APA GUIDELINES for Psychological Practice with Girls and Women

FEBRUARY 2018

AMERICAN PSYCHOLOGICAL ASSOCIATION

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INTRODUCTION

During recent decades, girls and women of diverse ethnicities and races, abilities, social classes, sexual orientations, gender identities, and life experiences have encountered dramatic and complex changes in education, work, reproductive and caregiving roles, and personal relationships. Many of these changes have yielded increased equality, improved opportunities, and enhanced quality of life. Still, girls and women continue to face challenges and concerns that warrant the revision of the 2007 *APA Guidelines for Psychological Practice with Girls and Women* in a way that takes these challenges into consideration.

Life experiences and contexts that continue to pose risks for girls and women are important for psychologists to understand, as they influence treatment, research, and psychologists' views of what are strengths and what qualifies as resistance. Of note, in some cultures, resistance is a healthy response to oppression. Particularly notable experiences and contexts include interpersonal violence, unrealistic and stereotypical media images of girls and women, discrimination and oppression, devaluation, limited economic resources, role overload, relationship disruptions, and work inequities. These contexts sometimes affect women of diverse identities differently. We offer a brief review of some notably salient scholarship below with an understanding that in a brief review, all identities, contexts, and life experiences of half the population cannot be adequately represented, so we refer readers to an accompanying monograph representing the comprehensive literature reviews completed to undergird and inform the revision of these guidelines.

Violence and sexual violence against girls and women continue to occur with great frequency. For example, United Nations data (2008) indicates that 70% of women experience some form of violence in their lifetime, with more recent research estimating this figure at 90% for the United States (U.S.) (Kilpatrick et al., 2013). About 1 in 5 women are raped at some point in their lives, most often by a male acquaintance or intimate partner (Black et al., 2011); 1 in 4 college women experience sexual assault (Cantor, 2015); and girls are more likely to have experienced sexual abuse in childhood than boys (Finkelhor, Shattuck, Turner, & Hamby, 2014). Long-term effects of child sexual abuse in women include dissociation, somatization, anxiety, depression, suicidality, substance use problems, and eating disorders (Briere & Jordan, 2009; Briere & Scott, 2014). In addition, girls who experience abuse may be at risk for experiencing additional trauma in adulthood (Parks, Kim, Day, Garza, & Larkby, 2011). Girls frequently experience sexual harassment in schools (Hill, C. & Kearl, H.,, 2013) and physical abuse in their dating relationships (Rennison & Addington, 2014). Women experience intimate partner violence more frequently than men, and such violence is often preceded and/or

accompanied by psychological abuse (e.g., jealousy, controlling tactics, verbal abuse; Breiding, Chen, & Black, 2014). Experiencing any interpersonal violence is especially prevalent among women in the military (Suris & Lind, 2008; Turchik & Wilson, 2010), adolescent girls (Black et al., 2011), girls and women of color (Hien & Ruglass, 2009), girls and women who are refugees (Björn, Bodén, Sydsjö, Gustafsson, & Gustafsson, 2013; Grabska, 2011) and transgender women (Human Rights Campaign, 2015). Elder abuse is more common among women than men, with 22% experiencing violence and 18% experiencing intimate partner violence after the age of 65 (United Nations, 2013). In China, Israel, and the European Union, research shows being female is one of the risk factors for elder abuse (United Nations, 2013). Enduring interpersonal violence is associated with a range of health outcomes, such as depression, post-traumatic stress disorder, chronic health problems, and physical injuries (APA, 2017a; Eshelman & Levendosky, 2012; Humphreys & Lee, 2009).

There are several kinds of stressors recently identified that have a unique impact on women throughout their lifespans, most notably social network–related stress and unemployment because of their links to depression (Kendler & Gardner, 2014; Van Praag, Bracke, Christiaens, Levecque, & Pattyn, 2009). Differences in sex role orientation affect women's coping styles and mental health (Lipińska-Grobelny, 2011; Nasit & Desai, 2014). The stress that accompanies racial discrimination appears to have a particularly adverse impact on the mental health of African American women (Greer, Laseter, & Asiamah, 2009). This is also true for LGBTQ individuals (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). Additionally, race- and gender-related discrimination exacerbate responses to other types of stressors (Perry, Harp, & Oser, 2013). Multiple roles and role overload have been named as stressors for women (Glynn, Maclean, Forte, & Cohen, 2009); for women who leave the workplace, the same stressors can contribute to difficulties in re-entry (Lovejoy & Stone, 2011). Women who occupy multiple roles often take home the message that they should not "stress" and that they should learn to "juggle" better, as Abrams and Curran (2009) found when they interviewed low-income mothers. Finally, gender inequities are among the many factors that affect women's health and mental health adversely (Gahagan, Gray, & Whynacht, 2015; Hawkes & Buse, 2013), and therapists must recognize this fact if they are to do more than help women adjust to the status quo.

Unrealistic and stereotypical media images of girls and women continue to be of concern to psychologists and intersect in various ways with girls' and women's vulnerabilities around self-esteem, eating disorders, depression, sexual development, general well-being, and feelings of belonging (Allen & Gervais, 2012; Balantekin, Birch, & Savage, 2017; Damiano, Paxton, Wertheim, McLean, & Karen, 2015; Murnen & Smolak, 2013; Rodgers, Wertheim, Damiano, Gregg, & Paxton, 2015; Ward, 2016). In Western media, women and girls are pervasively exposed to messages that encourage an appearance-based appraisal of social worth (Mischner, van Schie, & Engels, 2013). Stereotypes and media representations affect girls and women of various races, ethnicities, and sexualities, and those with disabilities. As one example, stereotypes of veiled Muslim women in the U.S. and Europe present a daily stress to girls and women (Everett et al., 2015).

Although overt forms of sexism and racism may have appeared to have decreased over time (Sue, 2010), more recently, a resurgence of overt racism and sexism is apparent nationally and globally (Bock, Byrd-Craven, & Burkley, 2017). Researchers have noted the effects of political changes on individuals (Hatzenbuehler, Keyes, & Hasin, 2009) and documented the continuing presence of more subtle forms of sexist and racist bias (e.g., microaggressions; Sue, 2010). Women with diverse marginalized identities, such as bisexual, lesbian, queer, and transgender women; women of color; and low socioeconomic class women face stressors that can result in considerable psychological distress (Balsam et al., 2011; Chaney, 2010). Women of color suffer from at least two intersected sources of discrimination—gender and race/ethnicity—and therefore are multiply marginalized (Carbado, 2013; Cho, Crenshaw, & McCall; 2013; Comas-Díaz & Greene, 2013; Enns, Rice, & Nutt, 2015). Within the medical sector, researchers have identified the influence of health care providers' biases in perpetuating health care disparities among racial and gender minorities (Chapman, Kaatz, & Carnes, 2013; Fitzgerald & Hurst, 2017; Igler et al., 2017).

Women's friendships are important and continue to provide them solace, support, and help in living happier lives (Comas-Díaz & Weiner, 2013; Rose, 2007). Girls also tend to have supportive friendships, notably more supportive friendships than boys, characterized by equality, self-disclosure, and empathy (De Goede, Branje, & Meeus, 2009; Rose et al., 2012). But difficulties in girls' and women's relationships can engender and/or exacerbate mental health issues. Researchers have demonstrated that the display of relational aggression is related to girls' attempts to seek power and feel powerful in ways that are deemed acceptable to society's definition of what is feminine—that is, in horizontal ways toward other girls, a safer target than boys, adults, or unfair policies and practices (Brown, 2016).

A key factor that affects mental health for women, consistent across heterosexual and same-sex relationships, is relationship quality (Leach, Butterworth, Olesen, & Mackinnon, 2013; Todosijevic, Rothblum, & Solomon, 2005; Uecker, 2012). Relationship quality is related to both positive and negative aspects of mental health, such as depression, substance abuse, anxiety, and personal well-being for both women and men (Barr, Culatta, & Simons, 2013; Proulx, Helms, & Buehler, 2007; Whisman, 2013), but women, compared to men, are more vulnerable to interpersonal stressors and they may be more affected by decrements in relationship quality (McBride & Bagby, 2006; Whitton & Kuryluk, 2012).

Although overall, legal marriage confers greater mental health benefits to all couples than to their counterparts not in legal marriages (Wight, LeBlanc, & Badgett, 2013), relationship status alone (e.g., married, dating, cohabitating) is not sufficient to understand mental health among women in an intimate relationship. Marriage equality is currently protected by federal law in the U.S., but lesbian/queer couples and their families continue to experience the psychological effects of discrimination against same-sex marriage and the withholding of legal and medical protections for same-sex families (e.g., adoptive parent protection).

As women continue to be primary caregivers of children, it is important to note that transition to motherhood for many women is difficult and that most couples experience an increase in conflict as well as a decline in relationship satisfaction after the birth of their first

child (Doss, Rhoades, Stanley, & Markman, 2009; Lawrence, Rothman, Cobb, Rothman, & Bradbury, 2008; Mitnick, Heyman, & Smith Slep, 2009). For many women, there is a disconnection between the discourse around the *joys of motherhood* and the lived experience of parenting (Mollen, 2014). Moreover, the discourse may serve as a way to cope with the strains and disappointments of parenting (Eibach & Mock, 2011a; Eibach & Mock, 2011b). There continue to be age penalties for motherhood in the workplace (Budig & Hodges, 2010) that affect women's well-being.

Women are also overrepresented in caregiver positions for their male partners, particularly during midlife (Glauber, 2017), and are more likely than other women to be in a sandwiched position of caring for children and elderly simultaneously (Suh, 2016). Primary informal caregivers tend to be women (e.g., unpaid providers of care), many of whom balance caring for their parents, parents-in-law, partners, and friends, while simultaneously working full-time or part-time (Lin, Fee, & Wu, 2012). Women of color are especially likely to serve in filial caregiving roles (Miyawaki, 2016). Numerous researchers have found that caregivers experience significant emotional, physical, and financial stresses (Penning & Wu, 2015). Nearly 10 million American women are caregivers of elderly people with dementia who often experience significant stress with that responsibility (Zauszniewski, Lekhak, Yolpant, & Morris, 2015).

Engaging in satisfying work is related to both positive mental and physical health (McKee-Ryan, Song, Wanberg, & Kinicki, 2005; Swanson, 2012) and is valued by many women for reasons beyond the financial benefits it accords (Weisgram, Bigler, & Liben, 2010). Basford, Offerman, and Behrend (2014) found that both women and men could identify gender-based microaggressions directed particularly toward women in the workplace. Sexual harassment continues to be a significant problem in workplace and educational settings (Quick & McFadyen, 2017; Rosenthal, Smidt, & Freyd, 2016). In addition to sexual harassment, gender inequities in the workplace also affect women's health adversely (Stamarski & Son Hing, 2015). Multiple roles with regard to work and family are exacerbated for women who are under financial stress. For example, chronic work, financial, and caregiving stressors for Mexican American women are associated with physiological dysregulation (Gallo, Jimenez, Shivpuri, Espinosa de los Monteros, & Mills, 2011).

While this brief introduction cannot do justice to all the research on girls and women and their intersecting identities to which these practice guidelines should be responsive, there are several groups that deserve special attention given continued invisibility in the literature and/or a current focus based on need: gender-nonconforming identities, older women, female veterans, and girls and women with disabilities. We refer readers to an accompanying monograph for research on other identities and on particular disorders not adequately described in this introduction.

Currently there is a dearth of research examining transgender women regarding mental illness or maladjustment. However, as noted by the American Psychological Association (APA)(2015a), the etiology of mental health problems may or may not be linked directly to a person's gender identity but to pervasive experiences of minority stress. Transgender and gender-nonconforming individuals are at increased risk for suicide attempts (i.e., 41% as compared to 1.6% in the general population), in part because of bias-related experiences such as sexual and physical victimization (Grant et al., 2011). Transgender women and feminine-of-center individuals who were assigned male at birth are impacted by heavily gendered societal pressures.

Psychologists and members of the public tend not to be aware of the psychological benefits of aging for women in the U.S., including feeling freer of gender-role stereotypes and gendered roles (Rosenthal, 2014); however, there are psychological issues for older women that practitioners need to be aware of, including problems with financial resources (Szanton et al., 2008), abuse (Cooper & Livingston, 2014; Daly, Merchant, & Jogerst, 2011), racial and ethnic bias (Ng et al., 2014; Stone, 2012), and bias against those with specific disabilities associated with aging (Jeppsson Grassman, Holme, Taghizadeh Larsson, & Whitaker, 2012). Compared to older men, they are more likely to be living in poverty, suffer from disabilities, and experience elder abuse and neglect (Yan & Brownell, 2015). Women account for 70% of all older adults with incomes below the poverty level (Administration on Aging, 2013). Older women can be especially at risk for depression, alcohol problems, and loneliness (APA, 2004; Kim, Richardson, Park, & Park, 2013). In addition, ageism persists (Nelson, 2016). Women of all ages face powerful negative stereotypes of who they will become as they grow old (Gergen, 2009; Mitchell & Bruns, 2011). Older women are seen, even by psychologists, as less competitive, less competent, less assertive, and less willing to take risks than younger women (Cuddy, Norton, & Fiske, 2005).

Female military veterans are a group of women particularly at risk. The nature of military service coupled with high rates of violence and trauma experienced throughout the female veteran's life can lead to a number of challenges. Nearly 90% of female veterans have endorsed at least one traumatic event in their life, a rate higher than their male counterparts as well as the general population (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007), and approximately 40% experience military sexual trauma (Kintzle et al., 2011; Turchik & Wilson, 2010). Female veterans reported the highest rates of lifetime and past-year post-traumatic stress disorder (PTSD) compared with female civilians, male veterans, and male civilians (Lehavot, Katon, Chen, Fortney, & Simpson, 2017), and military trauma contributes to the likelihood of developing PTSD (Kintzle et al., 2011). Although female veterans often enlist in the military to escape highly dysfunctional and violent backgrounds (Sadler, Booth, Mengeling, & Doebbeling, 2004), the combination of their earlier histories of interpersonal trauma and the various aspects of military service places them at increased risk for subsequent re-victimization (Suris & Lind, 2008; Vogt, King, & King, 2007). These experiences are not only associated with an elevated risk of PTSD but also other disorders, particularly those characterized by symptoms of disturbances of affect regulation, self-perception, interpersonal relationships, somatization, and systems of meaning (Luterek, Bittinger, & Simpson, 2011).

The World Health Organization (WHO)(2011) estimates more than 1 billion people worldwide live with some form of disability. According to the WHO report, there are 200 million individuals who have difficulty functioning. Girls and women with disabilities still tend to be underrepresented in our understanding of psychological practice. Children from under-resourced communities are more likely to be disabled and excluded from education around the world (Croft,

2013). Girls and women with disabilities are at greater risk of being abused (Alriksson-Schmidt, Armour, & Thibadeau, 2010; Robinson-Whelen et al., 2010) in the U.S. and internationally. Women with disabilities are less likely than temporarily abled women to receive a college education (Steinmetz, 2006). Of the women living with disabilities ages 21 to 64 years, 30.8% are employed and 28.4% live in poverty (Erickson, Lee, & von Schrader, 2014; Nazarov & Lee, 2012). Women with disabilities were also paid significantly less than men with disabilities and were also more likely to be unemployed (Office of Disability Employment Policy, 2014). With regard to disability caused by chronic pain, large-scale epidemiologic studies demonstrate a higher pain prevalence in women compared with men, although health care professionals are less likely to take women's pain complaints seriously (Igler et al., 2017).

These contexts, experiences, and identities form an important backdrop for psychologists to consider when treating girls and women. They also contribute to vulnerabilities regarding the development of diagnoses and maladaptive coping responses. For example, women who experience interpersonal violence are more likely to be diagnosed with psychosis (Fisher et al., 2009). Substance use and abuse among women and girls continues to rise (National Council on Alcoholism and Drug Dependence, 2012) as well as deaths from drug use among women (Reinberg, 2013). There has been an increase for women with respect to rates of incarceration, independent of male incarcerations (Hall, Golder, Conley & Sawning, 2013). Girls in the juvenile justice system have increased levels of mental health issues (Marston, Russell, Obsuth, & Watson, 2012). Recently, researchers have begun to discuss the pipeline to prison for marginalized individuals, particularly people of color and those disadvantaged by social class. The initial harms from sexual abuse can result in mental health problems for girls that, depending on their context (e.g., ethnicity, sexual orientation, gender identity, class), can lead to the juvenile justice system rather than mental health treatment (Conrad, Tolou-Shams, Rizzo, Placella, & Brown, 2014; Goodkind, Ng, & Sarri, 2006; Saar, Epstein, Rosenthal, & Vafa, 2015). With regard to body image and eating disorders, by the age of 5, most children are aware of dietary restrictions, including fasting and purging as a means to lose weight, and many have begun to express negative messages about people with larger bodies (Rodgers et al., 2015). Adolescent girls are susceptible to extreme dieting, particularly when their mothers and friends tease them about their weight, when their friends diet, and in response to media influence (Balantekin et al., 2017).

In terms of psychological vulnerabilities, researchers have continued to find that women are significantly more likely to experience depression, are more vulnerable to depression relapse, and endure longer depressive episodes than men (Essau, Lewinsohn, Seeley, & Sasagawa, 2010; Oquendo et al., 2013). Girls also experience depression at a greater frequency than boys, with girls who reach puberty earlier particularly vulnerable (Llewellyn, Rudolph, & Rosiman, 2012). Women who are subjected to individual and group discrimination are even more likely to experience depression (Klonis, Endo, Crosby, & Worell, 1997). Girls and women are also 10 times more likely to have eating disorders than boys and men (American Psychiatric Association, 2013; Striegel-Moore et al., 2009). In addition, women are more likely than men to be diagnosed with nearly every anxiety disorder, including panic disorder, agoraphobia, and PTSD, compared to men (APA, 2017a; McLean, Asnaani, Litz, & Hofmann, 2011).

Moreover, girls and women tend to bear the brunt of problematic diagnoses (Marecek & Hare-Mustin, 1998; Ussher, 2013). Specific diagnoses that have been analyzed in terms of overdiagnosis among girls and women as a result of gender bias include histrionic and borderline personality disorders, depression, dissociative disorders, somatization disorder, and agoraphobia (Bekker, 1996; Cosgrove & Caplan, 2004; Eriksen & Kress, 2008; Garb, 1997; Hartung & Widiger, 1998; Lerman, 1996; Ussher, 2013). Disorders diagnosed in childhood and adolescence, in particular attention deficit–hyperactivity disorder (ADHD) and autism spectrum disorder, as well as PTSD and antisocial personality disorder, are examples of potentially underdiagnosed disorders resulting from gender bias, such as failing to account for possible differences in presentation across genders (e.g., less overt symptomatology among girls and women; Becker & Lamb, 1994; Crosby & Sprock, 2004; Bruchmüller, Magraf, & Schneider, 2012; Dworzynski, Ronald, Bolton, & Happë, 2012; Fish, 2004). Finally, premenstrual dysphoric disorder and female sexual disorders have received attention as disorders specific to females that may be misapplications of pathology or disorder labels onto distress through its relation to the biology of the reproduction system (Tiefer, 2006; Ussher, 2013). While these diagnoses are often studied in isolation, patterns of misdiagnosis also appear across diagnoses (e.g., the under-diagnosis of one disorder coupled with the overdiagnosis of another) and point to the broader, systemic influence of bias on diagnostic assessment.

Girls and women draw on a considerable array of strengths and resilience to cope with these and other gender-based adversities. Throughout their lifespans, girls and women demonstrate marked resilience. (Desjardins, 2004).Women live longer than men and as they get older are less likely to be impacted by isolation. (Singh & Misra, 2009). While women are more likely to experience poverty, their relationships and strengths can mean they are less harmed by its effects compared to men (Clark & Peck, 2012; Stark-Wroblewski, Edelbaum, & Bello, 2008). Girls enjoy more supportive friendships characterized by equality, self-disclosure, and empathy (De Goede et al., 2009). Women are generally more sexually fluid over the lifespan (Diamond, 2008; Katz-Wise & Hyde, 2014), which may allow greater opportunities for more varied loving and/or sexual relationships.

The majority of those seeking mental health services continue to be female (Cox, 2014; Wang et al., 2007) and given the experiences and contexts described and the diversity of backgrounds may have unique treatment needs, particularly in areas of growing concern such as substance abuse and stress disorders (Trimble, Stevenson, Worell, & the APA Commission on Ethnic Minority Recruitment, Retention, and Training Task Force Textbook Initiative Work Group, 2003). The new Guidelines for the Practice of Girls and Women aims at including a broad range of girls and women in the U.S. and globally.

Purpose and Scope

The purpose of these guidelines is to assist psychologists in the provision of gender-sensitive, culturally competent, and developmentally appropriate psychological practice with girls and women across

the lifespan from all social classes, ethnic and racial groups, sexual orientations, abilities and disabilities, and other diversity statuses in the U.S. and globally. These guidelines provide general recommendations for psychologists who seek to increase their awareness, knowledge, and skills in psychological practice with girls and women. The guidelines address the strengths of girls and women, their intersectional identities (see Appendix A for a definition of *intersectional* and other important terms, as well as an explanation for the use of the word *fat*), the challenges they face, and lifespan considerations, as well as research, education, training, and health care. The beneficiaries include all consumers of psychological practice, including clients, students, supervisees, research participants, consultees, other health professionals, the media, and the general public. The guidelines and the extensive body of scholarship upon which they are based are applicable to psychological practice in its broadest sense.

Documentation of Need

This document is a revision of the 2007 *Guidelines for the Psychological Practice with Girls and Women*. APA policy states that guidelines for practice expire within 10 years of adoption. Review and revision routinely occur within 2 years of expiration or when new laws and other developments require earlier review and revision. Divisions 17 and 35 appointed a Task Force for the revision of *Guidelines of Psychological Practice with Girls and Women* in 2013. These guidelines reflect such revisions and updates and are based substantially on more research on girls as well as women than earlier guidelines, emphasizing the intersectionality of girls' and women's diverse identities while carefully considering their impact on development and psychological health. Additionally, the revised guidelines underscore global and transnational issues as they relate to girls' and women's psychological functioning, as well as an inclusion of gender-variant and trans girls and women. Moreover, these guidelines identify the high exposure to trauma in girls' and women's lives and the need for the inclusion of psychological ways to address such trauma. Finally, the revised literature and guidelines attempt to bring focus to girls' and women's strengths and resilience. To this end, an additional guideline has been added to the 2007 guidelines. We encourage readers to pursue, under separate publication, the extensive documentation, including the complete history of the development of the first set of guidelines and the updated literature review that undergirds the current guidelines.

Distinction between Standards and Guidelines

The *Professional Practice Guidelines: Guidance for Developers and Users* defines *guidelines* as "statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists" (APA, 2015b, p. 824). Guidelines differ from standards such that standards are mandatory and are generally enforceable, whereas guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. Guidelines may not be applicable to every professional and clinical situation. They "are not mandatory, definitive, or exhaustive . . . [nor] intended to take precedence over the professional judgments of psychologists" (APA, 2015b, p. 828). Federal or state laws may supersede these guidelines. For more information about the development of professional guidelines, see http://www.apa.org/practice/guidelines/index.aspx.

Compatibility

The following guidelines were written and revised to be compatible with the APA's *Ethical Principles of Psychologists* (APA, 2010) as well as existing APA guidelines, including the more recent the *Clinical Practice Guidelines for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults* (APA, 2017a), *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (APA, 2012b), *Guidelines for Psychological Practice with Transgender and Gender Non-Conforming Clients* (APA, 2015a), and the revised *Multicultural Guidelines for the 21st Century* (2017b).

We strongly encourage individual readers, departments, agencies, organizations, and institutions to discuss ways these guidelines may be applied to their specific settings and relevant activities. APA recommends guidelines will need to be reviewed and updated at least every 10 years (8 years is recommended) to consider changes in practice, research, and the effects of changing contemporary social forces and context. The following represents the first revision of the original guidelines.

It should be noted that many of the guidelines and recommended practices addressed in this document apply to individuals of all genders with diverse identities. For example, many of the guidelines encourage psychologists to understand the consequences of gender role development and its interactions with other social identities, such as race, ethnicity, sexual orientation, and ability, because not only women and girls but people of all genders experience sociocultural constraints related to their gender (APA, 2014a; Enns et al., 2015; Pittman, 1985; Pleck, 1995), and these processes influence the mental and physical health of people of all genders (Addis & Mahalik, 2003; Courtenay, 2000; Sierra Hernandez, Han, Oliffe, & Ogrodniczuk, 2014). Hence, the recommendation to integrate an understanding of how gender roles are produced into the practice of psychology should not be limited to working with girls and women. To advance this issue, APA developed the *Guidelines for Psychological Practice with Boys and Men* (2018) as well as the *Guidelines for Psychological Practice with Transgender and Gender Non-Conforming Clients* (2015a).

Practice Guidelines Process

Divisions 17 and 35 appointed three task force co-chairs—Sharon Lamb, Debra Mollen, and Lillian Comas-Díaz—in October 2013 to revise the set of guidelines published in 2007. The original guidelines were also drafted under the leadership of three task force co-chairs: Roberta L. Nutt, Joy K. Rice, and Carol Zerbe Enns. Implicit in this

charge was the mandate to disseminate the revisions for extensive review and submit it to APA for adoption. The three co-chairs divided the project into two overarching tasks: to examine and update the literature review sections at the beginning of the published guidelines, and to revise, as needed, the guidelines themselves and the rationale and application that followed each guideline. Those who contributed to the revisions of the guidelines, their rationale, and their application were the co-chairs in collaboration with a large number of volunteer clinicians, academics, and students. The guidelines team had five additional volunteers, including a student, clinicians, and academics (see Appendix B). Interested readers can access the extensive literature review upon request.

Selection of Evidence

Research and scholarly literature on the topic of psychological practice with girls and women is extensive and continues to increase. The brief literature review of the revised guidelines, as well as the guidelines themselves, present information about gender bias, life stresses, and mental health issues specific to girls and women with particular attention to diversity, intersectionality, and international considerations. The task force members focused primarily on peer-reviewed publications and complemented these sources with books, chapters, and psychological practice case reports that were gendered and culturally valid. Consistent with more recent practice guidelines' streamlined format, a great deal of literature review was removed from the guidelines and will be published separately as a companion piece.

Key terms within these guidelines are defined in Appendix A.

GENERAL PRACTICE WITH GIRLS AND WOMEN

For the purposes of this document, psychological practice is defined broadly to include activities related to all applied areas of psychology. Psychological practice, for the purposes of these guidelines, includes clinical practice and supervision, consultation, teaching, research, writing, work in social policy as a psychologist or on behalf of psychologists, and any of the other professional activities in which psychologists may engage as psychologists.

Guidelines for Psychological Practice with Girls and Women

GUIDELINE 1

Psychologists recognize girls' and women's strengths and resilience and work to honor and cultivate these.

Rationale

While girls and women face considerable adversities due to the effects of sexism, oppression, discrimination, and prejudice, and while the struggles they face are amplified when they are members of other marginalized groups (e.g., girls and women of color, fat girls and women, lesbian and bisexual girls and women, girls and women with disabilities, low income girls and women), girls and women are also often well equipped to confront and surmount the challenges in their lives. Specific advantages include biological, psychological, developmental, and relational strengths. There is widespread and substantial evidence, for example, that women live longer than men in nearly every society (Clark & Peck, 2012), women's immune systems respond especially well to treatment for HIV (Maskew et al., 2013), and older women are less impacted by social isolation (which also affects chronic inflammation) than older men (Yang, McClintock, Kozloski, & Li, 2013). Although girls and women exhibit higher suicide attempt rates than boys and men, boys and men are approximately 4 times more likely to die by suicide. African American girls and women have the lowest suicide completion rates of all ethnic groups in the U.S. (American Association of Suicidology, 2012). Girls enjoy more supportive friendships characterized by equality, self-disclosure, and empathy (De Goede et al., 2009), perhaps in part because they have greater expectations for friendships, value talking about problems, and self-disclose more often compared to boys (Rose et al., 2012). Girls show less sexual prejudice than boys, particularly to gay men, and they become less prejudiced toward gay men over time (Petersen & Hyde, 2010; Poteat & Anderson, 2012). Women are generally more sexually fluid throughout the lifespan (Diamond, 2008; Katz-Wise & Hyde, 2014), which may allow greater opportunities for more varied loving and/or sexual relationships.

Girls and women can become well equipped to overcome adversities in their lives and make significant contributions to society. Evidence of resilience has been identified in diverse samples, including sexually abused girls living in foster care settings (Edmond, Auslander, Elze, & Bowland, 2006), African American girls grieving the loss of a friend to homicide (Johnson, 2010), and African American girls in an urban, under-resourced environment (Trask-Tate, Cunningham, & Lang-DeGrange, 2010). Researchers have found resilience among a group of low income, HIV-positive women in Mexico (Holtz, Sowell, & Velasquez, 2012); a group of rural female senior citizens (Stark-Wroblewski et al., 2008); female survivors of a tsunami and a hurricane (Fernando & Hebert, 2011); and a largely non-White group of homeless women who had experienced considerable childhood and adult physical and sexual victimization (Huey, Fthenos, & Hryniewicz, 2013).

Application

Psychologists are encouraged to incorporate a strengths-based perspective in their work with girls and women without denying the adversities they face. They accomplish this by being especially cautious of the tendency to pathologize girls and women (see Guideline 7); employing diagnoses sparingly while considering the gendered, multicultural context of girls' and women's lives; and initiating discussions about coping mechanisms, resources, resilience, agency, and hardiness. Intersecting identities are strengths and resources for girls and women. For example, when providing treatment for girls and women who have experienced interpersonal abuse, instead of focusing only on mental health problems related to the abuse, psychologists should also strive to reflect qualities and exemplars of resilience and survivorship in their clients and to explore moments of agency even within victimization. Anger, resentment, and other similar emotions can be conceptualized and explored as signs of resiliency and engagement. Thus, psychologists are also cautioned not to ask women to move to forgive too quickly, especially when their rights have been violated (Lamb, 2006). When working with women who present with sexual problems, psychologists should also refrain from over pathologizing and medicalizing these, and instead consider contextual and cultural factors, such as fatigue resulting from competing role demands (Kaschak & Tiefer, 2002) or reliving previous sexual trauma. In the former case, psychologists can illustrate the strength required in performing multiple roles and assist clients and their partners in working toward more egalitarian domestic environments to alleviate women's fatigue. For trauma survivors, psychologists can help clients examine their sources of strength that helped them endure and work toward reclaiming their right to sexual agency. Especially with non-majority, marginalized girls and women, psychologists should make concerted efforts to identify, enumerate, cultivate, and encourage strengths in order to counteract sexist and other oppressive labels and descriptions that can demoralize or erode self-confidence. For instance, when working with a heterosexual woman who has a disability and is fat (for a discussion of our intentional use of this word, see Appendix A) and is seeking treatment for substance abuse after having her children removed from her care as a result of her substance abuse and, discriminatorily, her disability, a psychologist recognizes the strength it requires to seek treatment for substance abuse, understanding the importance of the psychologist earning the client's trust, and highlights other signs of resilience and successes in her life. These may include personal (e.g., areas of mental and physical health), relational (e.g., areas of connection, love, and empathy), cultural (e.g., sizeism, ableism, sexism), spiritual, educational, and vocational strengths. Psychologists may use a variety of therapies shown to be useful regarding addictions (e.g., motivational interviewing) but do so keeping in mind the strengths noted above. Supervision also can be strengths-based. For example, when an older African American supervisee communicates a complaint, the supervisor who is not African American might recognize the courage it takes to speak up given stereotypes about the "angry black woman" (Childs, 2005). She thus is especially cognizant of supporting the supervisee in expressing her concerns. Psychologists should be aware that while girls and women have numerous strengths on which to draw, some women may have had to assume disproportionate responsibility for coping with discrimination and oppression (Walker-Barnes, 2014) and may therefore have had to assume de facto positions of strength. When this is true, psychologists situate and

discuss such strengths within a sociocultural understanding of how they developed.

GUIDELINE 2

Psychologists strive to be aware that girls and women form their identities in contexts with multiple, contradictory, and changing messages about what it means to be female.

Rationale

Gender role socialization was one of the most powerful explanatory devices from the 1970s to 1990s when gender roles were being challenged. It refers to the process through which children learn culturally prescribed behaviors, which most often reinforces gender stereotypes (Bronstein, 2006; Bussey & Bandura, 2004) such as communal qualities of nurturance, passivity, helplessness, and preoccupation with appearance to girls and women; and agentic qualities such as assertiveness, independence, ambitiousness, and confidence to boys and men (Carothers & Reis, 2013; for the difference between proscriptive and prescriptive norms, see Prentice & Carranza, 2002). The idea of socialization may be somewhat limiting today given the postmodern influence in psychology in which different theories suggest processes other than social learning in which gender norms are conveyed and come to be instantiated in people. In spite of major changes in Western women's participation and roles in the workplace and politics, traditional gender prescriptions (and proscriptions) persist regarding femininity and heteronormativity (England, 2006), resulting in resulting in differential outcomes for men and women including health (Hartke, King, Heinemann, & Semik, 2006), performance in math and science (Tomasetto, Alparone, & Cadinu, 2011), interest in athletics (Hively & El-Alayli, 2014), and career aspirations (Fogliati & Bussey, 2014). In spite of pressure to conform to gender norms of femininity, those women who can defy gender stereotypes, who grow up to embrace feminist ideals and express moral outrage against social injustice, will do better individually and in relationships with others (Yoder, 2012; Yoder, Snell, & Tobias, 2012). Likewise, in a classic study, women who learned the sociopolitical causes of the discrimination were able to overcome the impact of the discrimination they experienced (Landrine & Klonoff, 1997).

Each girl and woman learns the discourses of gender or internalizes gender role stereotypes from her unique context that includes country and region of origin, family, neighborhood, and community and is influenced by her multiple group memberships, including socioeconomic status, race, ethnicity, body size, and ability status. Girls and women of color and those raised outside of the U.S. may especially have to integrate a complex and sometimes contradictory set of messages or ideologies related to gender: one that represents dominant White European Christian norms, and another that represents her specific sociocultural context and life experiences. Some researchers have found, for example, that Black girls' prescriptive gender roles include both communal characteristics such as nurturance and caretaking as well as agentic characteristics such as self-reliance and assertiveness (Buckley & Carter, 2005; Reid, 2002). Girls and women who were assigned male at birth, genderqueer girls and women, and other nonbinary girls and women face particular challenges, including linguistic limitations of the gender binary coupled with socially constricted expressions of gender fluidity, in navigating and crystalizing their identities (Kuvalanka, Weiner, Munroe, Goldberg, & Gardner, 2017).

Application

Psychologists strive to recognize and communicate how gender expectations come about and how stereotypes of gender may influence the overall health and well-being of girls and women in the U.S. and internationally. Psychologists endeavor to be attuned to the ways that these processes are connected to sociocultural factors, multiple and intersecting group memberships, and individual difference variables that may influence the degree to which a girl or woman internalizes societal pressure to regulate her behavior according to often inflexible gender standards. Psychologists recognize that girls and women receive competing and contradictory messages and help clients in teasing apart various proscriptions, prescriptions, and meanings. For example, for Black and Latina young women today, being sexy can mean being visible in a culture in which the predominant sexy images have been of White women or in which being sexy can mean being confident and sure of oneself (Lamb et al., 2016). However, these young women may pursue these meanings while simultaneously aware that White society can view displays of sexiness as confirmation of the stereotyped hypersexuality of Black and Latina women. Again, at the same time, the visibility that is so attractive might conform to a stereotype of heteronormative sexuality (see Appendix A) defined by men and could have degrading elements in it. In this way, the competing and contradictory messages about what is sexy and sexual for Black and Latina girls are multiplied and quite possibly confusing. A psychologist, in this example, should not only bring nuance to girls' and women's prescriptions for *acting female* and *being sexy* but also help clients explore other dimensions of their identity that may even reject social and mainstream prescriptions. In so doing, psychologists work to create identity safety for all girls and women since research has shown that contexts which recognize and affirm a broad range of identities and differences can offset threats related to negative stereotypes (Steele, Spencer, & Aronson, 2002). A strengths-based approach recognizes that talking about identity, prescriptions, and proscriptions can increase a client's identity safety and enhance the therapeutic relationship (Day-Vines et al., 2007).

GUIDELINE 3

Psychologists strive to recognize, understand, and use information about structural discrimination and legacies of oppression that continue to impact the lives and psychological well-being of girls and women.

Rationale

Discrimination is embedded in and driven by organizational, institutional, and social structures in multiple areas of society, including families and couples, language, schools, the workplace, health care systems, religious institutions, and legal systems. It can consist of exclusion, marginalization, devaluation of girls and women, and violence.

Despite advances in society, sexist discrimination persists. This discrimination manifests itself in the lived experiences of girls and women and may affect girls and women differently based on their race or ethnicity (Moradi & DeBlaere, 2010), age (Neumark, Burn, & Button, 2017), size (Puhl & Heuer, 2009), sexual identity (Friedman & Leaper, 2010), and ability status (Kavanagh et al., 2015).

Discriminatory practices can begin in grade school if not earlier, when some girls are harassed and bullied and subjected to discriminatory testing and counseling while receiving lower levels of encouragement and mentoring (Brown, 2003; Rueger & Jenkins, 2014), with compounding effects of racial identity (Cogburn, Chavous, & Griffin, 2011) and both sexual and gender identity (Mitchell, Ybarra, & Korchmaros, 2014). In the workplace, women continue to experience discrimination and sexual harassment (Brunner & Dever, 2014; Kabat-Farr & Cortina, 2014; Mainiero & Jones, 2013), creating an unsafe work environment as well as unfair hiring and promoting practices. Workplace discrimination may also be influenced by a woman's sexual identity, with workplace discrimination laws not protecting queer-identified women. Fat women experience discrimination in hiring practices because of their bodies, a particularly insidious example of the intersection of sexism and sizeism (Puhl & Heuer, 2009). Women and girls continue to experience barriers to accessing services and gaining advanced positions in religious institutions (Hill, Miller, Benson, & Handley. , 2016) and the justice system (Covington, 2007; Martin & Jurik, 2006; Pasko, 2013). In mixed-sex relationships, women continue to assume disproportionate responsibility for childcare, elder care, household management, and partner/spouse relationships (Donald, 2014). Men's violence against women, a particularly troubling form of discrimination, continues to occur at disproportionate levels and across international contexts (Bostock, Plumpton, & Pratt, 2009; Wong & Mellor, 2014; WHO, 2013). Transgender women are at a notably higher risk of violence than their cisgender counterparts (Langenderfer-Magruder, Walls, Kattari, Whitfield, & Ramos, 2016; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016), especially transgender women of color (Meyer, 2015). Finally, use of noninclusive and masculine-based language continues to be an additional systemic form of discrimination against girls and women (Johnston-Robledo, McHugh, & Chrisler, 2010).

Experiences of sexist discrimination have consistently been shown to negatively affect girls' and women's psychological health, for example by contributing to increased psychological distress (Fischer & Holz, 2010; Landry & Mercurio, 2009). Women who experience individual and group discrimination are more likely to experience depression (LaSalvia et al., 2013) and both decreased self-esteem and sense of identity (Nadal & Haynes, 2012), as they may be inclined to internalize negative cultural messages. Psychologists can help others become aware of the connection between broader societal messages and the harmful results of their internalization. Discrimination contributes more to women's negative perceptions of their psychiatric and physical symptoms than any other environmental stressor (Klonoff, Landrine, & Campbell; 2000; Moradi & Subich, 2002), with recent research confirming this finding while simultaneously highlighting the compounding effects of a lack of control and self-silencing on the relationship between sexist discrimination and decreased well-being (Fischer & Holz, 2010; Hurst & Beesley, 2013). Discrimination may also negatively affect girls' and women's physical well-being (Pascoe & Richman, 2009). Although spirituality and religion can often function as a protective, health-promoting factor (Hurlbut, Robbins, & Hoke, 2011; Jurkowski, Kurlanska, & Ramos, 2010), girls' and women's spiritual well-being may also be negatively influenced by discrimination. Discrimination from multiple identities in addition to gender identity can put girls and women in double or triple jeopardy, thus reflecting the compounding effects of discrimination (Moradi & DeBlaere, 2010). This may be particularly true for Muslim girls and women in the West (Everett et al., 2015). Women who have recently emigrated from cultures with more blatant sexism such as being submissive to men and not being allowed to pursue education, drive, travel, or make other personal choices, and to what extent women may have internalized such perspectives, can affect their experience of the Western world. Accordingly, psychologists are encouraged to understand this experience, what it is like to adjust to a different culture, and understand any biases that emerge.

Recognizing, understanding, and using this knowledge about the effects of structural discrimination and legacies of oppression on lives and psychological well-being of girls and women can enhance psychologists' efforts in their multifaceted roles.

Application

In working in their multifaceted roles with girls and women, psychologists strive to understand the impact of legacies of oppression and structural discrimination on the well-being of those with whom they work. They accomplish this by educating themselves about the forms of discrimination and legacies of oppression in the context of girls' and women's intersecting identities and within a global framework. Psychologists also engage in consciousness-raising and support resistance against oppression and activism toward change. Psychologists strive to accomplish these goals through a culturally competent and gender-affirmative lens. They endeavor to use gender-fair research results to inform their practice and use inclusive language that reflects respect for all their clients and students. As supervisors and teachers, psychologists ensure that they infuse their education

and training with information about the impact of discrimination on girls' and women's lives and ask that their supervisees attend to these issues with their clients.

Assistance from a psychologist may help women develop awareness of discriminatory experiences within, for example, the legal or educational system, and create strategies to resist or overcome the effects of those experiences. They may help clients work with systems, e.g., in obtaining equitable divorce settlements and adequate child support or equal opportunities for educational advancement and leadership. For example, while working with a young Chinese American girl who reports bullying by peers at her elementary school, the psychologist's awareness of interpersonal and structural racism, coupled with the systemic conditions that support bullying and horizontal violence, may help the girl to both stand up for herself and garner support from others, including family and friends, to change a toxic environment. When a Latina client discusses an experience of sexual harassment and blames herself, the therapist explains the law, normalizes self-blame, and challenges it by putting the client's experience in the context of greater structural inequities, explaining how self-blame is part of the mechanism of these structures to release those in power from responsibility. The therapist brings empathy to the situation in helping the client discuss whether to report the harassment, empowers the client to make her own decision about reporting or talking to the individual, supports the decision the client makes, helps the client anticipate reactions from those around her, discusses where she might get support in the workplace or at home, and also explores her stated feelings of guilt from a dynamic view, a cultural context, and/or a cognitive view (e.g., negative cognitions about female flirts). The therapist may also explore with her or his client cultural messages about women's sexuality. In these ways, psychologists engage in consciousness-raising and enact the principles of liberation psychology (Lykes & Moane, 2009) with the girls and women with whom they work, while at the same time using the common factors of psychotherapy (e.g., alliance-building, empathy, reflections) to aid them in developing the means to challenge and overcome those experiences of discrimination.

Psychologists also attend to the intersecting identities of individuals with whom they work, understanding that these identities have different legacies of oppression and privilege. For example, a psychologist may need to understand a client's dismissal from a job by acknowledging a number of discriminatory practices related to various identities intersecting with her gender. She may be a lesbian who was harassed because of her sexual identity and who may have been fired because she is a lesbian mother who missed work because of her child's illness. A U.S. Muslim woman may be fearful and/or depressed because of discriminatory statements or violence in the news toward women wearing hijabs, or about religious practices or media representations of Muslim women.

Psychologists are encouraged to acknowledge and be open to learning about legacies of oppression from their clients and initiate such discussions with an understanding that these legacies may intersect with presenting problems. Moreover, psychologists are encouraged to become knowledgeable about gender, racial, sexual orientation, elitist, ageist, and other types of microaggressions in order to avoid engaging in these behaviors within their professional roles (Nadal & Haynes, 2012). Microaggressions are "micro" alone, but over time and because of their frequency and intensity present an ongoing stress to minority women and girls. An illustration of a microaggression during the clinical hour is when the psychologist asks a Korean American girl or woman which country she is from, assuming she is foreign. This signifies a stress, however micro, in that the girl or woman is made to feel *other* in her own country. Psychologists pay attention to power dynamics and engage in educating supervisees and students about the impact of power inequities in the lives of their clients, students, and research participants.

The APA *Multicultural Guidelines for the 21st Century* (2017b) offer in-depth analysis of examples that focus on intersectionality; psychologists and the general public are referred to these.

GUIDELINE 4

Psychologists are encouraged to use interventions and approaches with girls and women that are affirmative, developmentally appropriate, gender and culturally relevant, and effective.

Rationale

Theories of psychotherapy continue to show biases that affect practice with girls and women. These include (a) overvaluing individualism and autonomy and undervaluing relational qualities, (b) overvaluing rationality instead of viewing mental health from a more holistic perspective, (c) paying inadequate attention to context and external influences on girls' and women's lives, (d) basing definitions of positive mental health on behaviors that are most consistent with masculine stereotypes or life experiences, and (e) overemphasizing certain aspects of girls' and women's lives (e.g., bullying) or depicting other aspects (e.g., mothering) in problematic ways. Approaches to mental health that have been identified as noninclusive or as containing subtle biases include humanistic (Serlin & Criswell, 2014), psychodynamic and object relations (Tummala-Narra, 2013), cognitive–behavioral therapy (Hays, 2009), and couples and family therapies (Nutt, 2013; Patterson & Sexton, 2013).

No matter the model of psychotherapy, teaching, or supervisory practice, psychologists' practice is enhanced by knowledge about the challenges, strengths, social contexts, and intersecting identities of girls and women, as well as interventions that are gender and culturally valid and associated with positive outcomes (Enns et al., 2015). Gender-valid, gender-relevant interventions are strengths-based, multidimensional approaches to treatment that acknowledge the social and cultural factors (e.g., poverty, race, gender inequality, disproportionate experiences of sexual violence) that influence women, and use this knowledge to create an environment that demonstrates an understanding of the realities of women's lives. Datchi and Ancis (2017) made recommendations for gender-relevant treatment of girls involved in the juvenile justice system, including gender-relevant treatment for girls with other diverse social and cultural identities.

Psychologists are encouraged to utilize evidenced-based or evidence-supported interventions while recognizing that such interventions may be incongruent and inapplicable for diverse populations, specifically people of color (Whaley & Davis, 2007) and women (Goldenberg, 2006), given the overrepresentation of White, young, able-bodied, verbal, intelligent, and successful clients in treatment efficacy and effectiveness studies (Carter & Goodheart, 2012; Maríñez-Lora & Atkins, 2012). Political forces may create an environment in which treatments that are gender and culturally valid for some girls and women are those lacking the political, institutional, social, and financial support to demonstrate their effectiveness and efficacy in mainstream ways (Goldenberg, 2006).

Application

Affirmative practice might be best accomplished using an integrative approach to treatment orientation that includes principles of feminist therapies, methods developed with the specific needs of diverse groups in mind, and international perspectives when appropriate (Berger, Zane, & Hwang, 2014; Brown; 2014; Enns, 2004; Enns et al., 2015; Frey, 2013; Rutherford, Capdevila, Undurti, & Palmary, 2011). Psychologists also need to attend to the varied experiences of their clients based on differing intersecting identities that may cause some inner conflict. For example, a psychologist conducting a therapy group focused on sexual identity issues for lesbian, bisexual, and queer women needs to understand that sexual minority women of color often struggle with tension between their sexual identities and their racial and ethnic identities and may feel like they must choose one identity over another, a struggle typically nonexistent for White sexual minority women (Brooks & Quina, 2009; Pachankis & Goldfried, 2013). Psychologists practice with the knowledge that some interventions for girls and women have yet to be empirically supported and are still determined to be effective. For example, psychospiritual approaches, such as those described in *Feeding Your Demons* (a Tibetan Buddhist approach; Allione, 2008) or notions of the feminine sacred, are under-researched and underfunded areas of study, yet therapists who work with these approaches report anecdotal clinical efficacy. Psychologists who undertake interventions that have not yet been tested nor are amenable to testing under traditional empirical methods do so after their own research and initially with supervision.

GUIDELINE 5

Psychologists are encouraged to reflect on their experiences with gender and on how their attitudes, beliefs, and knowledge about gender, and the way gender intersects with other identities, may affect their practice with girls and women.

Rationale

Self-awareness is recognized as an important component of psychological training. Self-awareness pertaining to attitudes and beliefs across differences related to gender, race, socioeconomic status, size, sexual orientation, age, and ability status is also critically important. Achieving self-awareness is a lifelong pursuit rather than a finite set of skills. It may require more than self-examination and include investment in activities such as continuing education, psychotherapy, and supervision. It also strengthens psychologists' ethical practice (Bowers & Bieschke, 2005; Pope, Sonne, & Holroyd, 1993).

As with all members of society, psychologists have attitudes, beliefs, and knowledge about gender that extend far beyond what training as a psychologist has provided them. There will always remain personal, familial, and culturally based beliefs and attitudes that inform relationships with people of all genders. These attitudes and beliefs are simultaneously shaped by multiple factors related to gender such as race, ethnicity, socioeconomic status, ability status, sexual orientation, physical size, age, and education (Fouad & Brown, 2000; Pedersen, 2008). Predispositions and assumptions can influence psychologists in their practice whether in providing psychotherapy or training, or in conducting research. Because implicit gender stereotypes are ubiquitous, they can affect a psychologist's perceptions of others without intent or the conscious realization that they have done so.

Female and lesbian, gay, and bisexual supervisors, as well as those supervisors who report an active commitment to feminism, are more likely to report collaborative relationships with supervisees and to address power differentials in the supervisory relationship than male and heterosexual supervisors. They are also more likely to address diversity issues in the context of supervision (Szymanski, 2005).

For nearly four decades, researchers and clinicians have addressed the notion of bias within the context of therapy. The monograph that accompanies these guidelines, for example, presents the literature on bias in diagnosis. Other research has found that therapists can express gender bias about women who express nontraditional female behaviors or hold nontraditional careers (Crosby & Sprock, 2004; Trepal, Wester, & Shuler, 2008) and about girls and women who do not conform to societal gender norms, such as vulnerability or heteronormativity (Bowers & Bieschke, 2005). This can be especially problematic given the differing gender role expectations within and between particular cultural groups (Blake, Lease, Olejnik, & Turner, 2010; Cooper, Guthrie, Brown & Metzger, 2011; Thomas, Hacker & Hoxha, 2011). Thus, psychologists have a particular responsibility to consult and consider this literature as a way to check for biases.

Finally, researchers have found that the majority of cases of sexual misconduct from a therapist to a client involve older, male therapists and younger, female clients (APA Ethics Committee, 2013; Kirkland, Kirkland, & Reaves, 2004; Pope, 2001; Pope et al., 1993). This most common profile involves a therapist engaging in a sexual boundary transgression with one client in a single incident or as a relationship that develops over time (Celenza, 2007; Celenza & Gabbard, 2002). Whether a check on entitlement, boundaries, or mental health is necessary, psychologists' self-awareness about countertransferential feelings should be included in this guideline.

Application

Psychologists endeavor to become aware of how their own personal and familial experi-

ences across their multiple identity groups influence their psychological practice with girls and women. Beyond increasing self-awareness, psychologists are encouraged to build their knowledge about racial, sexual orientation, elitist, ablest, ageist, and other types of microaggressions and how these intersect with their beliefs and attitudes about girls and women. As an example, a psychologist who is self-aware may recognize that she or he is experiencing gender bias toward her client who has decided to prioritize her career advancement by returning to work quickly following the birth of her newborn baby. This may intersect with feelings that her client, who also has a disability, may not be able to handle the stress. Her feelings about this decision may vary depending on the class and ability of the woman, and in supervision she might seek out why she feels differently in these cases. Peer or individual supervision might help this psychologist to explore the source of attitudes and beliefs that could be influencing working with this client as well as her or his own biases. By discussing these beliefs in supervision, the therapist may be less likely to unconsciously transfer, project, or displace negative feelings onto a client based on gender biases. Supervision might also suggest self-compassion and understanding about having these biases given a world that promotes negative stereotypes in subtle and overt ways. Recent thinking on optimal development recommends an approach that teaches not only self-scrutiny but also self-compassion (Germer & Neff, 2013; Neff, 2009).

Gender sensitivity training in combination with diversity training is recommended for psychologists in the form of continuing education. Research has shown that gender sensitivity and diversity training enhance therapist skills for working with girls, women, and families (Guanipa & Woolley, 2000). Psychologists might also educate themselves regarding feminist supervision approaches that attend to issues of power and include exploration of the self of the supervisee in the context of the practice.

GUIDELINE 6

Psychologists strive to foster therapeutic practice that promotes agency, critical consciousness, and expanded choices for girls and women.

Rationale

For girls and women, feeling powerless is associated with myriad physical and mental health issues, problems in relationships, and negative impacts on overall functioning. Symptoms of depression, disturbed body image and eating disorders, and dependency can emerge in a context of powerlessness (Filson, Ulloa, Runfola, & Hokoda, 2010; Peterson, Grippo, & Tantleff-Dunn, 2008). Experiences with coercion and fear of interpersonal violence (e.g., sexual assault, physical abuse) may undermine and limit girls' and women's full participation in society. They can negatively impact work performance, contribute to passivity and poor coping, and reduce self-confidence and agency (APA, 2005; Banyard, Potter, & Turner, 2011). Feelings of powerlessness and lack of self-efficacy may be compounded by other experiences relating to social class, race and ethnicity, sexual orientation, income and educational levels, physical illness, age, size, and physical ability (Pachankis & Goldfried, 2013; Potter & Banyard, 2011; Wong & Mellor, 2014).

Although there are numerous deleterious effects of trauma, not all survivors of trauma develop adverse symptomatology (Briere & Scott, 2014). In fact, across similar forms of trauma, women tend to report more post-traumatic growth than men, although the effect size is modest (Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010). Such changes often include increased empathy for others with similar histories, as well as positive changes in self-image, relationships with others, and spiritual and/or religious connection (de Castella & Simmonds, 2013; Frazier, Conlon, & Glaser, 2001). In addition, self-defense training—an empowerment-based approach—may foster women's resiliency because it enhances women's beliefs in and their actual abilities to cope and successfully defend themselves (Ullman, 2007), while decreasing vulnerability to sexual assault (Senn et al., 2015) and trauma symptoms (Brecklin & Ullman, 2005; David, Simpson, & Cotton, 2006; Gidycz & Dardis, 2014; Rozee, 2008).

Empowerment is more than an individual or internal process, as self-efficacy and self-confidence are both enhanced within relationships and systems wherein girls and women gain support and are treated justly (Bay-Cheng, 2012). Critical consciousness increases empowerment and entails being aware of social oppression and working with others to bring about social change (Freire, 1970; Kelso et al., 2014). A relational and action-oriented approach to critical consciousness and empowerment may be corrective of the negative effects of social oppression, particularly with African American women (Kelso et al., 2014). Researchers have found that African American, HIV-positive women with high critical consciousness showed less HIV disease progression; the researchers posited that critical consciousness may serve to combat the powerlessness that can result from discrimination and lead to psychological distress and poor physical health. Moreover, liberation psychology has been used effectively with transgender clients (Singh, 2016). Researchers have found that lesbians or bisexual women who suffer psychological distress in the face of political oppression, such as anti-LGB marriage amendments, find hope and display resilience through engaging in political activism (Rostosky, Riggle, Horne, Denton, & Huellemeier, 2010).

Girls' and women's activism can sometimes take the shape of giving social support. This prosocial behavior can be a major emotional resource for women and is associated with increased well-being, positive mental and physical health, increased self-confidence in abilities to cope with adversity and stressors, and improved romantic relationships (Goodman, Smyth, & Banyard, 2010; Graham & Barnow, 2013). Under some conditions, however, girls' and women's gender roles (e.g., caregiving) can also contribute to the depletion of emotional resources, decreased work productivity, fatigue, physical and mental health problems (e.g., chronic pain, depression), and a lack of self-development, independence, and personal choice (Farran, Miller, Kaufman, Donner, & Fogg, 1999; Juratovac & Zauszniewski, 2014; Morse, Shaffer, Williamson, Dooley, & Schulz, 2012). Thus, psychologists are cautioned to find expanding ways in which girls and women can come to understand giving and helping others.

Application

Psychologists are encouraged to make efforts to help women and girls develop an improved sense of initiative, resilience, and personal power and expand their non-stereotyped alternatives and choices. One example might be to encourage a girl who loves math and science to consider engineering or other nontraditional career choices. Another example might be for a therapist to address imbalances of power in intimate relationships by finding ways to increase female clients' self-worth and explore ways to increase their level of autonomy in their relationships (Filson et al., 2010). Given the research on the benefits of activism, a woman who has left a relationship in which she was abused by her partner might be encouraged to assist other women by volunteering for a hotline or working at a women's shelter. Helping women feel a sense of personal power in many areas of their lives (e.g., relationships, education, work, self-image) may allow them to resist internalizing unhealthy, oppressive societal messages that can lead to feelings of powerlessness (Peterson et al., 2008). Embracing a process that privileges neither autonomy nor communality but includes both can help women navigate recovery (Tiefer, 2014). These goals can certainly be accomplished in individual therapy, but group therapy can be a powerful tool for empowering clients, as research has shown that women participating in groups learn from other members' experiences, find new perspectives about themselves and the world, and acquire critical consciousness that allow them to make positive changes in their lives (Stang & Mittelmark, 2009). Heeding Bay-Cheng's (2012) directive that empowerment is more than just self-improvement, connecting girls and women to organizations and projects that will enable them to help others will aid in changing the systems that have oppressed them and continue to oppress other girls and women (see Guideline 10 for additional ideas).

To promote autonomy and agency, psychologists strive to foster relationships that reflect attention to gender roles, power differences, and differences in privilege between themselves and their clients, students, and supervisees in light of Guideline 3 as well. In so doing, they empower their clients, students, and supervisees through the therapy, teaching, or supervisory relationship. For example, although cognitive behavioral therapy (CBT) is an empirically supported treatment for depression, emphasizing that depressive symptoms are caused by dysfunctional cognitions could feel discounting and unhelpful to a low income, single mother who has no stable housing for herself and her children (Goodman et al., 2010). This client might benefit more from therapy if her psychologist validated her difficult circumstances and the systemic forces that contribute to it. At the same time, the psychologist would attend to all the personal, relational, and physical factors known to contribute to ongoing depression and not reduce the depression to merely an outcome of circumstances. Instead of adopting an expert stance, the psychologist may better serve clients as an ally collaborating with the client to meet the client's needs (Goodman et al., 2010). The psychologist might also share research findings about the effectiveness of CBT and other approaches used and discuss their limitations. Psychologists who give the client a choice of strategies contribute to empowerment. Clients who see their therapist more as an equal and who are less dependent and more secure in their own agency may have better therapy outcomes (McElvaney & Timulak, 2013).

Consent also empowers clients. APA's (2010) Ethical Principles of Psychologists and Code of Conduct requires that psychologists practice informed consent, which includes open discussions of several important issues (e.g., the psychologist's approach to treatment and supervision, understanding of the problem, course of treatment, alternative options, fees and payment, accessibility, and after-hours availability; see also Feminist Therapy Institute, 2000). Such transparency conveys respect for the decision-making capacity and personal agency of girls and women. It also empowers girls and women by providing the information needed to make educated decisions regarding therapy, education, and personal and career choices.

GUIDELINE 7

Psychologists strive to assign diagnoses to girls and women only if and when diagnosis is necessary, use unbiased assessment tools, and bring to bear an understanding of the history of misuses and gender biases and diagnoses and assessment.

Rationale

Psychologists have identified gender bias in the following areas of assessment and diagnosis: clinical judgment, theoretical foundations of assessment, diagnostic processes, psychological assessment measures, and the conceptualization of developmental experiences (Ali, Caplan & Fagnant, 2010). Many psychologists have criticized the increasingly biological nature of theories of psychopathology, the expansion of both the number of diagnostic categories and their boundaries, and the selective identification of distress as pathological or nonpathological depending on its degree of fit with cultural stereotype or expectation (Angell, 2004; Kirschner, 2013). Others have cautioned against diagnostic systems that overemphasize a narrow, unrealistic view of pathology and underemphasize lived experience and contexts that inform distress (Andreasen, 2007; Bluhm, 2011; Hornstein, 2013; Kirschner, 2013). Given that diagnoses in *DSM-5* (American Psychiatric Association, 2013) are not differentiated based on the source of distress (i.e., psychological, environmental, from other sources, or from a combination of sources), individuals' contexts, their identities, their experiences of oppression and its impact on distress, all factors need to consideration and integration in a psychologist's work (Enns et al., 2015).

The literature review on diagnosis, found in the accompanying monograph to these guidelines, shows that many specific diagnoses have been problematically applied to women and/or girls, including but not limited to histrionic and borderline personality disorders, without consideration of critical contextual factors. Experiencing events punctuated by high levels of betrayal and trauma, for example, are associated with characteristics of borderline personal-

ity disorder (Kaehler & Freyd, 2012; Sauer, Arens, Stopsack, Spitzer, & Barnow, 2014). Along with poverty, race and ethnicity increase the likelihood of being diagnosed with certain disorders, such as schizophrenia among African American women compared with White women. The diagnosis of gender dysphoria (previously gender identity disorder) has spurred debate about the role of diagnostic systems in reinforcing certain notions of gender (Sennott, 2011).

Psychologists assess girls and women for a variety of reasons beyond diagnosing. Forensic psychologists assess for the courts in matters such as competency, custody, and criminal responsibility. Other psychologists assess in order to provide feedback to employers, agencies, treatment centers, and clients themselves. Assessment can but does not necessarily include testing. Many psychologists perform an assessment to understand their clients better and inform their treatment. To this end, there are several ways of performing assessments that look at girls and women in context. Multicultural assessment that uses a process-oriented approach including tools such as cultural genograms may be particularly useful in work with girls and women as they emphasize assessment of various contexts, such as ethnocultural heritage (Comas-Díaz, 2012).

Some tests used to assess girls and women have been normed on populations that include girls and/or women as well as populations that match the race and/or ethnicity of the clients. Psychologists also need to be aware of bias in testing. Individual tests that are constructed to be "gender neutral" might mask differences at the extremes of scales, and "gender-based norms" might invite sexist interpretations (Baker & Mason, 2010). On the other hand, when *MMPI-2-RF* (Ben-Porath & Tellegen, 2008) was released, not using gender-based normative comparisons, there was critique of this approach (Butcher & Williams, 2009). They state that some women score significantly higher on the D scale (depression) and the Fake Bad Scale (FBS) and that using non-gendered T scores could result in biases. With regard to the FBS, the gender differences in response may not reflect actual faking and may instead reflect greater symptomatology in women with disabilities and physical illnesses, and those exposed to highly traumatic situations (Butcher, Gass, Cumella, Kally, & Williams, 2008). Psychologists are cautioned to find research on gender differences in various assessment tools before relying on tests that use non-gendered scoring.

Regarding standardized clinical scales pertaining to gender (e.g., Scale 5 on the MMPI-2), there has been criticism (Marin and Finn, 2010) suggesting that they caricature gender roles, see gender as dichotomous and unchanging, and show little correlation with gender identity or gender role–related behavior. (Woo & Oei, 2007) In assessing girls and women, psychologists should also be aware of the history of achievement tests favoring boys over girls and men over women through language and examples that favor experiences more familiar to boys and men (Le, 2000). Psychologists should also be aware that there are biases regarding the reference norms the client uses in responding to various questions. For example, for questions that ask a person to compare herself to other people, women often compare themselves to a generic male rather than to other women (Deaux & LaFrance, 1998). Certain scales had been originally produced to define a construct in men, and then later used to assess women (Schmidt, McKinnon, Chattha, & Brownlee, 2006). It is also important to note that while normative samples may be comparable to the U.S. population and provide norms for the "average American," the average American is often assumed to be White; as such, it may be inappropriate to apply these to African Americans, Asian Americans, Latino(a)s, indigenous individuals, or people of other non-White racial and ethnic groups.

Application

Psychologists, therefore, strive to diagnose by considering multiple relevant aspects of the experiences of girls and women and with an awareness of the biases inherent in the diagnoses themselves. Psychologists should include questions about life and developmental experiences in diagnostic interviews as well as questions about identity, group membership, social support systems, health, and abuse and traumatization. In applying or avoiding diagnoses, psychologists should take into consideration poverty and economic inequality as contextual factors influencing symptoms, as they influence the incidence of depression among women (Watson, Roberts, & Saunders, 2012). Psychologists also should be cognizant of ways in which diagnoses may help or hinder treatment and how they may unintentionally support stereotypes of girls and women through injudiciously applying certain diagnoses. They are also encouraged to describe the process of diagnosis in detail to their clients as well as problems inherent in the process of diagnosing, and share with their clients why they have chosen certain diagnoses over others. Psychologists are encouraged to include in their assessment ways to collect data on the strengths of girls and women, their coping capacities, and their past accomplishments.

Psychologists are also aware of other stigmatizing labels that appear through assessment. For instance, a personal communication from a psychologist told of an African American post-menopausal woman whom he referred to a new internist for a checkup and was told by her doctor, a White man in his mid-30s, that she had to make lifestyle changes because she was *obese*. The woman replied that she preferred to be told that she was fat instead of obese. When the doctor replied that obese was a medical term, the woman stated that obese sounded like *beast* to her. She reiterated she preferred the term fat instead of obese when he referred to her. Thus, the patient experienced this difference in communication as a microaggression. The psychologist, upon hearing this client's story, acknowledges the stigmatizing label, validates the woman's feelings of being disregarded and insulted, and shares resources and information with other professionals about sizeism and its intersections with other identities.

Psychologists strive to make unbiased, appropriate assessments by using several methods and multiple instruments that have been shown to be valid and reliable and which have included girls and women in the populations that established norms. When using tests, psychologists familiarize themselves with the normative samples on which the norms for various tests were produced. Psychologists also strive to integrate testing results with multiple relevant aspects of the experiences of girls and women and with an awareness of the biases inherent in the tests themselves. Psychologists are urged to seek

out research that presents new normative data for older tests (e.g., the R-PAS international data set for the Rorschach) and that examines the validity of certain tests with a variety of populations.

GUIDELINE 8

Psychologists strive to understand girls and women in their sociopolitical and geopolitical contexts.

Rationale

There is a full range of familial, sociopolitical, and geopolitical factors necessary for the contextualization of girls and women (Tummala-Narra & Kaschack, 2013). Oppressive circumstances, structural inequalities, and power differentials may hasten and sustain problems for girls and women, limit their agency, and/or blame them for their problems. For example, it is normative among certain cultural contexts, such as in some immigrant populations and conservative religious traditions, for women to tolerate domestic abuse as a survivalist mechanism due to sociopolitical pressures (Tummala-Narra & Kaschack, 2013). Fear of deportation may prevent immigrant women in the process of applying for U.S. residency from reporting partner abuse.

Girls and women around the world are subjected to oppression and abuse. Many are victims of familial and interpersonal violence, sex trafficking, sexual violence, maternal mortality, female infanticide, acid attacks, and other forms of *gendercide*, the daily slaughter of girls worldwide that in a decade kills more girls and women than all of the 20th century's genocides (Kristof & WuDunn, 2009). Moreover, it is normative in some cultural contexts for women to be physically coerced into marriage. Psychologists' perceptions of the social status, cultural identities, and sociopolitical status of girls and women, as well as their own unexamined worldviews, personal biases, internalized privilege, and cultural identities, may affect their assessment of the psychological functioning of girls and women.

National human rights policies, state and federal laws (e.g., immigration laws, marriage equality), international relations policies, and other geopolitical factors influence girls' and women's well-being (Enns et al., 2015). Girls' and women's life satisfaction differs by sociopolitical and geopolitical context and by cultural definitions of life satisfaction. Life satisfaction is highest among nations typified by gender equality (Crompton & Lyonette, 2005; Tesch-Roömer, Motel-Klingebiel, & Tomasik, 2008), as well as care for human rights, political freedom, acceptance of diversity, and access to knowledge. Developmental life stages, including the stage precipitated by immigration, must be considered regarding well-being.

Application

Psychologists strive to integrate sociopolitical and geopolitical factors such as national origin, immigration/acculturation, legal status, and other contextual information into their psychological conceptualizations and interventions of girls and women in their families. For instance, while working with an immigrant girl who is respectful of her father and wanting to contribute to the family income, a psychologist might worry about her working long hours for her family's business and whether it interferes with her schooling. Psychologists engage the girl and/or family with a consideration of the intersection of gender expectations and cultural and sociopolitical contexts (Tummala-Narra & Kaschack, 2013). In the U.S., considering changing immigration laws, psychologists need to bear in mind the additional stress of their clients regarding their own and family members' legal status, and the way in which changing laws and hate speech create confusion and fear, whether realistic or not. In working with girls and women from countries at war, psychologists can reframe fear as a mechanism of survival. They need to assess the existence of trauma—particularly gender-based trauma, as raping girls and women is a common weapon in war (Kristen & Yohani, 2010)—and if possible, initiate trauma work. However, psychologists should also bear in mind when treatment may pose safety hazards for their clients and understand their clients' adaptations and reactions to lack of safety. When working with refugees, therapists must assess for experiences of loss, violence, and rape specific to women that may have been part of the experience in refugee camps or in fleeing one's country of origin. Psychologists must also be mindful of grief reactions and take particular care not to pathologize these nor impose time limits for presumed appropriate grief.

GUIDELINE 9

Psychologists strive to be knowledgeable about, use, and provide support for relevant mental health, education, and community resources and, when indicated, folk, indigenous, and complementary or alternative forms of healing for girls and women.

Rationale

The APA ethics code's (2010) principle of fidelity and responsibility states: "Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work" (p. 3). Gaining information about the availability of community resources has also been identified as a culturally and socio-politically relevant factor for culturally competent work with girls and women in consideration of all their intersecting identities. Acknowledging and using a range of healing practices encourages psychologists to meet the unique needs of the girls and women with whom they work based on their worldview and perspective of holistic health (Brown, 2009; Iwasaki & Byrd, 2010). These forms of healing should be applied using an international perspective to help attend to the lived experience of girls and women (Rutherford et al., 2011).

Complex psychological problems with multiple causes might be best addressed by collaborative approaches that draw on personal, interpersonal, educational, spiritual, trauma-informed, and community resources. Community-based, culturally competent, collaborative systems of care can complement and enhance therapeutic, educational, and research efforts, although psychologists are cautioned to exercise particular care when using practices that have not been vetted through traditional empirical

research. These resources include, though are not limited to, women's support and consciousness-raising groups; women's centers, shelters, and safe houses; psychoeducational experiences for girls and women; work/training experiences; spiritual and faith-based communities; and public assistance resources. Further, alternative forms of healing and complementary and alternative medicine can facilitate wellness (Comas-Díaz, 2013; National Center for Complementary and Alternative Medicine, n.d.). These include modalities such as art therapy (Pretorius & Pfeifer, 2010), wilderness therapy (McBride & Korell, 2005), dance/movement therapy (DuBose, 2001; Malkina-Pykh, 2012; Meekums, Vaverniece, Majore-Dusele, & Rasnacs, 2012), religion (Barrera, Zeno, Bush, Barber, & Stanley, 2012; Comas-Díaz, 2006), and music therapy (Rüütel, Ratnik, Tamm, & Zilensk, 2004).

Many alternative and complementary approaches to treatment have demonstrated efficacy. Dance and movement therapy have been shown to be effective in supporting girls and women with eating disorders (DuBose, 2001), and wilderness therapy has been shown to be an effective approach to helping female survivors heal from trauma (McBride & Korell, 2005). Further, a study of effective treatment methods for female survivors of intimate partner violence found that alternative healing approaches such as prayer, meditation, yoga, other mindfulness practices, and art therapy in a group format contributed to decreased symptoms of post-traumatic stress for the participants (Allen & Wozniak, 2011).

Overall, when psychologists use and provide support for these alternative and indigenous forms of treatment, they can promote healing in a way that attends to the unique, intersecting identities of the girls and women with whom they work in their multifaceted roles.

Application

Psychologists educate themselves about community resources and alternative forms of healing that can enhance the work they do in their multiple roles. They accomplish this goal by seeking out not only evidence-based practice in alternative healing but also community resources and indigenous forms of healing. Psychologists remain open to alternative forms of healing that may have not yet been researched or may not yield themselves to typical effectiveness studies, while ensuring they do not practice beyond the scope of their psychology practice training, instead collaborating with and/or referring girls and women to other professionals and healers when indicated. When psychologists receive training in alternative forms of healing, they are clear with clients regarding the evidence of its effectiveness and describe their training as per the APA's ethics code (2010).

Psychologists recognize that healing occurs both within and outside their offices. Psychologists consult with other professionals who have expertise about alternative forms of healing that can support the girls and women with whom they work in all capacities, including but not limited to clients, students, and supervisees. When relevant, they may seek out opportunities to work with a trusted and recognized leader or healer in a community as a form of co-therapist (Hays, 2009). Likewise, psychologists encourage women's supportive relationships such as *sisters of the heart, sister/friends, hermanas del alma, comadres*, and others (Comas-Díaz & Weiner, 2013; Comas-Díaz & Weiner, 2014).

One example of the application of this guideline follows. A White supervisor visits her White student at her student's internship site, a treatment center serving Native Americans on tribal land in the U.S. Southwest, for an evaluation. Before providing supervision, the supervisor researches the culture and finds that the people who live on this land are markedly private and do not share much about their culture, choosing to transmit their history orally among themselves for religious reasons. Language, oral history, religion, and secular government are all closely intertwined in this culture, and regardless of how much information is researched, the meaningful core of the culture may not have been shared with anthropologists or others writing about the people. In order to be an effective supervisor, the supervisor should do her homework first, which should minimally include review of the history of exploitation and genocide of many tribes since first contact and the particular suffering of girls and women. There may be literature, in general, about gender, relationships, and power and intimacy between women and men. The supervisor can ask her supervisee to consult with the members who work in her clinic and ask them about the best way for the supervisor to come to the clinic and land so as not to infringe on tribal practices, which could be experienced as a lack of respect. While there, the supervisor spends time participating in rituals, when invited, that the clinic has devised in an effort to combine treatment with cultural practices. She also takes a tour of the tribal areas of significance when offered. She discusses with her supervisee the issues that have emerged for her regarding her status as a White woman treating Native women and how she might invite discussion about these differences and similarities in a group she leads. She invites her supervisee to research *colonial trauma response*, which is "a constellation of characteristics associated with massive cumulative group trauma across generations" (Brave Heart, 1999) and to apply this to the particularities of being a Native American woman who may have experienced gender-related violence as well. While the clinic staff does treat clients with substance abuse disorders, the supervisor proactively cautions her supervisee not to define individuals by this disorder and to understand that there is considerable negative stereotyping about Native Americans and alcohol that is contradicted by scholarship; for example, total abstinence rates exceed the general population and rates of use are similar (Cunningham, Solomon, & Muramoto, 2015). She finally discusses with her supervisee how extant, evidence-based substance abuse treatment strategies complement or need to be adapted to work effectively within this culture and with women who have endured ongoing grief, "soul wounds" (Duran, 2006), and quite possibly gender-related trauma as well.

Psychologists are also encouraged to develop a list of current resources on financial, legal, parenting, aging, reproductive health, religious and/or spiritual, professional, social service providers, and other organizations relevant to the needs and experiences of girls and women, as well as to the needs of boys and men for whom women so often provide care. Many colleges and universities maintain onsite resources to help increase women's knowl-

edge of supportive resources in the community and help women develop a sense of agency to make positive changes in their lives (e.g., re-entry centers to provide educational and employment resources for women), which psychologists could encourage the women with whom they work to utilize. A psychologist working with a woman who identifies as queer or lesbian who may be struggling with a conflict with a disapproving religious community can provide resources of affirming religious institutions or affirming religious support groups in the community.

Psychologists may also maintain lists of online resources to assist in identifying and evaluating electronic- or web-based information and support structures, such as social media and discussion boards, as potential resources for girls and women. In their role as supervisors, psychologists can inform their supervisees about community resources and alternative forms of healing for their own well-being as well as for consideration in their own work with clients. In this way, psychologists promote growth and healing at multiple levels and facilitate healing based on their clients' worldview.

Finally, when appropriate, psychologists are encouraged to collaborate with, consult with, and/or refer their female clients, students, or supervisees to other healers and resources in their community. Psychologists recognize that the scope of providing psychological services may be enhanced when they consult with other healers and resources in their communities and acknowledge the particular needs of girls and women in an international context. They may also obtain further training themselves in areas such as dance and art therapy, spiritual approaches, and other complementary approaches to psychotherapy.

GUIDELINE 10

Psychologists engage in work to change hostile environments and institutional, systemic, and global discrimination that interfere with the health and well-being of girls and women.

Rationale

Systemic injustice continues to diminish the well-being of girls and women. Psychologists work to improve the status and welfare of girls and women and promote a more egalitarian society by engaging in a multitude of prevention, education, and social policy activities. As directed by the APA's ethics code (2010), 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" (p. 4). In addition, beyond their own practice, psychologists "seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons" (p. 3). This injunction clearly guides psychologists to pursue a commitment to social change and justice within health, mental health, political, religious, familial, neighborhood, economic, legal, educational, and societal institutions, a view consistent with many leading psychologists and organizations (Brabeck & Ting, 2000; Enns & Williams, 2012; Feminist Therapy Institute, 2000; Johnson, Barnett, Elman, Forrest, & Kaslow, 2012; Rodríguez & Bates, 2012). The need to establish institutional climates that reflect advocacy, diversity, and support at all levels are also reflected in the APA's guidelines for lesbian, gay, and bisexual clients (2012b), multicultural guidelines (2017b), and guidelines for people with disabilities (2012a).

Recognizing that global well-being and prosperity requires advancing the status of women worldwide, the United Nations, through its Commission on the Status of Women, has developed a list of global priorities (United Nations, 1995, 2017). They include economic, social, political, gender-role, and workforce equity and the cessation of physical and sexual violence against girls and women. Examples of organized efforts to influence public policy within psychology have included APA task forces on male violence against women (Gracia, 2014; Koss, 1993), violence within the family (APA, 1996), women and poverty (Chin, Lott, Rice & Sanchez-Hucles, 2007; Heppner & O'Brien, 2006), and the sexualization of girls (APA, 2007).

Application

Psychologists are encouraged to participate in advocacy, prevention, education, and social policy as forms of psychological practice that improve the mental health and lives of girls and women. Opportunities to participate in such activities occur at local, county, state, national, and international levels. The nature and extent of psychologists' participation is likely to be influenced by their expertise, interests, spheres of influence, and the focus of their psychological practice (e.g., teaching, psychotherapy, research, consultation).

Psychologists are encouraged to advocate for unbiased, nondiscriminatory, and health-promoting practices for clients, students, supervisees, and colleagues within the institutions and agencies in which they work. For example, when working with girls and adolescents in school systems, psychologists should become knowledgeable about the prevalence of sexual and racial harassment (Bucchianeri, Eisenberg, & Neumark-Sztainer, 2013) and homophobic name-calling (Rinehart, Doshi, & Espelage, 2014) and work with teachers, administrators, students, and victims to raise awareness, create a more supportive and respectful climate, and develop enforceable effective policies. They may also contribute their expertise in these settings by promoting leadership opportunities, helping develop nonsexist materials, and monitoring how testing meets the needs of girls and adolescents, while ensuring such testing is racially and ethnically unbiased. When working in school-based mental health clinics in areas where students are impacted by poverty and neighborhood violence, psychologists may advocate in the community for their clients' social and safety needs in addition to addressing their therapeutic needs. Psychologists may also address the consequences of unequal power dynamics, questioning agency policies or colleagues' practices that appear biased toward clients, students, or supervisees, or by assisting clients who are intervening on their own

behalf. For example, psychologists seek ways for their agencies to better serve immigrant girls and women, both culturally and linguistically, while also cautioning against supervisees or colleagues of color serving as de facto translators for the organization. They also seek the adoption of treatment practices that ensure that the particular experiences of immigrant and refugee women, including sexual trauma, witnessing violence, grief and loss, economic discrimination, and intimate partner violence are identified and addressed.

When facing discriminatory worldviews or abusive practices, psychologists can provide interventions and collaborate with legal systems to establish standards of practice and public education for cases involving abuse of girls, intimate partner violence, economic discrimination, work exploitation, sexual harassment, sexual trafficking, hate crimes, or other victimizations of girls, women, and others.

In public policy, psychologists are encouraged to apply psychological research findings to major social issues, such as family leave, work–family interface, poverty, discrimination, homelessness, foster care, intimate partner violence, affirmative action policies, the effects of trauma, services for older adults, and media depictions of girls and women.

At a minimum, academic psychologists incorporate diversity and social justice issues in lectures and presentations and may go on to conduct research that considers the problems of individual girls and women in social contexts. Psychotherapists, school psychologists, consultants, and other psychologists may provide pro bono services and consultation to community organizations and work within organizational contexts and with other constituent groups to ensure effective service provision and increase access to psychological practice in its many forms.

Finally, psychologists are also encouraged to support their clients' contributions to positive microlevel and/or macrolevel actions that increase a sense of their own or other girls' and women's empowerment. At the macro level, these activities may involve helping at the state, regional, national, or international level to change policies related to women's issues and the lives of girls such as rape, intimate partner violence, pornography, sexual harassment, pay inequity, trafficking, and media objectification. At the micro level, the activities a psychologist may support could include naming sexism or the intersection of sexism with other -isms in a classroom or among friends, or stepping in rather than bystanding in situations where a girl or woman is at risk. When psychologists support their students, supervisees, and clients to address injustice or promote social justice related to women's issues, they contribute to the overall well-being of girls and women.

Conclusion

These practice guidelines, applying as they do to half the population, cannot be considered complete. They must be considered alongside other practice guidelines of the APA, particularly the multicultural guidelines (APA, 2017b), the guidelines for PTSD in adults (APA, 2017a), the guidelines for persons with disabilities (APA, 2012a), the guidelines for lesbian, gay, and bisexual clients (APA, 2011), and the recent guidelines for transgender and gender-nonconforming clients (APA, 2015a). In spite of the acknowledged limitation of the incompleteness of this revision, these guidelines help direct psychologists in their work with girls and women by encouraging them to be wary of diagnosis, focus on strengths and resilience, consider the social and situational factors that disrupt their well-being and normal coping, and serve as advocates and catalysts for change for their clients, supervisees, students, organizations, and local and global communities.

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APPENDIX

Definitions

Since the 1970s and until recently, the term *sex* has been used to refer to biological aspects of being male or female, and *gender* to psychological, social, and cultural experiences and characteristics associated with the biological aspects of being female or male (Unger, 1979). This differentiation was made to show that a person's sex assignment does not have a fixed meaning but rather one impacted by history, culture, and social circumstances (Magnusson & Marecek, 2012). Gender theorists have disputed the two-sex model (Fausto-Sterling, 2000) and anthropologists have identified social groups that use more than two sex categories (Magnusson & Marecek, 2012; Markus, 2008). *Gender-related attitudes* are often embedded in complex and unconscious beliefs that are shaped and reinforced by social interactions, institutional practices, and power structures in society (Bem, 1993). This document uses the term *gender* to refer primarily to the social experiences and expectations associated with being identified or identifying oneself as a girl or woman.

Gender bias is a construct that frequently occurs in psychological literature to refer to beliefs, attitudes, and/or predispositions that involve preconceived and stereotypical ideas about the roles, abilities, and characteristics of women and men. Gender bias is modified by and intersects with biases related to race, ethnicity, class, culture, age, ability, size, and sexual orientation (APA, 2010; Caplan & Cosgrove, 2004; De Barona & Dutton, 1997; Fikkan & Rothblum, 2012; Hall & Greene, 2003; Hartung & Widiger, 1998; Marecek, 2001; Ratey & Johnson, 1997; Ross, Frances, & Widiger, 1997). While it is impossible to live in a gendered culture without gender bias, psychologists need to cultivate a consistent awareness of these biases in themselves and the lives of the people with whom they work.

INTERSECTING IDENTITIES

The term *intersectionality* was coined by a Black feminist theorist (Crenshaw, 1991) and explored recently by psychologists (Cole, 2009; Shields, 2008; Warner & Shields, 2013). Identities are differentially formed, evolved, and claimed, and one's gender identity impacts and is impacted by one's race, ethnicity, physical and mental ability, culture, geographic location, sexual orientation, class, age, body size, religious affiliation, acculturation status, socioeconomic status, and other sociodemographic and personal attributes and variables. These other categories also have variable meanings based on gender.

Ethnicity refers to a group identity that may differ in terms of language, traditions, immigration history, and religious practice (Markus, 2008); however, ethnic groupings change over time as does the concept of ethnicity itself (Peterson & Ahlund, 2007; Smedley & Smedley, 2005). *Ethnic group* is a phrase often used to describe non-White people, a manifestation of White privilege such that White people are typically taught to see themselves as lacking an ethnic group and to envision themselves as typical or normative (McIntosh, 2014).

Fat is used as a descriptor of one's physical size. Heeding scholars such as Lee and Pausé (2016) and McHugh and Kasardo (2012), the term *fat* is used rather than those that suggest pathology such as *overweight*, which "implies that there is a correct weight," and *obese*, which "denotes a medical condition" (Abakoui & Simmons, 2010, p. 317). *We recognize that fat has been used as an insult and pejorative word, a form of oppression in itself. But language evolves, and current thinkers argue that words such as overweight and obese carry with them their own medicalizing and marginalizing effects. These scholars have advocated for a reclaiming of the word fat, much like the word* queer *was reclaimed, to free women and girls from body shame.*

Sexualities and Heteronormativity. Psychologists today understand that heterosexuality is not the only legitimate sexuality and that it has been defined in a way that prioritizes men's interests (Magnusson & Marecek, 2012; Tiefer, 1991). There is diversity, however, of human sexual practices, meanings, and identities across history, time, and location where more than two sexes are recognized and sexual practices are broader and more fluid than traditional heterosexual practices. *Heteronormativity* is the assumption that everyone is, or should be, heterosexual (Kitzinger, 2001). *Sexual objectification* is a process through which women's bodies are perceived as objects and valued for their use by others (Szymanski, Moffitt, & Carr, 2011), and one that impacts women's sexuality.

For the purposes of this document, the terms *transgender, gender variant, gender nonconforming,* and/or *assigned male at birth* have been used. It is acknowledged, however, that women use these and a variety of other identity terms to describe their gender expression or presentation. Moreover, it is probable that as the guidelines age over the next 10 years, these terms will change also and will need updating.

The term *microaggression* was first coined by psychiatrist Chester Pierce in the 1970s (Sue & Rivera, 2010). In 2004, it was revived as part of the concept of *aversive racism,* which described people of privilege and in particular well-intentioned White people who consciously believe in equality but unconsciously act in a racist manner (Dovidio & Gaertner, 2004). Microaggressions can occur against people of any marginalized identity. Racial microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color" (Sue et al., 2007, p. 273).

Oppression includes discrimination against and/or the systematic denial of resources to members of groups who are identified as different, inferior, or less deserving than others. Oppression is most frequently experienced by individuals with marginalized social identities. Oppression is manifested in blatant and subtle discrimination such as racism, ageism, sexism, and heterosexism, and it results in powerlessness or limited access to social power (Burnette & Hefflinger, 2017; Comas-Díaz & Bryant-Davis, 2016; Watson, DeBlaere, Langrehr, Zelaya, & Flores, 2016). By contrast, *privilege* refers to sources of social status, power, and institutionalized advantage experienced by individuals by virtue of their culturally valued social identities (McIntosh, 2014).

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