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APA *Multicultural Guidelines* Executive Summary: Ecological Approach to Context, Identity, and Intersectionality

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The initial version of the *Multicultural Guidelines,* titled *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,* was published in 2002. Since then, there has been significant growth in research and theory regarding multicultural contexts. The revised *Multicultural Guidelines* are conceptualized to reconsider diversity and multicultural practice within professional psychology at this period in time, with intersectionality as its primary purview. Psychologists are encouraged to incorporate developmental and contextual antecedents of identity and consider how they can be acknowledged, addressed, and embraced to generate more effective models of professional engagement. The *Multicultural Guidelines* incorporate broad reference group identities that acknowledge within-group differences and the role of self-definition. Identity is shaped across contexts and time by cultural influences including age, generation, gender, gender identity, ethnicity, race, religion, spirituality, language, sexual orientation, social class, education, employment, ability status, national origin, immigration status, and historical as well as ongoing experiences of marginalization. The theoretical model, a layered ecological model of the *Multicultural Guidelines,* is presented along with 10 corresponding guidelines. The guidelines are applicable to psychologists in their work with clients, students, research participants, and in practice, education, research, and/or consultation.

Keywords: multicultural guidelines, ecological, intersectionality, identity

The purpose of the *Multicultural Guidelines* is to provide psychologists with a framework from which to consider evolving parameters for the provision of multiculturally competent services that include practice, research, consultation, and education. The complete guidelines and related appendices can be found at http://www.apa.org/about/policy/multicultural-guidelines.aspx (American Psychological Association [APA], 2017). The original *Guidelines on Multicultural Educa-*

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tion, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2002) were based on the work of Sue and colleagues (1982), who presented a model of cross-cultural counseling competencies (MCCs). As discussed in the *Report of the Task Force on the Implementation of the Multicultural Guidelines* (APA, 2008), "the origins of the *Multicultural Guidelines* are rooted in various social, historical, and political events and inspired by a number of professional developments in the field of psychology" (p. 4), and within APA itself, over the past 50 years. The goal of this new version is to consider the term *multicultural* in its broadest conceptualization reflecting current literature that considers contextual factors and intersectionality, including age, generation, culture, language, gender, race, ethnicity, ability status, sexual orientation, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment, among other variables; these identities are considered within the context of domestic and international climates and human rights. This iteration recognizes contributions of culturally competent models of practice such as the American Counseling Association's *Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession* (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016), the American Psychiatric Association's *Cultural Formulation Interview* (APA, 2013), and the National Association of Social Workers' (NASW) *Standards and Indicators for Cultural Competence in Social Work Practice* (National Association of Social Workers, 2015).

Theoretical Framework: A Layered Ecological Model of the Multicultural Guidelines

The Multicultural Guidelines Task Force model, a *layered ecological model of the Multicultural Guidelines,* incorporates Bronfenbrenner's (1977, 1979) ecological model that proposed five nested, concentric circles: (a) the *microsystem* of immediate family, friends, teachers, and institutions that have direct influence on the individual; (b) the *mesosystem* that refers to interrelations of various social entities found in the microsystem that affect a person's life (e.g., home, school, community); (c) the *exosystem* that deals with societal and cultural forces, including public policies, laws, and governmental influences, that act upon the individual without necessarily having a direct link to individual experience; (d) the *macrosystem* that corresponds with the cultural context in which the individual lives, such as cultural values and norms; and (e) the *chronosystem* that deals with the passage of time, historical trends and transitions, and the historical context surrounding individual experience.

Description of the Current Model

The ecological model comprises dynamic, nested systems that transact over time. Figure 1 illustrates five levels of the model. *Level 1: Bidirectional Model of Self-Definition and Relationships* is represented by the two inner circles that capture a bidirectional model of self-definition and relationships. The circle on the left represents the individual's self-definition in the roles of client, student, research participant, or consultee. The circle on the right represents the individual's self-definition in the roles of clinician, educator, researcher, or consultant; these may also involve more than two people, for example, a couple, family, group, or research sample. The bidirectional arrow that intersects the two circles represents the bidirectional relationships considered within the model. *Level 2: Community, School, and Family Context* refers to the model's second layer. Specific areas considered include family, community, school, neighborhood, workplace, place of worship, and physical space. The context presented in Level 2 has direct influence on the bidirectional relationships described in Level 1. *Level 3: Institutional Impact on Engagement* examines the effects of institutional context on how clients and psychologists experience the community, school, and family contexts (Level 2) and how this experience influences both the individual's self-definition and relationships with one another (i.e., client, student, consultee, research participant and clinician, educator, researcher, consultant [Level 1]). *Level 4: Domestic and International Climate* considers the impact of the domestic climate (on the circle's left-hand side) and the international climate (on the circle's right-hand side).

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This fourth layer encompasses Levels 1–3. At the top of this fourth circle is consideration of the larger societal context and at the bottom is consideration of human rights. *Level 5: Outcomes* encompasses all prior levels and refers to those results, both positive and negative, that are derived from the bidirectional transactions between the client, student, research participant, and consultee and the clinician, educator, researcher, and consultant. Outcomes are influenced by interactions and experiences with Levels 1, 2, 3, and 4.

Dynamic Processes

Three dynamic processes—power–privilege, tensions, and fluidity—influence the model, creating a circle (or another layer) around Levels 1–5 to show that they drive the ecological model. *Power–privilege* represents a continuum of power and privilege that can be experienced by participants engaged in psychological endeavors as well as by psychologists providing services. *Tensions* between and among Levels 1–5 are dynamic and contextual and may result through intersections between and among various levels. *Fluidity* refers to the dynamic interaction between and among concentric circles and shifts within them. The upward facing arrow labeled *resilience* and the downward facing arrow labeled *trauma* represent the goal of increasing resilience and decreasing trauma.

Documentation of Need–Distinction Between Standards and Guidelines

APA distinguishes between standards (e.g., mandates that psychologists must adhere to) and guidelines (e.g., aspirational and informative; "2010 Amendments," 2010; APA, 2015b). Psychologists are encouraged to use the *Multicultural Guidelines* in tandem with the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002, amended in 2010) and to be aware that state and federal laws may override them and take precedence ("2010 Amendments," 2010; APA, 2015b). The *Multicultural Guidelines* refer to psychological practice (e.g., clinical work, consultation, education, research, and training) rather than treatment guidelines; the latter are client-focused and address intervention-specific recommendations for clinical populations or conditions (Reed, McLaughlin, & Newman, 2002). The guidelines are consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* and the *Standards of Accreditation for Health Service Psychology* (APA, 2015b; APA, Commission on Accreditation, 2015).

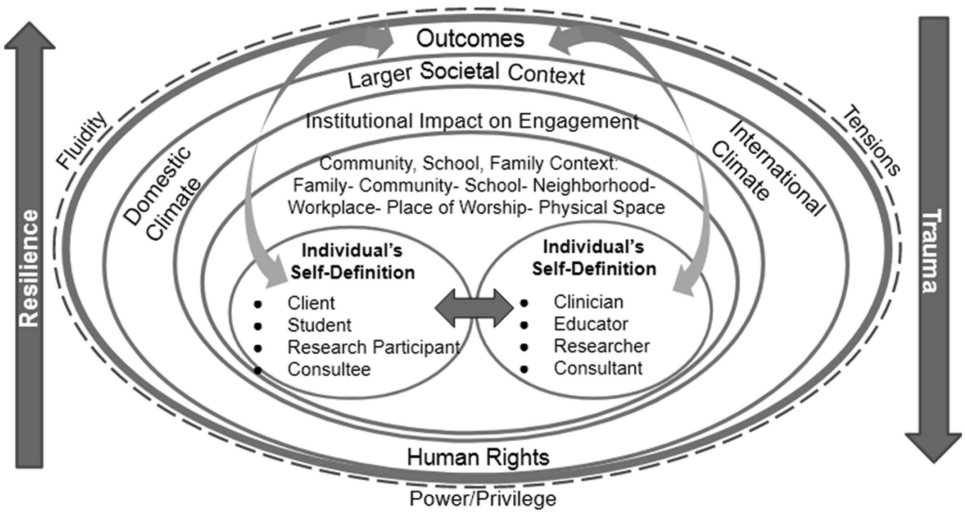
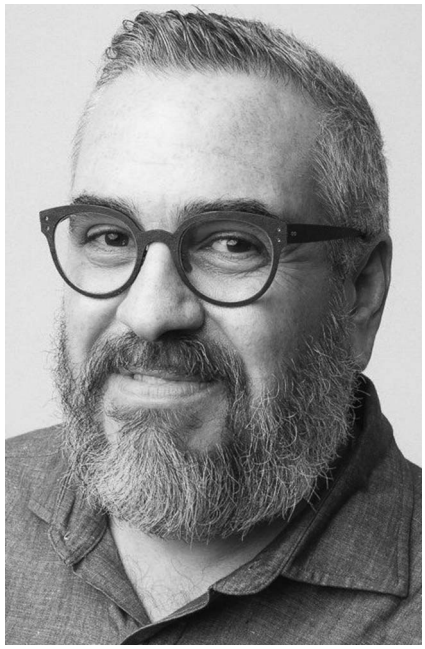


Figure 1. Ecological model of the *Multicultural Guidelines.*



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Level 1 Guidelines: Bidirectional Model of Self-Definition and Relationships

Guideline 1: Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

Identity reflects both individual and collective features of emotional and cognitive experience and develops within interpersonal and structural contexts. Identity can be conceptualized as an internal experience of "subjective self-sameness" that facilitates emotional experiences and behaviors that reflect an individual's actual or true self (Mann, 2006, p. 216). Identity develops across contexts and time and is shaped by cultural influences including age, generation, gender, ethnicity, race, religion, spirituality, language, sexual orientation, gender identity, social class, education, employment, ability status, national origin, immigration status, and historical as well as ongoing experiences of marginalization, among other variables (Comas-Díaz, 2012; Roysircar-Sodowsky & Maestas, 2000).

Various dimensions of identity associated with sociocultural contexts have been described in psychological theories (Cross, 1991). For example, racial identity has been described as a sense of collective identity rooted in individuals' perception that they share a common heritage with a specific racial group (Helms & Cook, 1999), and ethnic identity has been defined as the extent to which individuals identify as members of their ethnic group(s) (Phinney, 1996). Biracial identity and multiracial identity have been described as involving a sense of "border crossing," where individuals can experience hybridity as a reference point for identity (Root, 2003, p. 36). Research has indicated that identity varies across different sociocultural groups as well as within such groups (Comas-Díaz, 2012; Sue & Sue, 2016). Language describing identity (e.g., identity labels) conveys perceptions of and feelings about a particular group. For example, the use of pronouns among people with nonbinary gender identities, such as *zie* instead of *she* or *he,* moves society toward more accurate perceptions and conceptualizations of gender experiences. Identity development is dynamic and fluid, influenced by structural and interpersonal factors that may either constrain or expand possibilities for the expression of various experiences. Psychologists strive to attend to intersecting social, cultural, neurobiological, economic, and political contexts that contribute to an individual's diverse identities (Cho, Crenshaw, & McCall, 2013).

Applications to Practice, Research, and Consultation

Practice. Psychologists are encouraged to strive toward attunement to life experiences, transitions, and identity labels and how identity experience may change over time and context (Hays, 2016; Tummala-Narra, 2016). Regarding assessment and psychotherapy, clinicians can invite clients to describe their identities and labels, rather than relying on preconceived conceptualizations. Clinicians, researchers, educators, and consultants can attend to language that is affirming of an individual's or group's actual identity experiences and can recognize that this language may change over time (APA, 2015b).

Research. Intersectionality research focuses on the dynamics of power in the multiple systems that shape and limit differing levels of agency an individual person possesses in society. Intersectional researchers (cf. Sirin & Fine, 2008) have demonstrated that scholars can attend to structural dynamics resulting in social identities through the use of qualitative and quantitative research designs as well as interdisciplinary research teams (e.g., comprised of psychologists, sociologists, political scientists, women studies faculty, ethnic studies faculty, legal scholars). Greater collaboration with individuals and communities has been a core foundation of modern socioneurobiological approaches to contextual research regarding identity and affiliation.

Consultation. Consultants aim to address organizational issues that may stem from a lack of understanding related to identity. Consultants are also responsible for educating and collaborating with their clients (e.g., individuals, groups, communities) about the importance of respecting their own and others' self-definitions of identity.

Guideline 2: Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can

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influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

Psychologists' worldviews are rooted in their professional knowledge, personal life experiences, and interactions with others across their ecological contexts, and these worldviews influence empirical and clinical conceptualizations and approaches. Both conscious and unconscious factors may lead psychologists toward unwarranted assumptions about the client or data. Scholars have documented prevalent overt and subtle discrimination, as well as conscious and unconscious (e.g., implicit, aversive) stereotyping of and bias against women, racial and ethnic minorities, sexual minorities, religious minorities, transgender and gender-nonconforming individuals, older adults, people with disabilities, and people from low-income backgrounds, among other groups. Their negative effects on mental health outcomes, such as depression, anxiety, and suicidal ideation, and on health disparities have been documented (Goodley & Runswick-Cole, 2011). Psychologists' knowledge of cultural norms, beliefs, and values of clients, as well as sociopolitical influences, such as racism, xenophobia, Islamophobia, anti-Semitism, sexism, transphobia, cisgenderism, homophobia, heterosexism, classism, and ableism, influences the therapeutic relationship and, therefore, is a critical part of culturally informed practice.

Although recognizing the limitations of earlier models of psychotherapy and research, psychologists apply their knowledge to determine the models and theories most applicable to individuals, communities, and organizations with which they interact. A focus on intersectionality increases the capacity psychologists have for considering the multitude of positions and components of identity and personhood that exist within an array of communities, individuals, educational settings, and organizations.

Applications to Practice, Research, and Consultation

Practice. Psychologists are encouraged to consider the role of their worldviews and sociocultural histories in their clinical observations in assessment, interpretation of psychological tests, and formulation of diagnoses. Psychologists are encouraged to be aware that stereotypic thinking and overgeneralization may lead to engaging in inaccurate assessment and misdiagnosis, inappropriate treatment, and harmful microaggressions in research and clinical settings. This multicultural approach reveals psychologists' cultural humility (Hook & Watkins Jr., 2015).

Research. A collaborative approach that values the perspectives and sociocultural locations and identities of research participants, as well as the self-reflexivity of the researcher(s), is a hallmark of culturally informed empirical studies. Research concerning interactive aspects of cultural worldviews and experiences can provide a better self-understanding by psychologists of their own role as cultural beings. This in turn facilitates understanding of participant identities and self-definitions to avoid categorizing/overgeneralizing experiences.

Consultation. It is important that psychologists create a space that offers a basic sense of respect where supervisors initiate discussion with supervisees about their experiences of the supervision. It is also necessary that supervisors and educators work through their reactions to experiences such as racial and gender socialization, as well as sociocultural oppression and privilege (Tummala-Narra, 2016). Education in psychology can include models that focus on multicultural considerations across the life span throughout a curriculum. In a similar way, multicultural education is not intended to be provided solely by faculty who identify as minorities (e.g., racial, gender, or sexual), because this contributes to the problem of categorization and marginalization within psychology. It dismisses the importance of having faculty from all sociocultural backgrounds invest their time and resources to address multicultural issues.

Level 2 Guidelines: Community, School, and Family Context

Guideline 3: Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with

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whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

Psychologists are encouraged to consider the role of language in their professional relationships as well as within the context of the client's experience. The role of language and communication for the individual, couple, family, group, community, and/or organization relates to the fact that a language's intrinsic connection to culture can reflect social identity (Chiu & Chen, 2004). Psychologists also bring language and communication styles (both verbal and nonverbal) that reflect their lived experiences. Psychologists can seek to recognize the cognitive and affective components of bilingualism and multilingualism, psychological meanings associated with each language, and the connection between cultural values and identity associated with each language. Psychologists may engage in code switching, engaging both professional and personal language, to more fully enter and participate in a client's world (Clauss-Ehlers, 2006). Psychologists are encouraged to be aware of intergenerational language use, intergenerational relationships, and intergenerational conflicts that influence communication within a societal and cultural context. In a related vein, psychologists strive to be aware of how language varies according to developmental stage and the impact this variability has on individuals' lives, as well as on clinical, educational, research, and consultative interactions. Psychologists are encouraged to be aware of communication between cisgender and transgender and gender nonconforming individuals.

Applications to Practice, Research, and Consultation

Practice. Psychologists strive to engage in developmentally appropriate communication efforts that seek to understand how people, communities, and organizations self-identify and subsequently follow the lead presented by that individual's or group's identification, including an awareness of and responsiveness to nonverbal forms of communication. Psychologists strive to be aware of the use of interpreter guidelines when not versed in the language of the client. Psychologists working with interpreters can form a collaborative partnership that promotes understanding of the client's experience. When psychologists reflect the same language background as their client, whether it is a monolingual, bilingual/bicultural, or multilingual/multicultural experience, they are encouraged not to assume sameness between themselves and the client but rather to understand that language and culture may be experienced differently, even when a shared language exists. Issues with the application of standardized assessments to linguistically and culturally diverse communities include norms not being developed in the language of or for the population in which the assessment is being administered. Test items may reflect the dominant culture in which the assessment was developed rather than the examinee's heritage culture, compromising interpretation and applicability.

Research. Research psychologists are encouraged to incorporate local terms or phrases in research protocols to make the research more relevant to a participant's experience. Psychologists are encouraged to be aware of the role of language and informed consent to participate in research (e.g., provide informed consent documents written in the research participant's primary language or read aloud for those unable to read).

Consultation. Psychologists are encouraged to be attentive to the language(s) of the organization, as communicated by multiple constituencies, to develop a broad understanding of organizational issues. Consulting psychologists can act as conveners, bringing groups together to discuss experiences across organizational constituencies that may not understand one another.

Guideline 4: Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

Immediate social and physical environments provide many of the resources that affect people's lives. These resources represent what is sometimes called social capital and include factors such as the overall wealth and safety of neighborhood, quality of schools, pollution and other environmental hazards, quality and accessibility of the health care and transportation systems, and availability of nutritious food (Kawachi, Subramanian, & Kim, 2008). A

resource-rich environment can maximize the potential for a quality life, as well as for a successful resolution of a client's problems, whereas a resource-poor environment can minimize these potentials (Healthy People, 2017). Psychologists are encouraged to attend to resources available to clients, both now and in the past, including barriers to health care services, the quality of such services, and other social and physical environmental factors.

Psychologists are encouraged to recognize that environmental factors do not detract from the importance placed on a client's personal and perceived world. Rather, they encourage awareness of how life is experienced in the context of the social and physical environments where the client lives. The location of schools, police departments, clinics and hospitals, and even grocery and department stores, all of which represent elements of the so-called built environment (Opotow, 2018), can also be accessed, as can crime statistics. Addressing challenges to physical access to critical resources for people with disabilities is important to consider. Psychologists can also explore the influence of social media on individuals and communities and how it can be both a resource and a stressor.

Applications to Practice, Research, and Consultation

Practice. Clients from low-resource neighborhoods may present with problems exacerbated by living in neighborhoods characterized by poverty, poor health care, lack of access to health care and disability services, high crime rates that lead to chronic fears for personal safety, few public spaces, and inadequate staffing and resources in schools. Individuals living in low-resource environments, including both those from historically discriminated groups and more mainstream, may be more likely to receive lower quality care from health services and face more barriers to accessing care.

Research. Various physical health problems, such as mortality, cardiovascular disease, diabetes, asthma, and obesity, are disproportionately represented among persons living in low-resource neighborhoods (Diez Roux & Mair, 2010). The reasons for these disparities, however, are complex and deserve researchers' attention. For example, how can barriers to health care resulting from safety and other socioenvironmental factors be minimized for those with mobility impairments? Although rarely studied, higher levels of depressive symptomatology have also been reported in low-income areas (e.g., Diez Roux & Mair, 2010), as has the disproportionate numbers of LGBTQ+ youth in the juvenile justice system (e.g., Allen, Ruiz, & O'Rourke, 2016).

Consultation. What Berkman (2009) referred to as "social trajectory" is of particular interest to consulting psychologists (p. 34). Whereas health problems that result from early or cumulative exposure to adverse environments may be difficult to resolve, those that result from social trajectories may be more amenable to environmental interventions. Examples include efforts to reduce crime or gun violence or to improve educational or health care systems.

Level 3 Guidelines: Institutional Impact on Engagement

> *Guideline 5:* Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

Psychologists are encouraged to understand structural oppression embedded in institutional practices that produce disparities, disproportionalities, and inequities and to pursue an ongoing self-reflective process of their own social position. There are significant disparities in equitable treatment across the legal system. Profiling by the police targets individuals for suspicion of crime based on race, ethnicity, religion, immigration status, or national origin, resulting in people of color being disproportionately stopped, questioned, and ultimately arrested. Scholars have attributed this inequality to disparate criminal justice policies and implicit racism in decision-making among law enforcement and justice officials (Mauer, 2011). Although legal segregation ended 60 years ago, schools continue to be socially segregated by race, ethnicity, and class. Urban schools are marked by class segregation that intersects with ethnicity and low English proficiency (National Center for Education Statistics, 2016). Forty percent of urban students attend high poverty schools in comparison to 10% of suburban and 25% of rural students. Class inequality occurs in college access and intersects with racial/ethnic disparities.

As one example, barriers associated with mental health service utilization among immigrant populations can be characterized by examining dropping out of treatment and not seeking it, or waiting until symptoms become debilitating (Dow, 2011). Potential reasons include a cultural disconnect with Western conceptualizations and treatment, language barriers, and misdiagnosis (Dow, 2011). Many refugees and asylees, despite various physical and mental health concerns, avoid public programs and assistance, due to the fear of losing legal status. Additionally, religion and religious oppression can intersect with other social categories, such as race, gender, sexual orientation, gender identity, ability, or class status.

Applications to Practice, Research, and Consultation

Practice. Psychologists are encouraged to make diagnoses and conduct assessments that are culturally tailored and ecologically relevant and to consider preimmigration vulnerabilities (e.g., religious persecution, torture, rape, flight, and relocation camps) and postimmigration stressors (e.g., underemployment, absence of support, rejection by the host society, identity conflicts, and acculturative stress; Roysircar, 2004). Refugees who have been resettled are likely grieving multiple losses, including loss of role, community, and supports.

Research. Research can be dynamically focused on the multiple arenas of health care and service delivery. These may include access to and awareness of health care options; utilization; help-seeking attitudes; mainstream stigma of marginalized societies; cultural stigma; individuals' internalized stigma; sensitivity to between and within-group differences; and immigrant and refugee perceptions on health care options, delivery processes, and treatment outcomes.

Consultation. Psychologists are encouraged to consult with nongovernmental organizations and community groups to identify specific problems to be solved that reflect inequitable access including alternative service delivery.

> *Guideline 6:* Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

The term *culture-centered interventions* (Pederson, 1997) refers to efforts that view the integration of culture and language as central to the delivery of services. Related work has considered the role of culturally centered psychologists as a tool in the provision of culturally and linguistically relevant clinical services, the development of rapport from a cross-cultural framework (Hays, 2016; Tummala-Narra, 2016), and social justice efforts to decrease health disparities through the provision of culturally centered service delivery and development of more culturally responsive infrastructures. Research has found significant differences across communities in terms of access and utilization of services (U.S. Department of Health and Human Services [USDHHS], 2001).

Advocacy, prevention, and early intervention. Psychologists are encouraged to identify ways in which they may serve as advocates for system change or "collective mental health advocacy" (Gee, McGarty, & Banfield, 2015, p. 1; Stringfellow & Muscari, 2003).

Primary prevention efforts are designed to prevent the development of issues such as school violence, anxiety disorders, and internalizing/externalizing mental health problems in response to various content areas. Early intervention (Shonkoff & Meisels, 2000) refers to

> multidisciplinary services provided for children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning (pp. xvii–xviii).

Effective prevention programs are informed by the contextual needs of the community they are designed to serve.

Applications to Practice, Research, and Consultation

Practice. Psychologists are encouraged to be aware of cultural differences in perceptions of mental health and its significance and to consult the science of prevention and intervention, especially with respect to evidence-based support for culture-centered interventions (Zane, Bernal, & Leong, 2016). Relationship-centered advocacy emphasizes developing a mutually collaborative relationship based on a social justice framework. Through advocacy efforts, psychologists participate in a "cooperative community" (Gee et al., 2015, p. 2) that seeks to improve the lives of those struggling with mental health issues.

Research. Researchers are encouraged to foster the development of the science of culture-centered interventions (Zane et al., 2016). Psychologists strive to seek research participants who are diverse across multicultural variables so that findings reflect the needs of specific populations and respond to gaps in the literature by developing or applying research measures that address multicultural contexts. Testing and development of measures in different languages and among diverse cultures is critical to the development of the literature on culture-centered interventions and measures with culturally sound psychometric findings.

Consultation. Psychologists are encouraged to engage in consultation that furthers the development and implementation of culture-centered interventions. Consulting psychologists strive to support advocacy efforts that promote access to care and further develop a culturally centered mental health infrastructure.

Level 4 Guidelines: Domestic and International Climate

> *Guideline 7:* Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.

Psychologists, although acting locally, aspire to think globally and understand human conditions within broad global systems. International psychology represents a postmodern form of consciousness, with psychologists theorizing about universal conditions while also operationalizing

culture-specific manifestations of a universal experience. The United States' involvement in globalization requires attention. The U.S. military covers 75% of the world's nations and is deployed in more than 150 countries, with over 130,000 of active-duty personnel (Vine, 2015). The effect of U.S. wars (e.g., Operation Iraqi Freedom, Operation Enduring Freedom in Afghanistan) has made posttraumatic stress disorder (PTSD), traumatic brain injuries, and military suicide prevalent, affecting thousands of soldiers and millions of family members (Shen, Arkes, Kwan, Tan, & Williams, 2010). The number of international students at American colleges and universities grew by 7.1% to over one million in 2015–2016. An estimated 10% of all American undergraduates studied abroad (Open Doors, 2016). Another area of international psychology is *transnationalism,* defined as "the ability of individuals and families to travel and maintain relationships across national borders" (Byng, 2017, p. 131). Unaccompanied minors (i.e., children and adolescents who arrive in the United States without their parents or primary caregivers) are a growing community in U.S. and Canadian schools. Third culture kids are U.S. children and adolescents being raised in countries other than their passport country, who upon return to their birth–first country may face stress and/or trauma from feeling a lack of belonging in their countries of origin (Pollock & Van Reken, 2009). Increased possibilities of communicating across the globe through the Internet allow people to pursue connections and attachments so that the quest for discovery of new lands and people can easily shift from fantasy to reality and vice versa.

Applications to Practice, Research, and Consultation

Practice. U.S. psychologists aspire to prevent colonization of indigenous or culture-specific systems of health care. Psychologists are encouraged to export cultural empathy that is steeped in a sense of mutuality, openness, and deep empathic attunement. Partnerships between primary health care systems of other nations and U.S. behavioral health practices are needed for integrated treatment and increased human resources. U.S. psychologists in international primary care settings can broadly address in a limited number of short sessions an array of problems (i.e., medical, psychosomatic, relational, and culture-bound syndromes).

Research. Research is needed on the nature and status of mental health professions in different countries to understand the feasibility of a global helping paradigm to link psychology, psychotherapy, and indigenous healing across national boundaries. Many areas of research that intersect domestic and international psychology are understudied, areas such as those focused on structural forms of stigma (e.g., homophobia, transphobia) and their impact on individuals and communities, the adaptation among transcultural and transnational people, and the experiences of international adoptees. Psychologists are encouraged to consult with local nongovernmental organizations, health clinics, and stakeholders to develop local regulatory standards for their research.

Consultation. Psychologists are encouraged to consult about accessible, equitable, and effective global mental and behavioral health care and the impact of economic globalization.

> *Guideline 8:* Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

An individual's life cycle is heavily influenced not only by the immediate social and physical environment but also by current societal trends and historical period. For example, wars and economic depressions affect individuals at all stages of the life cycle; however, the effects may differ depending on age or experiential history (Takizawa, Maughan, & Arseneault, 2014). Some historical periods, such as the continuing impact of America's period of slavery and genocide, have a lasting influence. For these reasons, psychologists seek to develop and sustain an awareness of how an individual's identity has changed over time and how the person's identities, and the salience of each of these identities, are affected by the historical period and the concurrent immediate developmental, social, and familial contexts within which the individual is situated. To date, only minimal attention has been paid to considering intersectionality from the perspective of developmental stage and historical time, but the available literature supports the necessity of doing so (e.g., USDHHS, 2001).

Applications to Practice, Research, and Consultation

Practice. Psychologists attend to the impact that interventions may have on community identity and understanding. For example, a majority of children with profound hearing loss are born to parents without hearing loss (National Institute on Deafness and Other Communication Disorders, 2016), and nearly 60,000 children in the United States had received cochlear implants by 2012. Such implants have been a point of controversy in the deaf community, because many activists feel that a hearing "impairment" is neither an impairment nor a disability and look unfavorably on implants (Sparrow, 2005) as a challenge to deaf culture. They seek a broader consideration by professionals of the option to allow a child to grow up as deaf and not to stigmatize that option.

Research. Psychologists are encouraged to recognize various models of identity (e.g., Phinney, 1996). Further

research is needed on the multidimensional aspects of ethnic identity and developmental influences on individuals' intersectional identities. When conducting research, psychologists seek to pay close attention to and inform themselves of intersectional considerations that participants present and how these influence interpretations of findings regarding self, identity, group membership, and the consistency of presentation across groups of a psychological phenomenon or concept.

Consultation. Psychologists are encouraged to recognize the multiple and often unique factors underlying how well individuals thrive and meet goals during different stages of the life course.

Level 5 Guidelines: Outcomes

> *Guideline 9:* Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the *Layered Ecological Model of the Multicultural Guidelines*.

Psychologists acknowledge that assessment tools and nearly all clinical interventions have the potential to mischaracterize or even miss the behavioral health needs of diverse populations due to cultural and regional differences, stigma, literacy (including health), the unique presentation of symptoms, explanations of psychological distress, and distrust of providers and authority in general, among other factors (Sue & Sue, 2016). Focus groups and community involvement are forms of qualitative research that may be helpful in the early stages of cultural adaptation of psychological practices (Ramos & Alegría, 2014). Further, psychologists recognize that they do not work in isolation from the community. There is a responsibility to ensure sufficient outreach to allow community feedback and monitoring of services and to ensure that providers are well versed in the practice of multicultural competence and that community members themselves have had educational opportunities designed to inform them of signs and symptoms of behavioral health problems and how to access services (Chiriboga & Hernandez, 2015).

Applications to Practice, Research, and Consultation

Practice. Psychologists are aware that dropout rates among persons of color recruited for studies or participating in interventions are generally higher than those found among non-Latino/Hispanic/Latinx, White/White American research participants and clients (Zane et al., 2016). Among the reasons are problems with developing a therapeutic or research alliance, distrust, or a feeling that the intervention or research lacks relevance to the individual's life. Others may be reluctant to participate in research or therapy due to their legal status, stigma associated with mental health disorders, gender identity, and unfamiliarity with research or with the health care system. Psychologists recognize these barriers and seek to improve rapport.

Research. Given their reliance on primarily non-Latino/Hispanic/Latinx, White/White American samples, psychologists strive to recognize that the often-limited generalizability of randomized controlled trials may reduce the effectiveness of resulting evidence-based treatments (EBTs) with diverse groups (Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012). Culturally adapted interventions have demonstrated efficacy (Bernal & Domenech Rodríguez, 2012). There is a need for establishing the effectiveness of EBTs for specific groups with a history of discrimination and systematic disadvantage. Culturally adapted research and intervention is a hallmark of community-based participatory research (CBPR; Jernigan, Jacob, Styne, & the Tribal Community Research, 2015). CBPR and other community-engaged research approaches involve working closely with community members as partners and stakeholders and can improve recruitment of diverse groups, resolve potential problems of the community's trust or interest, reduce attrition, and improve cultural appropriateness.

Consultation. Glover and Friedman (2015) contend that when consulting with persons from diverse cultural groups, psychologists check their "cultural baggage" (p. 149). At issue is viewing clients/organizations from their own biased perspective. The consultant may wish to encourage the use of mixed methodologies where qualitative strategies can inform investigators of the validity of quantitative results.

> *Guideline 10:* Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

A strength-based approach seeks to consider and incorporate the positive attributes that diverse individuals, families, groups, and organizations bring to their experiences. Psychologists who operate from a strength-based perspective acknowledge challenges while also identifying positive ways in which diverse individuals, families, groups, communities, and organizations address life experiences. Resilience is one aspect of the strength-based approach that refers to the "process, capacity or outcome of successful adaptation despite challenges or threatening circumstances . . . good outcomes despite high risk status, sustained competence under threat and recovery from trauma" (Masten, Best, & Garmezy, 1990, p. 426). Recent models incorporate sociocultural context into an understanding of resilience and how social position factors can either promote or inhibit positive development (Clauss-Ehlers, 2008; García Coll & Marks, 2012; Roysircar, Colvin, Afolayan, Thompson, & Robertson, 2017). Culturally focused resilient adaptation is "a dy-

namic, interactive process in which the individual negotiates stress through a combination of character traits, cultural background, cultural values, and facilitating factors in the sociocultural environment" (Clauss-Ehlers, 2004, p. 36).

Although trauma is a universal experience, psychologists are encouraged to consider the cultural context in which traumatic events unfold. The interpretation of and response to trauma may be shaped by cultural constructs such as societal norms focused on individualism versus collectivism (i.e., a focus on the individual vs. a focus on the group), religion and spirituality, body and mind (i.e., connections between the mind and the body), social roles, and overarching cultural values. Harvey (2007) has argued that resilience is influenced by individuals' and communities' complex and dynamic contexts; as such, resilience in the process of trauma recovery entails negotiation of multiple domains of functioning within these contexts and is shaped by accessible resources and cultural values and beliefs.

Applications to Practice, Research, and Consultation

Practice. Culturally informed clinical and community-based interventions consider the role of historical and ongoing experiences of trauma and social injustice, as experienced and narrated by survivors (Brown, 2010). Attending to trauma and resilience in psychological practice further involves a consideration of traumatic exposure that is not currently recognized as a precipitant to PTSD in existing psychiatric diagnostic manuals. Specifically, traumatic stress rooted in exposure to violence based on sexism, racism, xenophobia, deportation policies, religious discrimination, poverty, heterosexism, homophobia, transphobia, social class discrimination, and ableism is a key problem that negatively affects individuals' and communities' psychological well-being. Psychologists in practice settings can inquire about individuals' and communities' experiences with social and political injustice and trauma and their impact on psychological health and access to appropriate care and resources.

Research. Research is needed on the local definitions of *resilience,* such as religious precepts (Roysircar, 2013), and political processes of nationalism and patriotism, to provide evidence for the concept of cultural resilience (Clauss-Ehlers, 2008). Research can incorporate samples that represent diverse sociodemographic and developmental variables. The application of qualitative and quantitative approaches will present diverse ways to explore relevant constructs.

Consultation. Consultation also encompasses attention to secondary traumatic stress and vicarious traumatization, including that of mental health providers. Systemic factors of resilience include reductions of disparity in health and psychological care.

Guideline Application: A Case Illustration

A novel element with the revised *Multicultural Guidelines* is the cases developed for each guideline, which serve as teaching tools to highlight their application. The following presents a summary of Anthony's experience (the name is a pseudonym and based on a composite of clients; see http://www.apa.org/about/policy/multicultural-guidelines.PDF for the complete case). It highlights key themes reflected in Guideline 4, with its focus on the social and physical environment, and incorporates developmental and ability status-related considerations.

Anthony, a 25-year-old, cisgender, biracial/multiethnic man, was referred for psychotherapy and vocational rehabilitation. He presented with a history of mild intellectual disability acquired secondary to a traumatic brain injury (TBI), sustained at age 15. Before his injury, Anthony was enrolled in a college prep high school and was active in athletics and extracurriculars. Anthony lost both his parents and two siblings when he and his family were in a car accident. Two older siblings now serve as his guardians. Clinical discussions indicated that Anthony was struggling with impulse control that led to difficulties at his residence and the sheltered employment program he attended. Early therapeutic work focused on helping Anthony share his experience of himself as a man with an acquired disability and how his viewpoint of himself had changed. Because he sustained injuries to his developing executive skills, he had challenges with flexibility, thinking strategically, and impulsivity, including saying inappropriate things to others. Anthony shared that he often felt dismayed that he was now seen as "ugly" and "stupid." He compared what was different for him across time, focusing on the scar he had because of his neurosurgeries, his inability to ambulate independently, and his altered growth, because he was notably shorter than peers. Anthony began to talk more directly about what he lost cognitively and emotionally because of the accident, sharing that he had been a budding wrestler and a good student before his TBI and that he had many friends then, too. Anthony stated that he was often reminded of his losses when he saw perceived neurotypical peers outside of his program and residence.

As treatment continued, discussions focused on Anthony's experience of loss and his ability to see the possibility of a life that was more layered and optimistic. Regarding his impulsive actions, the therapist helped Anthony better understand his range of feelings regarding intimacy and sexuality. They took into account that he had physical and cognitive differences that affected how he could express his attraction to someone. One important step forward occurred when Anthony was able to meet a wider range of peers, both for friendship and for potential dating, and to distinguish between an interest in intimacy and sexual desire. Therapy helped Anthony talk about and better understand his sexual desires and his body and to learn how to express his feelings in a socially appropriate manner. Anthony worked to recognize himself as not only

someone with a disability but also as a member of a wider array of communities. He was supported in mourning the trauma and losses he experienced and in beginning to view himself as resilient. This led Anthony to seek out new opportunities within his vocational program and to open himself up to the interest that a fellow peer had expressed with regard to dating him.

Conclusion

The goal of the 2017 *Multicultural Guidelines* is to present practice guidelines to help the practitioner, educator, researcher, and consultant strive to identify, understand, and respond to multicultural content in a helpful, professional way. The five layers of the *Layered Ecological Model of the Multicultural Guidelines*—bidirectional model of self-definition and relationships; community, school, and family context; institutional impact on engagement; domestic and international climate; and outcomes—present an ecological framework from which psychologists can consider and apply the *Multicultural Guidelines.*

References

Allen, S. T., Ruiz, M. S., & O'Rourke, A. (2016). Differences in the prevalence of risk behaviors between heterosexual and lesbian, gay, bisexual, and questioning (LGBQ) female adolescents in the juvenile justice system. *Journal of Gay & Lesbian Social Services, 28,* 171–175. http://dx.doi.org/10.1080/10538720.2016.1158137

2010 amendments to the 2002 "Ethical principles of psychologists and code of conduct." (2010). *American Psychologist, 65,* 493. http://dx.doi.org/10.1037/a0020168

American Psychiatric Association (APA). (2013). *American Psychiatric Association's Cultural Formulation Interview*. Washington, DC: Author.

American Psychological Association (APA). (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: Author.

American Psychological Association (APA). (2008). *Report of the Task Force on the Implementation of the Multicultural Guidelines*. Washington, DC: Author.

American Psychological Association (APA). (2015a). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70,* 832–864. http://dx.doi.org/10.1037/a0039906

American Psychological Association (APA). (2015b). Professional practice guidelines: Guidance for developers and users. *American Psychologist, 70,* 823–831. http://dx.doi.org/10.1037/a0039644

American Psychological Association (APA). (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality, 2017*. Retrieved from http://www.apa.org/about/policy/multicultural-guidelines.aspx

American Psychological Association, Commission on Accreditation. (2015). *Standards of accreditation for health service psychology*. Retrieved from http://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

Berkman, L. F. (2009). Social epidemiology: Social determinants of health in the United States: Are we losing ground? *Annual Review of Public Health, 30,* 27–41. http://dx.doi.org/10.1146/annurev.publhealth.031308.100310

Bernal, G., & Domenech Rodríguez, M. M. (Eds.). (2012). *Cultural adaptations: Tools for evidence-based practice with diverse populations*. http://dx.doi.org/10.1037/13752-000

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32,* 513–531. http://dx.doi.org/10.1037/0003-066X.32.7.513

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Brown, L. S. (2010). *Feminist therapy*. Washington, DC: American Psychological Association.

Byng, M. (2017). Transnationalism among second-generation Muslim Americans: Being and belonging in their transnational social field. *Social Sciences, 6,* 131. http://dx.doi.org/10.3390/socsci6040131

Chiriboga, D. A., & Hernandez, M. (2015). Multicultural competence in geropsychology. In P. A. Lichtenberg & B. T. Mast (Eds.), *APA handbook of clinical geropsychology* (pp. 379–419). Washington, DC: American Psychological Association.

Chiu, C. Y., & Chen, J. (2004). Symbols and interactions: Application of the CCC model to culture, language, and social identity. In S. H. Ng, C. N. Candlin, & C. Y. Chiu (Eds.), *Language matters: Communication, culture, and identity* (pp. 155–182). Hong Kong: City University of Hong Kong Press.

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society, 38,* 785–810. http://dx.doi.org/10.1086/669608

Clauss-Ehlers, C. S. (2004). Re-inventing resilience: A model of "culturally-focused resilient adaptation". In C. S. Clauss-Ehlers & M. D. Weist (Eds.), *Community planning to foster resilience in children* (pp. 27–41). http://dx.doi.org/10.1007/978-0-306-48544-2_3

Clauss-Ehlers, C. S. (2006). Bilingualism. In Y. Jackson (Ed.), *Encyclopedia of multicultural psychology* (pp. 70–71). http://dx.doi.org/10.4135/9781412952668.n33

Clauss-Ehlers, C. S. (2008). Sociocultural factors, resilience, and coping: Support for a culturally sensitive measure of resilience. *Journal of Applied Developmental Psychology, 29,* 197–212. http://dx.doi.org/10.1016/j.appdev.2008.02.004

Comas-Díaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. http://dx.doi.org/10.1037/13491-000

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

Diez Roux, A. V., & Mair, C. (2010). Neighborhoods and health. *Annals of the New York Academy of Sciences, 1186,* 125–145. http://dx.doi.org/10.1111/j.1749-6632.2009.05333.x

Dow, H. D. (2011). Migrants' mental health perceptions and barriers to receiving mental health services. *Home Health Care Management & Practice, 23,* 176–185. http://dx.doi.org/10.1177/1084822310390876

García Coll, C., & Marks, A. K. (2012). *The immigrant paradox in children and adolescents: Is becoming American a developmental risk?* http://dx.doi.org/10.1037/13094-000

Gee, A., McGarty, C., & Banfield, M. (2015). What drives systemic mental health advocates? Goals, strategies, and values of Australian consumer and carer advocacy organizations. *Sage Open, 5,* 1–8. http://dx.doi.org/10.1177/2158244015615384

Glover, J., & Friedman, H. L. (2015). *Transcultural competence: Navigating cultural differences in the global community*. http://dx.doi.org/10.1037/14596-000

Goodley, D., & Runswick-Cole, K. (2011). The violence of disablism. *Sociology of Health & Illness, 33,* 602–617. http://dx.doi.org/10.1111/j.1467-9566.2010.01302.x

Harvey, M. R. (2007). Towards an ecological understanding of resilience in trauma survivors. *Journal of Aggression, Maltreatment & Trauma, 14,* 9–32. http://dx.doi.org/10.1300/J146v14n01_02

Hays, P. A. (2016). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (3rd ed.). Washington, DC: American Psychological Association.

Healthy People 2020. (2017). *Social determinants of health*. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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

Hook, J. N., & Watkins, C. E., Jr. (2015). Cultural humility: The cornerstone of positive contact with culturally different individuals and groups? *The American Psychologist, 70,* 661–662.

Jernigan, V. B. B., Jacob, T., Styne, D., & the Tribal Community Research Team. (2015). The adaptation and implementation of a community-based participatory research curriculum to build tribal research capacity. *American Journal of Public Health, 105*(Suppl. 3), S424–S432. http://dx.doi.org/10.2105/AJPH.2015.302674

Kawachi, I., Subramanian, S. V., & Kim, D. (Eds.). (2008). *Social capital and health*. New York, NY: Springer.

Mann, M. A. (2006). The formation and development of individual and ethnic identity: Insights from psychiatry and psychoanalytic theory. *The American Journal of Psychoanalysis, 66,* 211–224.

Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2,* 425–444. http://dx.doi.org/10.1017/S0954579400005812

Mauer, M. (2011). Addressing racial disparities in incarceration. *The Prison Journal, 91,* S87–S101.

National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice*. Washington, DC: Author.

National Center for Education Statistics. (2016). *Urban schools: The challenge of location and poverty: Executive summary*. Retrieved from http://nces.ed.gov/pubs/web/96184ex.asp

National Institute on Deafness and Other Communication Disorders. (2016, December 6). *Quick statistics: National Institute on Deafness and Other Communication Disorders*. Retrieved December 6, 2016, from https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing

Open Doors. (2016). *Annual Open Doors report*. Retrieved from https://www.insidehighered.com/news/2016/11/14/annual-open-doors-report-documents-continued-growth-international-students-us-and-us

Opotow, S. (2018). Social justice theory and practice: Fostering inclusion in exclusionary contexts. In P. Hammack (Ed.), *The Oxford handbook of social psychology and social justice* (pp. 41–58). http://dx.doi.org/10.1093/oxfordhb/9780199938735.013.2

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

Phinney, J. S. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist, 51,* 918–927. http://dx.doi.org/10.1037/0003-066X.51.9.918

Pollock, D. C., & Van Reken, R. E. (2009). *Third culture kids: Growing up among worlds* (Rev. ed.). Boston, MA: Brealey.

Ramos, Z., & Alegría, M. (2014). Cultural adaptation and health literacy refinement of a brief depression intervention for Latinos in a low-resource setting. *Cultural Diversity and Ethnic Minority Psychology, 20,* 293–301. http://dx.doi.org/10.1037/a0035021

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44,* 28–48. http://dx.doi.org/10.1002/jmcd.12035

Reed, G. M., McLaughlin, C. J., & Newman, R. (2002). American Psychological Association policy in context: The development and evaluation of guidelines for professional practice. *American Psychologist, 57,* 1041–1047.

Root, M. P. P. (2003). Racial identity development and persons of mixed-race heritage. In M. P. P. Root & M. Kelly (Eds.), *The multiracial child resource book: Living complex identities* (pp. 34–41). Seattle, WA: Mavin Foundation.

Roysircar, G. (2004). Cultural self-awareness assessment: Practice examples from psychology training. *Professional Psychology: Research and Practice, 35,* 658–666. http://dx.doi.org/10.1037/0735-7028.35.6.658

Roysircar, G. (2013). Disaster counseling: A Haitian family case post January 12, 2010 earthquake. In S. Poyrazli & C. E. Thompson (Eds.), *International case studies in mental health* (pp. 155–180). http://dx.doi.org/10.4135/9781452240589.n10

Roysircar, G., Colvin, K. F., Afolayan, A. G., Thompson, A., & Robertson, T. W. (2017). Haitian children's resilience and vulnerability assessed with House-Tree-Person (HTP) drawings. *Traumatology, 23,* 68–81.

Roysircar-Sodowsky, G., & Maestas, M. (2000). Acculturation, ethnic identity, and acculturative stress: Evidence and measurement. In R. H. Dana (Ed.), *Handbook of cross cultural and multicultural personality assessment* (pp. 131–172). Mahwah, NJ: Erlbaum.

Shen, Y.-C., Arkes, J., Kwan, B. W., Tan, L. Y., & Williams, T. V. (2010). Effects of Iraq/Afghanistan deployments on PTSD diagnoses for still active personnel in all four services. *Military Medicine, 175,* 763–769.

Shonkoff, J. P., & Meisels, S. J. (2000). *Handbook of early childhood intervention* (2nd ed.). New York, NY: Cambridge University Press.

Sirin, S. R., & Fine, M. (2008). *Muslim American youth: Understanding hyphenated identities through multiple methods*. New York: New York University Press.

Southam-Gerow, M. A., Rodríguez, A., Chorpita, B. F., & Daleiden, E. L. (2012). Dissemination and implementation of evidence based treatments for youth: Challenges and recommendations. *Professional Psychology: Research and Practice, 43,* 527–534. http://dx.doi.org/10.1037/a0029101

Sparrow, R. (2005). Defending Deaf culture: The case of cochlear implants. *Journal of Political Philosophy, 13,* 135–152. http://dx.doi.org/10.1111/j.1467-9760.2005.00217.x

Stringfellow, J. W., & Muscari, K. D. (2003). Program of support for consumer participation in systems change: The West Virginia Leadership Academy. *Journal of Disability Policy Studies, 14,* 142–147. http://dx.doi.org/10.1177/10442073030140030301

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *Counseling Psychologist, 10,* 45–52. http://dx.doi.org/10.1177/0011000082102008

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). Hoboken, NJ: Wiley.

Takizawa, R., Maughan, B., & Arseneault, L. (2014). Adult health outcomes of childhood bullying victimization: Evidence from a five-decade longitudinal British birth cohort. *American Journal of Psychiatry, 171,* 777–784. http://dx.doi.org/10.1176/appi.ajp.2014.13101401

Tummala-Narra, P. (2016). *Psychoanalytic theory and cultural competence in psychotherapy*. http://dx.doi.org/10.1037/14800-000

U.S. Department of Health and Human Services (USDHHS). (2001). *Mental health: Culture, race and ethnicity: A supplement to mental health: A report of the Surgeon General*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK44243/

Vine, D. (2015). *Base nation: How U.S. military bases abroad harm America and the world.* New York, NY: Metropolitan Books/Henry Holt.

Zane, N., Bernal, G., & Leong, F. T. L. (Eds.). (2016). *Evidence-based psychological practice with ethnic minorities: Culturally informed research and clinical practice*. Washington, DC: American Psychological Association.

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