2: _____

Outreach Requirements

_____ Didactic/Interactive Presentation 1: _____

_____ Orientation 1: _____
_____ Orientation 2: _____
_____ Orientation 3: _____
_____ Screening Program: _____
_____ Bulletin Board: _____

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

Other
_____Research Presentation

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

_____ Didactic/Interactive Presentation 2: _____

_____ Program & File Development: _____
(topic/title)

FILE DUE NO LATER THAN LAST DAY OF FEBRUARY AND PRESENTATION NO LATER THAN 1ST WEEK OF APRIL

Evaluations
____ Mid-semester evaluation w/Practicum student (supervisee & supervisor)
_____ End of semester evaluation w/Practicum student (supervisee & supervisor)
_____ Quarterly Evaluations w/Supervisors
***October**

Formal Case Presentation Requirements
_____ Case Presentation 1
_____ Supervision Case Presentation 1

Self-Assessment: End of Internship

William and Mary Counseling Center
College of William and Mary

Intern: _____ Date:_____

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

Please rate your skills using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

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

Rating: _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY

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

Rating: _____

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

Summary Comments:

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

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

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

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _____

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

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

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _____

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

Summary Comments:

VI. ASSESSMENT

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

Rating: _____

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

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

Summary Comments:

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

Overall Rating: _____

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

Rating: _____

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

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

Summary Comments:

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

Rating _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

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

Rating: _____

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

Summary Comments:

VIII. CLINICAL SUPERVISION

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

Rating: _____

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

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _____

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

Self-Assessment: Beginning of Internship

William and Mary Counseling Center
College of William and Mary

Intern: _____ Date:_____

Please use this evaluation form to assess your skill in the following competencies. The goal of this self-assessment is to help you engage in self-reflection in terms of strengths and areas of growth and help your supervisor and others involved in training of interns be aware and intentional about your goals.

Please rate your skills using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

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

Rating: _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY

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

Rating: _____

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

Summary Comments:

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

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

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

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _____

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

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

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _____

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

Summary Comments:

VI. ASSESSMENT

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

Rating: _____

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

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

Summary Comments:

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

Overall Rating: _____

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

Rating: _____

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

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

Summary Comments:

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

Rating _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

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

Rating: _____

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

Summary Comments:

VIII. CLINICAL SUPERVISION

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

Rating: _____

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

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

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

Rating: _____

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

INTERN SEMINARS: COORDINATORS AND FORMAT

SEMINAR	COORDINATOR(S)	FORMAT	FREQUENCY
INTEGRATIVE SEMINAR (Clinical Issues, Assessment, Outreach)	Felicia Brown-Anderson	Different Presenters/ Readings +Discussion	1 hr Twice a week Fall semester only
DIVERSITY SEMINAR	Kevin Clancey, Psy.D,	Readings + Discussion	Every other week- Fall & Spring semesters
SUPERVISION SEMINAR/GROUP SUPERVISION OF SUPERVISION	Kevin Clancey, Psy.D. Colleen Reichmann, Psy.D.	Readings+ Discussion	Every other week Fall
	Group Supervision of Supervision Kevin Clancey, Psy.D. Colleen Reichmann, Psy.D.	Discussion + Case Presentation	Every other week Spring

NOTE : THE COORDINATOR OF THE SEMINAR IS THE PRESENTER UNLESS OTHERWISE INDICATED WITH INITIALS IN THE SEMINAR SCHEDULE/SYLLABUS (If presenters from other offices or from the community are invited their full name will appear in the schedule)

Passing Criteria

Competencies	Measured by	Passing Criteria
I. **RESEARCH** II. **ETHICAL AND LEGAL STANDARDS** III. **INDIVIDUAL AND CULTURAL DIVERSITY** IV. **PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS** V. **COMMUNICATION AND INTERPERSONAL SKILLS** VI. **ASSESSMENT** VII. **INTERVENTION** **A. Individual Therapy** **B. Crisis Intervention** **C. Group Therapy** **D. Outreach Programming** VIII. **SUPERVISION** IX. **CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS**	**Evaluation of Psychology Interns by Supervisor Form** Supervisors integrate information from digital recordings, supervision discussions, case/supervision/outreach presentations, supervisor meetings'feedback, etc. to complete the evaluation form.	**Minimum 4.0 in the overall competency and a 2.0 or above on all of the items evaluated under that competency, on the final evaluation of the internship year.**

DUE PROCESS AND GRIEVANCE PROCEDURES FOR PSYCHOLOGY INTERNS

The following guidelines have been drawn from multiple sources including:

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

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

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

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

General Guidelines for Due Process

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

General due process guidelines include:

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

EXPECTATIONS OF PSYCHOLOGY INTERNS

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

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

I. The Evaluation Process

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

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

Interns are supervised by experienced practitioners in the mental health field. Primary individual supervision is provided by psychologists licensed in the Commonwealth of Virginia. Formal evaluations occur quarterly. At these intervals, training staff pool input regarding the performance of the interns in all aspects of their training. Evaluations are shared with the intern's graduate program as necessitated by remediation plan or academic program requirements.

The Director of Training will meet with the intern cohort as a group at least bi-monthly and will meet with interns individually during alternate months in order to provide an opportunity to discuss how the training experience is progressing. In addition, interns may request to meet at any time with the Director of Training or CC Director to discuss any matters of concern, including those related to feedback and evaluation.

Evaluation Processes include:

1. Ongoing Feedback
Each clinical supervisor and seminar leader is responsible for providing ongoing feedback to interns regarding their strengths, areas for growth, and progress towards successful completion of the internship year.

2. Supervisor Meetings
During supervisor meetings, training staff share observations regarding interns' skills and areas for growth. Feedback is based upon all aspects of the intern's training experiences, including: observation of interns' case presentations; informal consultations regarding cases, observations by seminar leaders, reports by all clinical supervisors, and observations of professional behavior. The purpose of this process is to ensure an integrated approach towards developing the interns' skills.

3. Written Evaluation
Written evaluation forms are used to provide feedback and document the intern's clinical skills and professional development. Written evaluations occur quarterly and are compiled by each of the intern's primary individual supervisors. Each supervisor meets with the intern to discuss the evaluation, and all

sign it to indicate that it has been reviewed. The formal evaluations become a part of the intern's permanent file. The intern is encouraged to maintain a copy of the evaluations for their own records.

4. Providing Evaluation

Interns are asked to reflect on their own progress and experience during the evaluation periods. They complete written evaluations of their supervisors after the supervisor has completed and reviewed the formal evaluation with the intern.

II. Determining Adequate Intern Performance

Categories for consideration in determining adequate performance

a) Knowledge and application of professional standards (ethics, law, professional conduct).
b) Competency with skills (conceptualization, diagnosis and assessment, interventions).
c) Personal Functioning (awareness of self, use of supervision, management of personal stress).

Definition of Problem Behavior

Any behavior that does not conform to the general expectations outlined above and/or any behavior observed that does not meet the standard for satisfactory functioning in the Counseling Center according to agency policies and procedures, training requirements and guidelines, or instruction by licensed clinical supervisor while operating under their license. Such behavior will be evaluated with regard to both its intent and impact regarding professional practice in psychology, functioning as an agent or employee of the College of William and Mary and/or delivery of services within this agency.

Problem behavior as defined above will be noted on written evaluations in addition to being discussed with the intern by primary supervisors. Problem behaviors noted on written evaluations reflective of inadequate performance as an employee of the college, representative of the agency, or member of the profession will be discussed within the Training committee who will determine when, if, and how remediation is necessary.

Need for remediation will be based on interference in professional functioning that is reflected in one or more of the following ways:

a) An inability or unwillingness to acquire and integrate professional standards into one's repertoire.
b) An inability to acquire professional skills and reach an accepted level of competency.
c) An inability to control personal stress, psychological dysfunction, or emotional reactions.
d) An inability or unwillingness to acknowledge, understand, or address problematic behavior when identified.
e) Quality of service delivered consistently results in negative outcomes for clients.
f) Problematic behavior is not restricted to one area of professional functioning.
g) Problematic behavior could have ramifications in ethics and legalities if not addressed.
h) Disproportionate amounts of resources are required to support intern functioning.
i) Intern's behavior does not change as a function of feedback, remediation efforts, or time.
j) Intern's behavior negatively affects WMCC public image.

Problematic behavior that is not adequately addressed through supervision, academics or didactics will be attended to by the training committee with consultation from any entity which may be able to provide relevant remedies to adequately address the identified issue. These entities include but are not limited to professional standards, legal counsel, human resources, state licensing boards, professional consultants, national professional organizations, etc. Any such consultations will be documented and kept in a confidential file.

III. Procedures for Responding to Inadequate Performance by an Intern

All trainees' progress during the year is regularly discussed in a bi-weekly meeting of staff supervisors. Routine developmental issues that are the focus of training, seminars and clinical supervision are often identified. Supervisors make every effort to manage these within the normal scope of training activities. At any time during the year, a CC staff member or outside supervisor may determine some aspect(s) of an intern's performance as inadequate. When these issues represent a significant deficit that warrants specific attention, they are referred to the Training Committee and the following procedures are designed to provide a clear path for remediation.

*While the Training Committee is usually comprised of both staff and intern members these proceedings would only include staff supervisors in order to protect the integrity of the intern cohort and the individual nature of the intern experience.

A. The intern will be notified, in writing, that behavior is being referred to the Training Committee and a review of their performance will be occurring. The intern will be asked to respond to the identified issue by providing a written statement to the committee, and has the option to appear before the committee to present the statement. During this meeting the supervisor initially identifying the issues would not be present regardless of their membership on the Training Committee.

B. At this meeting, the Training Committee will discuss the nature of the behavior and all related information known about intern's conduct.

C. In discussing the identified issue and the intern's statement the Training Committee may determine that one or more of the following responses will be made.

1. No Action Required

The identified issue does not warrant any further action or the behavior is a part of a normal developmental issue for that intern to be addressed in the course of ongoing supervision. In such the supervisor and intern will be notified in writing of such and recommendations to address the behavior may be included.

2. Written Notice of Remediation

The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior
b. Actions required to correct the unsatisfactory behavior (e.g. increasing supervision, changing the format, emphasis, and/or focus of supervision, recommending personal therapy and/or psychological assessment, reducing the intern's clinical or other work load and/or requiring specific academic course work or other forms of training)
c. Timeline for correction
d. Explanation of the procedure that will be used to determine whether satisfactory progress has been made
e. Possible consequences if the problem is not corrected
f. A copy will be sent to the intern's academic program.

3. Suspension of Clinical Privileges

If it is determined that the intern's problem behavior might impact client welfare, the intern's clinical privileges will be suspended. The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior
b. Actions required to correct the unsatisfactory behavior and restore clinical privileges
c. Timeline for correction
d. Explanation of the procedure that will be used to determine whether satisfactory progress has been made

e. Possible consequences if the problem is not corrected
f. A copy will be sent to the intern's academic program.

4. Administrative Leave

The intern may be placed on leave, accompanied by suspension of all duties and responsibilities in the agency. The intern will be informed in writing about potential consequences resulting from suspension, which might include inability to complete program hours or other requirements. The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior
b. Actions required to correct the unsatisfactory behavior
c. Timeline for correction
d. Explanation of the procedure that will be used to determine whether satisfactory progress has been made
e. Possible consequences if the problem is not corrected
f. A copy will be sent to the intern's academic program.

5. Dismissal

The intern will be given a letter specifying the following:

a. Description of the unsatisfactory behavior and attempts to address it
b. Grounds for decision to dismiss
c. A copy will be sent to the intern's academic program.

Dismissal from the internship program might occur under the following circumstances:

a. It is determined that remediation cannot be successfully accomplished.
b. Serious violation of ethical standards
c. Serious violation of the WMCC policy and procedures
d. Serious violation of College Policy
e. Violation of federal or state statute
f. Any other condition that jeopardizes intern, client or staff welfare

D. The Director of Training or another member of the Training Committee will meet with the intern to review the outcome of the Training Committee action; the intern may also request to meet with the Training Committee as a whole. The intern may choose to accept the conditions or may choose to appeal the action. The procedures for appealing the action are presented in Section IV.

E. If the intern chooses not to appeal the Training Committee's decision it is expected that the intern's performance will be reviewed no later than the next evaluation period or the timeline specified in the letter of action

F. If the intern's performance is deemed satisfactory at the next review period the intern will be informed in writing and no further action will be taken. A copy will be sent to the intern's academic program.

G. However, if the Training Committee determines that there has not been sufficient improvement in the intern's performance to remove the conditions stipulated in the Training Committee action, the Training Committee may adopt any one of the following measures:

1. Issue an extension of the remediation for a specified time period in which the Training Committee will once again determine if sufficient improvement in the intern's behavior has been made.

2. Determine which further action is necessitated and follow outlined procedures (see actions in section C: 1-5 above).

IV. Appeal Process

A. If the intern wishes to appeal the action taken by the Training Committee he/she must inform the Director of Training in writing and explain the grounds for the challenge within five (5) working days of receipt of the decision.

B. Within three (3) working days of receipt of the appeal the Director of Training will convene an **Appeal Panel** consisting of two staff members selected by the Director of Training and two selected by the intern. An appeal hearing is conducted in which the challenge is heard. The Training Director is not present during the hearing, but provides initial instructions to facilitate the hearing process. The CC Director, who has final decision-making authority, will not sit on the Appeal Panel.

C. The Appeal Panel will render a decision to accept or reject the Training Committee action. All decisions and recommendations by the Appeal Panel are determined by majority vote.
   i. In the event that the committee's decision is upheld that decision is included in a written report to the Director of Training and the CC Director. The Training Director will notify the intern of this decision within 24 hours of the decision. If the intern chooses, he/she can exercise a final appeal to the CC Director.
   ii. If the committee's decision is overruled the appeal panel will submit a report to the Director of Training and Counseling Center Director including any recommendations for further action within two working days of the hearing. The intern will at this time receive a notice of the appeal decision. The intern meets with the Training Director who outlines the new recommendations for action as determined by the Appeal Panel.

D. Once a final decision has been made, the intern, intern's academic program and other appropriate individuals are informed in writing of the action taken.

V. Intern Complaint Procedures

In order to protect the needs and rights of all interns, a complaint procedure has been developed. While it is hoped that any concerns or complaints can be discussed and resolved informally, a formal mechanism is appropriate in light of the power differential between interns and supervisors. In general, interns are encouraged to work actively to create an experience that fits their needs and interests and to work with the CC staff to ensure that their needs are met. Giving feedback to staff members/supervisors or the Director of Training is encouraged in order to create an environment that facilitates open dialogue and feedback, and supports professional development.

Complaints may be initiated in the following situations:

1. an intern has a complaint concerning any staff member/supervisor regarding a situation other than an evaluation,

2. an intern has a complaint concerning another intern or trainee,

Complaints Regarding Non-Training Issues:

1. The intern is encouraged to speak directly with the colleague involved for a resolution.

2. If the situation is not resolved, or if the intern prefers not to speak directly to colleague one-on-one, the intern may choose any staff member to facilitate a discussion of the complaint with the identified colleague.

3. If the complaint is not or cannot be resolved in this manner then the intern may provide a written statement to the Training Committee who will make recommendations for resolution.

4. If the complaint remains unresolved, the Director of the CC will meet with the Training Committee to review and act upon the complaint.

All employees of the College of William Mary, including trainees, have the right to file formal grievances with the College. Guidelines for grievance procedures are outlined in W&M Human Resources Grievance Procedures. In the case of perceived harassment or discrimination (sexual, racial or other), which is not resolved through this procedure, the intern should refer to the W&M Sexual Harassment Policy

Weekly Activity Summary

This description is an approximation and subject to change during the peak times of the year.	Fall	Spring	Summer
Clinical Service			
Individual/Couples Counseling	15.0	15.0	10.0
Group Therapy	1.5	1.5	0.0
Intake Assessment	3.0	3.0	3.0
Formalized Assessment	Variable	Variable	Variable
Crisis	1.0	1.5	1.0
Consultation & Outreach	Variable	Variable	Variable
Supervision of Practicum Students	0.0	2.0	0.0
On call duties	Variable	Variable	Variable
Subtotal: Clinical Service	**20.5**	**23**	**14**
Supervision, Seminars, Research			
Individual Supervision	2.0	2.0	2.0
Group Therapy Supervision	1.5	1.5	0.0
Integrative Seminar	2.0	0.0	0.0
Supervision Theory/Practice Seminar	0.5	0.5	0.0
Diversity Seminar	0.5	0.5	0.0
Case Conference	1.0	1.0	2.0
Networking/Professional Development Meetings	0.25	0.25	0.0
Prep for seminars/readings	2.0	2.0	0.0
Research/Prep for research presentation/Program Evaluation/Professional Development (e.g. studying for EPPP)	Variable	Variable	12
Subtotal: Supervision, Seminars, Research	**9.75**	**7.75**	**16.0**

Administrative			
Staff Meeting	0.25	0.25	
Documentation/Paperwork	7.0	7.0	5.0
Phone calls/email	**(variable)**2.0	**(variable)**2.0	**(variable)**1.0
Meetings With Training Director	.5	.25	As needed
Subtotal: Administrative	**9.75**	**9.50**	**6**
Other			
Summer Project			3
Subtotal: Other	**0.0**	**0.0**	**3.0**
Total Hours/Week	**40.00**	**40.75**	**39.0**

INTERNSHIP REQUIREMENTS

Interns are expected to behave according to the **Ethical and Legal Standards of Health Service Psychology** and to exhibit the **Professional Values, Attitudes, and Behaviors** as well as professionally appropriate **Communication and Interpersonal Skills** at all times and in all their professional roles at the agency. Similarly, it is expected that interns will demonstrate knowledge, skill, and competency in the area of **Individual and Cultural Diversity,** in all their professional functions at the Counseling Center.

> Note: See Evaluation of Psychology Intern by Supervisors form, Section II. Ethical and Legal Standards, Section III. Individual and Cultural Diversity, Section IV Professional Values, Attitudes, and Behaviors, Section V. Communication and Interpersonal Skills, and Section IX. Consultation and Interprofessional/Intedisciplinary skills to familiarize yourself with how these areas will be evaluated.

CLINICAL SERVICE

1. **Individual/couples Therapy**: Schedule individual/couples for **an average of fifteen (15) clinical hours/week.** In order to complete the 500 clinical hours required for completion of the internship, interns may need to have more than 15 clinical hours per week scheduled during some weeks of the semester. During other weeks, particularly at the beginning of fall and spring semesters interns may have less than 15 clinical hours scheduled. Interns' caseloads will be composed of clients who, based on clinical need are seen weekly, and other clients who will be seen every other week or less frequently.
2. **Group Therapy**: Co-facilitate **one on-going therapy group** with a senior staff member during the fall and spring semesters.
3. **Initial assessment**: Participate in clinical teams one day per week. Interns will be scheduled up to **three half-hour initial assessment sessions** on their team day, except the **first weeks of the semester**, when interns will be scheduled for **four**. In addition, interns and the other members of the team will distribute among themselves any crisis situations and walk-ins. Interns as well as senior staff members may be called to help with crisis situations and even intakes on other days if the team for that day is managing excessive clinical need.
4. **On call**: Provide at least **one week of on-call after-hours coverage per semester** during the academic year.

> Note: See Evaluation of Psychology Intern by Supervisors form (Section VI Assessment, and Section VII Intervention, Individual Tx, Crisis Intervention, Group Tx, sections, VIIA-VIIC) to familiarize yourself with how your clinical skills will be evaluated.

OUTREACH (Total outreach: 9 programs during the academic year as described below)

1. **Observe/Co-Facilitate at least three** different outreach programs during the W&M students' orientation in addition to the ones already included on the intern orientation schedule.
2. **Program Evaluation**: Interns will engage in the program evaluation component of the RA suicide risk reduction training. Under the mentorship of an identified staff member, interns will analyze data of the pre and post evaluation obtained during the RA suicide risk reduction training -that takes place at orientation- (the evaluation forms have already been developed and they will be administered just prior and at the end of the program). In addition, interns will develop a follow-up evaluation form/process to be used at the end of the academic year to explore whether RAs a) retained the information presented at orientation and b) felt prepared to engage in RA appropriate risk reduction interventions (e.g. ask questions about safety, refer) with their residents. Interns will work in the summer to analyze the data and provide feedback about potential ways to improve the program.
3. **Didactic/interactive outreach**: **Facilitate** a minimum of **three didactic/interactive** outreach workshops **per semester**, for a total of **six** didactic outreach programs during the internship **year**. These six programs could be in response to requests received by the Counseling Center or based on own interest. The executive administrative assistant regularly emails Counseling Center staff to inform about the programs that have been requested. Opportunities for outreach with established audiences include presentations for student leaders and classes on mental health topics offered to peer-educators. If you want to develop your own program based on your own interests, it would be helpful to choose either a population you want to reach out to or a topic you believe students would be interested in. It would be important to take into account the academic calendar and students' schedules to increase the likelihood of getting an audience. Generally speaking, students are too busy to attend programs after the first week in April.
4. **Screening Programs**: **Participate** in all screening program during the internship **year, for a maximum of one screening per semester** (e.g. mental health/eating disorders/depression/alcohol screening).
5. **Passive Programming through the use of the Counseling Center Bulletin Board**: Interns will create (conceive and construct) bulletin boards at the beginning of the fall semester, the beginning of the spring semester and after spring break. They may work individually or in groups, selecting appropriate materials -preventive or affirmative messages/articles- based on the time of the academic year and what students may be facing at that time.

Note: See Evaluation of Psychology Intern by Supervisors form (Section VII Intervention- section D Outreach programming-) as well as the Evaluation of Intern Outreach Presentation form to familiarize yourself with how your outreach planning and implementation/ facilitation skills will be evaluated.

ASSESSMENT

1. **Interns are to complete two comprehensive Case Presentations during the year. In doing so, interns are to administer at least two assessment instruments in their case presentations (at least one instrument in addition to CCAPS). See Case Presentation Requirement described below.**

OPTIONAL: -For interns interested in acquiring more experience with assessment - Complete **referred or additional assessment** cases. They may be full or partial assessment batteries based on the referral question. **A maximum of 2 cases** during the internship **year**. These assessment cases should be approved by the intern's primary supervisor.

Note: See Evaluation of Psychology Intern by Supervisors form (Section VI Assessment) as well as the Case Presentation Evaluation form to familiarize yourself with how your assessment skills will be evaluated

SUPERVISION

1. **Individual Supervision**: **Receive two-hours/ week** of clinical supervision for individual cases and initial assessment evaluations. In the spring, interns also receive 1 hour of supervision of supervision. This is provided by the assigned supervisor for the spring semester. Make up all missed supervision sessions (see document re: supervisor and supervisee responsibilities).
2. **Provide Clinical Supervision to an Advanced Practicum student**: Provide two (2) hours of individual supervision for a doctoral level practicum student in the spring semester. Digitally record **ALL** supervision sessions. Review their documentation as well as digital recordings of their intakes and sessions with individual clients. Documentation of all cases supervised by the intern, including case notes, initial assessment, and termination reports, are to be signed on line #2 by the psychology intern as supervisor and line #3 by the supervisor of supervision.
    - Maintain documentation of supervision sessions. **Supervision documentation is to stay at the center after the completion of internship**. The Training Director is to receive this documentation at the end of the supervision experience with a given supervisee.

- Use the appropriate evaluation forms for mid-semester and end of semester feedback for the student you supervise. VCPCP and VCU students have different evaluation forms.
- As a component of the supervision of a Practicum Student and in congruence with the Developmental and Experiential training philosophy at the WMCC, supervision of supervision will involve supervisee-supervisor-supervisor of supervision meetings. The triad model provides:
- Practicum students with a) the opportunity to brainstorm ideas in the moment with two supervisors, b) direct contact with the supervisor of supervision, and c) recordable hours of supervision with a licensed psychologist.
- Interns with a) the opportunity to brainstorm ideas in the moment with another supervisor, b) regular access to direct consultation and c) mentorship regarding clinical supervision practice.
- Supervisor of supervision with a) direct contact with the practicum student, b) a more direct discussion about the work with clients, c) direct observation of practicum students' therapy skills, conceptualization, clinical judgment, professionalism and ethical decision making, and d) the opportunity to assess practicum students' and intern supervisor's ability to receive and integrate feedback into their clinical/supervisory practice.

These meetings are to take place approximately once a month. All members of the umbrella supervision triad (practicum student, intern, supervisor of supervision) can request these meetings based on specific goals or needs.

Given our **commitment to training and if believed to be helpful**, different staff members may **watch videos** of your supervision work. Oftentimes, it may be helpful for the group supervisor of the practicum student or for other senior staff involved in training, to watch supervision tape. This helps coordinate efforts among training staff and provide helpful ideas/feedback to the practicum student or the intern supervisor.

3. **Group therapy supervision**: Receive up to **one and a half-hour/week group therapy** supervision. A half-hour will be provided by your group co-leader. In addition interns, practicum students, and all members of the staff involved in group work meet for one hour per week to process and receive feedback about their experiences in group therapy.
4. **Case Conference**. This meeting is considered supervision within a group format. Interns are expected to bring cases in order to hear different perspectives and receive feedback from those in attendance, including their individual supervisor and other senior staff members. Peer input is valued. Practicum students bring cases to these meetings too and interns are to provide input as a way to

demonstrate their conceptualization and clinical skills. Senior staff may present cases that provide good learning opportunities.

5. **Case presentation**: Conduct a minimum of **one formal case presentation** (including written report) **per semester during case conference**. The goal of case presentation is for interns to show their work and request feedback. As such, it is recommended that interns provide a summary of the case and their work for approximately 10minutes, show video for another 10 minutes, and use the rest of their time to ask/answer questions and receive feedback.
   Interns are to provide a short (3 page) write-up for the case presentation including:
   - Demographic data
   - Presenting concerns
   - Assessment data including a) instrument(s) utilized, b) rationale for why these instruments were selected (e.g. clarify diagnosis, inform treatment, and/or track symptoms/therapeutic progress), c) assessment results, d) How is your understanding of the case and your clinical work being informed by assessment data/implications for treatment.
   - Diagnosis
   - Summary of treatment
   - Conceptualization
   - Theoretical understanding of the case and/or theory behind your treatment approach.
   - How is your understanding of the case and your clinical work being informed by science (use research findings that address some of the clinical issues your client is dealing with as well as some research findings that support your treatment approach).
   - Questions (specific issues you want input on)
   - References

   The write up should be no more than 3 pages, single spaced, 12 point font. The write up should be distributed at least 24 hours prior to the presentation.
   A video clip should be included in the presentation.
   In order for you and your client to benefit from the feedback that is provided, interns are to present before April 15.
6. **Supervision of Supervision**: **Receive up to one hour of individual supervision of supervision in the spring semester.**
7. **Supervision case presentation**: Conduct one formal supervision case presentation during supervision of supervision seminar-Spring semester. This presentation should be conceived as an opportunity to showcase your

supervision and as an in depth consultation about a specific/salient supervision theme (e.g. cultural aspects in supervision, ethical decision making, etc.)

Provide a short (2 page) write up with the following parameters:

- Summary of the current status of supervision: # of supervisory sessions, content covered, salient issues, other aspects of the supervision that seem relevant.
- Brief summary of the supervisee's caseload, e.g. presenting concerns, basic demographics, # of sessions.
- Model or models of supervision that are being utilized to conceptualize the supervisory relationship.
- How is your understanding of the issues being addressed in supervision and your supervisory work as a whole being informed by science (use research findings that address some of the issues you are facing in supervision as well as some research findings that support your supervisory approach).
- Questions, requests for input from the S.O.S. group, about any specific supervision issues as well as in connection to a salient supervisory theme.

The write up should be no more than 2 pages, single spaced, 12 point font and be distributed at least 24 hours in advance.

Note: See Evaluation of Psychology Intern by Supervisor form (Section VIII Clinical Supervision) as well as the Supervision Presentation Evaluation form to familiarize yourself with how your use of supervision and your supervision skills will be evaluated

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TRAINING ACTIVITIES

1. **Training Seminars**: Attend and participate in all of the scheduled training seminars. (You are also to participate in case conference, group therapy supervision and supervision of supervision sessions as described above).
   Complete all the readings and any additional requirements for the different seminars:
   - **Integrative seminar - This seminar integrates themes related to Clinical, ethical, and professional issues, assessment, and outreach experiences.** Two (2) - 1hour sessions per week fall semester - See syllabus.
   - **Diversity seminar** – 1hr every other week during the academic year. See diversity seminar requirements in seminar's syllabus.

- **Supervision seminar** - 1hr every other week during the fall semester year. The seminar will transition to supervision of supervision within a group format during the spring semester. See supervision requirements above.

2. Participate in all **networking and staff development meetings**
3. **Staff meetings**: Attend and participate in the Staff Meetings ALL scheduled throughout the year.
4. Attend and participate in **meetings with training director** (scheduled as needed). The purpose of these meetings is to address potential questions or concerns about the training program or any aspect of training and/or provide feedback about the training program or the training director. Interns are always welcome to request an individual meeting with the training director.
5. **Student Affair Meetings**. Attend student affairs meetings. During the academic year, particularly at the busiest times, interns may ask their supervisors and training director about the possibility of missing a Student Affairs meeting and stay at the Counseling Center to complete some professional activity (scheduling clients would only be allowed if a senior staff is at the Center). Supervisors/TD may not recommend missing meetings that are considered to be significant based on their intended professional developmental/informational content.
6. **Recording Sessions**: Digitally record **ALL** counseling sessions once Clients have **signed consent/permission to record**– <u>This form should be updated whenever there is a change of supervisor for the case</u> (usually at the beginning of a new semester).

   Given our **commitment to training and if believed to be helpful**, different staff members may **watch videos** of your work. Oftentimes, it may be helpful for you and your supervisor to have someone else watch your work with a specific client or clients; this may result in additional understanding of a case or ideas on how to proceed.

7. Log of clinical and outreach work. Update the clinical work log and training requirement log (F/S semester) weekly.
8. Optional: Attend and participate in **Student Affairs Task-Force/Committee Meetings** if interested.

<u>RESEARCH</u>

It is expected that interns will **apply scholarly work and research findings in all activities and roles assumed** during the internship year. In addition, interns will give a research presentation as described below.

Research Presentation: Present some research you have recently worked on or are currently involved in. This presentation can be scheduled at any time during the

academic year as part of the staff development meetings or can take place during the summer. You can present your dissertation, dissertation proposal or any other piece of research. Interns who decide to present during staff development (vs. summer) would need to inform, early in the semester, the staff member who is coordinating staff development of their intent to do so in order for their presentation to be scheduled during one of the Staff Development meeting times.

> Note: See Evaluation of Psychology Intern by Supervisors form, (Section I Research), to familiarize yourself with how the Research Competencies will be evaluated.

TEACHING

Practicum Seminar Presentation: Present or co-present on any topic of expertise/interest during the practicum seminar in the spring semester. **Consult with the training director and the coordinator of the practicum seminar** to explore how practicum students could best benefit from your presentation.

> Note: See Evaluation of Teaching in Seminar Evaluation Form, to familiarize yourself with how your teaching will be evaluated.

EVALUATION ACTIVITIES

All evaluations will be part of your portfolio and will be maintained indefinitely at the Agency in a restricted file to which only the Director, Training Director, and Administrative staff members have access to.

1. **Supervisor(s) Evaluations**: Interns receive evaluations from supervisors four times during the internship year (October, January, April, and July). The "Evaluation of Psychology Interns by Supervisors" is used for this purpose. A score of 4 on each of the major aims of the internship and not less than 2 in each competency under each aim in the last evaluation of the internship year is required to pass the internship.
2. **Interns' evaluation of supervisors**: All supervisors are evaluated by the intern **after** the intern has been evaluated by the supervisor. Interns complete these evaluations four times a year (October, January, April, July).
3. **Interns' evaluation of practicum student supervisee**: Interns complete the evaluation form for the practicum student they are supervising. They are to complete these evaluations by mid and end of the semester(s) they are supervising. VCPCP and VCU students have different evaluation forms.
4. **Supervisees' evaluation of intern as supervisor**: Practicum students will evaluate the intern in his/her role of supervisor using the same evaluation form that interns use to evaluate their supervisors. Practicum students provide the

evaluation to the intern supervisor after they have received the evaluation from the intern supervisor.

5. **Case Presentation Evaluation**: Staff members and trainees in attendance during interns' presentations will be asked to a case presentation evaluation form. The training director will collect the evaluations and pass the complete set to the presenter for review.
6. **Supervision Presentation Evaluation**: The coordinator(s) of the Supervision Seminar and all interns in attendance during interns' presentations will be asked to complete a supervision presentation evaluation. The training director will collect the evaluations and pass the complete set to the presenter for review.
7. **Outreach Evaluation Form**: Completed by a member of the training committee able to attend an outreach program facilitated by the intern. Interns are asked to be proactive and request with enough notice that a staff member observes their outreach.
8. **Forms for Academic Programs**: Interns are responsible for informing the training director and submitting all required forms to the doctoral program if their academic program requires specific forms to be completed. Interns are to provide copies of these evaluation forms to the training director and supervisor(s).

All evaluations will be part of your portfolio and will be maintained indefinitely at the Agency in a restricted file to which only the Director, Training Director, and Administrative staff members have access.

DOCUMENTATION

1. **Case notes**: Document contact with clients following agency documentation policies. Clients' files are to include all case notes of individual/group sessions and any other contact the intern had with the client including phone conversations. Consultation is also to be documented.
2. **Initial assessment reports and terminations**: Write intake and termination reports following agency documentation policies.
3. Sign all of your supervisee's case notes and termination reports once reviewed and ready to sign by intern supervisor.
4. **Scan all forms**: All signed release forms and signed permission to digitally record are part of the client file.
5. **Training and Clinical work log**: Maintain a weekly log of all professional activities. Turn in this log to supervisor with a copy to the director of training (see form).

6. **Leave log**: Turn in the "leave" form to the director of training to request leave approval whenever there is need to be absent from the Center. Vacation and professional leave approval will be based on specific clinical needs at a given time in the semester as well as the satisfactory progress toward the accrual of direct clinical service hours required to complete the internship. Interns are to inform their supervisor whenever they will be absent and they are to make sure they are covering all professional duties that were to take place at the time of their absence. In case of an unscheduled absence (e.g. illness) interns are to call or email front desk staff as soon as possible so that clients can be rescheduled. A message can be left on the answering machine before 8am.

SUMMER PROJECT

Congruent with our developmental approach, at a stage when interns are moving towards independence, and as a way to demonstrate ability to integrate knowledge into a tangible outcome that can meet a counseling center's need and be marketable for job search, interns will be involved in a summer project approximately 2-4 hours a week -once the academic year ends-. The specific project will be one of interest to the intern. Some examples are: review of clinical forms/brochures, improvements to counseling center website, projects identified as Counseling Center needs, and clinical or training related projects as identified by staff, the training committee or director of training, such as collecting training resources or resources regarding specific evidence-based treatments, designing psycho-educational groups, etc.

> Note: See Evaluation of Psychology Intern by Supervisors form, Section II. Ethical and Legal Standards, Section III. Individual and Cultural Diversity, Section IV Professional Values, Attitudes, and Behaviors, Section V. Communication and Interpersonal Skills, and Section IX. Consultation and Interprofessional/Intedisciplinary skills to familiarize yourself with how these areas will be evaluated.

MAINTENANCE OF RECORDS - PORTFOLIO

All training records including Internship Application, contract letter, evaluations, projects and presentations, any remediation plans, passing criteria forms, hour log, and certificate of completion of internship will be part of your portfolio. The portfolio will be maintained indefinitely at the Agency in a restricted file to which only the Director, Training Director, and Administrative staff members have access to.

AIMS OF THE INTERNSHIP

The field of health service psychology demands a flexible and integrated repertoire of skills and competencies. In congruence with the Standards of Accreditation in Health Service Psychology, interns are expected to develop the following Profession-Wide Competencies:

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

I. RESEARCH

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

II. ETHICAL BEHAVIOR AND LEGAL STANDARDS

An overarching goal of the WMCC is to instill a commitment to ethical practice. Interns will have opportunity to discuss ethical issues in the different didactic seminars offered during the year as well as in case conference and in supervision. Interns will be expected to behave according to the Ethical Principles of Psychologists and Code of Conduct of

the American Psychological Association (2002) and demonstrate knowledge regarding the rules, regulations and standards governing health service psychology. In addition, interns are to familiarize themselves with the Virginia Law regarding the ethical practice of psychology. Interns will be expected to recognize ethical dilemmas and apply ethical decision making processes competently. In addition, interns are expected to follow the Counseling Center policies and procedures, maintain an appropriate professional role with clients, develop appropriate interaction with staff and trainees, and maintain accurate documentation records.

III. INDIVIDUAL AND CULTURAL DIVERSITY

Interns participate in didactic and experiential training regarding multicultural competence. Sensitivity to issues of power and privilege as well as social justice issues are central to the mission of the Counseling Center and the Training program. As such, interns are to demonstrate ability to engage in self-reflection about the way in which their own personal/cultural history affect how they understand and interact with people different from themselves, including peers, colleagues, supervisees, supervisors, other staff/professionals, and those seeking services. Interns are expected to demonstrate cultural sensitivity and competence in service delivery with clients, groups, and organizations from diverse cultural backgrounds and other forms of individual difference. Multicultural competence is defined according to APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change of the American Psychological Association (2003). Interns are to practice also according to the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (2002), the Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2011), the Guidelines for Assessment of and Intervention with Persons with Disabilities (2011), and the Guidelines for Psychological Practice with Girls and Women (2007).

IV. PROFESSIONAL VALUES, ATTITUDES AND BEHAVIORS

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

V. COMMUNICATION AND INTERPERSONAL SKILLS

Appropriate communication and interpersonal skills are essential for positive interactions and effective work with others. Communication and interpersonal skills are

the foundations for many of the other vital competencies in the field of health service psychology. As such, interns are expected to utilize and develop appropriate interpersonal skills. Interns are to demonstrate the ability to maintain effective relationships with a wide range of individuals including clients, peers, colleagues, supervisees, supervisors, and other staff/professionals, being sensitive to individual and cultural differences as well as to issues of power and privilege.

VI. ASSESSMENT

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

VII. INTERVENTION

A. Individual Psychotherapy:

Interns will be able to offer individual psychotherapy to college students with a variety of presenting concerns and clinical issues during the internship year. Interns will receive didactic and experiential training as well as weekly supervision to assure competent service delivery. Interns are expected to appropriately apply their knowledge about therapy gained in graduate school as well as what they learn in supervision in their interventions with clients. It is expected that interns will be able to competently utilize their clinical formulation and conceptualization of cases and their approaches to therapy considering clients' needs and diversity variables. Interns are expected to timely and accurately document their clinical interventions with clients

B. Crisis Intervention:

Interns receive didactic and experiential training as well as supervision and consultation regarding crisis intervention skills. During working hours or through after-hours on-call duties (with a back-up supervisor), interns will be able to provide crisis intervention for clients experiencing acute personal distress or symptomatology. Interns are expected to be appropriately assess clients' needs and help reduce their immediate distress. Interns are to demonstrate ability to evaluate clients' safety regarding risk of danger to self and/or others and mobilize resources accordingly.

C. Group Psychotherapy:

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

D. Outreach Programming:

Interns are presented with multiple opportunities to engage in outreach programming and are encouraged to consult with staff and supervisors about specific programs and presentation skills. Interns are expected to be able to design and implement psycho-educational presentations and workshops for audiences within the campus community. Interns receive didactic and experiential training in crisis management; it is expected that interns will be able to respond to critical incident or crisis debriefing outreach events if there are situations of this caliber during their internship year.

VIII. SUPERVISION

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

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

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

PHILOSOPHY OF TRAINING

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

Developmental-Experiential-Mentorship based Training

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

Integration of Research/Scholarly work and practice

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

Mentoring, Modeling, and Supervision

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

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

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

W&M Counseling Center Internship Training

LEAVE REQUEST FORM

NAME	MONTH	YEAR

Use the following leave symbols for completing your leave for the month in the grid below.
S – Sick Leave
P – Professional Leave
V – Vacation

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
16	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

Please be aware that you need to:
Exchange team days Done? Yes ____ No ____
Make up supervision sessions missed. Done? Yes ____ No ____
Inform your supervisor about your absence and clients of concern. Done? Yes ____ No ____
Inform on call therapist about clients of concern Done? Yes ____ No ____

I have arranged for my responsibilities to be covered while I am away by ….. (describe/be specific or N/A).

Intake/Team Day	Seminar	Sup of Prac Student	Own supervision	Clinical work 1:1 and group

NOTE: Interns are expected to save at least 5 working days of vacation for the end of the internship year.

Date	Trainee Signature	Date	Training Director Signature

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

Supervisee Training Goals:	General Supervision Discussion and Feedback

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

Supervisee Training Goals:	General Supervision Discussion and Feedback

Client Initials & Demographics	# of Sessions	Last session date	Presenting Issue	Treatment Goals/Disposition Treatment Plan	Safety concerns

Date of last Sup Discussion	Supervision Discussion:
Date of Sup of Sup Discussion	Sup of Sup Discussion:

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

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

Supervision Log & Discussion

Supervisee_____ Supervisor_____ Date_____

The College Of
WILLIAM&MARY

Counseling Center

Blow Memorial Hall, Suite 240
P.O. Box 8795
Williamsburg, VA 23187-8795
757/221-3620, Fax 757/221-3615

Consent to Supervision of Supervision and Recording of Supervision Sessions

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

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

I understand that:

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

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

_____.

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

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

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

_____ _____
Practicum Student Signature Date

_____
Name (Print)

The College Of
WILLIAM&MARY

Counseling Center

Blow Memorial Hall, Suite 240
P.O. Box 8795
Williamsburg, VA 23187-8795
757/221-3620, Fax 757/221-3615

Consent to Supervision, Observation, and Recording of Counseling Sessions

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

It is our strict policy that recordings are viewed only at the Counseling Center and these digital video files are deleted regularly on a monthly basis. Video files are protected in accordance with confidentiality laws. They are saved in encrypted format and stored in password-protected computers accessible to Counseling Center staff only. You have the right to refuse recording and may withdraw your consent at any time. However, this may result in your case being transferred to another clinician.

I understand that:

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

Counselor's Primary Supervisor is: _____

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

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

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

_____ _____
Client Signature Date

_____
Name (Print)

TRAINING NEEDS, SUPERVISORS, GROUPS

Name: _____ Date: _____

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

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

Warrenetta Mann:

Jeanne Face:

Carina Sudarsky-Gleiser:

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

USO w/ Felicia:

USO w/Kevin:

USO graduate:

USO women (Carina):

Family of Origin (Patrick):

Ups and Downs (Warrenetta):

THERAPY SESSION PROCESS-CONTENT NOTES

CLIENT VERBALIZATIONS	CLIENT'S NON-VERBALS	THERAPIST REACTIONS/ FEELINGS	THERAPIST BEHAVIOR/ INTERVENTION	WHAT COULD HAVE BEEN DONE DIFFERENTLY

College of William and Mary Counseling Center
MINIMAL EXPECTATIONS OF INTERNS AND CLINICAL SUPERVISORS DURING CLINICAL SUPERVISION

SUPERVISEES	SUPERVISORS
INITIAL ASSESSMENTS	**INITIAL ASSESSMENTS**
1. Conduct initial assessments as assigned – Obtain and maintain in electronic file scanned written informed consent for supervision and digital recording. Manage the clients you assess and establish a caseload. An average of 15 client hours per week is necessary to complete the 500 clinical hours required to complete the internship. This will require maintaining more clients at a time to ensure client hours.	Review signed informed consent for supervision and recording. Provide supervision of the initial assessment and case management process. Consult about disposition of initial assessments. Monitor readiness for specific cases.
2. Write initial assessment reports and provide to supervisor for review following the agency's documentation timelines.	Review and sign-off on all initial assessments following the agency's documentation timelines.
CASES	**CASES**
3. Provide supervisor with information about clients on caseload (forms for recording this information are available).	Review all new cases under supervisee's care.
4. Document all client contact and write progress notes for all clients after each session following the agency's documentation timelines.	Review of progress of all cases on a regular basis and assist with all case conceptualizations. Review and sign-off on all case notes.
5. Digitally record all clients unless supervisor gives permission to waive taping for a specific case.	Regularly review/monitor recordings of supervisee's sessions with clients outside the supervisory session. Reviewing one hour of recording per week is encouraged.
6. Request types of clients and presenting concerns you are particularly interested in from supervisor and agency during case conference or staff meetings.	Maintain a current overview of the kinds of clients needed by the supervisee for a broad/diverse training experience.
7. Consult with supervisor regarding any potential/actual emergency and/or situation outside of general responsibilities of counseling. If supervisor is not available, seek consultation with any other senior staff.	Provide back-up/emergency consultation as needed. If intern's supervisor is not available serve as back-up for the intern.
8. Make up time due to any absence and make appropriate arrangements for clients if canceling appointment due to absence.	Monitor client welfare (trainee's assigned clients) during intern's absence.
9. Write termination summaries within the documentation timelines of the Center.	Review and sign-off on all termination summaries.
10. Identify specific clients, issues, etc. to focus on in supervision as applicable	Keep regular weekly supervision process notes for each supervision session.

11. Provide evaluation of supervisor(s) after supervisors have provided with the written evaluation of supervisee.

Provide quarterly evaluations according to stipulated dates agreed by Training Committee

12. At end of training year, ensure that all files are closed and signed-off by supervisor. Erase all digital recordings.

At the end of the training year, ensure that all case files are closed with termination summaries written; sign-off on all cases; ensure that all terminated clients are removed from the intern's clients' lists; ensure that all digital recordings are deleted

SUPERVISION OF PRACTICUM STUDENT

13. Provide supervision of practicum student according to responsibilities described in the "expectation of practicum students and clinical supervisors." Consult with supervisor of supervision based on need. Bring any issues/challenges with providing supervision to the supervision seminar or supervision of supervision as appropriate.

SUPERVISION OF SUPERVISION

Supervisor of Supervision: Review and sign-off all initial assessments, case notes and terminations signed by intern as supervisor of practicum student. Engage in triad meetings (intern, practicum student, supervisor of supervision) at least once a month for at least part of the intern-practicum supervision session. Inform the training director of any "out of the ordinary" issues/challenges in the intern's supervision of practicum students.

OUTREACH

14. Consult as needed and respond to requests for outreach in order to fulfill the outreach requirements.

PARTICIPATION IN SUPERVISION MEETINGS

Supervisors are to participate in supervision meetings and openly share their evaluation of the clinical skills and overall functioning of their sueprvisee in the agency. It is expected that supervisors will share the supervisee's strengths, progress in areas of growth as well as challenges the supervisee may be experiencing. It is encouraged for the supervisor to seek consultation from other supervisors on how to best help a supervisee with their learning needs, gain further clinical skills or any type of competency.

Supervision

Self-Assessment: End of Internship

William and Mary Counseling Center
College of William and Mary

Intern: _____ Date:_____

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

Please rate your skills using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

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

Rating: _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY

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

Rating: _____

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

Summary Comments:

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

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

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

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _____

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

7. Demonstrates awareness of multicultural issues within the supervisory relationship _____
8. Demonstrates ability to seek supervisory help resulting from a self-perceived need _____

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _____

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

Summary Comments:

VI. ASSESSMENT

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

Rating: _____

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

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

Summary Comments:

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

Overall Rating: _____

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

Rating: _____

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

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

Summary Comments:

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

Rating _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

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

Rating: _____

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

Summary Comments:

VIII. CLINICAL SUPERVISION

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

Rating: _____

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

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _____

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

Self-Assessment: Beginning of Internship

William and Mary Counseling Center
College of William and Mary

Intern: _____ Date: _____

Please use this evaluation form to assess your skill in the following competencies. The goal of this self-assessment is to help you engage in self-reflections in terms of strengths and areas of growth and help your supervisor and others involved in training of interns be aware and intentional about your goals.

Please rate your skills using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

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

Rating: _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

III. INDIVIDUAL AND CULTURAL DIVERSITY

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

Rating: _____

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

Summary Comments:

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

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

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

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _____

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

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

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _____

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

Summary Comments:

VI. ASSESSMENT

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

Rating: _____

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

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

Summary Comments:

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

Overall Rating: _____

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

Rating: _____

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

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

Summary Comments:

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

Rating _____

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

Summary Comments:

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

Rating: _____

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

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

Summary Comments:

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

Rating: _____

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

Summary Comments:

VIII. CLINICAL SUPERVISION

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

Rating: _____

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

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS
Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _____

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

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

Date_____

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

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

Please use the following scale for your rating:
5=excellent
4=good
3=adequate
2=poor
1=unsatisfactory

GOALS OF THE INTERNSHIP

I. RESEARCH

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

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

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

Comments:

_____
_____
_____
_____
_____
_____
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_____
_____

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

Comments:

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

Comments:

_____
_____
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_____
_____

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

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

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

Comments:

_____
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_____
_____

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

Comments:

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

Comments:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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V. COMMUNICATION AND INTERPERSONAL SKILLS

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

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

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

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

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

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VI. ASSESSMENT

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

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

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

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

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

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VII. INTERVENTION (Sections A-D)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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VIII. CLINICAL SUPERVISION

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

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

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

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

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

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IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

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

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

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

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

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

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

Please rate the following statements using the scale below:

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

The Training Director

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

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

Comments

INTERN EVALUATION OF SUPERVISION

Name of Supervisor: _____

Name of Graduate Clinician: _____

Period Covered: _____ to _____

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

1. ____ Concrete feedback was provided.

2. ____ Feedback and evaluation were based on adequate observation of my counseling.

3. ____ Alternative ways to handle specific client situations were provided.

4. ____ Adequate time was allocated for supervision.

5. ____ My supervisor was prompt for supervision sessions.

6. ____ Questions and suggestions regarding clients were helpful in conceptualizing cases and developing treatment plans.

7. ____ Treatment models were discussed that were different from my supervisor's.

8. ____ I was provided with helpful suggestions when at an impasse with a client.

9. ____ Concern was shown for me as a person.

10. ____ I was provided feedback about personal behaviors and characteristics that might aid or interfere with my effectiveness.

11. ____ I was treated with respect.

12. ____ Disagreements with my supervisor were supported and discussed openly.

13. ____ My feelings of inadequacy generated by cases were explored.

14. ____ The interaction between my supervisor and me was used as a medium for understanding my work with clients.

15. ____ My supervisor acknowledged his/her limitations.

16. ____ Assistance was given in identifying my personal strengths which increased my confidence as a helping professional.

17. ____ My supervisor was available to give help outside of our regular supervision time.

18. ____ My ideas and concerns were respected.

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

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

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

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

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

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

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

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

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

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

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

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

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

32. ____ Overall rating of the supervision experience.

Other comments:

Evaluation of Intern Research Presentation

College of William and Mary Counseling Center

Intern: _____

Date _____

Evaluated by: _____

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

Please rate trainee using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

I. RESEARCH	1. Demonstrates theoretical rationale for their selected research question or review approach _____ 2. Demonstrates a thorough understanding of the existing evidence base and literature in their area of focus _____ 3. Demonstrates appropriate use of research design and methodology _____ 4. Identifies appropriate directions for future research based on current findings or status of evidence base _____
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to legal and ethical issues related to the conduct of research _____

III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Demonstrates knowledge, skills, and competence to attend to issues of diversity and contextual variables in the design, methodology, and discussion of research findings _____
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Strives to promote accuracy/Demonstrates integrity regarding the science of psychology _____ 2. Demonstrates awareness of their professional and scientific responsibility to society and the communities potentially impacted by the research study _____ 3. Demonstrates receptiveness to feedback _____
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding the study_____ 2. Communicates research findings with clarity while identifying any relevant limitations to conclusions and implications of practical use of findings _____ 3. Demonstrates ability to present the study taking in consideration the allotted schedule, allowing time for questions and feedback _____ 4. Demonstrates effective use of technology and/or visual aids to provide understanding of the research being presented _____

Overall Rating _____

COMMENTS including particular strengths and areas for further development:

EVALUATION OF TEACHING IN SEMINAR

Intern:_____ Evaluator: _____Date: _____

Presentation Title: _____

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

Please rate trainee using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic and advanced tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring in carrying out advanced tasks in this area.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing advanced skills in this area.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the advanced level. Requires periodic supervision for refinement of advanced skills in this area.

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

I. RESEARCH	1. Demonstrates thorough literature review ____ 2. Demonstrates ability to include up to date research information about the content area ____
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to ethical and legal concerns as relevant____
III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Presents in a manner that is inclusive and/or affirming of issues of diversity ____

IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Demonstrates integrity and a professional demeanor during the presentation _____ 2. Demonstrates knowledge about the content area _____ 3. Demonstrates receptiveness to feedback _____
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Demonstrates consideration of needs of the target audience. _____ 2. Integrates the necessary information for a clear understanding of the topic_____ 3. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding content area_____ 4. Demonstrates ability to respond to the needs of the audience throughout the presentation and engages the audience in an effective manner _____ 5. Demonstrates ability to present the information taking in consideration the allotted schedule, allowing time for questions and feedback _____ 6. Demonstrates effective use of technology, handouts, and/or visual aids _____
VI. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Demonstrates willingness to consult with other professionals to present the most accurate information _____

Overall Rating _____

COMMENTS including particular strengths and areas for further growth:

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Evaluation of Intern Outreach Presentation

William and Mary Counseling Center
College of William and Mary

Intern: _____

Observer: _____

Presentation Title: _____

Date of Presentation: _____ Location: _____

Audience/# of Participants _____

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

Please rate trainee using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic and advanced tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring in carrying out advanced tasks in this area.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing advanced skills in this area.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the advanced level. Requires periodic supervision for refinement of advanced skills in this area.

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

Overall Rating _____

COMMENTS including particular strengths and areas for further growth:

Evaluation of Intern Supervision Presentation

College of William and Mary Counseling Center

Intern: _____

Date _____

Evaluated by: _____

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

Please rate trainee using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

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

	9. Demonstrates ability to monitor their supervisee professional functioning and quality of services provided _____ 10. Demonstrates ability to take risks that allow supervisory skills to develop _____
IX. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Demonstrates willingness to consult with other professionals to provide the most effective supervision _____

Overall Rating _____

COMMENTS including particular strengths and areas for further development:

Evaluation of Intern Clinical Case Presentation

College of William and Mary Counseling Center

Intern: _____

Date _____

Evaluated by: _____

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

Please rate trainee using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

I. RESEARCH	1. Demonstrates flexibility in therapeutic techniques, including the ability to use and adapt evidence-based approaches, based on assessment data, treatment goals, diversity and contextual variables, and evaluation of intervention effectiveness _____ 2. Demonstrates ability to use evidence based methodology to conduct suicide risk assessment _____
II. ETHICAL AND LEGAL STANDARDS	1. Demonstrates attention to ethical and legal concerns _____

III. INDIVIDUAL AND CULTURAL DIVERSITY	1. Demonstrates ability to integrate issues of identity into their case conceptualization, treatment planning, and interventions _____ 2. Demonstrates sensitivity of how self and client are shaped by individual and cultural diversity and the cultural context and sub-cultures in which they function _____ 3. Demonstrates sensitivity to issues of power and privilege as they interact with client _____
IV. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS	1. Demonstrates integrity and a professional demeanor in the interaction with the client _____ 2. Demonstrates concern for the client's welfare _____ 3. Demonstrates ability to monitor their reactions and behaviors _____ 4. Demonstrates receptiveness to feedback _____
V. COMMUNICATION AND INTERPERSONAL SKILLS	1. Provides clear, succinct, and comprehensive written case presentation report _____ 2. Presents in a clear, succinct, and comprehensive manner which aids the audience in understanding the therapeutic work_____ 3. Demonstrates ability to present the case taking in consideration the allotted schedule, allowing time for questions and feedback _____ 4. Demonstrates effective use of technology and/or visual aids to provide understanding of the work being presented _____
VI. ASSESSMENT	1. Demonstrates ability to make appropriate diagnostic impressions based on assessment data _____ 2. Demonstrates ability to select, use and interpret assessment data being sensitive to clients' cultural identity(ies) _____
VII. INTERVENTION	1. Demonstrates appropriate level of rapport with client _____ 2. Demonstrates ability to gather data and to facilitate exploration _____ 3. Demonstrates ability to integrate data into meaningful conceptualizations _____ 4. Demonstrates ability to conceptualize according to an identified theoretical orientation _____ 5. Demonstrates ability to formulate treatment strategies that integrate theory, current evidence-based information, assessment findings, diversity and contextual variables _____

	6. Appropriately utilizes complementary approaches/services based on client need and diversity/cultural/contextual variables _____ 7. Demonstrates use of self as a therapeutic tool in treatment planning and intervention _____ 8. Helps client identify and understand appropriate goal for therapeutic work _____ 9. Demonstrates ability to handle theirs and their client's affect _____ 10. Demonstrates effective timing of interventions _____ 11. Demonstrates ability to expand own skills in order to benefit the client _____
IX. CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS	1. Demonstrates willingness to consult with other professionals to provide the most effective treatment for the client _____

Overall Rating _____

COMMENTS including particular strengths and areas for further growth:

INTERN PERFORMANCE IN SEMINAR

Intern _____
Seminar _____
Date _____
Evaluator(s) _____

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

_____Attendance

_____Participation

_____Quality of presentation (if applicable)

_____Preparedness

_____Overall Performance:

Comments:

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SUPERVISORS MEETING Intern: _____Date: _____

	I.RESEARCH: Ability to critically evaluate and integrate/utilize research/scholarly work into practice.	**II.ETHICAL AND LEGAL STANDARDS: Ability to apply ethical knowledge in all professional activities. Recognizes ethical dilemmas and applies ethical decision-making processes.**
Strengths	• _____ • _____	• _____ • _____
Growth areas	• _____ • _____	• _____ • _____

	III.INDIVIDUAL AND CULTURAL DIVERSITY: Ability to conduct professional activities with sensitivity to human diversity/Demonstrates knowledge, awareness, sensitivity and skills when working with diverse individuals and communities.	**IV.PROFESSIONAL VALUES AND ATTITUDES: Demonstrates integrity, professional demeanor, professional identity, accountability, eagerness to learn/grow, and concern for others. Engages in self-reflection. Engages in activities to maintain/improve performance, well-being, and professional effectiveness. Demonstrates openness to feedback. Responds professionally in increasingly complex situations with a greater degree of independence as they progress through the internship.**
Strengths	• _____ • _____	• _____ • _____
Growth areas	• _____ • _____	• _____ • _____

	V.COMMUNICATION AND INTERPERSONAL SKILLS: Develops and maintains effective relationships with a wide range of individuals (colleagues, trainees, supervisors, clients, communities). Demonstrates effective interpersonal skills. Utilizes effective oral, nonverbal, and written communication.	VI.ASSESSMENT: Demonstrates competence in initial assessments and assessing level of crisis and risk. Demonstrates competence in selecting and using assessment measures -including CCAPS-. Consults appropriately.
Strengths	• _____ • _____	• _____ • _____
Growth areas	• _____ • _____	• _____ • _____

	VI. INTERVENTION: A) Individual therapy: Demonstrates ability to provide effective services to a wide range of individual clients with diverse presenting concerns.	VI. INTERVENTION: B) Crisis Interventions: Demonstrates ability to assess crisis situations and provide effective interventions. Collaborates with team leader, consults appropriately, etc.
Strengths	• _____ • _____	• _____ • _____
Growth areas	• _____ • _____	• _____ • _____

	VI. INTERVENTION: C) Group therapy: Demonstrates knowledge and skills in group therapy work. Refers appropriately, collaborates with co-leader, demonstrates openness to feedback, etc.	VI. INTERVENTION: D) Outreach: Demonstrates interest and commitment to outreach. Demonstrates ability to plan and conduct outreach programs that are culturally and developmentally appropriate.
Strengths	• _____ • _____	• _____ • _____
Growth areas	• _____ • _____	• _____ • _____

	SUPERVISION OF PRACTICUM STUDENT: Demonstrates knowledge and ability to apply knowledge of supervision theory in working with practicum student supervisee. Demonstrates commitment to supervision, consults appropriately, etc.	CONSULTATION AND INTER-PROFESSIONAL/INTERDISCIPLINARY SKILLS: Demonstrates knowledge and respect for the roles and perspectives of other professions. Intentionally collaborates with other professionals to address a problem, share knowledge, or promote effectiveness in professional activities.
Strengths	• _____ • _____	• _____ • _____
Growth areas	• _____ • _____	• _____ • _____

Comments:

Evaluation of Psychology Interns by Supervisors

College of William and Mary Counseling Center

Intern: _____
Clinical Supervisor: _____
Group Supervisor: _____
Evaluation Period: _____ to _____ Date:_____

The goal of this evaluation is primarily that of stimulating feedback regarding the perceived status and progress of the intern being evaluated. As such, the ratings should be reflective of the expected developmental progress at the time of the evaluation; at the beginning of the year, interns are evaluated according to what the profession describes as "readiness to enter internship" and at the end of year based on the competencies expected for "entry into the profession." Given this framework, interns could make progress on any given aim/competency and receive the same score on two different evaluation periods considering what is developmentally expected at that point in the internship year. It is hoped that the written evaluation will promote meaningful discussion concerning specific areas of the trainee's training, progress, and the means by which skills can be acquired or improved.
A score of 1 or 2 on any given item should be accompanied by specific data or description in the narrative/comment section addressing why the intern is receiving such rating for that competency.
Passing Criteria: As a reminder, a score of 4 is required on each of the nine professional competencies and a minimum of 2 on any given item listed for each competency on the last internship evaluation.

Please rate trainee using the following 5-point scale.

Level 1. Performs inadequately for a psychology intern in this area. Requires significant and close supervision and monitoring of basic tasks in this area. Remediation plan required.

Level 2. Demonstrates marginal competence in carrying out basic tasks in this area; requires frequent supervision and close monitoring. Remediation may be considered or recommended or is available by intern request.

Level 3. Demonstrates competence in carrying out basic tasks in this area. Requires training and ongoing supervision for developing.

Level 4. Demonstrates advanced skills of basic tasks in this area. Requires ongoing supervision for performance of advanced skills in this area. Occasionally and spontaneously demonstrates advanced skills in this area.

Level 5. Demonstrates mastery of basic tasks in this area. Often performs at the level expected for an early career professional.

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

Mark the work that you supervised	Mark the methods used to supervise/evaluate
o Individual Psychotherapy	o Video recordings
o Group Psychotherapy	o Co-therapy
o Day Crisis Intervention	o Verbal summary of cases
o Intake Assessment	o Case documentation/written notes
o Objective/Personality Assessment	o Assessment data
o Symptom Assessment	o Written intakes or assessment reports
o On-call Crisis Intervention	o Case presentations
o Outreach	o Outreach/Research presentations
o Consultation	o Case Conference
o Supervision Provision	o Didactic seminars
o Other (Please describe) _____	o Feedback provided by other supervisors/senior staff
	o Other (Please describe) _____

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

Rating: _____

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

Summary Comments:

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

Rating: _____

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

Summary Comments:

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

Rating: _____

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

Summary Comments:

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

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

Rating: _____

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

Rating: _____

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

Summary Comments:

B: Demonstrates ability to effectively use supervision

Rating: _____

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

Summary Comments:

V. COMMUNICATION AND INTERPERSONAL SKILLS

Rating: _____

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

Summary Comments:

VI. ASSESSMENT

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

Rating: _____

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

Summary Comments:

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

Overall Rating: _____

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

Rating: _____

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

Summary Comments:

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

Rating _____

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

Summary Comments:

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

Rating: _____

1. Demonstrates ability to refer appropriate clients to groups _____
2. Demonstrates effective use of pre-group interviews _____
3. Builds rapport and cohesion in group work _____
4. Demonstrates ability to integrate data into meaningful conceptualizations for group members and for the group as a whole _____
5. Demonstrates ability to integrate theory and practice of group work _____
6. Demonstrates effective timing of interventions according to the group stage _____
7. Demonstrates ability to integrate diversity issues into their conceptualization, treatment planning, and interventions in group _____
8. Demonstrates ability to formulate treatment strategies based on group dynamics _____
9. Implements interventions informed by current group therapy scientific literature/ evidence-based treatment_____
10. Demonstrates collaboration and effective communication with group co-leader _____
11. Demonstrates receptiveness to feedback about group counseling skills and ability to implement feedback and new ideas into group therapy practice _____
12. Demonstrates ability to handle their own and the group's affect _____
13. Maintains accurate documentation records _____
14. Demonstrates ability to handle termination issues of group work _____

Summary Comments:

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

Rating: _____

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

Summary Comments:

VIII. CLINICAL SUPERVISION

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

Rating: _____

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

Summary Comments:

IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS
Collaborates with others to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

Rating: _____

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

_____ _____

Supervisor **Date**

Intern's Comments:

_____ _____

Psychology Intern **Date**

Evaluation Forms

REFERRALS

Dean of Students Office – 1-2510 Campus Center 109
Marjorie Thomas – Dean of Students
Ben Boone – Assistant Dean of Students, Enrollment and Transfer Student Services
Nancy Everson – Assistant Dean- Academic Enrichment Programs
Leslie Henderson – Assistant Dean-Student Accessibility Services
Dave Gilbert – Associate Dean and Director of Student Conduct
Vernon Hurte- Senior Associate Dean of Students, Assistant to the Vice President and Director, Center for Student Diversity
Rachel McDonald- Director, Care Support Services
Wilmarie Rodriguez- Assistant Dean of Students, Student Services
Zara Sibtain- Coordinator of Parent and Family Programs
Mark Sikes – Associate Dean of Students and Director of Parent and Family Programs
Mark Weston- Assistant Dean of Students, Student Conduct

Student Health Center 1-4386 for appointment 1-2998
Virginia Wells, M.D. – Director
Amy Americo, M.D.
Jim Barton, M.D.
David Dafashy, M.D.

A referral to the Student Health Center can be generated through Titanium and then faxed, along with the signed release-of-information to the SHC.
- see "Creating Health Center Referral Notes" in Titanium Guidelines handout

Health Promotion **Offices at the Campus Center** Room 154 – ext. **1-7369**
Eric Garrison – Sexual Health
Myanthi Jayawardena – Sexual Violence Prevention Specialist

Psychiatrists
Trish Roy- WMCC Psychiatrist

Referrals to off-campus Psychiatry and Therapists
Christine Ferguson helps with referrals to the community. An internal referral form through Titanium to Christine is needed. Signed release-of-information is needed to communicate with external referrals.

See list of therapists – G: drive

Deidre Connelly **1-3386** **Wm & Mary Hall 207**
Sports Psychologist who is part of CC staff; her office is located within the Athletic Department, William & Mary Hall. She is available to provide stress management skills, as well as work with students with performance related stress/concerns.

Career Services **1-3231** **Center besides Sadler Center**

Center for Student Diversity **1-2300 Campus Center 159**
Vernon Hurte
Margie Cook

International Student Office **1-3590 Reves Center**

Campus Ministers – see handout of "Campus Ministries United" – CaMU

Substance Abuse Treatment
New Leaf Clinic 757-615-2288

The Counseling Center, LLC 757-229-4645
206 Packets Court, Suite C
Williamsburg
(McLaws Circle area)

The Haven
The Haven is a peer-based ***confidential***, resource center for those impacted by sexual violence and harassment, relationship abuse and intimate-partner violence, stalking, and other gender-based discrimination.

Title IX Compliance and Equity Office

Faculty/Staff/Students may contact the Title IX Coordinator or Deputy Title IX Coordinator with questions or concerns, or to file a complaint regarding sex- and gender-based discrimination, including sexual assault and other forms of sexual harassment.

Counseling Services

Progress Notes: Key Phrases

Mood/Affect:

Appropriate with/to content
Congruent with content
Incongruent with content
Tearful at times
Laughing inappropriately
Mood lability
Lethargic
Subdued
Ruminative
Pensive
Insightful
Melancholic mood
Anxious as evidenced by _____
Annoyed
Agitated
Angry
Dysphoric
Hypervigilant
Cautious
Vulnerable
Appears preoccupied with _____
Tangential thinking
Extreme attention to detail
Apprehensive

Bright
Euphoric
Euthymic
Positive
Pleasant
Calm
Initially calm but appeared anxious as session progressed
Confident affect
Appears detached
Indifferent
Flat
Blunted
Constricted affect
Appears disengaged
Appears disengaged from environment
Appears disoriented
Bizarre behavior and thinking as evidenced by _____
Distressed
Distraught
Stressed
Depressed as evidenced by: _____
Sad

Sx:

Difficulty with concentration
Significant weight loss/gain
Sleep disturbance
Restless sleep
Insomnia or hypersomnia
Increased agitation
Fidgetiness or restlessness
Recurrent thoughts of death
Anhedonia (unable to experience pleasure)
Diminished pleasure in daily activities
Feelings of worthlessness
Self-deprecating remarks
Excessive or inappropriate guilt
Indecisiveness
Emotional lability
Emotional dysregulation

Appetite changes (increase/decrease)
Psychomotor agitation or retardation
Rapid speech observed
Irritable mood
Depressed mood
Suicidal ideation
Sad or empty feelings
Fatigue
Anergia (lack of energy)
Discouraged
Verbally expresses conflicted emotions/thoughts about:_____
Panic attacks:
Reports increased heart rate, rapid breathing, sense of impending doom, increased perspiration, nausea or gastrointestinal distress

Action:

Client disclosed _____
Expresses willingness to implement self-care techniques.
Implements recommended coping strategies/ techniques
Follows through with HW
Verbalizes intent to: _____
ex: contact psychiatrist for appt.
Shows reservations about follow through w/ recommendations to:_____
Rec medical assessment
Demonstrates willingness/committed to:_____
Actively develops insight related to: _____
Shows connection between personal actions and underlying theme of:_____
Takes problem-solving approach to:_____
Chooses option of _____ to:_____
Appears to reconcile:_____

Issues/Themes:

Academic concerns
Academic performance
Academic responsibilities
Broad generalizations re: _____
Career decisions
Developmental issues
Family relationships
Family relationships; esp. re: _____
Sibling relationships
Intimacy
Interpersonal concerns
Explored peer relationships
Fear of: _____
Food issues, particularly w/_____
Eating concerns
Body image issues
Self-esteem
Self-worth
Self-hatred
Self-efficacy
Self-protective tendency/stance
Conflict w/ _____
Expresses conflict re:_____
Daily stress
Financial concerns
Maturational issues
Phase-of-life concerns
Post-graduation plans
Personal responsibility
Meaning and purpose
Religious/spiritual issues, esp. _____
Values
Issues of loss/grief
Locus of control
Disconnections from his/her emotions
Trust issues
Substance usage
Work concerns
Termination
Reviewed events since last visit including: _____
Multicultural issues
Acculturation
Prejudice (racism, sexism, ageism, homophobia, etc.)

Plan/Rec:

Monitor Sx of depression/anxiety
Rec psychiatric assessment
Rec career counseling
Rec see academic advisor
Rec see international student advisor
Rec consult with financial aid or registrar
Rec community resources
Rec academic tutoring
Rec consult with professor
Rec a wellness approach to lifestyle
Rec increased balance in lifestyle
Bibliotherapy
Continue to offer counseling support
Coping strategies

Continue to process feelings and thoughts
especially in regards to:_____
Coping strategies include:_____

Work towards counseling termination
Plan for transition to community resources
Plan for summer break

Risk Management:

References

Murdock, N. L. (1991). Case conceptualization: Applying theory to individuals. *Counselor Education & Supervision*, *30*(4), 355.

Section:

in the field

CASE CONCEPTUALIZATION: APPLYING THEORY TO INDIVIDUALS

A model of case conceptualization is presented that can be used with any theoretical approach to counseling. Issues surrounding the use of this model are discussed.

Over the course of training, counseling students are taught numerous counseling theories, yet little systematic attention is directed toward using these theories to understand and help individual clients. In many counseling texts students are directed to construct their own perspective in working with clients (Corsini & Wedding, 1989; Gilliland, James, & Bowman, 1989; Ivey & Simek-Downing, 1980; Pietrofesa, Hoffman, & Splete, 1984), a stance that seems to encourage a flexible eclecticism. Other writers argue for the adoption of a single theoretical perspective in counseling practice (Patterson, 1985; Russell, 1986). Regardless of which path the student takes (it is not my intent to enter this debate), it seems that the learning process prior to this choice could be enhanced by increased emphasis on applying the various theories students are taught in the course of their training.

Theoretical case conceptualization is a difficult process, but it also may be one of the most effective routes to complete understanding of a theoretical perspective. The process of conceptualization fosters a more thorough understanding of a theory because it requires complex types of learning (Bloom, Madaus, & Hastings, 1981). Bloom et al. identified six levels of learning. The first two, knowledge and comprehension, are routinely achieved in teaching theories of counseling. However, higher levels of learning--application, analysis, synthesis, and evaluation--are involved in applying theory if the application process involves critical evaluation of the approach in question. Case conceptualization should engage all of these learning processes. Conceptualization also should result in an awareness of the strengths and weaknesses of a particular approach. Some clients may present problems or issues that require extension of the theory beyond the convenient examples provided in textbooks. For example, a client displaying a great deal of emotion presents a conceptual challenge for person-centered theory (Raskin & Rogers, 1989), because this theory has traditionally focused on helping clients who repress affect. Understanding the emotive client from this perspective requires more conceptual work and therefore a more complete understanding of person-centered theory.

Numerous calls have been made for counselor educators to teach the skills and processes of case conceptualization (Bernier, 1980; Borders & Leddick, 1987; Fuqua, Johnson, Anderson, & Newman, 1984; Holloway, 1988). Although various models of case conceptualization have been proposed (e.g., Biggs, 1988; Halgin, 1985; Held, 1984; Hulse & Jennings, 1984; Loganbill & Stoltenberg, 1983; Swensen, 1968), most of these do not emphasize the integrated application of a single theoretical perspective. Most efforts seem to specify categories of information that are essential to the counseling process (e.g., specific demographic information, interpersonal style, and personality dynamics; Hulse & Jennings, 1984; Loganbill & Stoltenberg, 1983), or they construct an integrative eclectic approach useful in conceptualizing cases (Halgin, 1985; Held, 1984; Swensen, 1968). Biggs (1988) discussed briefly how theory contributes to case conceptualization and detailed factors that influence the conceptualization process. Models that guide the systematic application of one theory that can be used with a wide range of theoretical approaches, however, seem scarce. This article presents a model that I find useful in teaching case conceptualization, in the supervision of practicum students, and in my own counseling practice. My primary purpose was to provide a structure that can be used with almost any well-developed theory of counseling and that will help the student through this most difficult and complex process.

THEORETICAL STRUCTURE

Before applying a theory, the counselor must have a solid understanding of the theory in question. The counselor must know how the theory defines the healthy personality and psychological dysfunction. In order to help, counselors need to have some idea of where the client "should" be going and why the client has come to counseling. Linked to this theoretically based construction are the specific areas, of the client's presentation that are considered most important. To give a rather simplistic example, a counselor adopting a behavioral approach that emphasizes operant learning (e.g., Kazdin, 1980) assumes that the client presents for help because of faulty learning (or the failure to learn a desired behavior). This therapist is then interested in a number of aspects of the client's life, including (a) the specific behavior to be modified, (b) the history of the behavior, (c) the type of learning that first produced the behavior, and (d) the stimuli that evoke the behavior. In contrast, psychoanalytic therapists (e.g., Arlow, 1989) would be interested in very different information because, from their theoretical base, the origins of dysfunction are found in conflicts that reside in the unconscious. Thus, psychoanalysts would be interested in issues such as (a) what the client remembers of early childhood, (b) past and current relationships with parental figures, (c) past and current relationships with siblings and other significant persons, and (d) the client's character style as indicated by current interactions.

The preceding types of issues are considered preliminary to the actual process of conceptualizing a client; they represent information that ensures the needed

understanding of the theory before it is applied. Questions that help counselors obtain a sufficient level of understanding prior to application are the following:

1. What is the core motivation of human existence?
Whether explicitly or implicitly, theories of counseling tend to emphasize one major theme that directs or governs individuals' lives. For example, classic psychoanalytic theory emphasizes the conflicts between the various mental structures. In contrast, Gestalt theorists (Perls, Hefferline, & Goodman, 1951) postulated that humans tend toward homeostasis.

2. How is the core motivation expressed in healthy ways? What are the characteristics of a healthy personality?

Too often counselors find themselves focused on definitions of pathology. At least as important (and possibly more so) are definitions of health. Definitions of psychological health are theory linked. Cognitive theorists (e.g., Beck & Weishaar, 1989) are interested in helping the client become healthy through the elimination of faulty thought processes. According to multigenerational family theorists (e.g., Kerr & Bowen 1988), health is defined as relatively clear differentiation from the family of origin. Thus the counselor seeking to remain theory-consistent must recognize that the approach chosen specifies the most important characteristics that define psychological health.

Cross-cultural and gender-role issues are important factors to consider at this point. Because many theories were developed in a restricted cultural context (i.e., Western, White, male, middle to upper socioeconomic status), definitions of health and dysfunction are products of these cultures. The degree to which these definitions apply across cultures and to women is certainly not established, although the idea that human universals exist has not been entirely disconfirmed (Draguns, 1981). Therefore, great care must be taken by the practitioner in applying these definitions, and the degree to which the theory's definitions of health are inconsistent with the client's cultural definitions must be carefully assessed. For example, theories that advocate autonomy from one's family of origin may be in conflict with the cultural norms learned by a Japanese client (Sue & Zane, 1987). If confronted with this type of situation, the counselor must assess the impact of helping the client individuate. Deciding that individuation might do more harm than good, the counselor may simply attempt to help the client understand the effect of his or her family system. In this case, understanding of cultural norms may help the client devise ways to individuate that do not seriously conflict with important cultural rules. At times, however, the counselor may find that extension of a theory in an attempt to incorporate cultural concerns is impossible and may at this point consider adopting a theoretical structure more compatible with the client's cultural background.

3. How does the process of development get derailed or stuck? What are the factors that contribute to psychological dysfunction?

The complement of the question of psychological health is the issue of how individuals get "unhealthy." Theories are often better at specifying factors that lead to dysfunction than they are at describing psychological health. In considering these definitions, attention to cultural and gender-role issues is again critical. Classic psychoanalytic theory has been criticized, for example, because its definition of health for women is stereotypic, tending to support traditional roles and values. Therefore, a nontraditional female client may be judged to be dysfunctional under this system. A counselor aware of this bias could revise this definition but still remain theory-consistent by acknowledging the influence of sexual conflicts while avoiding interpretations that promote stereotypes.

4. What stages of the client's life are considered key in the developmental process?

Theorists clearly differ on developmental factors. Some theories incorporate almost no developmental theory (e.g., rational emotive therapy, Ellis, 1989), while others stipulate that development is crucial to the presenting problem (e.g., psychoanalytic theory).

5. Who are the critical individuals in the client's presentation? Does the theory restrict the focus to the individual, or does it extend to interactions with family and acquaintances or to multigenerational issues?

Most theories deal with social interaction in some form. Some theories conclude that internal processes are primary (e.g., cognitive theories), although they may affect relationship events. Other approaches postulate that relationships are the key to psychological functioning (i.e., interpersonal theory; Kiesler, 1983; Strong & Claiborn, 1982) and, therefore, place great emphasis on these factors in determining psychological health. Past relationships are significant for some approaches, even relationships generations removed (Kerr & Bowen, 1988).

6. What are the relative importance of affect, cognition, and behavior in this theory?

Theories place different emphases on the roles of affect, cognition, and behavior in determining psychological life. Some approaches identify emotional factors as primary (e.g., person centered, Gestalt, and psychoanalytic), others emphasize cognitive factors (cognitive therapy and rational emotive therapy), and still others target behavior (behavioral approaches). Regardless of the focus, the other two components are usually considered, so this postulate does not direct the counselor to ignore any of these domains. Neglect of any of these factors probably indicates a misunderstanding of the theory; rather, the point of this discussion is to understand the theoretical relationships of these components.

GATHERING INFORMATION

Armed with a theoretical framework, the counselor attempting to apply theory must next understand the client as fully as possible. Two types of information are important in this process. First, the counselor will probably want general information that is not strongly theory linked, such as demographics (age, sex, and ethnic origin), current living situation, and physical health. Although different theories might place different emphasis on this type of information, or ignore it altogether, a counselor attempting to fully understand his or her client generally collects these data. Demographics also help the counselor to avoid misunderstandings due to cultural bias.

Second, the counselor seeks information that is theory specific as determined by his or her understanding the basic issues emphasized by the theory. The six questions that help build theoretical structure (listed previously) can guide this information search.

INTEGRATION

Perhaps the most difficult aspect of case conceptualization is the process of tatting together in a coherent way the pieces of the puzzle presented by the client. The counselor must translate the specific presentation of the client into theoretical terms. This process requires the counselor to carefully compare the client's presentation to the theoretical structure to be used. Some questions to be considered are the following:

1. Do the details of the presenting problem fit the theory's postulates concerning psychological dysfunction?

   If the elements of the client's presenting problem fit easily, the counselor can proceed to treatment planning, keeping in mind that further information gained from the client may alter this conceptualization. Because clients rarely speak in theoretical terms, however, it is more likely that some, or many, elements seem to be outside of the theory's structure to at least some degree. In fact, the first difficulty in the process of conceptualization is that the counselor is often tempted to focus narrowly on the "presenting problem." For instance, clients often present with interpersonal problems that can be labeled as lack of assertiveness. Although this label might be useful at times, the counselor attempting to use theoretical conceptualization may get distracted by the label. At this point, the counselor usually reports that a particular theory says nothing about assertiveness and hence decides to use another theory instead. Instead of prematurely abandoning the theoretical approach, the counselor should consider why (in a theoretical sense) the client is nonassertive. To answer this question, the counselor must return to the core principles of the theoretical structure to focus on the underlying mechanisms that lead to the appearance of the "symptom." A cognitive counselor would therefore translate lack of assertion into behavior that is the result of distorted thinking and proceed to determine what irrational thoughts or beliefs the client holds. The process of going beyond "symptoms" therefore involves translating them into theoretical terms that emphasize the links between client presentations and theoretical definitions of health and dysfunction.

The example of the person-centered therapist confronted with a highly emotive client also can illustrate this process. According to the procedure outlined previously, the therapist would consider how emotional outbursts could be understood through the construct of incongruence. For example, the counselor might see the affect as resulting from aspects of experience that are distorted and then denied, but which are then overtly expressed, because repressive processes are depleted by unusual levels of stress. Again, the general method is to first detach from the symptom to a more general understanding and then transfer back to the anomaly.

In rare cases, discrepancies between client presentation and theory may call for a change of perspective. I have not encountered this situation unless the client is of a different culture from that in which the theory originated. As previously noted in the case of the Japanese client (Sue & Zane, 1987), at times the core postulates may be in direct opposition to the norms of the client's culture. Therefore, the counselor must make a careful study of the multicultural counseling situation and may decide that modification to deal with cultural issues does not destroy the usefulness of the theory. Alternatively, the counselor may elect to shift perspectives to one that is more consistent with the client's culture. In instances in which hypothetical cases are in use (e.g., in practicing case conceptualization in theory classes), abandoning the original perspective should be considered a last resort as it may lead to a superficial understanding of the theory. In practicums, in which students are conceptualizing the clients they are counseling, consideration of alternative theoretical structures might be introduced more quickly than when hypothetical cases are in use because the risk of harm to the client is real.

Issues regarding gender bias seem more subtle. Most theoretical definitions of health do not seem blatantly biased (except perhaps for classic psychoanalytic theory, which in some interpretations emphasizes the acceptance of traditional aspects of the female role). Some of the major theories of counseling could be criticized for relying on a male-biased model of health in their emphasis on rational thought and consequent relative neglect of affective processes (e.g., rational emotive therapy, cognitive therapy, and cognitive-behavior modification). Likewise, the experiential theories (person-centered, Gestalt, and other existential approaches) could be criticized for being female-biased in their reliance on what is a stereotypically feminine process (affect). This bias, however, seems somehow less clear than cultural bias, and in many cases it seems likely that gender bias often resides in the application of the theory, not in its basic assumptions. For example, the personal attitudes of the counselor can lead the counselor to encourage a female client to adopt traditional behaviors regardless of what theory he or she is applying (an analogous situation may occur in multicultural counseling). If the counselor determines that the source of gender bias lies in the

central postulates of the theory, the counselor has the same options as those outlined for the situation in which cultural bias appears.

2. How do other aspects of the client's presentation fit with the postulates of the theory and the presenting problem?

Once the counselor has gained a theoretical understanding of the presenting problem, the counselor must integrate this knowledge with the rest of the client's presentation to obtain a coherent picture of the client. In the person-centered example, the therapist would look for other aspects of experience that are repressed, plus examine the conditions of worth held by the client and how they were learned. Also, the therapist would look for evidence of the client's self-actualizing tendencies that are sure to be at least faintly evident.

3. Based on this theory, where does the client need to go (i.e., what changes does the theory specify)?

Because the beginnings of intervention start with the understanding of the theory's definition of the healthy person, the therapist should establish how this client would appear as a healthy person. In the case of the emotive client, the person-centered therapist would want the client to be able to experience the volatile emotions in a meaningful, accepting way. Similarly, the Gestalt counselor would want the client to increase his or her awareness in all areas of experience.

4. How can I help the client get where he or she needs to go?

Interventions designed for the client should follow directly from the definitions of health developed for this individual. Some theorists are specific about productive interventions whereas others are less so. Rather than confining the therapist to theory-specified interventions, I agree wish' other authors (e.g., Lazarus, 1974) that many interventions could be employed to help a given client. An important point to add, however, is that these interventions should be undertaken with a theoretical goal in mind. The critical question becomes why this intervention now? 1 cannot count the times students have offered empty-chair interventions but have had no specific theoretical goal in mind. Another common problem is that students often equate intervention with technique. Techniques are easily understood because they are generally concrete, circumscribed actions taken by the counselor. Interventions (at least in my understanding) can be more general in nature (such as when the psychoanalytic counselor provides an ambiguous situation on which the client can project) and are often overlooked by students even though they are powerful change tools. Continuing the person-centered example, a major intervention is allowing the client to disclose to an accepting, empathic therapist. Instead, the student who must choose an intervention may identify a more concrete technique (such as having the client keep a self-talk log). Although such a specific technique may be helpful in this case, the student may bypass the simpler, broader intervention specified by person-centered theory.

5. How will I know when the client is better?

Although implicit in the specification of health as defined by theory, it should be emphasized that the specific criteria for health for the client be defined by the counselor through applying the basic concepts of the theory. This consideration brings up yet another important question: What about the client's input in this process? When conceptualizing from a theoretical base, are we ignoring the client's stated goals and wishes? Misguided use of theory could result in this rigid stance. Careful consideration, however, of the client's goals in light of the theory can integrate this aspect of the client's presentation into the theoretical structure. In my example, the client's stated wish to deal with her affective outbursts can be construed as the client's self-actualizing tendencies, encouraging her toward more authentic experiencing of her existence.

USES OF THE MODEL

The case conceptualization model presented in this article can be used in several ways. Because this approach is only recently developed, I have no empirical outcome data to present, simply my impressions that are based on the comments of students who have used the model. As noted by previous writers in the area of case conceptualization (Bernier, 1980; Borders & Leddick, 1987; Fuqua et al., 1984; Holloway, 1988), cognitive style and developmental issues need to be recognized in the training process. Therefore, the following suggestions for using this model are loosely guided by such concerns.

In beginning-level (master's) theories courses, I have presented the model as a general outline to teach case conceptualization. Students at this stage are struggling to learn the various theories presented, and the six questions about theoretical structure seem to help them in organizing information. Application of theory seems to be most difficult at this level of learning and these students have had little or no supervised counseling experience. Laboratory sections of several classes are devoted to case conceptualization, using the steps of the integration portion of the model as a guide. One case is assigned across small groups of students, and groups present and compare their conceptualizations.

In practicums, I ask students to present their theoretical perspectives by answering the six questions outlined under theoretical structure. This process helps them to clarify the basic assumptions of their perspectives. Often, students find this process quite difficult, because they have devoted little systematic thought to organizing their perspectives. They are then asked to conceptualize cases based on the guidelines in the model. Students report that the structure gives direction to what is normally a rather ambiguous

assignment. My observation is that their conceptualizations seem clearer and more organized than those when they do not have guidelines to follow.

I am currently using this model in my advanced (doctoral) theories of counseling course. In this class, students spend the majority of class time presenting theoretical conceptualizations of clients they have previously counseled. Class members supply written case studies for class use. Each student is responsible for supplying readings on a major theoretical approach, and all students complete reaction papers on each theory studied. Students are also required to develop a research proposal that tests a well-developed theory relevant to counseling. The first portion of each class meeting (approximately 45 minutes of a 2-hour and 40-minute total class time) is devoted to outlining each theory according to the six questions relevant to theoretical structure. For the remainder of the class, two class members present case conceptualizations (of different clients) developed according to the model as if they were proponents of the theory under discussion. The presenters attempt to integrate aspects of the client's presentation, set theory-based goals, and design theoretically consistent interventions. These presentations can be organized around the five integration questions specified by the model. The rest of the class challenges these conceptualizations, with particular attention paid to theoretical anomalies in the cases or in the presenters' theoretical explanations. Presenters are required to use only explanations that are consistent with the approach they are advocating and are therefore not able to avoid aspects of the cases that are theoretically inconvenient by shifting to other perspectives. This case-intensive approach leads to active discussions that include cross-cultural and gender-role issues. Often, different theoretical approaches are pitted against one another and compared for their utilities in understanding the case in question. The case conceptualization model therefore guides students in all steps of the application process, and students report that this approach is quite helpful to them.

CONCLUSION

Given the lack of systematic guides for the process of case conceptualization, the model presented seems to be a step toward improved teaching in this area. As mentioned previously, however, the model is relatively untested, because it has been evolving over the last several years. Further use of the model will demonstrate whether it achieves its purpose of leading to a clearer understanding of the counseling process, improved training of students, and thus, better services to our clients.

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By NANCY L. MURDOCK

Nancy L. Murdock is an assistant professor in the Division of Counseling Psychology and Counselor Education, University of Missouri--Kansas City. Thanks are extended to Barbara Baer and Rodney Goodyear, who provided helpful comments on earlier versions of this article. Acknowledgment is also due to the numerous students who have commented on this approach during the course of their training.
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Crafting a Case Conceptualization

What is case conceptualization? How is it different from a summary?
A case conceptualization is an explanation of how the therapist understands the client's problem or issue. The therapist's conceptualization is a generated from the information that they have gathered from the client regarding their experience, and is articulated through the lens of a particular theoretical orientation or other manner of organizing individual biopsychosocial data. The client provides the specifics of their experience and symptoms, if any. The theory helps the therapist to understand how client's experience has come to be; and what can be done to change it.

The following are some questions that can guide you as you conceptualize clients:

- What is the presenting problem or the client's explanation for why they are seeking help and/or support at this time? What are the therapist's ideas about what is bringing the client in at this time?

- What factors have contributed to the current situation based on their:
    - Identity variables
    - Cultural and contextual history
    - Biological and physical context
    - Family of origin
    - Developmental milestones and other significant markers of transition
    - Academic history
    - Current level of social support
    - Relationship with substances, food, exercise, etc.
    - Previous attempts to solve problems and/or address challenges

- How has the client adaptively or maladaptively managed his or her problem(s)/issue(s) thus far? Has this been a pattern over time?

- What relational or intrapsychic dynamics did you hear or observe in hearing the client's story? What are the common themes?

- Based on your orientation, what factors underlie the client's presenting concern? How do these factors maintain, exacerbate, or otherwise influence the client's concern?

- What ties it all together? How do you make sense of the information being presented?

- What do you think needs to happen for the client to reach some positive resolution or growth?

Suicide Risk Assessment for John Doe

Prepared by _____ Date _____

1a. Chronic Risk Factors
1b. Acute Risk Factors
1c. Protective Factors
1d. Suicidal Ideation, Planning, and Intent

2. Based on the assessment findings listed above, indicate your judgment of this client's risk for suicide.

Risk Level	Chronic Risk Factors	Acute Risk Factors
Low		
Moderate		
High		

I deation – threats to kill/hurt self, looking for access to means, talking/writing about death

S ubstance abuse – increased or excessive use of alcohol or drugs

P urposelessness – No reason for living; no sense of purpose in life

A nxiety – Anxiety, agitation, unable to sleep or sleeping all the time

T rapped – Feeling trapped, like no way out, resistance to help

H opelessness – Hopeless about the future

W ithdrawal – Withdrawing from friends, family and society

A nger – Rage, uncontrolled anger, seeking revenge

R ecklessness – Acting reckless or engaging in risky activities; impulsivity

M ood change – Dramatic mood change

Risk and Protective Factors at a Glance

		Risk Factors	Protective Factors
Bio-psycho-social	Biological	**Mental disorders,** particularly mood disorders such as major depression and bipolar disorder. Also schizophrenia and anxiety disorders; recent psychiatric symptoms; history of mental disorders **Substance use** - Alcohol and other substance use disorders Co-morbidity - Combined mental health and substance abuse issues **Medical** – Loss of health from physical illness, loss of functioning, body parts or physical integrity; low CSF 5-HIAA, low cholesterol blood levels, low blood glucose, chronic physical pain	Effective clinical care for mental, physical and substance use disorders Motivation for treatment Support through ongoing medical and mental health care relationships
	Psychological	**Certain personality types**– Borderline and antisocial disorders with poor reality testing, ineffective coping styles; sexual identity conflict; impulsive/aggressive or depressive/withdrawn temperament types **States of Mind** – Self-hate, despair, low self-esteem, feeling of being cut off from other people; psychic pain, feelings of hopelessness or helplessness; suicide ideation **Developmental history** - emotional or sexual trauma or abuse; previous suicide attempt(s), previous psychiatric treatment **Family history** of violence, suicide or alcoholism or drug abuse; parental psychopathology	Coping skills; problem-solving abilities Sense of optimism; self-efficacy beliefs Individual strengths; social contacts
Socio- cultural	Social	**Stressful life events** - Loss (relational, social, identity, status, work, or financial), unemployment, family conflicts, lack of social support, geographic mobility, legal issues, arrests, incarceration, alternative lifestyles **Exposure to suicide** - influence of media, others (family, peers, significant others) who have died by suicide, local clusters of suicide that have a contagious influence	Support networks Conflict resolution and nonviolent handling of disputes Strong family connections
	Cultural	**Cultural, religious, spiritual beliefs** – positive or negative perception of suicide, belief that suicide is a noble resolution of personal dilemmas Stigma vs. cultural acceptance of violence Experience of humiliation or shame	Cultural and religious beliefs, practices and activities that discourage suicide and support self preservation
	Environment	**Barriers** - Unwillingness to seek help due to stigma, unable to access health care services/treatment Easy access to lethal methods, especially guns Economic conditions; natural disasters/other traumatic events	Access to mental health care, support for help-seeking Restricted access to lethal means of suicide
	Demographic	-Male gender (for completions); female gender (for non-fatal attempts) Single, divorced, separated, widowed, people living alone or socially isolated; lesbian, gay, & bisexual youth Whites, Native Americans; teens and the elderly	Social and community support

Patient 2

Patient is an 18 year old single Caucasian female college freshman with a history of a suicide attempt one year ago by overdose (and brief hospitalization) secondary to academic stress in her senior year in high school. She reportedly had been physically ill and "worn out," earning an incomplete which was later changed to a "D," resulting in her not being valedictorian of her graduating class. She currently reports feeling fatigued and overwhelmed by her academic workload. She has just received a diagnosis of mononucleosis.

Patient states that she feels "like [she is] going crazy." She describes many negative thoughts most specifically with regard to not doing well academically. Patient's boyfriend broke up with her three weeks ago and is currently courting a friend of hers. Current symptoms appear precipitated by this. She stated, "I'm lonely. No one loves me… I'm not worth squat to anyone, I'm just using up the world's resources and have don't have anything to give back, I just take up useless space…I want him to know how much pain he's caused me."

Mental status exam revealed a tearful young woman who maintained poor eye contact. She spoke in soft tones throughout, giving one word answers. Memory appears good and she was oriented x 4. Insight and judgment are poor. Patient reports poor sleep, anhedonia, increased guilt, decreased energy and concentration. Appetite is reported as okay. She admitted to having suicide ideation, stating that "if it gets any worse, I simply want out." She reported having hoarded a considerable amount of medication from last year, "so I'll be ready." Sleep has been poor (3-4 hours per night), eating erratic; she admits to binge drinking during which she vents rage toward anyone near her.

WHEN TO CONSULT?
A RESOURCE GUIDE

This guide is meant to help ensure that follow-up is conducted if certain red flags emerge during an initial assessment.

1. **Has the client stated specific or vague references to suicide?**

2. **Has the client stated specific or vague references to homicide?**

3. **Has the client indicated any history of abuse (emotional, physical, sexual)? Are you suspicious of any abuse or neglect that the client has referenced experiencing as a minor?**
   - Even if client is over 18 y/o, are minors currently in the home with alleged perpetrator (e.g., younger siblings)?
   - Inquire about whether the alleged perpetrator still has a caretaking role of minors generally
   - Remind client of applicable limit of confidentiality and inform them of your need to consult with a supervisor

4. **Has the client referenced other issues that could be reportable to CPS?**
   - Minors witnessing domestic violence in the home
   - Substance use/alcohol use is creating a dangerous environment (e.g., intoxicated parent driving children around, selling of drugs in the home)
   - Neglectful behavior (e.g., leaving children in home unsupervised for extended periods of time or overnight)

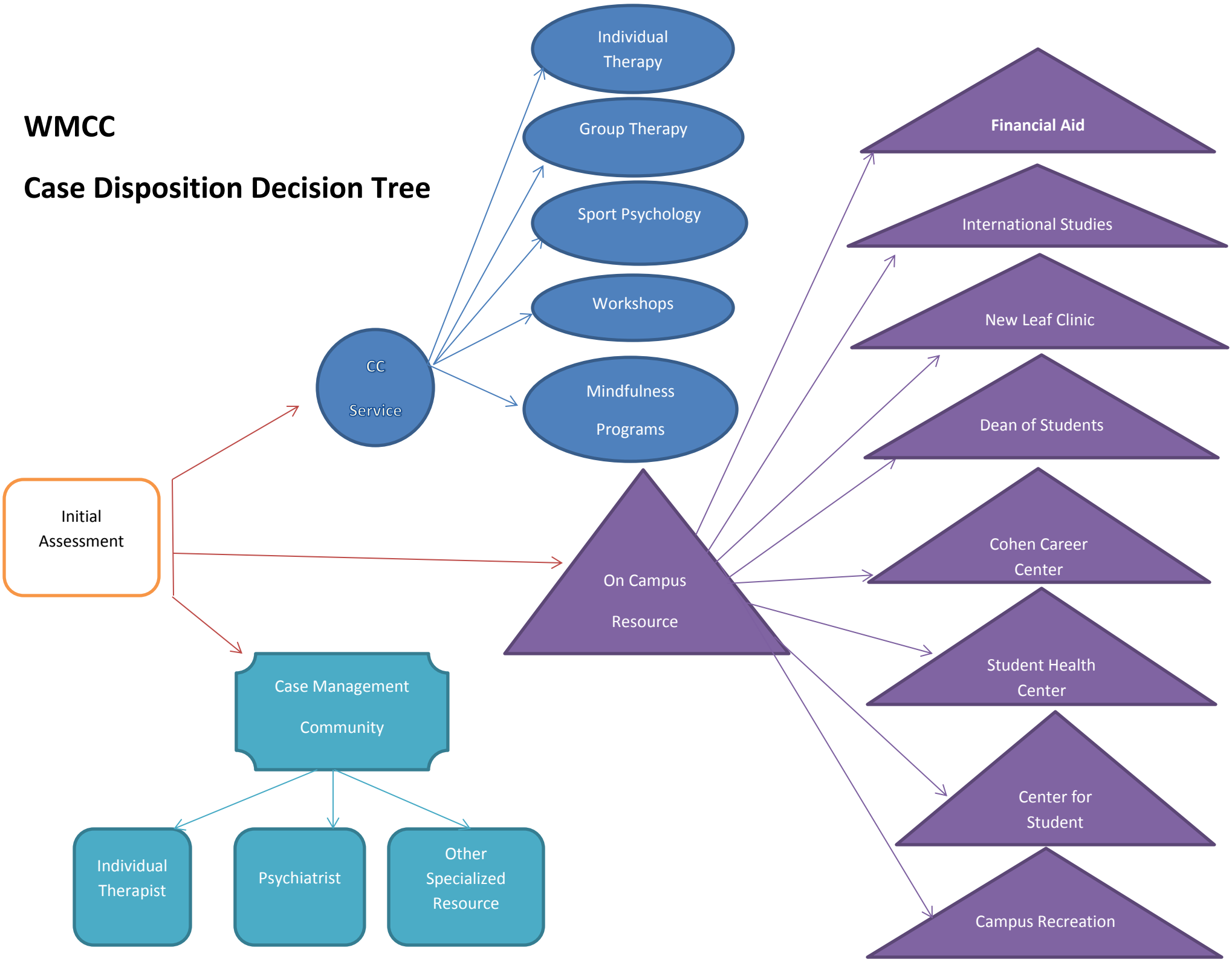
****** If any of these are present, be sure to consult **ASAP** by following the below steps:

Initial Assessment	Ongoing Client
1) Consult with supervisor ****** if unavailable, go to step 2	1) Consult with supervisor ****** if unavailable, go to step 2
2) Consult with Team Leader ****** if unavailable, go to step 3	2) Consult with any available senior staff
3) Consult with any available senior staff	
****** If client is to be transported to hospital, the on-call staff member is involved at this step.	

Note: Be sure to update supervisor accordingly if she/he was not involved in the consultation process.

WMCC

Case Disposition Decision Tree



WMCC Initial Assessment Disposition Questions

The Initial Assessment meeting is designed to be a consultation with a student/client who is seeking services to address an issue or concern they are having. While they may have an idea of what they think will be helpful, your professional expertise is an important part of that person ultimately addressing the issue that they are concerned about. You have specific knowledge about how particular conditions can be alleviated or exacerbated by certain interventions. Based on all of the information you have, and the information about their situation that they provide, you will make recommendations to the client regarding the service(s) that could be **MOST helpful** to them. While financial factors, transportation, parental and social support, and other environmental factors should be taken into account, the first question you and the client should work to answer is "what would best meet their clinical need at this time?" Once you have answered this question, work to find a reasonable approach to using the resources we have to meet that need. You can work with your supervisor, other staff, and/or the Mental Health Services Coordinator to develop this plan.

Here are some questions that can help guide your thinking as you plan:

Is this their first therapy experience? (Could some psychoeducational and or transitional experience in brief treatment be helpful?)

Are they able to identify goals? (Specific goals with observable or measurable outcomes lend themselves to brief treatment)

What is their previous level of need or previous experience with therapy? (When was the last time this person functioned without services and for how long? Is their current stress level or transitional phase likely to exacerbate issues or diminish them? Are they requesting a specific frequency of contact or specific type of intervention?)

Are they demonstrating behaviors indicating high need or high risk? (Patterns of substance use/abuse that involve risky behaviors; maybe not in crisis but with extensive history of previous mental health experience either with or without previous treatment; recent crisis (honor, legal involvement, conduct issues); to adequately address issues bi-weekly therapy is likely not a good fit or is contraindicated; recent significant loss; low CAF score or level of current functioning; CCAPS profile; timing of the semester and ability to reassess at a later time; really specific clinical presentation that requires a specific intervention that is beyond expertise or ability to impact well in this setting; need for access to on-demand or frequent crisis services)

Is there some combination of services that could address the issue(s) adequately? (e.g. community therapy ongoing and group at WMCC; academic support from Dean's office with brief treatment)

Is the presenting issue likely to respond to short term and/or Bi-weekly sessions? (Is the client's presenting issue amenable to brief models of treatment? Is the client able to tolerate biweekly sessions? Does the client see their issue as able to be addressed in a time sensitive manner?)

Is the presenting issue better suited for another resource? (Would Motivational Interviewing; Mindfulness; and/or Academic and Career advising, better address the needs?)

Are the extenuating factors compelling or can they be overcome (Can underinsurance or financial issues be further addressed; can brief therapy help overcome family of origin barriers to treatment?)

Does the client have the flexibility or capability of following through with the plan? (Level of functioning indicates they can carry out steps of plan without help or they need support of MHSC to make transition to appropriate treatment modality. Currently ready for group or need brief individual therapy to be ready)

William and Mary Counseling Center
Scope of Services

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

For those students whose presenting issues suggest a need for more long-term services, the staff at the Counseling Center can help facilitate a referral to private mental health care in the community. Counseling Center services will not be an appropriate substitute for long-term, intensive psychological services. Some common examples of issues that may be more suited to an outside referral include but are not limited to:

- student issues that may require more than weekly appointments
- student issues which require a specific type of therapy not practiced by staff
- student issues which required long-term, ongoing psychotherapy before coming to William and Mary
- student issues that tend to worsen in short-term counseling
- students seeking to be seen more than a semester at a time

We are not likely to provide ongoing services for students who:

- Have a history of requiring weekly therapy over long periods of time (> 6 months)
- Seeking therapy for the entire year or more on a weekly basis
- Actively abusing substances beyond alcohol
- Significant Personality Disorder is primary presentation
- Active psychosis or unstable bipolar disorder
- High distress with low coping skills and low distress tolerance requiring frequent crisis intervention
- Medication non-compliant major mood and psychotic disorders
- Dissociative disorders
- Have extensive trauma history which is previously unexplored

Any services provided to this type of students would be an initial consultation and support to ensure stability and referral.

Clinical Information

Ethics
& Law

AMERICAN PSYCHOLOGICAL ASSOCIATION

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

Adopted August 21, 2002
Effective June 1, 2003

With the 2010 Amendments
Adopted February 20, 2010
Effective June 1, 2010

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

CONTENTS

INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A–E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably, appropriate, potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

The American Psychological Association's Council of Representatives adopted this version of the APA Ethics Code during its meeting on August 21, 2002. The Code became effective on June 1, 2003. The Council of Representatives amended this version of the Ethics Code on February 20, 2010. The amendments became effective on June 1, 2010 (see p. 15 of this pamphlet). Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242. The Ethics Code and information regarding the Code can be found on the APA website, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:

American Psychological Association. (1953). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist, 14,* 279–282.

American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist, 18,* 56–60.

American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist, 23,* 357–361.

American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor,* 22–23.

American Psychological Association. (1979). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist, 36,* 633–638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist, 45,* 390–395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060-1073.

Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242, or phone (202) 336-5510.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of

their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national

origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

3.09 Cooperation With Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02,

Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipi-

ents of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter With Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer–employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships With Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such

as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies With Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy With Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies With Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

2010 AMENDMENTS TO THE 2002 "ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT"

The American Psychological Association's Council of Representatives adopted the following amendments to the 2002 "Ethical Principles of Psychologists and Code of Conduct" at its February 2010 meeting. Changes are indicated by underlining for additions and striking through for deletions. A history of amending the Ethics Code is provided in the "Report of the Ethics Committee, 2009" in the July-August 2010 issue of the *American Psychologist* (Vol. 65, No. 5).

Original Language With Changes Marked

Introduction and Applicability

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner~~. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority~~ in keeping with basic principles of human rights.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.~~ Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and ~~to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.~~ take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

NOTES

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ASSOCIATION

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Psychology

Table of Contents

§ 54.1-3600. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Applied psychologist" means an individual licensed to practice applied psychology.

"Board" means the Board of Psychology.

"Certified sex offender treatment provider" means a person who is certified to provide treatment to sex offenders and who provides such services in accordance with the provisions of §§ 54.1-2924.1, 54.1-3005, 54.1-3505, 54.1-3611, and 54.1-3705 and the regulations promulgated pursuant to these provisions.

"Clinical psychologist" means an individual licensed to practice clinical psychology.

"Practice of applied psychology" means application of the principles and methods of psychology to improvement of organizational function, personnel selection and evaluation, program planning and implementation, individual motivation, development and behavioral adjustment, as well as consultation on teaching and research.

"Practice of clinical psychology" includes, but is not limited to:

1. "Testing and measuring" which consists of the psychological evaluation or assessment of personal characteristics such as intelligence, abilities, interests, aptitudes, achievements, motives, personality dynamics, psychoeducational processes, neuropsychological functioning, or other psychological attributes of individuals or groups.

2. "Diagnosis and treatment of mental and emotional disorders" which consists of the appropriate diagnosis of mental disorders according to standards of the profession and the ordering or providing of treatments according to need. Treatment includes providing counseling, psychotherapy, marital/family therapy, group therapy, behavior therapy, psychoanalysis, hypnosis, biofeedback, and other psychological interventions with the objective of modification of perception, adjustment, attitudes, feelings, values, self-concept, personality or personal goals, the treatment of alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, pain, injury or disability.

3. "Psychological consulting" which consists of interpreting or reporting on scientific theory or research in psychology, rendering expert psychological or clinical psychological opinion, evaluation, or engaging in applied psychological research, program or organizational development, administration, supervision or evaluation of psychological services.

"Practice of psychology" means the practice of applied psychology, clinical psychology or school psychology.

The "practice of school psychology" means:

1. "Testing and measuring" which consists of psychological assessment, evaluation and diagnosis relative to the assessment of intellectual ability, aptitudes, achievement, adjustment, motivation, personality or any other psychological attribute of persons as individuals or in groups that directly relates to learning or behavioral problems that impact education.

2. "Counseling" which consists of professional advisement and interpretive services with children or adults for amelioration or prevention of problems that impact education.

Counseling services relative to the practice of school psychology include but are not limited to the procedures of verbal interaction, interviewing, behavior modification, environmental manipulation and group processes.

3. "Consultation" which consists of educational or vocational consultation or direct educational services to schools, agencies, organizations or individuals. Psychological consulting as herein defined is directly related to learning problems and related adjustments.

4. Development of programs such as designing more efficient and psychologically sound classroom situations and acting as a catalyst for teacher involvement in adaptations and innovations.

"Psychologist" means a person licensed to practice school, applied or clinical psychology.

"School psychologist" means a person licensed by the Board of Psychology to practice school psychology.

(1976, c. 608, § 54-936; 1987, cc. 522, 543; 1988, c. 765; 1994, c. 778; 1996, cc. 937, 980; 2004, c. 11.)

§ 54.1-3601. Exemption from requirements of licensure.

The requirements for licensure provided for in this chapter shall not be applicable to:

1. Persons who render services that are like or similar to those falling within the scope of the classifications or categories in this chapter, so long as the recipients or beneficiaries of such services are not subject to any charge or fee, or any financial requirement, actual or implied, and the person rendering such service is not held out, by himself or otherwise, as a licensed practitioner or a provider of clinical or school psychology services.

2. The activities or services of a student pursuing a course of study in psychology in an institution accredited by an accrediting agency recognized by the Board or under the supervision of a practitioner licensed or certified under this chapter, if such activities or services constitute a part of his course of study and are adequately supervised.

3. The activities of rabbis, priests, ministers or clergymen of any religious denomination or sect when such activities are within the scope of the performance of their regular or specialized ministerial duties, and no separate charge is made or when such activities are performed, whether

with or without charge, for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination or sect, and the person rendering service remains accountable to its established authority.

4. Persons employed as salaried employees or volunteers of the federal government, the Commonwealth, a locality, or any agency established or funded, in whole or part, by any such governmental entity or of a private, nonprofit organization or agency sponsored or funded, in whole or part, by a community-based citizen group or organization, except that any such person who renders psychological services, as defined in this chapter, shall be (i) supervised by a licensed psychologist or clinical psychologist; (ii) licensed by the Department of Education as a school psychologist; or (iii) employed by a school for students with disabilities which is certified by the Board of Education. Any person who, in addition to the above enumerated employment, engages in an independent private practice shall not be exempt from the licensure requirements.

5. Persons regularly employed by private business firms as personnel managers, deputies or assistants so long as their counseling activities relate only to employees of their employer and in respect to their employment.

6. Any psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction consulting with licensed psychologists in this Commonwealth.

7. Any psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction when in Virginia temporarily and such psychologist has been issued a temporary license by the Board to participate in continuing education programs or rendering psychological services without compensation to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

8. The performance of the duties of any commissioned or contract clinical psychologist in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States while such individual is so commissioned or serving.

9. Any person performing services in the lawful conduct of his particular profession or business under state law.

10. Any person duly licensed as a psychologist in another state or the District of Columbia who testifies as a treating psychologist or who is employed as an expert for the purpose of possibly testifying as an expert witness.

(1976, c. 608, § 54-944; 1986, c. 581; 1988, c. 765; 1996, cc. 937, 980; 2000, c. 462.)

§ 54.1-3602. Administration or prescription of drugs not permitted.

This chapter shall not be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine as defined in Chapter 29 (§ 54.1-2900 et seq.) of this title.

(1976, c. 608, § 54-945; 1988, c. 765.)

§ 54.1-3603. Board of Psychology; membership.

The Board of Psychology shall regulate the practice of psychology. The membership of the Board shall be representative of the practices of psychology and shall consist of nine members as follows: five persons who are licensed as clinical psychologists, one person licensed as a school psychologist, one person licensed as an applied psychologist and two citizen members. At least one of the seven psychologist members of the Board shall be a member of the faculty at an accredited college or university in this Commonwealth actively engaged in teaching psychology. The terms of the members of the Board shall be four years.

(1976, c. 608, § 54-937; 1981, c. 447; 1982, c. 165; 1985, c. 159; 1986, cc. 464, 510; 1988, cc. 42, 765; 1996, cc. 937, 980.)

§ 54.1-3604. Nominations.

Nominations for professional members may be made from a list of at least three names for each vacancy submitted to the Governor by the Virginia Psychological Association, the Virginia Academy of Clinical Psychologists, the Virginia Applied Psychology Academy and the Virginia Academy of School Psychologists. The Governor may notify such organizations of any professional vacancy other than by expiration. In no case shall the Governor be bound to make any appointment from among the nominees.

(1986, c. 464, § 54-937.1; 1988, c. 765; 1996, cc. 937, 980.)

§ 54.1-3605. Powers and duties of the Board.

In addition to the powers granted in other provisions of this title, the Board shall have the following specific powers and duties:

1. To cooperate with and maintain a close liaison with other professional boards and the community to ensure that regulatory systems stay abreast of community and professional needs.

2. To conduct inspections to ensure that licensees conduct their practices in a competent manner and in conformance with the relevant regulations.

3. To designate specialties within the profession.

4. To issue a temporary license for such periods as the Board may prescribe to practice psychology to persons who are engaged in a residency or pursuant to subdivision 7 of § 54.1-3601.

5. To promulgate regulations for the voluntary certification of licensees as sex offender treatment providers.

6. To administer the mandatory certification of sex offender treatment providers for those professionals who are otherwise exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 and to promulgate regulations governing such mandatory certification. The regulations shall include provisions for fees for application processing, certification qualifications, certification issuance and renewal and disciplinary action.

7. To promulgate regulations establishing the requirements for licensure of clinical psychologists that shall include appropriate emphasis in the diagnosis and treatment of persons with moderate and severe mental disorders.

(1976, c. 608, §§ 54-929, 54-931; 1983, c. 115; 1986, cc. 64, 100, 464; 1988, c. 765; 1993, c. 767; 1994, c. 778; 1996, cc. 937, 980; 1997, c. 556; 1999, c. 630; 2001, cc. 186, 198; 2004, c. 11.)

§ 54.1-3606. License required.

A. In order to engage in the practice of applied psychology, school psychology, or clinical psychology, it shall be necessary to hold a license.

B. Notwithstanding the provisions of subdivision 4 of § 54.1-3601 or any Board regulation, the Board of Psychology shall license, as school psychologists-limited, persons licensed by the Board of Education with an endorsement in psychology and a master's degree in psychology. The Board of Psychology shall issue licenses to such persons without examination, upon review of credentials and payment of an application fee in accordance with regulations of the Board for school psychologists-limited.

Persons holding such licenses as school psychologists-limited shall practice solely in public school divisions; holding a license as a school psychologist-limited pursuant to this subsection shall not authorize such persons to practice outside the school setting or in any setting other than the public schools of the Commonwealth, unless such individuals are licensed by the Board of Psychology to offer to the public the services defined in § 54.1-3600.

The Board shall issue persons, holding licenses from the Board of Education with an endorsement in psychology and a license as a school psychologist-limited from the Board of Psychology, a license which notes the limitations on practice set forth in this section.

Persons who hold licenses as psychologists issued by the Board of Psychology without these limitations shall be exempt from the requirements of this section.

(1979, c. 408, § 54-939.1; 1988, c. 765; 1996, cc. 937, 980; 1999, cc. 967, 1005.)

§ 54.1-3606.1. Continuing education.

A. The Board shall promulgate regulations governing continuing education requirements for psychologists licensed by the Board. Such regulations shall require the completion of the equivalent of fourteen hours annually in Board-approved continuing education courses for any license renewal or reinstatement after the effective date.

B. The Board shall approve criteria for continuing education courses that are directly related to the respective license and scope of practice of school psychology, applied psychology and clinical psychology. Approved continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment and care of patients with moderate and severe mental disorders. Any licensed hospital, accredited institution of higher education, or national, state or local health, medical, psychological or mental health association or organization may submit applications to the Board for approval as a provider of continuing education courses satisfying the requirements of the Board's regulations. Approved course providers may be required to register continuing education courses with the Board pursuant to Board regulations. Only courses meeting criteria approved by the Board and offered by a Board-approved provider of continuing education courses may be designated by the Board as qualifying for continuing education course credit.

C. All course providers shall furnish written certification to licensed psychologists attending and completing respective courses, indicating the satisfactory completion of an approved continuing education course. Each course provider shall retain records of all persons attending and those persons satisfactorily completing such continuing education courses for a period of four years following each course. Applicants for renewal or reinstatement of licenses issued pursuant to this article shall retain for a period of four years the written certification issued by any course provider. The Board may require course providers or licensees to submit copies of such records or certification, as it deems necessary to ensure compliance with continuing education requirements.

D. The Board shall have the authority to grant exemptions or waivers or to reduce the number of continuing education hours required in cases of certified illness or undue hardship.

(2000, c. 83.)

§ 54.1-3607. .

Repealed by Acts 1996, cc. 937 and 980.

§ 54.1-3608. .

Repealed by Acts 2001, cc. 186 and 198.

§§ 54.1-3609. , 54.1-3610.

Repealed by Acts 2004, c. 11.

§ 54.1-3611. Restriction of practice; use of titles.

No person, including licensees of the Boards of Counseling; Medicine; Nursing; Psychology; or Social Work, shall claim to be a certified sex offender treatment provider unless he has been so certified. No person who is exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 shall hold himself out as a provider of sex offender treatment services unless he is certified as a sex offender treatment provider by the Board of Psychology.

(1994, c. 778; 1999, c. 630; 2000, c. 473.)

§ 54.1-3612. .

Repealed by Acts 1997, c. 698.

§ 54.1-3613. .

Repealed by Acts 2004, cc. 40 and 68.

§ 54.1-3614. Delegation to unlicensed persons.

Any licensed psychologist may delegate to unlicensed personnel supervised by him such activities or functions as are nondiscretionary and do not require the exercise of professional judgment for their performance and which are usually or customarily delegated to such persons by psychologists, if such activities or functions are authorized by and performed for such psychologist and responsibility for such activities or functions is assumed by such psychologist.

(1996, cc. 937, 980.)

§ 54.1-3615. .

Repealed by Acts 2004, c. 64.

§ 54.1-3616. Use of title "Doctor.".

No person regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in advertising in connection with his practice unless he simultaneously uses a clarifying title, initials, abbreviation or designation or language that identifies the type of practice for which he is licensed.

(1996, cc. 937, 980.)

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF PSYCHOLOGY

VIRGINIA BOARD OF PSYCHOLOGY

Title of Regulations: 18 VAC 125-20-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 36 of Title 54.1 of the *Code of Virginia*

Revised Date: March 9, 2017

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Phone: (804) 367-4697
FAX: (804) 527-4435
psy@dhp.virginia.gov

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Part I. General Provisions.

18VAC125-20-10. Definitions.

The following words and terms, in addition to the words and terms defined in §54.1-3600 of the Code of Virginia, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"APA" means the American Psychological Association.

"APPIC" means the Association of Psychology Postdoctoral and Internship Centers.

"Board" means the Virginia Board of Psychology.

"Candidate for licensure" means a person who has satisfactorily completed the appropriate educational and experience requirements for licensure and has been deemed eligible by the board to sit for the required examinations.

"Demonstrable areas of competence" means those therapeutic and assessment methods and techniques, and populations served, for which one can document adequate graduate training, workshops, or appropriate supervised experience.

"Internship" means an ongoing, supervised and organized practical experience obtained in an integrated training program identified as a psychology internship. Other supervised experience or on-the-job training does not constitute an internship.

"NASP" means the National Association of School Psychologists.

"NCATE" means the National Council for the Accreditation of Teacher Education.

"Practicum" means the pre-internship clinical experience that is part of a graduate educational program.

"Professional psychology program" means an integrated program of doctoral study designed to train professional psychologists to deliver services in psychology.

"Regional accrediting agency" means one of the six regional accrediting agencies recognized by the United States Secretary of Education established to accredit senior institutions of higher education.

"Residency" means a post-internship, post-terminal degree, supervised experience approved by the board.

"School psychologist-limited" means a person licensed pursuant to §54.1-3606 of the Code of Virginia to provide school psychology services solely in public school divisions.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual consultation, guidance and instruction with respect to the skills and competencies of the person supervised.

"Supervisor" means an individual who assumes full responsibility for the education and training activities of a person and provides the supervision required by such a person.

18VAC125-20-20. [Repealed]

18VAC125-20-30. Fees required by the board.

A. The board has established fees for the following:

	Clinical psychologists Applied psychologists School psychologists	School psychologists-limited
1. Registration of residency (per residency request)	$50	
2. Add or change supervisor	$25	
3. Application processing and initial licensure	$200	$85
4. Annual renewal of active license	$140	$70
5. Annual renewal of inactive license	$70	$35
6. Late renewal	$50	$25
7. Verification of license to another jurisdiction	$25	$25
8. Duplicate license	$5	$5
9. Additional or replacement wall certificate	$15	$15
10. Returned check	$35	$35
11. Reinstatement of a lapsed license	$270	$125
12. Reinstatement following revocation or suspension	$500	$500

B. Fees shall be made payable to the Treasurer of Virginia and forwarded to the board. All fees are nonrefundable.

C. Between April 30, 2016 and June 30, 2016, the following renewal fees shall be in effect:

1. For an active license as a clinical, applied or school psychologist, it shall be $84. For an inactive license as a clinical, applied or school psychologist, it shall be $42.

2. For an active license as a school psychologist-limited, it shall be $42. For an inactive license as a school psychologist-limited, it shall be $21.

Part II. Requirements for Licensure.

18VAC125-20-40. General requirements for licensure.

Individuals licensed in one licensure category who wish to practice in another licensure category shall submit an application for the additional licensure category in which the licensee seeks to practice.

18VAC125-20-41. Requirements for licensure by examination.

A. Every applicant for examination for licensure by the board shall:

1. Meet the education requirements prescribed in 18VAC125-20-54, 18VAC125-20-55, or 18VAC125-20-56 and the experience requirement prescribed in 18VAC125-20-65 as applicable for the particular license sought; and

2. Submit the following:

a. A completed application on forms provided by the board;

b. A completed residency agreement or documentation of having fulfilled the experience requirements of 18VAC125-20-65;

c. The application processing fee prescribed by the board;

d. Official transcripts documenting the graduate work completed and the degree awarded; transcripts previously submitted for registration of supervision do not have to be resubmitted unless additional coursework was subsequently obtained. Applicants who are graduates of institutions that are not regionally accredited shall submit documentation from an accrediting agency acceptable to the board that their education meets the requirements set forth in 18VAC125-20-54, 18VAC125-20-55 or 18VAC125-20-56; and

e. Verification of any other health or mental health professional license or certificate ever held in another jurisdiction.

B. In addition to fulfillment of the education and experience requirements, each applicant for licensure by examination must achieve a passing score on the Examination for Professional Practice of Psychology.

C. Every applicant shall attest to having read and agreed to comply with the current standards of practice and laws governing the practice of psychology in Virginia.

18VAC125-20-42. Prerequisites for licensure by endorsement.

Every applicant for licensure by endorsement shall submit:

1. A completed application;

2. The application processing fee prescribed by the board;

3. An attestation of having read and agreed to comply with the current Standards of Practice and laws governing the practice of psychology in Virginia;

4. Verification of all other health and mental health professional licenses or certificates ever held in any jurisdiction. In order to qualify for endorsement, the applicant shall not have surrendered a license or certificate while under investigation and shall have no unresolved action against a license or certificate;

5. A current report from the National Practitioner Data Bank; and

6. Further documentation of one of the following:

a. A current listing in the National Register of Health Service Psychologists;

b. Current diplomate status in good standing with the American Board of Professional Psychology in a category comparable to the one in which licensure is sought;

c. A Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards;

d. Ten years of active licensure in a category comparable to the one in which licensure is sought, with an appropriate degree as required in this chapter documented by an official transcript; or

e. If less than 10 years of active licensure, documentation of current psychologist licensure in good standing obtained by standards substantially equivalent to the education, experience and examination requirements set forth in this chapter for the category in which licensure is sought as verified by a certified copy of the original application submitted directly from the out-of-state licensing agency or a copy of the regulations in effect at the time of initial licensure and the following:

(1) Documentation of post-licensure active practice for at least 24 of the last sixty months immediately preceding licensure application;

(2) Verification of a passing score on the Examination for Professional Practice of Psychology as established in Virginia for the year of that administration; and

(3) Official transcripts documenting the graduate work completed and the degree awarded in the category in which licensure is sought.

18VAC125-20-43. Requirements for licensure as a school psychologist-limited.

A. Every applicant for licensure as a school psychologist-limited shall submit to the board:

1. A copy of a current license issued by the Board of Education showing an endorsement in psychology.

2. An official transcript showing completion of a master's degree in psychology.

3. A completed Employment Verification Form of current employment by a school system under the Virginia Department of Education.

4. The application fee.

B. At the time of licensure renewal, school psychologists-limited shall be required to submit an updated Employment Verification Form if there has been a change in school district in which the licensee is currently employed.

18VAC125-20-50 to 18VAC125-20-53. [Repealed]

18VAC125-20-54. Education requirements for clinical psychologists.

A. The applicant shall hold a doctorate from a professional psychology program in a regionally accredited university, which was accredited by the APA in clinical or counseling psychology within four years after the applicant graduated from the program, or shall meet the requirements of subsection B of this section.

B. If the applicant does not hold a doctorate from an APA accredited program, the applicant shall hold a doctorate from a professional psychology program which documents that it offers education and training which prepares individuals for the practice of clinical psychology as defined in §54.1-3600 of the Code of Virginia and which meets the following criteria:

1. The program is within an institution of higher education accredited by an accrediting agency recognized by the United States Department of Education or publicly recognized by the Association of Universities and Colleges of Canada as a member in good standing. Graduates of programs that are not within the United States or Canada must provide documentation from an acceptable credential evaluation service which provides information that allows the board to determine if the program meets the requirements set forth in this chapter.

2. The program shall be recognizable as an organized entity within the institution.

3. The program shall be an integrated, organized sequence of study with an identifiable psychology faculty and a psychologist directly responsible for the program, and shall have an identifiable body of students who are matriculated in that program for a degree. The faculty shall be accessible to students and provide them with guidance and supervision. The faculty shall provide appropriate professional role models and engage in actions that promote the student's acquisition of knowledge, skills and competencies consistent with the program's training goals.

4. The program shall encompass a minimum of three academic years of full-time graduate study or the equivalent thereof.

5. The program shall include a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in each of the following substantive content areas.

a. Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy).

b. Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion).

c. Social bases of behavior (e.g., social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues).

d. Psychological measurement.

e. Research methodology.

f. Techniques of data analysis.

g. Professional standards and ethics.

6. The program shall include a minimum of at least three or more graduate semester credit hours or five or more graduate quarter hours in each of the following clinical psychology content areas:

a. Individual differences in behavior (e.g., personality theory, cultural difference and diversity).

b. Human development (e.g., child, adolescent, geriatric psychology).

c. Dysfunctional behavior, abnormal behavior or psychopathology.

d. Theories and methods of intellectual assessment and diagnosis.

e. Theories and methods of personality assessment and diagnosis including its practical application.

f. Effective interventions and evaluating the efficacy of interventions.

C. Applicants shall submit documentation of having successfully completed practicum experiences in assessment and diagnosis, psychotherapy, consultation and supervision. The practicum shall include a minimum of nine graduate semester hours or 15 or more graduate quarter hours or equivalent in appropriate settings to ensure a wide range of supervised training and educational experiences.

D. An applicant for a clinical license may fulfill the residency requirement of 1,500 hours, or some part thereof, as required for licensure in 18VAC125-20-65 B, in the pre-doctoral practicum supervised experience that meets the following standards:

1. The supervised professional experience shall be part of an organized sequence of training within the applicant's doctoral program, which meets the criteria specified in subsections A or B of this section.

2. The supervised experience shall include face-to-face direct client services, service-related activities, and supporting activities.

a. "Face-to-face direct client services" means treatment/intervention, assessment, and interviewing of clients.

b. "Service-related activities" means scoring, reporting or treatment note writing, and consultation related to face-to-face direct services.

c. "Supporting activities" means time spent under supervision of face-to-face direct services and service-related activities provided on-site or in the trainee's academic department, as well as didactic experiences, such as laboratories or seminars, directly related to such services or activities.

3. In order for pre-doctoral practicum hours to fulfill the all or part of the residency requirement, the following shall apply:

a. Not less than one-quarter of the hours shall be spent in providing face-to-face direct client services;

b. Not less than one-half of the hours shall be in a combination of face-to-face direct service hours and hours spent in service-related activities; and

c. The remainder of the hours may be spent in a combination of face-to-face direct services, service-related activities, and supporting activities.

4. A minimum of one hour of individual face-to-face supervision shall be provided for every eight hours of supervised professional experience spent in direct client contact and service-related activities.

5. Two hours of group supervision with up to five practicum students may be substituted for one hour of individual supervision. In no case shall the hours of individual supervision be less than one-half of the total hours of supervision.

6. The hours of pre-doctoral supervised experience reported by an applicant shall be certified by the program's director of clinical training on a form provided by the board.

18VAC125-20-55. Education requirements for applied psychologists.

A. The applicant shall hold a doctorate from a professional psychology program from a regionally accredited university which meets the following criteria:

1. The program is within an institution of higher education accredited by an accrediting agency recognized by the United States Department of Education, or publicly recognized by the Association of Universities and Colleges of Canada as a member in good standing. Graduates of programs that are not within the United States or Canada must provide documentation from a credential evaluation service acceptable to the board which demonstrates that the program meets the requirements set forth in this chapter.

2. The program shall be recognizable as an organized entity within the institution.

3. The program shall be an integrated, organized sequence of study with an identifiable psychology faculty and a psychologist directly responsible for the program, and shall have an identifiable body of students who are matriculated in that program for a degree. The faculty shall be accessible to students and provide them with guidance and supervision. The faculty shall provide appropriate professional role models and engage in actions that promote the student's acquisition of knowledge, skills and competencies consistent with the program's training goals.

4. The program shall encompass a minimum of three academic years of full-time graduate study or the equivalent thereof.

5. The program shall include a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in each of the following substantive content areas.

a. Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy).

b. Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion).

c. Social bases of behavior (e.g., social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues).

d. Psychological measurement.

e. Research methodology.

f. Techniques of data analysis.

g. Professional standards and ethics.

B. Demonstration of competence in applied psychology shall be met by including a minimum of at least 18 semester hours or 30 quarter hours in a concentrated program of study in an identified area of psychology, e.g., developmental, social, cognitive, motivation, applied behavioral analysis, industrial/organizational, human factors, personnel selection and evaluation, program planning and evaluation, teaching, research or consultation.

18VAC125-20-56. Education requirements for school psychologists.

A. The applicant shall hold at least a master's degree in school psychology, with a minimum of at least 60 semester credit hours or 90 quarter hours, from a college or university accredited by a regional accrediting agency, which was accredited by the APA, NCATE or NASP, or shall meet the requirements of subsection B of this section.

B. If the applicant does not hold a master's degree in school psychology from a program accredited by the APA, NCATE or NASP, the applicant shall have a master's degree from a psychology program which offers education and training to prepare individuals for the practice of school psychology as defined in §54.1-3600 of the Code of Virginia and which meets the following criteria:

1. The program is within an institution of higher education accredited by an accrediting agency recognized by the United States Department of Education, or publicly recognized by the Association of Universities and Colleges of Canada as a member in good standing. Graduates of programs that are not within the United States or Canada must provide documentation from a credential evaluation service acceptable to the board which demonstrates that the program meets the requirements set forth in this chapter.

2. The program shall be recognizable as an organized entity within the institution.

3. The program shall be an integrated, organized sequence of study with an identifiable psychology faculty and a psychologist directly responsible for the program, and shall have an identifiable body of students who are matriculated in that program for a degree. The faculty shall be accessible to students and provide them with guidance and supervision. The faculty shall provide appropriate

professional role models and engage in actions that promote the student's acquisition of knowledge, skills and competencies consistent with the program's training goals.

4. The program shall encompass a minimum of two academic years of full-time graduate study or the equivalent thereof.

5. The program shall include a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in each of the following substantive content areas.

a. Psychological foundations (e.g., biological bases of behavior, human learning, social and cultural bases of behavior, child and adolescent development, individual differences).

b. Educational foundations (e.g., instructional design, organization and operation of schools).

c. Interventions/problem-solving (e.g., assessment, direct interventions, both individual and group, indirect interventions).

d. Statistics and research methodologies (e.g., research and evaluation methods, statistics, measurement).

e. Professional school psychology (e.g., history and foundations of school psychology, legal and ethical issues, professional issues and standards, alternative models for the delivery of school psychological services, emergent technologies, roles and functions of the school psychologist).

6. The program shall be committed to practicum experiences which shall include:

a. Orientation to the educational process;

b. Assessment for intervention;

c. Direct intervention, including counseling and behavior management; and

d. Indirect intervention, including consultation.

18VAC125-20-60. [Repealed]

18VAC125-20-65. Supervised experience.

A. Internship requirement.

1. Candidates for clinical psychologist licensure shall have successfully completed an internship that is either accredited by APA, APPIC, or the Association of State and Provincial Psychology Boards/National Register of Health Service Psychologists, or one that meets equivalent standards.

2. Candidates for school psychologist licensure shall have successfully completed an internship accredited by the APA, APPIC or NASP or one that meets equivalent standards.

B. Residency requirement.

1. Candidates for clinical or school psychologist licensure shall have successfully completed a residency consisting of a minimum of 1,500 hours in a period of not less than 12 months and not to exceed three years of supervised experience in the delivery of clinical or school psychology services acceptable to the board, or the applicant may request approval to begin a residency

2. Supervised experience obtained in Virginia without prior written board approval will not be accepted toward licensure. Candidates shall not begin the residency until after completion of the required degree as set forth in 18VAC125-20-54 or 18VAC125-20-56. An individual who proposes to obtain supervised post-degree experience in Virginia shall, prior to the onset of such supervision, submit a supervisory contract along with the application package and pay the registration of supervision fee set forth in 18VAC125-20-30.

3. There shall be a minimum of two hours of individual supervision per week. Group supervision of up to five residents may be substituted for one of the two hours per week on the basis that two hours of group supervision equals one hour of individual supervision, but in no case shall the resident receive less than one hour of individual supervision per week.

4. Residents may not refer to or identify themselves as applied psychologists, clinical psychologists, or school psychologists; independently solicit clients; bill for services; or in any way represent themselves as licensed psychologists. Notwithstanding the above, this does not preclude supervisors or employing institutions for billing for the services of an appropriately identified resident. During the residency period they shall use their names, the initials of their degree, and the title, "Resident in Psychology," in the licensure category in which licensure is sought.

5. Supervision shall be provided by a psychologist licensed to practice in the licensure category in which the resident is seeking licensure.

6. The supervisor shall not provide supervision for activities beyond the supervisor's demonstrable areas of competence, nor for activities for which the applicant has not had appropriate education and training.

7. At the end of the residency training period, the supervisor or supervisors shall submit to the board a written evaluation of the applicant's performance.

8. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervisors.

C. For a clinical psychologist license, a candidate may submit evidence of having met the supervised experience requirements in a pre-doctoral practicum as specified in 18VAC125-20-54 D in substitution for all or part of the 1,500 residency hours specified in this section. If the supervised experience hours completed in a practicum do not total 1,500 hours, a person may fulfill the remainder of the hours by meeting requirements specified in subsection B of this section.

D. Candidates for clinical psychologist licensure shall provide documentation that the internship and residency included appropriate emphasis and experience in the diagnosis and treatment of persons with moderate to severe mental disorders.

18VAC125-20-70. [Repealed]

Part III. Examinations.

18VAC125-20-80. General examination requirements.

A. An applicant for clinical or school psychologist licensure enrolled in an approved residency training program required in 18VAC125-20-65 who has met all requirements for licensure except completion of that program shall be eligible to take the national written examinations.

B. A candidate approved by the board to sit for an examination shall take that examination within two years of the date of the initial board approval. If the candidate has not taken the examination by the end of the two-year period here prescribed, the applicant shall reapply according to the requirements of the regulations in effect at that time.

C. The board shall establish passing scores on the examination.

18VAC125-20-90 to 18VAC125-20-110. [Repealed]

Part V. Licensure Renewal; Reinstatement.

18VAC125-20-120. Annual renewal of licensure.

Every license issued by the board shall expire each year on June 30.

1. Every licensee who intends to continue to practice shall, on or before the expiration date of the license, submit to the board a license form supplied by the board and the renewal fee prescribed in 18VAC125-20-30.

2. Licensees who wish to maintain an active license shall pay the appropriate fee and verify on the renewal form compliance with the continuing education requirements prescribed in 18VAC125-20-121. First-time licensees by examination are not required to verify continuing education on the first renewal date following initial licensure.

3. A licensee who wishes to place his license in inactive status may do so upon payment of the fee prescribed in 18VAC125-20-30. No person shall practice psychology in Virginia unless he holds a current active license. An inactive licensee may activate his license by fulfilling the reactivation requirements set forth in 18VAC125-20-130.

4. Licensees shall notify the board office in writing of any change of address of record or of the public address, if different from the address of record. Failure of a licensee to receive a renewal notice and application forms from the board shall not excuse the licensee from the renewal requirement.

18VAC125-20-121. Continuing education course requirements for renewal of an active license.

A. Licensees shall be required to have completed a minimum of 14 hours of board-approved continuing education courses each year for annual licensure renewal. A minimum of 1.5 of these hours shall be in courses that emphasize the ethics, laws, and regulations governing the profession of psychology, including the standards of practice set out in 18VAC125-20-150. A licensee who completes continuing education hours in excess of the 14 hours may carry up to seven hours of continuing education credit forward to meet the requirements for the next annual renewal cycle.

B. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the practice of psychology and is provided by a board-approved provider that meets the criteria specified in 18VAC125-20-122.

1. At least six of the required hours shall be earned in face-to-face or real-time interactive educational experiences. Real-time interactive shall include a course in which the learner has the opportunity to interact with the presenter and participants during the time of the presentation.

2. The board may approve up to four hours per renewal cycle for specific educational experiences to include:

a. Preparation for or presentation of a continuing education program, seminar, workshop or course offered by an approved provider and directly related to the practice of psychology. Hours may only be credited one time, regardless of the number of times the presentation is given, and may not be credited toward the face-to-face requirement.

b. Publication of an article or book in a recognized publication directly related to the practice of psychology. Hours may only be credited one time, regardless of the number of times the writing is published, and may not be credited toward the face-to-face requirement.

3. The board may approve up to two hours per renewal cycle for membership on a state licensing board in psychology.

C. Courses must be directly related to the scope of practice in the category of licensure held. Continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment and care of patients with moderate and severe mental disorders.

D. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

E. The board may grant an exemption for all or part of the continuing education requirements for one renewal cycle due to circumstances determined by the board to be beyond the control of the licensee.

F. Up to two of the 14 continuing education hours required for renewal may be satisfied through delivery of psychological services, without compensation, to low-income individuals receiving mental health services through a local health department or a free clinic organized in whole or primarily for the delivery of those health services as verified by the department or clinic. Three hours of volunteer service is required for one hour of continuing education credit.

18VAC125-20-122. Continuing education providers.

A. The following organizations, associations or institutions are approved by the board to provide continuing education:

1. Any psychological association recognized by the profession or providers approved by such an association.

2. Any association or organization of mental health, health or psychoeducational providers recognized by the profession or providers approved by such an association or organization.

3. Any association or organization providing courses related to forensic psychology recognized by the profession or providers approved by such an association or organization.

4. Any regionally accredited institution of higher learning. A maximum of 14 hours will be accepted for each academic course directly related to the practice of psychology.

5. Any governmental agency or facility that offers mental health, health or psychoeducational services.

6. Any licensed hospital or facility that offers mental health, health or psychoeducational services.

7. Any association or organization that has been approved as a continuing competency provider by a psychology board in another state or jurisdiction.

B. Continuing education providers approved under subsection A of this section shall:

1. Maintain documentation of the course titles and objectives and of licensee attendance and completion of courses for a period of four years.

2. Monitor attendance at classroom or similar face-to-face educational experiences.

3. Provide a certificate of completion for licensees who successfully complete a course.

18VAC125-20-123. Documenting compliance with continuing education requirements.

A. All licensees in active status are required to maintain original documentation for a period of four years.

B. After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.

C. Upon request, a licensee shall provide documentation as follows:

1. Official transcripts showing credit hours earned from an accredited institution; or

2. Certificates of completion from approved providers.

D. Compliance with continuing education requirements, including the maintenance of records and the relevance of the courses to the category of licensure, is the responsibility of the licensee. The board may request additional information if such compliance is not clear from the transcripts or certificates.

E. Continuing education hours required by disciplinary order shall not be used to satisfy renewal requirements.

18VAC125-20-130. Late renewal; reinstatement; reactivation.

A. A person whose license has expired may renew it within one year after its expiration date by paying the penalty fee prescribed in 18VAC125-20-30 and the license renewal fee for the year the license was not renewed.

B. A person whose license has not been renewed for one year or more and who wishes to resume practice shall:

1. Present evidence to the board of having met all applicable continuing education requirements equal to the number of years the license has lapsed, not to exceed four years;

2. Pay the reinstatement fee as prescribed in 18VAC125-20-30; and

3. Submit verification of any professional certification or licensure obtained in any other jurisdiction subsequent to the initial application for licensure.

C. A psychologist wishing to reactivate an inactive license shall submit the renewal fee for active licensure minus any fee already paid for inactive licensure renewal, and document completion of continued competency hours equal to the number of years the license has been inactive, not to exceed four years.

18VAC125-20-140. [Repealed]

Part VI. Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement.

18VAC125-20-150. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Psychologists respect the rights, dignity and worth of all people, and are mindful of individual differences.

B. Persons licensed by the board shall:

1. Provide and supervise only those services and use only those techniques for which they are qualified by training and appropriate experience. Delegate to their employees, supervisees, residents and research assistants only those responsibilities such persons can be expected to perform

competently by education, training and experience. Take ongoing steps to maintain competence in the skills they use;

2. When making public statements regarding credentials, published findings, directory listings, curriculum vitae, etc., ensure that such statements are neither fraudulent nor misleading;

3. Neither accept nor give commissions, rebates or other forms of remuneration for referral of clients for professional services. Make appropriate consultations and referrals consistent with the law and based on the interest of patients or clients;

4. Refrain from undertaking any activity in which their personal problems are likely to lead to inadequate or harmful services;

5. Avoid harming patients or clients, research participants, students and others for whom they provide professional services and minimize harm when it is foreseeable and unavoidable. Not exploit or mislead people for whom they provide professional services. Be alert to and guard against misuse of influence;

6. Avoid dual relationships with patients, clients, residents or supervisees that could impair professional judgment or compromise their well-being (to include but not limited to treatment of close friends, relatives, employees);

7. Withdraw from, adjust or clarify conflicting roles with due regard for the best interest of the affected party or parties and maximal compliance with these standards;

8. Not engage in sexual intimacies or a romantic relationship with a student, supervisee, resident, therapy patient, client, or those included in collateral therapeutic services (such as a parent, spouse, or significant other) while providing professional services. For at least five years after cessation or termination of professional services, not engage in sexual intimacies or a romantic relationship with a therapy patient, client, or those included in collateral therapeutic services. Consent to, initiation of, or participation in sexual behavior or romantic involvement with a psychologist does not change the exploitative nature of the conduct nor lift the prohibition. Since sexual or romantic relationships are potentially exploitative, psychologists shall bear the burden of demonstrating that there has been no exploitation;

9. Keep confidential their professional relationships with patients or clients and disclose client records to others only with written consent except: (i) when a patient or client is a danger to self or others, (ii) as required under §32.1-127.1:03 of the Code of Virginia, or (iii) as permitted by law for a valid purpose;

10. Make reasonable efforts to provide for continuity of care when services must be interrupted or terminated;

11. Inform clients of professional services, fees, billing arrangements and limits of confidentiality before rendering services. Inform the consumer prior to the use of collection agencies or legal measures to collect fees and provide opportunity for prompt payment. Avoid bartering goods and services. Participate in bartering only if it is not clinically contraindicated and is not exploitative;

12. Construct, maintain, administer, interpret and report testing and diagnostic services in a manner and for purposes which are appropriate;

13. Keep pertinent, confidential records for at least five years after termination of services to any consumer;

14. Design, conduct and report research in accordance with recognized standards of scientific competence and research ethics; and

15. Report to the board known or suspected violations of the laws and regulations governing the practice of psychology.

18VAC125-20-160. Grounds for disciplinary action or denial of licensure.

The board may take disciplinary action or deny a license for any of the following causes:

1. Conviction of a felony, or a misdemeanor involving moral turpitude;

2. Procuring of a license by fraud or misrepresentation;

3. Misuse of drugs or alcohol to the extent that it interferes with professional functioning;

4. Negligence in professional conduct or violation of practice standards including but not limited to this chapter;

5. Performing functions outside areas of competency;

6. Mental, emotional, or physical incompetence to practice the profession;

7. Failure to comply with the continued competency requirements set forth in this chapter; or

8. Violating or aiding and abetting another to violate any statute applicable to the practice of the profession regulated or any provision of this chapter.

18VAC125-20-170. Reinstatement following disciplinary action.

A. Any person whose license has been revoked by the board under the provisions of 18VAC125-20-160 may, three years subsequent to such board action, submit a new application to the board for reinstatement of licensure. The board in its discretion may, after a hearing, grant the reinstatement.

B. The applicant for such reinstatement, if approved, shall be licensed upon payment of the appropriate fee applicable at the time of reinstatement.

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

American Psychological Association

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

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

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Correspondence concerning this article should be directed to the Public Interest Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

This document is scheduled to expire as APA policy by 2009. After this date, users are encouraged to contact the APA Public Interest Directorate to confirm the status of the document.

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Preface

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

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

In these Guidelines, education refers to the psychological education of students in all areas of psychology, while training refers more specifically to the application of that education to the development of applied and research skills. We refer to research that

involves human participants, rather than research using animals or mathematical simulations. Practice refers to interventions with children, adolescents, adults, families, and organizations, typically conducted by clinical, consulting, counseling, organizational, and school psychologists. Finally, we focus on the work of psychologists as administrators, consultants, and in other organizational management roles positioned to promote organizational change and policy development.

These Guidelines address U.S. ethnic and racial minority[1] groups as well as individuals, children, and families from biracial, multiethnic, and multiracial backgrounds. Thus, we are defining "multicultural" in these Guidelines narrowly, to refer to interactions between individuals from minority ethnic and racial groups in the United States and the dominant European-American culture. Ethnic and racial minority group membership includes individuals of Asian and Pacific Islander, Sub-Saharan Black African, Latino/Hispanic, and Native American/American Indian descent, although there is great heterogeneity within each of these groups. The Guidelines also address psychologists' work and interactions with individuals from other nations, including international students and immigrants and temporary workers in this country.

The term "guidelines" refers to pronouncements, statements or declarations that suggest or recommend specific professional behavior, endeavors or conduct for psychologists (APA, 1992). Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism (APA, 2001). They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional

and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists. In addition, federal or state laws may supercede these Guidelines.

Scope of Guidelines

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

While these Guidelines have attempted to incorporate empirical studies of intergroup relations and ethnic identity, professional consensus, and other perceptions and experiences of ethnic and racial minority groups, it is beyond the scope of this document to provide a thorough and comprehensive review of all literature related to race, ethnicity, intergroup processes, and organizational development strategies to

address multiculturalism in employment and professional education contexts. Rather, we have attempted to provide examples of empirical and conceptual literature relevant to the Guidelines where possible.

Racial/Ethnic Diversity in the United States and Psychology

Individuals of ethnic and racial minority and/or with a biracial/multiethnic/multiracial heritage represent an increasingly large percentage of the population in the United States (Judy & D'Amico, 1997; United States Census Bureau, 2001; Wehrly, Kenney, & Kenney, 1999). While these demographic trends have been discussed since the previous census of 1990, educational institutions, employers, government agencies, and professional and accrediting bodies are now beginning to engage in systematic efforts to become more knowledgeable, proficient, and multiculturally responsive. Census 2000 data clarify the changes in U.S. diversity (U.S. Census Bureau, 2001). Overall, about 67% of the population identify as White. Of the remaining 33%, approximately 13% indicated they were African American, 1.5% American Indian or Alaskan Native, 4.5% Asian/Pacific Islander, 13% Hispanic, and about 7% indicated some other race. These categories overlap, since individuals were able to choose more than one racial affiliation. Racial/ethnic diversity varies greatly by state. Summarized in a series of maps by Brewer and Suchan from the Census 2000 data (2001), high diversity states (those with 60-77% racial/ethnic minority groups) tend to be on the coast, or Mexican border and include California, Texas, Arizona, New Mexico, and Virginia. In addition to these, however, medium-high diversity (49%-59% racial/ethnic minority groups) states are found across the country, and include Maryland, New York, Illinois, Washington State, Nevada, Colorado, Montana, Alaska, North

Dakota, South Dakota, Minnesota, Wisconsin, Michigan, Arkansas, Louisiana, Alabama, and North and South Carolina.

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

Ethnic, racial, and multiracial diversity in the population is reflected in higher education. This is important to psychologists because it reflects changes in the ethnic composition of students we teach and train. College enrollment increased 62% for students of color between 1988 and 1998 (the latest data available), although college completion rates differed among Whites and racial/ethnic minority students. College completion rates in 2000 (U.S. Census Bureau, 2001) for White individuals between 25-29 years was 29.6%, compared to 17.8% for African Americans, 53.9% for Asian/Pacific Islander Americans, and 9.7% for Hispanics. Corresponding statistics in 1991 vs. 1974,

were 24.6% vs. 22% for Whites, 11% vs. 7.9% for African Americans/Blacks, and 9.2% vs. 5.7% for Hispanics. Data for Hispanics were first collected in 1974; data for Asian/Pacific Islanders were not collected until the mid-90's. Clearly these data indicate that racial/ethnic minority students are graduating at a lower rate than White students, but the data also show that they are making educational gains.

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

Thus, racial/ethnic minority students, either because of personal or because of environmental reasons (e.g., discrimination and barriers due to external constraints),

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

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

Also informing these Guidelines is research, professional consensus, and literature addressing perceptions of ethnic minority groups and intergroup relationships

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

Definitions

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

Culture. "Culture" is defined as the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations (media, educational systems; Fiske, Kitayama, Markus, & Nisbett, 1998). Inherent in this definition is the acknowledgement that all individuals are cultural beings and have a cultural, ethnic, and racial heritage. Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group. These definitions

suggest that culture is fluid and dynamic, and that there are both cultural universal phenomena as well as culturally specific or relative constructs.

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

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

Multiculturalism and Diversity. The terms "multiculturalism" and "diversity" have been used interchangeably to include aspects of identity stemming from gender, sexual orientation, disability, socioeconomic status, or age. Multiculturalism, in an absolute sense, recognizes the broad scope of dimensions of race, ethnicity, language,

sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions. All of these are critical aspects of an individual's ethnic/racial and personal identity, and psychologists are encouraged to be cognizant of issues related to all of these dimensions of culture. In addition, each cultural dimension has unique issues and concerns. As noted by the Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000), each individual belongs to/identifies with a number of identities and some of those identities interact with each other. To effectively help clients, to effectively train students, to be most effective as agents of change and as scientists, psychologists are encouraged to be familiar with issues of these multiple identities within and between individuals. However, as we noted earlier, in these Guidelines, we will use the term multicultural rather narrowly, to connote interactions between racial/ethnic groups in the U.S. and the implications for education, training, research, practice, and organizational change.

The concept of diversity has been widely used in employment settings, with the term given greater visibility through research by the Hudson Institute reported in *Workforce 2000* (Johnson & Packer, 1987) and *Workforce 2020* (Judy & D'Amico, 1997). The application of the term began with reference to women and Persons of Color, underrepresented in the workplace, particularly in decision-making roles. It has since evolved to be more encompassing in its intent and application by referring to individuals' social identities including age, sexual orientation, physical disability, socioeconomic status, race/ethnicity, workplace role/position, religious and spiritual orientation, and work/family concerns (Loden, 1996).

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

Historical and Sociopolitical Developments for Guidelines

There are a number of national events, APA-specific developments, and initiatives of other related professional associations that provide an historical context for the development of multicultural and culture-specific guidelines, with a focus on racial/ethnic minority groups. Nationally, in 1954, the Supreme Court struck down the "separate but equal" doctrine of segregated education. Benjamin and Crouse (2002) note that in addition to setting the stage for greater social equity in education, *Brown vs Board of Education* was an important turning point for psychology, because it was the "first time that psychological research was cited in a Supreme Court decision" (p. 38). A decade later, the 1964 passage of the Civil Rights Act set the stage for sociopolitical movements and the development of additional legislation to protect individual and group rights at national, state, and local levels. These movements and resulting legislation have

specifically addressed the rights of equity and access based on gender, age, disability, national origin, religion, sexual orientation, and of course, ethnicity and race. However, it is also important to note that movements to dismantle Affirmative Action in California, Michigan, and Texas, are sociopolitical efforts that threaten the advancement of the rights of individuals and groups historically marginalized.

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

Psychologists' perspective of the role of race in education has been addressed for nearly a century (a historical perspective is provided by Suzuki & Valencia, 1997). Indeed the construct of race, culture, and intergroup relationships have been areas of research for psychologists since nearly the beginning of psychology, including Clark & Clark (1940), Allport (1954), and Lewin (1945) (see Duckitt, 1992, for a historical review).

Within the profession of psychology, attention to culture as a variable in clinical practice was first mentioned at the Vail Conference of 1973 (Korman, 1974). One of the recommendations from this conference was to include training in cultural diversity in all

doctoral programs and through continuing education workshops. Attention to appropriate training based on multicultural and culture-specific constructs and contexts continued through the next two decades. The APA Committee on Accreditation's "Accreditation Domains and Standards" included cultural diversity as a component of effective training in 1986 and continuing to the 2002 guidelines (APA, 2002). These efforts recognize the importance of cultural and individual differences and diversity in the training of clinical, counseling, and school psychologists. Subsequently, the training councils of these disciplines began to incorporate cultural diversity into their model programs, including the Council of Counseling Psychology's model training program in counseling psychology (Murdock, Alcorn, Heesacker, & Stoltenberg, 1998), and Standards of the National Council of Schools and Programs of Professional Psychology (Peng & Nisbett, 1999).

Concomitantly, changes to reflect greater attention to cultural diversity were occurring through structural and functional changes within the APA organization. The Office of Ethnic Minority Affairs (OEMA) was established in 1979. A year later the Board of Ethnic Minority Affairs (BEMA) was established. BEMA was charged with promoting the scientific underpinning of the influence and impact of culture, race, and ethnicity on individuals' behavior, as well as advancing the participation of ethnic minority psychologists within the organization. BEMA established a Task Force on Minority Education and Training in 1981, and a second Task Force on Communication with Minority Constituents was formed in 1984. In 1990, the Board for the Advancement of Psychology in the Public Interest (BAPPI) was formed, as was the Committee on Ethnic Minority Affairs (CEMA). These entities replaced BEMA within APA's governance

structure. The Commission on Ethnic Minority Recruitment, Retention, and Training was formed in 1994, and published a report and 5-year plan to increase the number of students in psychology. These multiple efforts of APA and the Divisions began to culminate in the production of policy. The *General Guidelines for Providers of Psychological Services* were "developed with the understanding that psychological services must be planned and implemented so that they are sensitive to factors related to life in a pluralistic society such as age, gender, affectional orientation, culture and ethnicity" (APA, 1987).

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

The current Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change have developed as a result of the sociopolitical environment within the United States and the resulting work of psychologists within the professional organization. While there have been a variety of organizational initiatives that have focused on race and ethnicity, these Guidelines are the first to address the implications of race and ethnicity in psychological education, training, research, practice and organizational change. These Guidelines are the latest step in an on-going effort to provide psychologists in the United States with a framework for services to an

increasingly diverse population and to assist psychologists in the provision of those services. In effect, there is a societal and guild/organizational history steadily indicating a rationale for attending to a multicultural and culture-specific agenda more formally.

Introduction to the Guidelines: Assumptions and Principles

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

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

and societal racism, prejudice, and all forms of oppression based on stereotyping and discrimination.

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

1. Ethical conduct of psychologists is enhanced by knowledge of differences in beliefs and practices that emerge from socialization through racial and ethnic group affiliation and membership and how those beliefs and practices will necessarily affect the education, training, research and practice of psychology (Principles D and F, APA Code of Ethics, 1992; Council of National Associations for the Advancement of Ethnic Minority Issues, 2000).
2. Understanding and recognizing the interface between individuals' socialization experiences based on ethnic and racial heritage can enhance the quality of education, training, practice, and research in the field of psychology (American Council on Education, 2000; American Council on Education and American Association of University Professors, 2000; Biddle, Bank, & Slavings, 1990).
3. Recognition of the ways in which the intersection of racial and ethnic group membership with other dimensions of identity (e.g., gender, age, sexual orientation, disability, religion/spiritual orientation, educational attainment/experiences, and socioeconomic status) enhances the understanding and treatment of all people (Berberich, 1998; Greene, 2000; Jackson-Triche, Sullivan, Wells, Rogers, Camp, & Mazel, 2000; Wu, 2000).
4. Knowledge of historically derived approaches that have viewed cultural differences as deficits and have not valued certain social identities helps psychologists to

understand the under representation of ethnic minorities in the profession, and affirms and values the role of ethnicity and race in developing personal identity (Coll, Akerman, & Cicchetti, 2000; Medved, Morrison, Dearing, Larson, Cline, & Brummans, 2001; Mosely-Howard & Burgan Evans, 2000; Sue, 1999; Witte & Morrison, 1995).

5. Psychologists are uniquely able to promote racial equity and social justice. This is aided by their awareness of their impact on others and the influence of their personal and professional roles in society (Comas-Díaz, 2000).
6. Psychologists' knowledge about the roles of organizations, including employers and professional psychological associations are potential sources of behavioral practices that encourage discourse, education and training, institutional change, and research and policy development, that reflect rather than neglect, cultural differences. Psychologists recognize that organizations can be gatekeepers or agents of the status quo rather than leaders in a changing society with respect to multiculturalism.

Commitment to Cultural Awareness and Knowledge of Self and Others

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

Psychologists, like all people, are shaped and influenced by many factors. These include, but are not limited to, their cultural heritage(s), various dimensions of identity including ethnic and racial identity development, gender socialization, and socioeconomic experiences, and other dimensions of identity that predispose individual psychologists to certain biases and assumptions about themselves and others.

Psychologists approach interpersonal interactions with a set of attitudes, or worldview, that helps shape their perceptions of others. This worldview is shaped in part by their cultural experiences. Indeed, cross-cultural and multicultural literature consistently indicates that all people are "multicultural beings," that all interactions are cross-cultural, and that all of our life experiences are perceived and shaped from within our own cultural perspectives (Arredondo et al., 1996; Brewer & Brown, 1998; Fiske et al., 1998; Fouad & Brown, 2000; Markus & Kitayama, 1991; Pedersen, 2000; Sue et al., 1992; Sue et al., 1982; Sue, Ivey, & Pedersen, 1996).

Psychologists are encouraged to learn how cultures differ in basic premises that shape worldview. For example, it may be important to understand that a cultural facet of mainstream culture in the United States is a preference for individuals who are independent, focused on achieving and success, who have determined (and are in control of) their own personal goals, and who value rational decision-making (Fiske et al., 1998; Markus & Kitayama, 1991; Oyserman, Coon, & Kemmelmeir, 2002). By contrast, individuals with origins in cultures of East Asia may prefer interdependence with others, orientation towards harmony with others, conforming to social norms, and subordination of personal goals and objectives to the will of the group (Fiske et al., 1998). A preference for an independent orientation may shape attitudes towards those with preferences for same, or other orientations. This preference is a concern when a different orientation is unconsciously and automatically judged negatively (Greenwald & Banaji, 1995).

The perceiver in an interaction integrates not only the content of the interaction, but also information about the target person, including personality traits, physical appearance, age, sex, ascribed race, ability/disability, among other characteristics (Kunda

& Thagard, 1996). All of these perceptions are shaped by the perceiver's worldview, and organized in some coherent whole to make sense of the other person's behavior. The psychological process that helps to organize the often-overwhelming amount of information in perceiving others is to place people in categories, thereby reducing the information into manageable chunks of information that go together (Fiske, 1998). This normal process leads to associating various traits and behaviors with particular groups (e.g., all athletes are more brawn than brain, all women like to shop) even if they are inaccurate for particular, many, or even most individuals.

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

Relevant to these Guidelines are factors that influence categorization and its effect on attitudes towards individuals who are racially or ethnically different from self. These include a tendency to exaggerate differences between groups and similarities within one group and a tendency to favor one's in-group over the out-group; this, too, is done outside conscious processing (Fiske, 1998). In-groups are more highly valued, more trusted, and engender greater cooperation as opposed to competition (Brewer & Brown,

1998; Hewstone, Rubin, & Willis, 2002), and those with strongest in-group affiliation also show the most prejudice (Swim & Mallett, 2002). This becomes problematic when one group holds much more power than the other group or when resources among in-groups are not distributed equitably, as is currently the case in the United States.

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

Although the associations between particular stereotypic attitudes and resulting behaviors have not been consistently found, group categorization has been illustrated to influence intergroup behavior including behavioral confirmation (Stukas & Snyder, 2002), in-group favoritism (Hewstone et al., 2002), and subtle forms of behaviors (Crosby, Bromely, & Saxe, 1980). Psychologists are urged to become more aware and sensitive to their own attitudes towards others as these attitudes may be more biased and

culturally limiting then they think. It is sobering to note that, even those who consciously hold egalitarian beliefs, have shown unconscious endorsement of negative attitudes toward and stereotypes about groups (Greenwald & Banaji, 1995). Thus, psychologists who describe themselves as holding egalitarian values and/or as professionals who promote social justice may also unconsciously hold negative attitudes or stereotypes.

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

While the color-blind approach is based in an attempt to reduce inequities, social psychologists have provided evidence that a color-blind approach does not, in fact, lead to equitable treatment across groups. Brewer and Brown (1998), in their review of the literature, note "…ignoring group differences often means that, by default, existing intergroup inequalities are perpetuated" (p. 583). For example, Schofield (1986) found that disregarding cultural differences in a school led to reestablishing segregation by ethnicity. Color-blind policies have also been documented as playing a role in differential employment practices (Brewer & Brown). In these cases, the color-blind approach may have the effect of maintaining a status quo in which Whites have more power than do People of Color. There is also some evidence that a colorblind approach is less accurate than a multicultural approach. Wolsko et al., (2000) for example, found that when White students were instructed to adopt a color-blind or multicultural approach, those with a multicultural approach had stronger stereotypes of other ethnic groups as well as more positive regard for other groups. White students in a multicultural approach also had more accurate perceptions of differences due to race/ethnicity and used category information about both ethnicity and individual characteristics more than those in the color-blind condition. Wolsko et al. concluded, "When operating under a color-blind set of assumptions, social categories are viewed as negative information to be avoided, or suppressed. … In contrast, when operating under a multicultural set of assumptions, social categories are viewed as simply a consequence of cultural diversity. Failing to recognize and appreciate group similarities and differences is considered to inhibit more harmonious interactions between people from different backgrounds." (p. 649)

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

The literature on social categorization places all human interaction within a cultural context, and encourages an understanding of the various factors that influence our perceptions of others. These premises suggest that the psychologist is a part of the multicultural equation; therefore, on-going development of one's personal and cross-cultural awareness, knowledge, and skills is recommended. Fiske (1998) notes that automatic biases can be controlled with motivation, information, and appropriate mood. Given the above research, psychologists are encouraged to explore their worldview—beliefs, values, and attitudes – from a personal and professional perspective. They are encouraged to examine their potential preferences for within group similarity, and realize that, once impressions are formed, these impressions are often resistant to

disconfirmation (Gilbert, 1998). Moreover, psychologists are encouraged to understand their own assumptions about ways to improve multicultural interactions and the potential issues associated with different approaches. Psychologists' self-awareness and appreciation of cultural, ethnic, and racial heritage may serve as a bridge in cross-cultural interactions, not necessarily highlighting but certainly not minimizing these factors as they attempt to build understanding (Arredondo et al., 1996; Hofstede, 1980; Ibrahim, 1985; Jones, Lynch, Tenglund, & Gaertner, 2000; Locke, 1992; Sue, 1978**;** Sue & Sue, D., 1999; Triandis & Singelis, 1998).

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

the focus is on interpersonal communication (Brewer & Brown, 1998; Hewstone et al., 2002). In addition, psychologists may want to actively increase their tolerance (Greenberg, Solomon, Pyszczynski, Rosenblatt, & et al. 1992) and trust of racial/ethnic groups (Kramer, 1999).

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

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

As noted in Guideline #1, membership in one group helps to shape perceptions of not only one's own group, but also other groups. The link between those perceptions and attitudes are loyalty to and valuing of one's own group, and devaluing the other group. The Minority Identity Development model (Atkinson, Morten, & Sue, 1998) is one such example applying to ethnic/racial minority individuals but also to others who have

experienced historical oppression and marginalization. The devaluing of the other group occurs in a variety of ways, including the "ultimate attributional error" (Pettigrew, 1979), the tendency to attribute positive behaviors to internal traits within one's own group, but negative behaviors to the internal traits of the out group (although Gilbert, 1998, suggests that the ultimate attribute error may be culturally specific to individually oriented cultures, such as the United States). In the United States, then, the result may be positive, such as ensuring greater cooperation within one's group, or negative, such development of prejudice and stereotyping of other groups. Decades of research and multiple theories have been developed to reduce prejudice of other groups, most developing around the central premise that greater knowledge of, and contact with, the other groups will result in greater intercultural communication and less prejudice and stereotyping (Brewer & Miller, 1998; Gaertner & Dovidio, 2000). Brewer and Miller delineate the factors that have been found to be successful in facilitating prejudice reduction through contact among groups: social and institutional support, sufficient frequency and duration for relationships to occur, equal status among participants, and cooperation. It appears, as discussed in Guideline #1, that attention to out-group stereotyping reduces prejudice (Reynolds & Oakes, 2000), as does overt training to reduce stereotyping (Kawakami, Dovidio, Moll, Hermsen, & Russin, 2000).

It is within this framework that psychologists are urged to gain a better understanding and appreciation of the worldview and perspectives of those racially and ethnically different from themselves. Psychologists are also encouraged to understand the stigmatizing aspects of being a member of a culturally devalued "other group." (Crocker et al., 1998; Major et al., in press). This includes experience, sometimes daily,

with overt experiences of prejudice and discrimination, awareness of the negative value of one's own group in the cultural hierarchy, the threat of one's behavior being found consistent with a racial/ethnic stereotype (stereotype threat), and the uncertainty (e.g., due to prejudice or individual behavior) of the attribution of the stigmatizing comments and outcomes.

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

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

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

Concomitantly, psychologists are encouraged to understand the impact of the dismantling of Affirmative Action and anti-bilingual education legislation on the lives of ethnic and racial minority groups (Fine, Weis, Powell, & Wong, 1997; Glasser, 1988).

Built on variations of the social categorization models described in Guideline #1 ethnic and racial identity models such as the Minority Identity Model (Atkinson et al., 1998) noted earlier have also been developed for specific racial/ethnic minority groups (Cross, 1978; Helms, 1990; Parham, 1989, 2001; Ruiz, 1990; Vandiver et al., 2001; Worrell et al., 2001). These models propose that members of racial/ethnic minority groups initially value the other group (dominant culture) and devalue their own culture, move to valuing their own group and devalue the dominant culture, and integrate a value for both groups in a final stage. These models are key constructs in the cross cultural domain, and psychologists are encouraged to understand how the individual's ethnic and racial identity status and development affects beliefs, emotions, behavior and interaction styles (Brewer & Brown, 1998; Fiske et al., 1998; Hays, 1995; Helms & Cook, 1999). This information will help psychologists to communicate more effectively with clients, peers, students, research participants, and organizations and to understand their coping responses (Crocker et al., 1998; Major et al., in press; Swim & Mallet, 2002). Psychologists are encouraged to become knowledgeable about ethnic and racial identity research including research on Asian, Black, White, Mexican, Mestizo, minority, Native American, and biracial identity models (Atkinson et al., 1998; Cross, 1991; Fouad & Brown, 2000; Helms, 1990; Hong & Ham, 2001; Phinney, 1991; Ramirez, 1998; Root, 1992; Ruiz, 1990; Sodowsky, Kuo-Jackson, & Loya, 1997; & Wehrly et al., 1999). Additionally, psychologists may also learn about other theories of identity development

that are not stage models, as well as other models that demonstrate the multidimensionality of individual identity across different historical contexts (Santiago-Rivera et al., 2000; Oetting & Beauvais, 1990-1991; Oyserman, Gant, & Ager, 1995; Robinson & Howard-Hamilton, 2000; Root, 1999; Sellers, Smith, Shelton, Rowley, & Chavous, 1998; Thompson & Carter, 1997).

Education

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

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

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

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

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

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

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

During the past 10-15 years, more reports and perspectives about best practices and guidelines for cross culture-centered education and training have emerged.

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

Psychologists as educators strive to become knowledgeable about different learning models and approaches to teaching from multiple cultural perspectives. In order to go beyond a single multicultural counseling course or to mention in passing that the racial/ethnic diversity is increasing in the United States, it is suggested that educators include statements of philosophy and principles in course syllabi that guide the multicultural educational focus (Leach & Carlton, 1997). Psychologists are encouraged to review philosophical models that influence multicultural training. These include race-based models (Carter, 1995; Helms, 1990); theories regarding oppression (Atkinson,

Morten, & Sue, 1998; Freire, 1970; Katz, 1985); Multicultural Counseling and Therapy (MCT) (Sue et al., 1996); Multicultural Facets of Cultural Competence (Sue, 2001); common factors within psychotherapy and healing (Fischer, Jome, & Atkinson, 1998; Frank & Frank, 1998) and multicultural competency-based models (Arredondo & Arciniega, 2001; Arredondo et al., 1996; Middleton, Rollins, & Harley, 1999). In addition, the research on intergroup biases and categorization theories described in Guidelines #1 and #2 suggest that optimal intergroup contact is predicted by equal status among those interacting (e.g., teacher and students), cooperation as opposed to competition, perspective taking, and empathy (Finlay & Stephan, 2000; Gaertner & Dovidio, 2000; Galinsky & Moskowitz, 2000; Hewstone et al., 2002; Pettigrew, 1998). These models and approaches, then, may be used to encompass didactic courses across the curriculum (e.g., learning about career theories and practices related to various cultural groups) as well as assessment, organizational behavior, clinical practice and supervision, and research approaches.

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

encouraged to consider ways to make the multicultural focus thematic to the educational program.

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

Psychologists as educators are encouraged to continue to be knowledgeable about research findings about the effects of multicultural counseling and psychology coursework (Constantine & Yeh, 2001; Holcomb-McCoy & Myers, 1999; Kiselica, 1998; Klausner, 1998; Koeltzow, 2000; Manese et al., 2001; Parker et al, 1998; Ponterotto, 1998; Pope-Davis, Breaux, & Lui, 1997; Salvador, 1998; Sevig & Etzkorn, 2001;

Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998) and general undergraduate education (American Council on Education & American Association of University Professors, 2000; Chang et al., 2000).

Research

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

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

The treatment of culture in psychological research has shifted in the past century from ignoring cultural variables to treating culture as a nuisance variable. Thus, for example, early research participants were White males, yet the results were assumed to

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

attainment from research studies that focused on the students' lack of individual achievement rather than in social disadvantage. Again, using a culture-centered perspective would lead to different conclusions in these studies, as well as in the application of this research in school systems and college admissions.

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

A third concern is that all People of Color are presumed to be similar, and, as discussed in Guideline #1, large within-group differences are ignored (Fouad & Brown, 2000; Quintana et al., 2001). In fact, the CNPAAEMI (2001) Guidelines for Research in Ethnic Minority Communities (2000) describes the great within-group heterogeneity of all the major racial/ethnic groups in the United States, as does the Surgeon General's

Report on race, culture and mental health (USDHHS, 2000; 2001). Indeed using only African Americans from the southern United States and generalizing from this sample to all African Americans would raise questions about the appropriateness of doing so. Similarly, there are studies that make reference to Native Americans, overlooking the fact that there are more than 550 tribes in the United States. Psychologists are encouraged to consider the multidimensionality of ethnic, linguistic, and racial minority individuals and groups when planning research studies.

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

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

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

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

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

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

Assessment. The second area of research is assessment. Culturally sensitive psychological researchers strive to be knowledgeable about a broad range of assessment techniques, data generating procedures, and standardized instruments whose validity, reliability, and measurement equivalence have been investigated across culturally diverse sample groups (CNPAAEMI, 2000; Helms, 1992; Marin & Marin, 1991; Padilla, 1995; Spengler, 1998). They are encouraged not to use instruments that have not been adapted

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

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

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

results to be of benefit to the community, and to represent the participants' perspectives accurately and authentically (CNPAAEMI, 2000).

Practice

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

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

Psychologists are likely to find themselves increasingly engaged with others ethnically, linguistically, and racially different from and similar to themselves as human resource specialists, school psychologists, consultants, agency administrators, and

clinicians. Moreover, visible group membership differences (Atkinson & Hackett, 1995; Carter, 1995; Cross, 1991; Helms, 1990; Herring, 1999; Hong & Ham, 2001; Niemann,

2001; Padilla, 1995; Santiago-Rivera et al., 2002; Sue & Sue, 1999) may belie other identity factors also at work and strong forces in individuals' socialization process and life experiences. These include language, gender, biracial/multiracial heritage, spiritual/religious orientations, sexual orientation, age, disability, socioeconomic situation, and historical life experience; e.g., immigration and refugee status (Arredondo & Glauner, 1992; Davenport & Yurich, 1991; Espin, 1997; Hong & Ham, 2001; Lowe & Mascher, 2001; Prendes-Lintel, 2001). Projections regarding the increasing numbers of individuals categorized as ethnic and racial minorities have been discussed earlier in these Guidelines. The result of these changes is that in urban, rural, and other contexts, psychologists will interface regularly with culturally pluralistic populations (D'Andrea & Daniels, 2001; Ellis, Arredondo, & D'Andrea, 2000; Lewis, Lewis, Daniels, & D'Andrea, 1998; Middleton, Arredondo, & D'Andrea, 2000).

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

1996; Ridley, 1995; Santiago-Rivera et al., 2002; Sue, et al., 1998; Sue, Bingham, Porche-Burke, & Vasquez, 1999; Sue & Sue, 1999) have outlined the urgent need for clinicians to develop multicultural sensitivity and understanding.

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

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

Walls, 2000; Root, 1992; Santiago-Rivera et al., 2002; Seeley, 2000; Sue, 1998; Sue, Ivey, & Pedersen, 1996).

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

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

Historical experiences for various populations differ. This may be manifested in the expression of different belief systems and value sets among clients and across age cohorts. For example, therapists are strongly encouraged to be aware of the ways that enslavement has shaped the worldviews of African Americans (Cross, 1991; Parham et al., 1999). At the same time, the within-group differences among African Americans and others of African descent also suggest the importance of not assuming that all persons of African descent will share this perspective. Thus, knowledge about sociopolitical viewpoints and ethnic/racial identity literature would be important and extremely helpful when working with individuals of ethnic minority descent. Culturally centered practitioners assist clients in determining whether a "problem" stems from institutional or societal racism (or other prejudice) or individual bias in others so that the client does not inappropriately personalize problems (Helms & Cook, 1999; Ridley, 1995; Sue et al., 1992). Consistent with the discussion in Guideline #2 about the effects of stigmatizing, psychologists are urged to help clients recognize the cognitive and affective motivational processes involved in determining whether they are targets of prejudice (Crocker et al., 1998). Psychologists are also encouraged to be aware of the environment (neighborhood, building, and specific office) and how this may appear to clients or employees. For example, bilingual phone service, receptionists, magazines in the waiting room, and other signage can demonstrate cultural and linguistic sensitivity (Arredondo, 1996; Arredondo et al., 1996; Grieger & Ponterotto, 1998).

Psychologists are also encouraged to be aware of the role that culture may play in the establishment and maintenance of a relationship between the client and therapist. Culture, ethnicity, race, and gender are among the factors that may play a role in the

perception of, and expectations of therapy and the role the therapist plays (American Psychiatric Association, 1994; Carter, 1995; Comas-Díaz & Jacobsen, 1991; Cooper-Patrick et al., 1999; Seely, 2001).

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

Lopez, 1989; Paniagua, 1994, 1998; Ponterotto, Casas, Suzuki, & Alexander, 1995; Samuda, 1998).

Interventions. Cross-culturally sensitive practitioners are encouraged to develop skills and practices that are attuned to the unique worldview and cultural backgrounds of clients by striving to incorporate understanding of client's ethnic, linguistic, racial, and cultural background into therapy (American Psychiatric Association, 1994; Falicov, 1999; Flores & Carey, 2000; Fukuyama & Ferguson, 2000; Helms & Cook, 1999; Hong & Ham, 2001; Langman, 1998; Middleton, Rollins, & Harley, 1999; Santiago-Rivera et al., 2002). They are encouraged to become knowledgeable about the *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990) and *Guidelines for Research in Ethnic Minority Communities* (CNPAAEMI, 2000). They are encouraged to learn about helping practices used in non-Western cultures within as well as outside the North American and Northern European context that may be appropriately included as part of psychological practice. Multiculturally sensitive psychologists recognize that culture-specific therapy (individual, family, and group) may require non-traditional interventions and strive to apply this knowledge in practice (Alexander & Sussman, 1995; Fukuyama & Sevig, 1999; Ridley, 1995; Santiago-Rivera et al., 2002; Sciarra, 1999; Society for the Psychological Study of Ethnic Minority Issues, Division 45 of the American Psychological Association & Microtraining Associates, Inc., 2000; Sue et al., 1998; Sue & Sue, 1999). This may include inviting recognized helpers to assist with assessment and intervention plans. Psychologists are encouraged to participate in culturally diverse and culture-specific activities. They are also encouraged to seek out community leaders, change agents, and

influential individuals (ministers, storeowners, non-traditional healers, natural helpers), when appropriate, enlisting their assistance with clients as part of a total family or community-centered (healing) approach (Arredondo et al. 1996; Grieger & Ponterotto, 1998; Lewis et al., 1998).

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

Organizational Change and Policy Development

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

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

knowledgeable about the possible ways to facilitate culturally informed organizational development of policies and practices.

This Guideline is designed to inform psychologists about the following: (1) the contemporary and future contexts that provide motivators for psychologists' proactive behavior with organizational change processes; (2) perspectives about psychologists in transition; (3) frameworks and models to facilitate multicultural organizational development; and (4) examples of processes and practices reflective of psychologists' leadership in the development of culture-centered organizations. Supporting this Guideline are contextual data that provide a rationale for positioning multiculturalism as thematic to structures, functions, and strategic planning within an organization as well as example of changes in psychology policies and practices.

Changing Context for Psychologists

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

gap have been identified (U.S. Census Bureau, 2001), the aging and longer living baby boomers, and changing family patterns have implications for psychology-at-large.

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

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

integration in to the U.S. economy, national and global deregulation, and quick economic growth in heretofore-underdeveloped nations (Judy & D'Amico, 1997). All of these examples have implications for psychology, as psychologists will be called upon to engage with other disciplines and sectors of society, including government agencies, in attempting to forge new policies and guidelines that promote human development, knowledge-building, and societal improvement. While these forces will, of necessity, influence our own work, we are also uniquely trained to help others cope with these changes. All of these data and forces highlight the necessity of institutional change particularly for the delivery of health and mental health services (Schlesinger & Gray, 1999) psychology education, and employment practices.

Psychologists in Transition

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

Examples of changes in policy and practices have also come from within the profession. In 1993, the Massachusetts state licensing board approved a regulation change, requiring doctoral coursework and internship experiences with multicultural and cross-cultural foci (Daniel, 1994). Georgia passed a similar change in 2000. More recently, the state of New Mexico passed legislation that now allows psychologists to

prescribe medication, recognition of our scientific roots. Part of the rationale for change in prescription privileges was to provide greater access for rural patients and clients with mental health concerns, which includes a large number of People of Color. When such policies go into effect, there are challenges and opportunities that ensue for training programs, internship sites, and institutions that hire psychologists.

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

Frameworks and Models for Multicultural Organizational Development

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

To assist organizations in clarifying their approach to multiculturalism and diversity, Thomas and Ely (1996) conceptualize a continuum of philosophical positions that range from fairness and equity to valuing diversity. Sue (2001) offers another conceptualization through his multidimensional facets of cultural competence model. He

posits cultural competence at individual, professional, organizational, and societal levels. By bringing in the societal foci, Sue is also addressing issues of social justice and responsibility, and opportunities for psychologists' change agency.

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

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

Borrowing from the work of organizational change consultants, psychologists can become knowledgeable about recommendations from learning organization models

(Morgan, 1997; Senge, 1990). These advocate for organizations to anticipate environmental change, "developing an ability to question, challenge and change operating norms and assumptions" (Morgan, 1997, p. 90), and engage in new planning. By so doing, psychologists, prepared as change agents, have the opportunity to apply clinical and research methodology to promote goal-oriented systems change with measurable outcomes.

Examples of Multicultural Practices within Organizations

Psychologists are encouraged to review examples of multicultural organizational change that are reported in publications from a variety of sources within APA, as well as from the American Counseling Association and management journals. These evolutionary processes of change are both deliberate and systemic (e.g., Arredondo & D'Andrea, 2000; D'Andrea, Daniels, & Arredondo, 1999; D'Andrea et al., 2001). Examples from both APA and the American Counseling Association point to behaviors at the professional organization level with implications for the practice of psychology. Thematic to these examples is the role of leadership, sustained attention to diversity-related objectives, and changes in policy and practices that make the organization operationalize its mission of inclusiveness and pluralism. Division 17, Counseling Psychology; Division 35, Society for the Psychology of Women; Division 44, Society for the Psychological Study for Lesbian, Gay, and Bisexual Issues; Division 51, Society for the Psychological Study of Men and Masculinity; and Division 42, Psychologists in Independent Practice all have dedicated slates or positions for an ethnic/racial minority psychologist on their executive councils or as representatives to the Council of Representatives. Division 12, Society of Clinical Psychology, has recently voted to have

an ethnic minority slate for Council of Representatives when two positions are vacant at the same time. Additional examples come from Divisions 12, 17, and 35 that have subcommittees or sections to address ethnic/racial minority objectives. Finally, Division 45, Society for the Psychological Study of Ethnic Minority Issues has added a "diversity" Member-at-Large position, inviting representation from a member who is not a person of color (all other positions have traditionally been Persons of Color). These are practices that operationalize a given Division's mission and objectives to promote multiculturalism and diversity, and organizational change. By the same token, APA's immediate response to the terrorist attacks of September 11, 2001, and the work of individual psychologists within their communities are ways that psychologists have responded quickly to a changing world.

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

plans. With the presence of psychologists from different specializations in non-traditional and other disciplinary contexts (e.g., CIA) as noted previously, knowledge and understanding of these Guidelines seems very timely.

Psychologists as Change Agents and Policy Planners

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

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

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

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

Traditional and evolutionary perspectives in applied psychology (Colarelli, 1998), and models of organizational change (Hofstede, 1986; Lewin, 1951; Morgan, 1997) can guide behavior that allows psychology to bridge with the multiple communities with which it interacts. Psychologists are encouraged to become familiar with leadership literature (Greenleaf, 1998; Nanus, 1992) as this offers constructs and descriptions of

roles relevant to psychologists in policy planning. In effect, policy development is a change management process, one that can be informed by the vision, research, and experiences of psychologists.

Conclusion

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

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

psychology. It is anticipated that, with this increased knowledge base and effectiveness of applications, the Guidelines will continue to evolve over the next seven years.

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Footnote:

1. **The term Person/s of Color is preferred by some instead of minority because of the technical definition the latter term connotes.

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

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7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);

4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	**Venous thromboembolic disease**[A] Gallstones Elevated liver enzymes Weight gain **Hypertriglyceridemia**	**Polycythemia** Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	**Hypertension** Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes **Hyperlipidemia**
Possible increased risk with presence of additional risk factors[B]	**Type 2 diabetes**[A]	**Destabilization of certain psychiatric disorders**[C] **Cardiovascular disease** **Hypertension** **Type 2 diabetes**
No increased risk or inconclusive	**Breast cancer**	Loss of bone density **Breast cancer** **Cervical cancer** **Ovarian cancer** **Uterine cancer**

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII
Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones*:* Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing**,** may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

Members of the Standards of Care Revision Committee[1]

Eli Coleman, PhD (USA)* - Committee chair
Richard Adler, PhD (USA)
Walter Bockting, PhD (USA)*
Marsha Botzer, MA (USA)*
George Brown, MD (USA)
Peggy Cohen-Kettenis, PhD (Netherlands)*
Griet DeCuypere, MD (Belgium)*
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Randi Ettner, PhD (USA)
Evan Eyler, MD (USA)
Jamie Feldman, MD, PhD (USA)*
Lin Fraser, EdD (USA)*
Rob Garofalo, MD, MPH (USA)
Jamison Green, PhD, MFA (USA)*
Dan Karasic, MD (USA)
Gail Knudson, MD (Canada)*
Arlene Istar Lev, LCSW (USA)
Gal Mayer, MD (USA)
Walter Meyer, MD (USA)*
Heino Meyer-Bahlburg, Dr. rer.nat. (USA)
Stan Monstrey, MD, PhD (Belgium)*
Blaine Paxton Hall, MHS-CL, PA-C (USA)
Friedmann Pfaefflin, MD, PhD (Germany)
Katherine Rachlin, PhD (USA)
Bean Robinson, PhD (USA)
Loren Schechter, MD (USA)
Vin Tangpricha, MD, PhD (USA)
Mick van Trotsenburg, MD (Netherlands)
Anne Vitale, PhD (USA)
Sam Winter, PhD (Hong Kong)
Stephen Whittle, OBE (UK)
Kevan Wylie, MB, MD (UK)
Ken Zucker, PhD (Canada)

International Advisory Group Selection Committee

Walter Bockting, PhD (USA)
Marsha Botzer, MA (USA)
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Evan Eyler, MD (USA)
Jamison Green, PhD, MFA (USA)
Blaine Paxton Hall, MHS-CL, PA-C (USA)

1 * Writing Group member
All members of the *Standards of Care, Version 7 Revision Committee* donated their time to work on this revision.

International Advisory Group

Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FTM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Tone Marie Hansen, Harry Benjamin Resource Center (Norway)
Rupert Raj, Shelburne Health Center (Canada)
Masae Torai, FTM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)

Technical Writer

Anne Marie Weber-Main, PhD (USA)

Editorial Assistance

Heidi Fall (USA)

Policies
& Protocols

EMERGENCY PROCEDURES FOR CLINICIANS IN THEIR OFFICES

General Office Safety Guidelines:

1. Leave office door unlocked.

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

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

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

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

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

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

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

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

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

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

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

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

7. Campus Police will:

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

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